

Appendix C

An Analysis of Reform Options Developed by Other States

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June 2005

Executive Summary

This paper summarizes some of the issues and options in health insurance coverage, and lists some 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. Various initiatives are identified and examined with examples given for particular states. Case studies of five states are presented to examine the methods they have used to extend coverage. The states examined are Maine, Florida, Arkansas, Colorado and Minnesota. These states all have different programs and varying rates of uninsurance, with Minnesota the lowest rate in the nation. We conclude with some options that may work in Texas. Since Texas has the highest uninsurance rate in the nation, multiple initiatives will likely be needed to address the problem. These could include reforms to public programs like Medicaid and SCHIP, changes to insurance regulation (such as rate-setting and allowing the self-employed to buy into group plans), and more revenue for the Texas high-risk pool to subsidize a larger percentage of the premiums so more people can afford this option.

Introduction

Various states in the U.S. 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 structure (some states have significantly more elderly persons who are eligible for Medicare). De-linking Medicaid from welfare in the 1980s opened up the possibility for some states to be expansive about coverage. Washington and Minnesota were two states that greatly expanded coverage to poor children and their parents, while Massachusetts sought to follow Hawaii's lead and to mandate that virtually all employers provide coverage (although in the Massachusetts' case it was "pay or play"). The Massachusetts mandate did not survive nor did an ambitious plan in Vermont. Nonetheless, with the relative prosperity of the 1990s and some of the impact of HIPAA (the Health Insurance Portability and Accountability Act of 1996) that required the development of either high risk pools or guaranteed issue and the incentives afforded to states to expand children's coverage through SCHIP, a number of states were able to push their uninsured rates near or less than 10 percent.

Encouraged by these low rates, Congress funded a number of states to study how they might drive the uninsured population even lower. Although the initial focus was on states with high coverage rates, State Planning Grants were also given to some of the states with high numbers of uninsured, such as Texas. At the same time the economic slow-down since 2000 has had an impact on a number of states and led to cutbacks in SCHIP and Medicaid, as well as in some of the more innovative partnerships developed with private insurers and providers.

Issues and Options for Extending Coverage

States have adopted a number of strategies in recent years to attempt to extend or guarantee health insurance coverage to those who cannot otherwise obtain it for various reasons. These include the following options. Note that HIPAA requires guaranteed issue of group coverage and guaranteed renewal of individual coverage, but does not address insurer's rating practices or the cost of insurance.¹⁹¹ 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, and they are also subject to outside factors in the larger political and economic climate that affect industries, employment, and insurance .

Developing premium assistance programs for employees or dependents through SCHIP and Medicaid that reimburse eligible employees for premiums paid for private coverage that substitutes in part for SCHIP or Medicaid coverage. Six states currently have a 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 the private plan would be more cost-effective than enrolling them in SCHIP.¹⁹² Ten states, including Texas, have Medicaid HIPP (Health Insurance Premium Payment) programs. These programs are employer buy-in programs for Medicaid-eligible people with access to employer-sponsored insurance and pay for premiums, coinsurance and deductibles when proven cost-effective for the state.¹⁹³

Allowing families who do not qualify 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 by paying the full premiums with no state subsidy.¹⁹⁴

Establishing reinsurance pools to partially subsidize small group insurance coverage or improve individual access to coverage. Reinsurance pools assume a portion of insurers' high-cost claims for individuals and/or groups, as well as help to stabilize the market, sometimes by subsidizing health insurance for small groups or low-income workers. 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.¹⁹⁵ The Texas Department of Insurance recently recommended that Texas' reinsurance pool be phased out, as mentioned in the section on Texas below.

Passing legislation that permits the sale of limited-benefits policies that exclude a number of state-mandated benefits. This lets insurers and thus employers offer lower-cost insurance, though it does not cover all care that might be needed. The plans exclude some benefits and have high deductibles, limits on the number of doctor visits, and/or annual caps, so 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-benefits policies, also called consumer-choice plans, to small groups, including Colorado, Florida,

Minnesota, and Texas.¹⁹⁶ Texas law requires that all insurers that offer small-group coverage also offer limited-benefits policies — 41 in Texas. As of December 31, 2004, these plans had 14,000 enrollees in Texas, including 4,000 who were previously uninsured.¹⁹⁷

Implementing pared-down benefit packages for Medicaid or SCHIP expansion populations under HIFA (Health Insurance Flexibility and Accountability) waivers. This approach is being further refined by the U.S. Department of Health and Human Services and HHS Secretary Mike Leavitt. See the section on Utah in the next part for more information on how that state increased coverage while decreasing benefits for some beneficiaries.

Allowing 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) than each group member could get individually. There are several different types of group purchasing arrangements, including association health plans (AHPs), employer alliances or health insurance purchasing coalitions (HIPCAs), and multiple employer welfare arrangements (MEWAs). The pools can be run by a state agency or established by individuals or employers, and may be for-profit or not-for-profit.¹⁹⁸ It is difficult to determine the exact numbers of these pools since there are different types and they do not all have to register with any one authority. Texas used to have a state purchasing pool, and currently has several private pools. One example of a private pool is the Austin Chamber of Commerce, which announced in June 2005 that it was developing a pool for its small-business members in the Austin area. Small employers generally express interest in purchasing pools, but insurers are often not interested in working with them.¹⁹⁹ Such pools generally become unaffordable over time due to adverse selection.

Establishing 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 to subsidize high-risk pools comes from government revenue or assessments on insurers. Premiums are generally higher than similar coverage would be in the individual market. Thirty-two states operate high-risk pools, including Texas, Arkansas, Colorado, Florida, and Minnesota.²⁰⁰ More information on some of these pools is contained in the profiles of individual states below.

Establishing mandates for employers to provide health insurance. Hawaii is the only state with an employer mandate currently in force. It was enacted in 1974, and although somewhat similar mandates were passed in Massachusetts, Oregon, and Washington in the 1980s and early 1990s, none was implemented for various reasons.²⁰¹ An employer mandate was also part of President Clinton’s health care reform plan in the mid-1990s. This model called for all employers to pay into regional pools from which employees could choose health plans.²⁰² More recently, 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. This act would have required employers with 50 or more employees to either offer insurance coverage and pay at least 80 percent towards its cost, or to pay into a state purchasing pool which would have provided benefits for uninsured workers.²⁰³ Requiring employers to offer insurance could be found to be in violation of ERISA (the U.S. Employee Retirement Income Security Act of 1974), but by offering the option of “play or pay,” and carefully designing other features of a plan, it is thought that a state initiative of this type could withstand ERISA challenges.²⁰⁴ However, these plans are still often controversial.

Establishing state-only tax incentives that provide a tax deduction or credit to employers and individuals who purchase health insurance. A tax credit is subtracted directly from the amount of income tax owed, while a tax deduction is subtracted from taxable income, thus indirectly reducing the amount of tax owed. Most tax credits are non-refundable, meaning if the credit is more than the tax owed, the individual or company does not receive a refund for the difference. Fifteen states including Maine and Colorado provide tax relief in one of these ways, though the target populations vary. Many of these states offer credits or deductions to the self-employed or individuals (and their spouses and dependents), while several offer one of these 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.²⁰⁵

Regulating insurance rates for small groups. Larger groups (often defined as 50 or more employees) are often not subject to the individual underwriting that smaller groups face from insurers. Therefore, rates for small groups can vary widely depending on the characteristics of individual employees in the group. While their exact formulas are proprietary, most insurance carriers calculate rates for small groups based on each applicant's age, sex, occupation, and geographic location. Although HIPAA restricts the extent to which they can use individual health status, by using these other "manual rating methods" insurers can still 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.²⁰⁶ Many states limit the amount of manual rating that is permitted for these small groups. 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 — see the information on New York in the next section for more details. Besides rate bands and community rating, the third type of small-group regulation is modified community rating, where 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.²⁰⁷

Implementing guaranteed issue for individual policies. 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.²⁰⁸ (States must have a high-risk pool if they do not have guaranteed issue for the HIPAA-eligible.) 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.²⁰⁹ Some feel that guaranteed issue without price controls or mandating coverage for everyone can be harmful in that it encourages people to seek insurance only when they think they will need it, creating adverse selection and forcing prices up, which causes more people to drop insurance, resulting in only the sick having insurance.²¹⁰

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. Appendix A shows all 50 states and some of the initiatives they have enacted to increase the number of people with access to health insurance.

Table 1 shows Texas compared to the five selected states and the U.S. regarding population, average income, and breakdown of sources of health insurance. See the “Profiles of Selected States” section later in this paper for more details on each of these states.

Table 1. Characteristics of Selected States and the U.S., 2003

	Population	Median Household Income	Percent Uninsured	Percent in Medicaid/SCHIP	Percent in Medicare	Percent Employer-Based	Percent Individual Insurance
Texas	21,660,190	\$40,934	25	13	9	48	4
Arkansas	2,661,490	\$33,259	17	17	15	46	5
Colorado	4,441,080	\$50,224	17	11	9	58	6
Florida	16,637,520	\$38,572	18	12	16	48	6
Maine	1,272,010	\$37,619	11	18	15	51	5
Minnesota	5,060,020	\$54,480	8	10	10	65	6
U.S.	287,368,410	\$43,527	16	13	12	54	5

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, which is conducted by the U.S. Census Bureau and is 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.

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. Several other innovative ideas are shown in the profiles of the five selected states later in this paper, such as the Dirigo plan in Maine and the proposal to overhaul Medicaid in Florida.

Guaranteed Issue, Community Rating, Reinsurance Plans — New York

The state of New York has passed a variety of proactive health insurance reforms in the past 15 years. Guaranteed issue for individual insurance and community rating (charging everyone in the same community the same price for insurance, regardless of individual health status) were passed in 1993, and New York is one of the few states with these measures in place.

New York passed the Health Care Reform Act of 2000, which included significant coverage expansions and market reforms to increase the availability of health insurance for uninsured individuals and small businesses (less than 50 employees) in the state. One of these new coverage options is Healthy New York. The Healthy New York plan has a streamlined benefits package and must be offered by all HMOs in the state to people who qualify (other types of insurers have the option of whether to participate). The only choice in the benefit plan is whether to pay extra for prescription drug coverage or not. The program is a state-subsidized reinsurance program that reimburses health plans for 90 percent of claims that they pay between \$5,000 and \$75,000 in a calendar year for each member.²¹¹

Small employers, sole proprietors, and individuals have a list of criteria to meet in order to qualify to buy Healthy New York, including such things as having not been insured in the last 12 months (with exceptions), a family member being employed in the last 12 months, and a household income below 250 percent FPL. Small employers have income limits on a percentage of their employees, and must contribute at least half of the premiums for employees (they do not have to contribute to the premiums for employees' families). Premiums are community-rated and do not vary by eligibility category but can vary by county and HMO.²¹²

As of December 2004, Healthy New York had 76,700 enrollees: 60 percent of these were working individuals, 20 percent were sole proprietors, and 20 percent were small-group employees. The state budgeted \$49.2 million for Healthy New York for 2004, some of which is funded by tobacco taxes.²¹³

Covering Parents under SCHIP—New Jersey and Others

The Centers for Medicare and Medicaid Services issued guidelines in 2000 on how states could apply for 1115 waivers to allow their SCHIP programs to cover uninsured parents of SCHIP-eligible children. New Jersey, Rhode Island, Minnesota, and Wisconsin were the first states to obtain waivers for SCHIP parents (in 2001), and six more states had done so by 2002. The first four states had already been covering low-income parents through Medicaid waivers, Section 1931 expansions, and state-only funds, but obtaining the SCHIP 1115 waivers allowed them to receive the higher SCHIP matching rate for this population. It was easier for these first four states to apply for the waiver than it might be for other states because they were already covering a substantial number of low-income parents through other programs, thus they were not adding a large new population to the public insurance rolls. They also had not spent all of their SCHIP allotments at the time they applied for waivers, so they likely would have lost SCHIP money, unlike other states who already spend most or all of their SCHIP funds on children and thus do not have any left to cover parents.²¹⁴ It is important to note that since funding for each state is capped under SCHIP, it is not necessary to show that the expansion will be revenue-neutral.

The New Jersey SCHIP parent program (part of the New Jersey FamilyCare program, which also includes Medicaid recipients), was closed to new parent enrollment in June 2002 as enrollment exceeded expectations, causing funding problems. The state's waiver application stated they would cap enrollment at 125,000, and in 2002 enrollment was 180,000. In order to be able to keep these additional parents enrolled, as well as enroll the 12,000 people who applied after the enrollment freeze, the state applied for and received an 1115 HIFA waiver in 2003 in order to standardize the benefit packages of parents with incomes under 133 percent FPL who are covered by a Medicaid 1931 to be the same as the benefits package for the parents from 133 percent to 200 percent FPL, which is equivalent to the most widely sold

commercial health insurance in the state. Allowing the Medicaid group to not receive the full Medicaid benefits package was expected to save money to cover more parents in the program. Permission was given for Medicaid funds to be used to cover these parents if SCHIP funds run out.²¹⁵

Expanding Coverage through Reduced Medicaid Benefits — Utah

Utah received an 1115 waiver in February 2002 to extend a limited Medicaid benefits package to low-income people that were not previously eligible, including childless adults. The state cut services and raised co-pays for some enrollees to fund the expansion, which was the first time this was done with an 1115 waiver. This is the prototypical HIFA option, though the waiver is not technically considered a HIFA waiver. The HIFA initiative, introduced in 2001, allows financing of a waiver by methods that were already allowed under 1115 waivers, but also provides several new ways of financing waivers (since waivers must be budget-neutral), such as reducing coverage, increasing cost-sharing requirements, and capping enrollment for the newly eligible expansion groups.²¹⁶ One way that the Utah 1115 waiver differs from a HIFA waiver is that the state was allowed to cut some benefits for mandatory populations as well as for optional and expansion groups.²¹⁷

Several other states have received HIFA-type waivers as well, but Utah is a good example of the major changes that can be implemented by increasing flexibility with benefits and cost-sharing, as most of the other states have not reduced Medicaid benefits for existing enrollees or increased cost-sharing.²¹⁸ Utah's waiver, called the Primary Care Network (PCN), expands Medicaid to uninsured adults aged 19 and older with incomes up to 150 percent FPL (originally estimated to be 25,000 people). In 2003, an amendment to the waiver was approved to provide a premium assistance option called Covered at Work (CAW), which subsidizes the employee's portion of employer health insurance for up to five years. The waiver made changes such as reducing benefits, instituting an enrollment fee of \$15 to \$50 for people in the expansion populations and increasing hospital admission co-payments from \$100 to \$220.²¹⁹

Benefits that were reduced for the mandatory population include eliminating non-emergency transportation and reducing mental health benefits. Benefits that were reduced for the optional population include cuts in dental, vision and speech services, and in the number of visits to physical therapists, chiropractors and psychiatrists. The PCN benefit package focuses on preventive care and does not include prescription drugs or inpatient hospitalization, however, the state negotiated a certain amount of donated care from hospitals and specialists to help those who need these services.²²⁰ No benefits are reduced for children, pregnant women, the disabled, or the elderly.²²¹ The regular state plan Medicaid population has a maximum out-of-pocket expense cap of \$500 per year; this cap is \$1,000 for the PCN waiver population.

As of December 31, 2004, 17,643 people were considered "State Plan Eligibles" and were enrolled in Utah's reduced benefit plan. These are people who are eligible for Medicaid through Transitional Medical Assistance, Temporary Assistance to Needy Families or Medically Needy (who are not elderly, blind, or disabled). This does not include pregnant women, children, the disabled or the elderly, since benefits were not cut for these groups and thus they remain in what Utah terms "traditional Medicaid." An additional 18,910 were enrolled in the Primary Care Network (the expansion population who were previously uninsured and who receive primary care benefits only), 67 people were enrolled in Covered at Work, and 82 people were enrolled in another demonstration population consisting of high-risk pregnant women with assets over \$5,000 (the maximum allowed in the state's traditional Medicaid program).²²²

Hospital Cost Containment — Maryland

Maryland established a hospital cost containment system in 1974, when the state had some of the highest hospital costs in the nation. The Health Services Cost Review Commission (HSCRC) sets rates for hospitals, resulting in Maryland hospital rates changing from among the mostly costly to one of the most cost-effective in the U.S. One unique feature of this system is that all payers pay the same rates, and all must participate, so the costs of the uninsured are not spread just to a small group of commercial payors, but to all payors.²²³ When HSCRC was first implemented, it had authority only over the rates that hospitals charged to nonfederal purchasers, as Medicaid and Medicare laws did not allow state regulation. However, in 1977, Maryland received a waiver to test alternative payment approaches, which included Medicaid and Medicare, and in 1980 this arrangement became permanent, provided the program continued to meet federal standards. The HSCRC states that the waiver for this program “made it possible to achieve equitable pricing of hospital services for purchasers of care, creating consistent incentives for hospitals in dealing with the various types of payors.”²²⁴

HSCRC established base rates for each hospital in 1977 as a requirement for Medicare and Medicaid participation, and now hospitals are given an annual guide that shows how much they can charge for that fiscal year. In order to keep the waiver permanent, the state must show that the federal government’s payments per case in Medicare have not increased more rapidly in Maryland than in the rest of the nation over time. The rate system evolved for several decades and was successful at keeping cost increases below the national average for most years. Performance of the system began to slip in the 1990s and the system was redesigned in 2000. HSCRC states that “The goals of the redesign were to provide predictability and stability; be prospective in nature; recognize input cost inflation; be streamlined; and, be reflective of the national experience. Four major components of the Maryland payment system were established: 1) an annual update formula; 2) revamped full rate review process; 3) unit rates for each revenue center; and 4) an overall charge-per-case target.”²²⁵ There are many other significant components to the system, but these are the foundation of Maryland’s equitable payment system.

Unlike other states, in Maryland, uncompensated care is covered by all payers including Medicaid and Medicare, so there are no charity hospitals in the state. Maryland is the only state that guarantees care for its citizens at any of its hospitals regardless of their ability to pay.²²⁶

Situation in Texas

State Demographics

As of July 2004, Texas’ estimated population was 22,490,022.²²⁷ About 22 percent of the population had incomes under 100 percent of the federal poverty level (FPL) , and an additional 22 percent had incomes that were 100 to 199 percent FPL in 2003.²²⁸ Texas has a lower percentage of residents with employer-sponsored insurance than the national average and a much higher percentage of uninsured people. In 2003, 48 percent of the Texas population had employer-sponsored insurance; 4 percent had individual insurance; 13 percent had Medicaid, SCHIP, or other public insurance (including dual eligibles with Medicaid and Medicare); 9 percent had Medicare; and 25 percent were uninsured.²²⁹

Medicaid Eligibility

Pregnant women become eligible for Medicaid at an income at 185 percent FPL or less. Medicaid eligibility for non-working parents is 14 percent FPL (\$188 monthly income for a family

of three), and for working parents is 23 percent FPL for a family of three. The eligibility level for people on Supplemental Security Income (SSI) is 74 percent FPL. Texas has not implemented the option offered by the Omnibus Reconciliation Act of 1986 (OBRA '86), which allows states to extend Medicaid benefits to aged, blind and disabled people with incomes up to 100 percent FPL, including using more flexibility with income and assets tests.²³⁰ Medicaid eligibility for children ages 0-1 is 185 percent FPL, ages 1-5 is 133 percent, and ages 6-19 is 100 percent FPL.²³¹ There are additional limitations on family assets and a requirement that the person be a legal resident of the U.S. for at least five years before obtaining services.

Medicaid Financing Method

Texas' federal matching rate for Medicaid is 63.17 percent for fiscal year 2004, 60.87 percent for FY2005, and 60.66 percent for FY2006.²³² The state portion of Medicaid funding comes mostly from general revenue, with a small part from tobacco settlement funds, hospitals and Federally Qualified Health Centers.²³³ Funding also comes from quality assurance fees paid by ICF/MRs (intermediate care facilities for the mentally retarded).²³⁴ Total Medicaid spending in Texas in FY 2003 was \$15,280,859,187. The average Medicaid spending per enrollee in FY 2000 was \$3,284. This varied from an average of \$1,666 spent on each child to an average of \$9,803 spent per enrollee in the blind and disabled group.²³⁵

Medicaid Benefits

Medicaid in Texas offers inpatient and outpatient hospital services, skilled and intermediate care facilities, religious non-medical health care institution and practitioner services, and services at freestanding ambulatory surgery centers, federally qualified health centers, and rural health clinics. The following are types of benefits offered:

- Dental services, eyeglasses, hearing aids, and services for speech, hearing and language disorders (not dentures).
- Laboratory and X-ray services.
- Medical equipment and supplies (not prosthetic and orthotic devices).
- Early and periodical screening, diagnosis and treatment services; family planning services; rehabilitation services (not substance abuse for adults).
- Services by these health care providers: physicians, certified registered nurse anesthetists, chiropractors, other medical and remedial care practitioners, dentists providing medical surgical services, nurse midwives, nurse practitioners, optometrists, podiatrists and psychologists.
- Prescription drugs.
- Physical and occupational therapy services.
- Ambulance services, non-emergency medical transportation services.
- Home health services, hospice services and targeted case management (no personal care services or private duty nursing services).
- Intermediate care facilities for the mentally retarded, nursing facility services (no inpatient institutional services).²³⁶

SCHIP Characteristics

SCHIP is funded by both the federal and state governments like Medicaid. The federal share for SCHIP is 72.15 percent in Texas for FFY 2004 and the state share is 27.85 percent of each

dollar spent.²³⁷ Texas spent almost \$330 million on SCHIP in FY 2004, including both federal and state funds.²³⁸ As of March 1, 2005, there were 328,350 children enrolled in SCHIP.²³⁹ This represents a steep decline from September 2003, right before cost-saving changes were implemented, when enrollment stood at 507,259.²⁴⁰ To qualify for SCHIP, children must be younger than 19, U.S. citizens or legal residents, not eligible for Medicaid or state employee coverage, not have private insurance, and have a family income below 200 percent of the federal poverty level.²⁴¹ Families must also have assets within allowable limits (liquid assets such as cash and bank accounts, as well as some vehicle values, count toward the assets test, while real estate, retirement accounts, and certain other types of accounts are exempt).²⁴² Families pay premiums, deductibles and co-payments that vary according to their income levels. The services that SCHIP beneficiaries can receive in Texas are the following:

- Doctor, hospital, X-ray and lab services;
- Well-baby and well-child visits;
- Immunizations;
- Prescription drugs;
- Durable medical equipment and prosthetic devices (\$10,000 limit per enrollment period);
- Case coordination and enhanced services for children with special health care needs and children with disabilities;
- Physical, speech and occupational therapy;
- Home health care;
- Transplants;
- Limited mental health services;
- Services that cover pre-existing conditions.²⁴³

Private Insurance Regulation and High-Risk Pool

Texas has an 11.3 percent HMO penetration rate. Regarding small-group market reforms (applies to groups of 2 to 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. 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. 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.²⁴⁴

For people who have been denied health coverage or could not afford the coverage they were offered, Texas has a high-risk pool started in 1997 and funded by enrollee premiums and assessments on insurers. The pool is led by a nine-member board of directors and selects a third-party administrator to run the program. The number of people who can afford the high-risk pool, however, is limited since the premiums are higher than average. The premiums in the pool cannot exceed 200 percent of the standard rate for commercial individual health insurance for the person’s gender, age and geographic area, and although rates were initially set lower, premiums are now at their legal maximum. Premiums do not cover all claims costs since the enrollees are high-risk and often need costly medical care, so losses beyond what are covered by premiums are paid through annual and interim assessments on HMOs and other health

insurers based on their amount of business in Texas. Premiums for Medicaid, Medicare and small group coverage are excluded from the assessment pool, as are ERISA plans. In 2003, the average monthly premium was \$437, total claims paid were \$171 million, and assessments on 210 insurers brought in \$62.6 million. Texas' high-risk pool has more than 25,000 enrollees, making it one of the largest pools in the country.²⁴⁵

Benefits in the high-risk pool are similar to the benefits of an average individual insurance plan, covering inpatient and outpatient care, prescription drugs and other services. Participants select an annual deductible from \$500 to \$5,000, then monthly premiums are determined by age group, sex, residence in one of six areas of the state and whether the person uses tobacco or not. Participants using the network pay 20 percent co-insurance up to an annual maximum of \$3,000, and all enrollees have a lifetime maximum benefit of \$1.5 million.²⁴⁶

To be eligible to enroll in the high-risk pool, a person must be a legal resident of Texas for at least 30 days, and a U.S. citizen or a permanent U.S. resident for at least three continuous years. Potential enrollees must show one of the following to qualify: 1) proof of refusal by an insurer to issue health insurance to the person based on health reasons, 2) certification from an insurance agent showing that the agent could not obtain coverage similar to the pool coverage due to health status, 3) offer of coverage or a current policy that excludes one or more medical conditions, 4) offer or current policy with substantially similar coverage to the pool but with higher premiums, or 5) diagnosis of a qualifying medical condition such as cancer, cardiovascular disease or cerebral palsy. A person can also qualify if he/she is a legal Texas resident who has had health insurance for the previous 18 months (with no break more than 63 days) if the coverage was through an employer-sponsored, church or government plan; who had health insurance under another state's qualified HIPAA program but lost coverage due to moving to Texas, if the person applies for coverage in Texas within 63 days of losing previous coverage; or if the person is eligible under the Health Coverage Tax Credit Program. (This program is part of the Trade Act of 2002 and helps workers displaced through foreign trade obtain health insurance through a federal income tax credit; states have several options on how to implement this program and Texas chose its high-risk pool as the vehicle.) Spouses and children of people who qualify and enroll in the high-risk pool are also eligible.²⁴⁷

Incentives for Small Groups

The Texas Legislature enacted group health insurance reforms in 1993, 1995 and 2003. Standard benefit plans and mandated benefits have changed over the years, as well as certain benefits for small groups. In the 1990s, the legislature authorized the formation of public and private small employer purchasing alliances, as well as directing the state to establish a statewide purchasing pool. The Texas Insurance Purchasing Alliance was successful at first but ended after five years due to various problems. New legislation would be needed to create another statewide purchasing pool, but the law already 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. Surveys carried out for Texas' State Planning Grant activities showed that 95 percent of small employers surveyed wanted some form of purchasing pool, and that 72 percent did not know that Texas law already allows private pools. However, insurers interviewed expressed little interest in participating and did not think that purchasing pools would lower rates as much as expected.²⁴⁸ 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.²⁴⁹ As of March 2005, there was one health group cooperative registered with the Texas Department of Insurance, based in Dallas.²⁵⁰

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. Every insurance carrier who covers small groups must either join the system or request approval to become a “risk assuming carrier.” The system has a board of directors that determines the premiums to be charged to insurers for participating. The number of carriers participating in the system has been declining while claims have been decreasing, so the Texas Department of Insurance recently recommended to the Texas Legislature that the system be phased out. A report to the legislature claims that its smaller size does not allow enough spreading of risk, the small insurance market is strong, and small carriers can obtain reinsurance in the private market, so the state system has served its purpose and should be phased out in a nondisruptive way. Only about one-third of small carriers in the state (21) are considered “participating insurers” (the rest assume their own risk or obtain reinsurance elsewhere), and only 11 of those have ceded lives to the system, so only 342 lives are covered in the system.²⁵¹

As mentioned previously, though HIPAA limits the use of individual health status in calculating group rates, insurers may still use this in a limited way, plus other variables such as age, sex, location, and type of industry. The rates in most states that have implemented rating reforms vary less than the rates in Texas. In Texas, the cost of insurance for small groups can vary widely based on the characteristics of individuals in the group. Texas law allows insurers of small groups to adjust premiums based on age, sex, location, industry and group size, plus an adjustment of 25 percent up or down for health status. When all variables are calculated according to each insurer’s formulas, the highest rate for a group cannot be more than 67 percent higher than the lowest rate for a group in the same class (with the same non-health-related characteristics).²⁵² Although some information on rates and underwriting results for small groups and individuals policies may be reported to the Texas Department of Insurance, it has not to our knowledge been systematically assembled and examined to determine the condition of these markets.

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.²⁵³ 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.²⁵⁴ A bill for an 1115 women’s health waiver was passed by 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’ program was implemented in 1996.²⁵⁵

Texas is one of six states that offers extended eligibility for Transitional Medicaid Assistance (TMA) past the required 12 months. Texas and Tennessee offer it for 18 months and four other states offer it for 24 months. Transitional Medicaid was created in 1988 by the Family Support Act and the program has been extended several times.²⁵⁶

See the paper “Medicaid and the State Children’s Health Insurance Program in Texas: History, Current Arrangements, and Options” by David C. Warner, Lauren R. Jahnke, and Kristie Kimbell (April 2005) for more information on Medicaid and SCHIP in Texas.²⁵⁷

Profiles of Selected States

It is useful to compare and contrast Texas to a few other states that differ in terms of income, percent uninsured, eligibility levels for public program, population and other factors. Florida, Arkansas, Colorado, Maine and Minnesota were all 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 what might or might now work here and why, and in considering such questions as why poorer states like Arkansas and Maine have higher insured rates than Texas. By looking at a complete state package it is easier to see the broader state policy options.

Florida

State Demographics

Florida had a population of 16.6 million in 2003. Seventeen percent of the population had incomes under 100 percent of the federal poverty level, and an additional 20 percent had incomes that were 100 to 199 percent FPL.²⁵⁸ Florida has a lower percentage of residents with employer-sponsored insurance than the national average, and a higher percentage of people on Medicare due to the older population. In Florida, 48 percent of the population had employer-sponsored insurance; 6 percent had individual insurance; 12 percent had Medicaid, SCHIP, or other public insurance (including dual eligibles with Medicaid and Medicare); 16 percent had Medicare; and 18 percent were uninsured in 2003.²⁵⁹

Medicaid Eligibility

Medicaid eligibility for pregnant women in Florida is set at an income at 185 percent FPL or less. Medicaid eligibility for non-working parents is 23 percent FPL and for working parents is 62 percent FPL. There are different eligibility criteria for two other Medicaid groups: 74 percent FPL for people on Supplemental Security Income (SSI) and 90 percent FPL for the Aged, Blind and Disabled group.²⁶⁰ Medicaid eligibility for children ages 0 to 1 is 200 percent FPL, and ages 1-5 is 133 percent FPL. Eligibility for children ages 6 to 19 is 100 percent FPL.²⁶¹

Medicaid Financing Method

Florida's federal matching rate for Medicaid is 61.88 percent for fiscal year 2004, 58.90 for FY 2005, and 50.89 for FY 2006.²⁶² The state portion of Medicaid funding comes from general revenue, provider assessments, cigarette taxes, tobacco settlements funds, tobacco non-general funds, other non-general funds, state fraud recoupments and local county funds.²⁶³

Total Medicaid spending in Florida in FY 2003 was \$10,989,070,010. The average Medicaid spending per enrollee in FY 2000 was \$3,131. This varied from an average of \$975 spent on each child to an average of \$7,827 spent per enrollee in the blind and disabled group.²⁶⁴

Medicaid Benefits

Medicaid in Florida offers outpatient hospital services and services at freestanding ambulatory surgery centers, public and mental health clinics, federally qualified health centers, religious non-medical health care institutions and rural health clinics. It also offers inpatient hospital services. The following are types of benefits offered:

- Dental services, eyeglasses, hearing aids (dentures and services for speech, hearing, and language disorders are not covered).
- Laboratory and X-ray services.

- Medical equipment and supplies, prosthetic and orthotic devices (no physical therapy or occupational therapy covered).
- Early and periodical screening, diagnosis and treatment services; family planning services; rehabilitation services (mental health and substance abuse).
- Services by these health care providers: chiropractors, dentists providing medical surgical services, nurse midwives, nurse practitioners, optometrists, physicians and podiatrists (not psychologists).
- Prescription drugs.
- Ambulance services, non-emergency medical transportation services.
- Home health services, hospice services, targeted case management (no personal care services or private duty nursing services).
- Institutional services: institutions for mental disease, intermediate care facilities for the mentally retarded, nursing facility services (no inpatient psychiatric services under age 21 or inpatient hospital nursing facility and intermediate care facility services for mental disease age 65 and older).²⁶⁵

SCHIP Characteristics

Florida has a combination Medicaid-SCHIP program. There are two SCHIP-funded programs in Florida, MediKids for ages 1-4 and Healthy Kids for ages 5-19 (and their younger siblings in some locations).²⁶⁶ These programs, plus two others – Children’s Medical Services Network (CMS, for children with special health care needs) and Children’s Medicaid – make up Florida’s KidCare program. There is one enrollment point where applicants are screened to see which program they qualify for. Medicaid enrollees are accepted at any time, however, there are specific enrollment periods for the other three programs, and they are not entitlement programs, so there may be waiting lists.²⁶⁷

The federal share for SCHIP in Florida is 71 percent for FFY2005 and the state share is 29 percent of each dollar spent. Florida spent \$388.5 million on SCHIP in FY 2004, including both federal and state funds. As of December 2003, there were 319,477 children enrolled in SCHIP in Florida.²⁶⁸ To qualify for SCHIP, children must be younger than 19, a U.S. citizen or legal resident, not eligible for Medicaid or state employee coverage, not have private insurance, and have a family income below 200 percent of the federal poverty level.²⁶⁹ MediKids and CMS Network offer the same benefits as Medicaid, except for waiver services.²⁷⁰ Healthy Kids includes the medical services that the state was already providing before SCHIP, since Florida was one of three states with existing programs grandfathered in to the SCHIP legislation, and also includes enhanced mental health and dental services.²⁷¹

Florida implemented an enrollment freeze for SCHIP in July 2003 due to insufficient funds, and maintained waiting lists of potential enrollees. In June 2004, Florida allocated funds to enroll the children who were on the list as of March 2004, and then disbanded the waiting list, telling families who applied after March 11, 2004, that they would have to reapply during future open enrollment periods. This only applies to SCHIP-funded programs — Medicaid enrollment cannot be limited and applications are screened for Medicaid eligibility.²⁷²

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.²⁷³

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 this was implemented by the Florida legislature in 2004. The Small Employers Access Program was appropriated \$250,000 and is authorized to solicit bids for standard and alternative benefit packages, but one provision recommended by the task force was not in the final bill, which was allowing the winning bidder in each geographic region the exclusive opportunity to provide coverage to small groups in that region. Not having this could weaken the market for potential bidders. The Office of Insurance Regulation is talking to small group carriers about interest in the program and implementation. Just as in Texas, some group carriers have expressed skepticism about purchasing pools and reluctance to participate.²⁷⁴

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.²⁷⁵ The CHPAs developed from a pilot project funded by the Robert Wood Johnson foundation, and the program went statewide in 1993 with the legislation. 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, so these made the CHPAs not as important. They had a costly infrastructure and carriers began to drop out by 1997, so they were repealed in 2003 and replaced with Health Care Alliances, which were also not embraced by insurers.²⁷⁶

Medicaid and SCHIP Initiatives

In Florida, 64.3 percent of Medicaid beneficiaries are enrolled in managed care.²⁷⁷ 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.²⁷⁸ Florida has used Section 1931 to expand Medicaid coverage by increasing income disregards. After a beneficiary has been enrolled for 12 months or more, the state may disregard a family's first \$200 in monthly earnings and 50 percent of the remaining monthly earnings before calculating if families' incomes are below the eligibility level to qualify for Medicaid.²⁷⁹ Florida has a full-cost buy-in program for parents to buy SCHIP insurance at full cost for children ages 5 to 9 with family incomes over 200 percent FPL.²⁸⁰

Not counting waivers that are pending or have expired, Florida has three 1915(b) Freedom of Choice Waivers (for managed care, children's inpatient psychiatric services, and 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.²⁸¹

Other Health Insurance Reforms/Initiatives

Florida Governor Jeb Bush recently proposed 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. Since the state would pay the health plans instead of the providers directly, this new government-funded insurance program would have to be approved by the state and the federal government, and the governor hopes to get these approvals by the end of 2005. He said it is not clear yet whether federal approval will include a cap on federal funds and if so, if the state or patients would be required to pay more if costs increase more than expected.²⁸²

In this proposal, the private plans would set limits on care and coverage, and savings is expected to come from competition between plans for patients. Basic services covered currently (mandatory and optional Medicaid services) would still be covered, and health plans could offer additional services to attract patients, giving them a choice on the best plans for their health situations. Beneficiaries who take responsible health measures, like participating in disease management programs or immunizing their children, could earn credit for enhanced Medicaid services like over-the-counter drugs. There would be a cap on Medicaid benefits to decrease some of the financial risk for insurers, and patients who reached the cap would be covered by a catastrophic care fund created from a percentage of premiums.²⁸³ A concept paper was published in March 2005 outlining the proposed reforms,²⁸⁴ and several bills were considered by the Florida Legislature in April and May 2005 to allow the state to apply for an 1115 HIFA waiver to implement some of the changes.²⁸⁵

In May 2005, the legislature passed Senate Bill 838,²⁸⁶ 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 that the legislature approve the implementation in the state of any waiver that CMS approves for the pilot project.²⁸⁷

Arkansas

State Demographics

Arkansas had a population of 2.6 million in 2003. Twenty-two percent of the population had incomes below 100 percent FPL, and an additional 22 percent had incomes between 100 and 199 percent FPL.²⁸⁸ Arkansas has a lower than national average percentage of residents with employer sponsored insurance and higher than national average percentages on Medicaid and Medicare and who are uninsured. In Arkansas in 2003, 46 percent of the residents had employer sponsored insurance; 5 percent had individual insurance; 17 percent had Medicaid, SCHIP or other public insurance (including dual eligibles with Medicaid and Medicare); 15 percent had Medicare; and 17 percent were uninsured.²⁸⁹

Medicaid Eligibility

For pregnant women in Medicaid the eligibility level is 200 percent of FPL. For working parents the eligibility level is 20 percent of FPL and for non-working parents, 16 percent of FPL. Eligibility for individuals on SSI is 74 percent; there is not eligibility extension for aged, blind, and disabled (through OBRA '86). Arkansas has no state supplemental program. For children ages 0-19 years, eligibility has been extended to 200 percent of FPL with an 1115 waiver.²⁹⁰ The Medically Needy program is limited to parents with incomes below 22 percent of FPL.²⁹¹

Medicaid Financing Method

Arkansas' federal matching rate for Medicaid is 77.62 percent for fiscal year 2004, 74.75 percent for 2005, and 73.77 for 2006.²⁹² Total Medicaid spending in 2003 was \$2,465,444,536. Per enrollee spending (in FY2000) was \$2,966 (national average \$3,762). Per enrollee spending ranged from \$1,222 (children) to \$7,414 (elderly) in FY 2000. In 1992, the state instituted a soft drink tax, the proceeds of which are paid directly to the Arkansas Medicaid Trust Fund.²⁹³ In May 2003, the state legislature approved new taxes on cigarettes, other tobacco products, and individual incomes to help cover growing Medicaid expenditures.²⁹⁴

Medicaid Benefits

Medicaid in Arkansas offers outpatient hospital services and services at freestanding ambulatory surgery centers, public and mental health clinics, federally qualified health centers, and rural health clinics. It also offers inpatient hospital services. The following are types of benefits offered:

- Dental; dentures; eyeglasses; hearing aids; and services for speech, hearing and language disorders.
- Lab and X-ray.
- Medical equipment and supplies; and prosthetic and orthotic devices.
- EPSDT; family planning; and rehab services (mental health and substance abuse).
- Services by these health care providers: certified registered nurse anesthetist, chiropractor, dentists providing medical surgical services, nurse midwife, nurse practitioner, optometrist, physician, podiatrist, psychologist.
- Prescription drugs.
- Physical and occupational therapy services.
- Ambulance services, non-emergency medical transportation services.
- Home health services, hospice services, personal care services, private duty nursing services, targeted case management.
- Institutional services: inpatient psychiatric services under age 21, inpatient hospital nursing facility and intermediate care facility services for mental disease age 65 and older, institutions for mental disease, intermediate care facilities for the mentally retarded, nursing facility services.²⁹⁵

SCHIP Characteristics

The federal share for SCHIP in Arkansas is 82 percent for FFY 2005 and the state share is 18 percent of each dollar spent.²⁹⁶ Arkansas spent \$1.9 million on SCHIP in FY 2002, including both federal and state funds.²⁹⁷ In 1998, phase one of the Arkansas SCHIP plan expanded

Medicaid to children born after September 30, 1982, and prior to October 1, 1983, whose family income was at or below 100 percent of FPL. In 2001, an amendment to the program was approved allowing Arkansas to establish a separate child health program, which essentially covered the children from 150 to 200 percent of FPL already served under the ARkids B Medicaid waiver expansion program. The application form, ID card, and benefit package remained the same for the ARkids B expansion program.

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. High risk pool rates are capped at 200 percent of the rate that would be charged in the private insurance market for a healthy individual of the same age. There is no annual limit, but a life-time maximum of \$1 million. There is no enrollment cap, but a waiting period of six months. 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. Arkansas has a state COBRA expansion program, up to 120 days, for small firms.²⁹⁸

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.²⁹⁹

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.³⁰⁰ 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.³⁰¹

Other current comprehensive state health reform 1915 and 1115 waivers:

- ConnectCare: 1915(b) — managed care through a PCCM model for children's Medicaid.
- ARkids B: an 1115 Waiver originally approved in 1997, which expands Medicaid coverage for kids through age 18 up to 200 percent FPL.
- Tefra: an 1115 waiver which provides Medicaid coverage for disabled children (SSI definition) whose parental income is less than the long-term care income limit; child's asset limit must be below \$2000.
- Family Planning Waiver: (since 1995) providing Medicaid coverage to women ages 14 to 44 years, now up to 200 percent FPL.
- Ticket to Work Medicaid Buy-In: for low-income (up to 250 percent FPL) disabled adults intending to remain in the workforce.³⁰²

Pending Waivers:

- Arkansas Senior Rx 1115 Waiver: to establish prescription drug coverage, up to two prescriptions per month, for non-institutionalized elderly at up to 90 percent FPL. This waiver is currently on hold.
- Arkansas Employer Sponsored Insurance Initiative: a HIFA waiver, which was scheduled to begin on July 1 2003, to provide health insurance coverage to an additional 55,000 residents of the state of Arkansas with incomes at or below 200 percent of the federal poverty level, using SCHIP funds, state general revenue (employer taxes calculated based on the size of the business) and cost-sharing. The waiver is pending.³⁰³

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. There is no presumptive eligibility although retroactive eligibility extends three months back. The application process mirrors that of Medicaid, may be done by mail, and is only renewed every 12 months. There is no asset testing for Medicaid or ARkids B. The eligible child must not have had insurance other than Medicaid in the prior six months (unless it was lost through no fault of the applicant). ARkids B includes a reduced benefit package and operates as a fee-for-service primary care case management model.

Since the establishment of ARkids B, the state has sought several additional expansion waivers, described above: the Senior Rx waiver, the Medicaid Employer Buy-In waiver, and the Employer-Sponsored SCHIP buy-in waiver.

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.³⁰⁴

Colorado

State Demographics

Colorado had an estimated population of 4,550,688 in 2003.³⁰⁵ This is a 35 percent increase in population since 1990. Thirty percent of Coloradans have incomes below 200 percent of the federal poverty line (FPL), with 13 percent below 100 percent FPL.³⁰⁶ More Coloradans have private insurance than the national average. Fifty-eight percent have employer-based insurance coverage, and 6 percent have individual coverage. Regarding public assistance, Colorado's percent coverage is slightly lower than the national average with 11 percent covered by Medicaid, SCHIP or other public insurance (including dual eligibles with Medicaid and Medicare) and 9 percent covered by Medicare. Seventeen percent of Coloradans are uninsured.³⁰⁷

State Fiscal Environment

Colorado has a unique fiscal environment because of two tax and expenditure limitations (TEs) that have been written into the state constitution: 1) Article X, Section 20, called the Taxpayer's

Bill of Rights or “TABOR”; and 2) Article IX, Section 17, called the Colorado Public School Finance Act of 1994 or “Amendment 23.” Passed by voters in 1992, TABOR impacts almost all areas of state government and is widely considered the most restrictive TEL in the nation. TABOR limits Colorado government in four ways:³⁰⁸

1. *Revenue increases*: Voter approval is required for any revenue increases.
2. *Revenue collections*: TABOR prescribes a formula for growth in spending and requires that all revenue collected in excess of that amount must be returned to the taxpayers unless voters approve of government keeping it and spending it. At the state level, the formula is the Consumer Price Index (CPI) plus percent change in state population.³⁰⁹
3. *“Weakening Provision”*: The government cannot spend more than six percent over the prior year’s General Fund appropriations. This can only be weakened or changed by a popular vote.
4. *Limitations on form of taxation*: Specifically prohibits new real estate transfer taxes, local income taxes and state property taxes. Additionally, the state income tax must be a flat tax. At the state-level, TABOR limitations apply to the General Fund and to the Cash Funds.

TABOR does not let government account for revenue swings and does not allow government to benefit from real economic growth. TABOR’s limits on revenue collection and on spending causes a “ratcheting down” effect on the government budgets for fiscal years that experience economic down-turns.

Amendment 23 requires an increase in public K-12 school funding. The amendment requires the legislature to increase educational funding by the number of new students plus inflation increased by one percent every year for 10 years (from 2001-2011), and by inflation after that.³¹⁰ It did not raise taxes or levy any new ones. State legislators cannot modify or undo it without a vote of the people.³¹¹

There is a growing consensus that the restrictions of TABOR coupled with the spending requirements of Amendment 23 is slowly having a “crowding out” effect on all the other programs that are funded out of the General Fund, including public healthcare safety net programs. Since the pie that is the General Fund isn’t growing fast enough even to meet population plus inflation, but the slice of pie destined for K-12 Education must slowly increase each year, the other pieces of the pie have no choice but to absorb a disproportionate amount of the ratcheting effect.³¹² Because Medicaid and CHP+ are safety net programs, they are most utilized when the state experiences economic downturns. Colorado does not have a Rainy Day Fund to be used to mitigate severe revenue swings. Currently the tobacco settlement dollars have been treated by the legislature as the state’s rainy day fund, securitizing portions of the settlement and redirecting funding to fill budget holes, including financing healthcare. However, as a result of this extremely constrained financial situation, Colorado’s Medicaid and CHP+ programs are bare bones, offering only the minimal amount of benefits and covering only the mandated populations.

Medicaid Eligibility

Medicaid eligibility for pregnant women is set at an income at 185 percent FPL or less. Medicaid eligibility for working parents is 39 percent FPL and non-working parents is 32 percent FPL. There are different eligibility criteria for several other Medicaid groups: 74 percent FPL for people on Supplemental Security Income (SSI), and 79 percent FPL for people on State Supplementary Payments (SSP an expansion group). Colorado does not cover the Aged, Blind,

and Disabled group.³¹³ Medicaid eligibility for children ages 0 to 5 is 133 percent FPL. Eligibility for children ages 6 to 19 is 100 percent FPL.³¹⁴

Medicaid Financing Method

Colorado's federal matching rate for Medicaid is 52.95 percent for fiscal year 2004, and 50 percent for fiscal years 2005 and 2006.³¹⁵ The state portion of Medicaid funding comes from general revenue, sliding-scale premiums and copayments, a 2 percent provider tax, and a 1 percent premium tax on health maintenance organizations, nonprofit health service plan corporations, and community integrated service networks.³¹⁶

Total Medicaid spending in Colorado in FY 2003 was \$2,567,544,672.³¹⁷ The average Medicaid spending per enrollee in FY 2000 was \$4,624. This varied from an average of \$1,662 spent on each child to an average of \$11,501 spent per enrollee in the blind and disabled group.³¹⁸

Medicaid Benefits

Medicaid in Colorado offers outpatient hospital services and services at freestanding ambulatory surgery centers, public and mental health clinics, federally qualified health centers, and rural health clinics. It also offers inpatient hospital services. The following are types of benefits offered:

- Eyeglasses and services for speech, hearing and language disorders.
- Laboratory and X-ray services.
- Medical equipment and supplies, prosthetic and orthotic devices.
- Early and periodic screening, diagnosis, and treatment services; family planning services; rehabilitation services (mental health and substance abuse).
- Services by these health care providers: certified registered nurse anesthetist, dentists providing medical surgical services, nurse midwife, nurse practitioner, optometrist, physician, podiatrist.
- Prescription drugs.
- Ambulance services, non-emergency medical transportation services.
- Home health services, hospice services, private duty nursing services, targeted case management.
- Institutional services: inpatient psychiatric services under age 21, inpatient hospital nursing facility and intermediate care facility services for mental disease age 65 and older, institutions for mental disease, intermediate care facilities for the mentally retarded, nursing facility services.³¹⁹

SCHIP Characteristics

Colorado has a separate SCHIP program. Statutorily, the program is called the Children's Basic Health Plan (CBHP) program, but publicly it is called Children's Health Plan *Plus* or CHP+. CHP+ covers children ages 0-5 between 133 to 185 percent FPL and children ages 6-19 between 100 to 185 percent FPL.³²⁰ CHP+ also covered, for a short time, pregnant women 19 years of age and older who were income-eligible, for medical care during their pregnancy plus two months after birth. The prenatal program operated from October 2002 to May 2003 when additional enrollment was suspended for budgetary reasons.³²¹

The federal share for CHP+ is 65 percent for FFY2005 and the state share is 35 percent of each dollar spent. Colorado spent \$62.5 million on SCHIP in FY 2003, including both federal and state funds. As of December 2003, there were 49,978 children enrolled in CHP+.³²² To qualify for CHP+, a child must be younger than 19, a U.S. citizen or legal resident, not eligible for Medicaid or state employee coverage, not have private insurance, and have a family income below 185 percent of the federal poverty level. Colorado instituted an enrollment freeze from November 1, 2003 to June 30, 2004 due to insufficient funds. This only applied to CHP+ — Medicaid enrollment cannot be limited and applications are screened for Medicaid eligibility.³²³

CHP+ is a public-private partnership, in which many of the services are provided by private contractors. Services are provided primarily through managed care. Four HMOs have full-risk contracts with the state to provide services to 39 counties, representing 84 percent of the CHP+ caseload.³²⁴

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 and 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.³²⁵

Incentives for Small Groups

Colorado's small group reforms began in 1995. Currently, all small groups with 2 through 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.³²⁶

Rates for all small group plans can vary by age, region, family size, and factors like smoking status, health status, claims experience, and standard industrial classification (workplace and job characteristics). Rates are allowed to range from a discount of 25 percent to an increase of 10 percent dependent on the health status of group members. Guarantee issue is required of all small group plans offered in the state, not just the Basic and Standard plans.³²⁷

SCHIP and Medicaid Initiatives

1915(b) Managed Care

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.³²⁸ This rate has dropped significantly recently for reasons that will be explained below.

In the mid-1990s Colorado made a dramatic shift to managed care with the hope that this would be a money-saving strategy for the state. In 1995 the state was granted a 1915(b) waiver

(which expired in 2003) and in 1997 the state legislature mandated that 75 percent of all Medicaid clients be enrolled in managed care by 2000 (SB97-05).³²⁹ Enrollment into the waiver program was mandatory for eligible TANF, TANF-related, SSI, and SSI-related recipients. The Managed Care Program was administered in 59 of 63 counties statewide and included the Primary Care Physician Program (PCPP) and the managed care organization (MCO) capitated program.³³⁰ Approximately three to four years ago, the state began having problems negotiating rates with the managed care organizations (MCOs). Several MCOs filed lawsuits against the state citing inappropriate rate-setting.³³¹ These lawsuits were settled out of court, however, after that, state officials became disenchanted with MCOs and moved dramatically toward fee-for-service.³³²

Currently, the state is contracting with one managed care plan as a health maintenance organization and is contracting with three health plans to provide services to clients as Administrative Service Organizations, or ASOs. An ASO receives a monthly administrative fee per client and bills the state for only the services provided to each client, at negotiated rates.³³³

Other Waivers

Colorado has received five 1915(c) Home and Community-Based Services Waivers: Children's Home and Community Based Waiver (2004), Brain Injury Waiver (2004), Persons Living with AIDS (2004), and Elderly, Blind and Disabled Waiver (2004). The state has also received two 1115 waivers: the Consumer Directed Attendant Support Project and the Alternatives in Medicaid Home Care Project.³³⁴ The Consumer Directed Attendant Support Project enables beneficiaries in this program to purchase home health services from attendants they choose, including family members.³³⁵ The Alternatives in Medicaid Home Care Project permits greater flexibility in defining where Medicaid home health visits can occur. Instead of limiting visits to a beneficiary's place of residence, the demonstration permits the same types of services to be provided in a variety of other settings (e.g., schools, work sites, or day treatment centers). This proposal also allows certain skilled nursing functions to be delegated to nurse aides, thus allowing individuals greater flexibility in selecting home health aides of their choice.³³⁶ Additionally, after receiving legislative approval last session, the state is seeking a Children with Autism waiver and a Substance Abuse Treatment for Native Americans waiver.³³⁷

Tobacco Tax Revenue to Fund Expansions

In November 2004, Colorado voters approved Constitutional Amendment 35, a \$0.64 tax increase on all tobacco products. This raised the overall tax on cigarettes to \$0.84 per pack. The additional revenue, estimated at \$169.2 million in FY05-06 (fiscal year July 1, 2005 to June 30, 2006) and exempt from TABOR restrictions, must be spent on healthcare and public health programs. Specifically the additional revenue must be divided as follows: 46 percent Medicaid and SCHIP expansions, 19 percent community health centers, 16 percent tobacco prevention and cessation, and 16 percent pulmonary, cardiovascular and cancer prevention, detection and treatment. The remaining 3 percent is reserved for the state's general fund and programs funded under the original \$0.20 tax to compensate for tax revenue reductions attributable to lower tobacco sales resulting from the higher tax.³³⁸

Currently, several bills are being considered by the legislature related to the 46 percent designated for Medicaid/SCHIP expansions (\$77.8 million in FY05-06). The debate is about exactly how those programs should be expanded. To date, the proposal most likely to pass is outlined in HB05-1262, authored by the Citizens for a Healthier Colorado Coalition and sponsored by the committee chairs of the Health and Human Service Committees of both Houses.³³⁹ Among other things, HB1262 calls for the following expansions to Medicaid and

SCHIP: increased eligibility in CHP+ for children and pregnant women to 200 percent FPL, removal of the Medicaid asset test, increased children enrolled in the HCBS Waiver Program and the Children's Extensive Support (CES) Waiver Program, increased Medicaid eligibility for parents up to 75 percent FPL, restoration of Medicaid for legal immigrants, \$430,000 for cost-effective marketing of CHP+, and presumptive eligibility to pregnant women under Medicaid.³⁴⁰ Additionally, it calls for the creation of a reserve fund specifically for the health care expansion fund. The reserve fund will start with FY04-05 revenues (\$23 million) and subsequently capture 10 percent of the expansion fund revenues every year (10 percent of 46 percent of the total revenue) until the total balance in the reserve fund equals half of the annual amount transferred to the health care expansion fund.³⁴¹ This money can be accessed only if the appropriations necessary to sustain the populations specified in the health care program expansions exceed the annual transfer of moneys to the health care expansion fund.³⁴² The sustainability of these expansions is a topic of hot debate. Forecasts show that these expansions are sustainable for the next five years.³⁴³ The question is if all this can be done for approximately \$80 million.

HIFA Waiver Proposal

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.

The comparative analysis of Medicaid and CHIP service utilization among children: The principal finding was that there is comparable utilization. As a result a proposal has been created to develop a uniform benefit package. The recommendation is for a "Core" benefit package and a "Core Plus" wrap-around benefit package (referred to as the "Core-Core Plus" structure). Based on the finding in the comparative analysis that the current CHIP benefit package is comprehensive enough to cover the majority of enrolled children's health care needs, the "Core" benefit package for all children on both Medicaid and CHIP would be the current CHIP plan. For children with special health care needs who require expanded services, the "Core Plus" wrap-around benefit package would be added. However, the proposal does not currently include several populations of children who require more intensive services than other Medicaid clients and therefore are much less likely to bounce between Medicaid and CHIP (foster care, adoption, SSI, etc.).

The state is hoping the Core-Core Plus structure will allow for multiple purchasing strategies, and will ensure greater efficiency and cost-effectiveness of care. Where possible, the same provider networks will be used regardless of whether their reimbursement is from Medicaid or CHIP, in order to create a seamless system from the perspective of the client. It is important to note that, under this proposal, CHIP and Medicaid would remain separate programs with respect to federal funding, maintaining their separate matching fund streams. However, from the perspective of the client, services would not change with a move from Medicaid to CHIP or visa versa. It is also important to note that it appears that the HIFA waiver would swing the state back towards a managed care system. Currently the proposal is waiting to be introduced officially to the legislature in the current session and therefore has not yet been submitted to CMS.

Other Health Insurance Reforms/Initiatives in the State

Colorado Benefits Management System (CBMS) — Colorado is the first state in the nation to develop and implement a fully integrated eligibility system for cash assistance and benefits.³⁴⁴ The system became operational in Fall 2004, however, it has been plagued with problems and the legislature has had to appropriate additional funds to address the problems that have resulted.

Maine

State Demographics

The population of Maine in 2003 was 1,272,010.³⁴⁵ The percent uninsured was 11 percent.³⁴⁶ Fifteen percent of the population had incomes below the federal poverty level.³⁴⁷

Medicaid (MaineCare) Eligibility

- Pregnant women: 200 percent FPL.
- Infants: 200 percent FPL.
- Children ages 1-19: 150 percent FPL.
- SCHIP Children (CubCare): 200 percent FPL.
- Parents: 150 percent FPL.
- Single adults (non-categoricals): 100 percent FPL, scheduled to be expanded to 125 percent FPL three months after Dirigo Health begins enrollment (see below).
- Parents of MaineCare eligible children: 150 percent FPL, scheduled to be expanded to 200 percent FPL three months after DirigoHealth begins enrollment (see below).³⁴⁸

MaineCare Financing Method

Total Medicaid spending in Maine in FY 2003 was \$1.8 billion.³⁴⁹ Maine's federal matching rate for Medicaid was 69 percent for fiscal year 2004, and will be 65 percent and 63 percent for FY 2005 and 2006, respectively.³⁵⁰ Maine's state Medicaid expenditures accounted for 20 percent of state general fund expenditures in 2003.³⁵¹

The average Medicaid spending per enrollee in FY 2000 was \$6,240. This varied from an average of \$2,817 spent on each child to an average of \$14,645 spent per enrollee in the blind and disabled group.³⁵² The estimate of Maine's payments per enrollee for children is much higher than expected. This is largely due to much higher than average amounts of payments reported under "other services" for this group. It is unlikely that all of the payments attributed to children actually should be attributed to children, or at least to those children currently enrolled in the program.

MaineCare Benefits

MaineCare offers inpatient and outpatient hospital services, public and mental health clinics, federally qualified health centers, religious non-medical health care institution and practitioner services, and rural health clinics. The following are types of benefits offered:

- Dental services, dentures, eyeglasses and services for speech, hearing and language disorders.
- Laboratory and X-ray services.

- Medical equipment and supplies and prosthetic and orthotic devices.
- Inpatient hospital services.
- Diagnostic, screening and preventive services.
- Early and periodical screening, diagnosis, and treatment services; family planning services; rehabilitation services, including mental health and substance abuse.
- Services by these health care providers: physicians, chiropractors, dentists providing medical surgical services, nurse midwives, nurse practitioners, optometrists, podiatrists, and psychologist.
- Prescription drugs.
- Physical and occupational therapy services.
- Ambulance services and non-emergency medical transportation services.
- Home health services, hospice services, personal care services, private duty nursing services, and targeted case management.
- Institutional services: inpatient psychiatric services for individuals under age 21, inpatient hospital, nursing facility, and intermediate care facility services in institutions for mental disease for individuals age 65 and older; intermediate care facilities for the mentally retarded, institutions for mental disease, and nursing facility services.³⁵³

SCHIP Characteristics

The federal share for SCHIP is 75 percent in Maine for FFY 2005 and the state share is 25 percent of each dollar spent.³⁵⁴ Maine spent \$23 million on SCHIP in FY 2002, including both federal and state funds.³⁵⁵ As of December 2003, there were 13,085 children enrolled in SCHIP.³⁵⁶ To qualify for SCHIP, a child must be younger than 19, a U.S. citizen or legal resident, not eligible for Medicaid or state employee coverage, not have private insurance, and have a family income below 200 percent of the federal poverty level. Families pay premiums, deductibles, and co-payments that vary according to their income levels. Children eligible for SCHIP are eligible for services provided under MaineCare (see above).

SCHIP and Medicaid Initiatives

- HIFA Section 1115 waiver to expand MaineCare (Medicaid/SCHIP) coverage to childless adults up 100 percent poverty, approved October 1, 2002.³⁵⁷ This expansion financed by redirecting a portion of its disproportionate share hospital (DSH) allocation to cover this population.³⁵⁸
- Section 1115 waiver to provide a limited set of Medicaid benefits to individuals with HIV/AIDS who would not otherwise be eligible for Medicaid. The expansion population includes individuals with HIV/AIDS with a gross family income at or below 250 percent of FPL.³⁵⁹

State Initiatives: Dirigo Health

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.”³⁶⁰ 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.³⁶¹ 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. One such measure is a “savings offset payment,” whereby the savings resulting from reducing the amount of uncompensated care will be redirected, through a tax of up to 4 percent on insurers, to help finance the plan.³⁶² The success of the program is also dependent on the willingness of small businesses to participate in the plan.

Dirigo Health Program Eligibility

The DHP will be rolled out in two phases:

Those eligible under Phase One (first year of implementation):

- Three months after Dirigo Health begins enrollment, Medicaid (i.e., MaineCare) eligibles expanded to single adults (non-categoricals) from 100 to 125 percent FPL, parents of MaineCare eligible children from 150 to 200 percent FPL, and SCHIP children from 200 percent FPL.
- Businesses with fewer than 50 employees.
- Self-employed individuals.
- Individuals.

In Phase Two (second year on), eligibility will be expanded to businesses with more than 50 employees.³⁶³

Dirigo Health Financing Method

The plan is projected to cost about \$90 million in the first year and is projected to be self-funded after that. The plan hopes to save \$80 million per year by eliminating unreimbursed medical costs.³⁶⁴ The program is financed through a variety of mechanisms:

1. For the first year of operations, \$53 million in state general revenue.³⁶⁵
2. Medicaid dollars for those who are eligible for MaineCare.³⁶⁶
3. Coverage expansion to noncategorical adults financed by redirecting a portion of its disproportionate share hospital (DSH) allocation.
4. Employer contributions: Employers pay a minimum of 60 percent of the employee cost of the premium, even for those who are eligible for MaineCare. Although employers must offer family coverage, they are not responsible for covering any portion of this coverage.³⁶⁷
5. Individual contributions: Individuals who are eligible for MaineCare pay nothing,³⁶⁸ and those with incomes above MaineCare but below 300 percent FPL pay discounted monthly premiums and deductibles and limited total out-of-pocket expenditures.³⁶⁹ The amount individuals are required to pay is determined on a sliding scale based on income.

6. Funds obtained through the recovery of bad debt and charity care.³⁷⁰ This idea is based on the premise that bad debt and charity care is shifted to higher provider rates and premiums. By providing affordable access to health insurance, Maine is anticipating that savings in the health care system will be obtained through reducing the amount of charity care. If health system savings can be documented, the state will recoup some of the costs of bad debt and charity care through levying up to 4 percent of insurers' revenue to help fund the Dirigo Health Plan (though this is not mandatory).³⁷¹
7. Maine is also relying on the successful implementation of several other cost containment strategies to keep the program affordable. These efforts include:
 - a) Certificate of Need (CON) changes:³⁷²
 - Expanded to include ambulatory surgery centers and doctors' offices.
 - Requirement for review predicated on function and cost as opposed to site of care.
 - Capital Investment Fund to establish a statewide budget for capital expenditures and "to ensure a wise and appropriate allocation of resources" (expenditures must not exceed the limitations of the fund).
 - Reviews investments in new technologies costing more than \$1.2 million and capital expenditures over \$2.4 million.
 - b) Insurance Overview: expands individual coverage rate review to small group products. Carriers will also be required to report administrative costs and underwriting gain.³⁷³
 - c) Voluntary Limits on Growth of Insurance Premiums and Health Care Costs: Hospitals and other providers are asked to voluntarily limit their cost growth to 3 percent and their operating margins to 3.5 percent. Insurers are also being asked to limit their operating margin to 3.5 percent.³⁷⁴
 - d) Hospital Planning: The Commission to Study Maine's Hospitals will conduct analysis of Maine's hospitals, including an analysis of hospital finances, structures, roles, reimbursement, capital, technology, staffing needs, other pertinent areas of study.³⁷⁵

Dirigo Health Benefits

The benefits offered by Dirigo Health are:

- Traditional services including inpatient and outpatient hospital care,³⁷⁶ physician and specialist visits, emergency services and prescription drugs.
- Disease management, and health promotion and wellness initiatives.
- Preventive services such as routine physicals, blood tests, Pap test, flu shots, mammograms and well-baby care.
- Routine diagnostic tests, X-rays and surgery.
- Occupational, speech and physical therapy.
- Chiropractic services.
- Skilled nursing care facility.
- Ambulance services.
- Cardiac rehabilitation.
- Durable Medical Equipment.

- Prosthesis.
- Smoking cessation programs and medications.
- Hospice and home health services.³⁷⁷

Private Insurance Regulation

There is no separate high risk pool. After Dirigo Choice has been in operation for three years, the Dirigo Health Agency must compare the impact of Dirigo on premium and uninsured rates in Maine with states that have established High Risk Pools. If trends in the other states are more favorable than Maine, the Dirigo Health Board of Directors will submit legislation to create a high risk pool in Maine.^{378,379}

Maine has 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 a policy.³⁸⁰ 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.³⁸¹ 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.

Quality of Care Initiatives

The Maine Quality Forum will provide the public with information on costs and quality of health care. It will disseminate research and adopt quality and performance measures, including comparisons of provider performance. It will be funded in part by the savings offset payment (SOP) assessed on insurers.

More Effective Use of Data is an effort to consolidate and streamline disparate data sources into one cohesive database. It will include clinical and administrative data.³⁸²

Status Report

MaineCare Program Expansions

Maine is scheduled to implement its MaineCare (i.e., Medicaid) program expansions in April 2005.³⁸³ However, these expansions will be made amid a possible \$80 million reduction in federal funds due to a decrease in the state's federal matching rate.³⁸⁴ Additionally, in February 2005, Maine's Governor announced a MaineCare enrollment freeze for "noncategorical" childless adults.³⁸⁵ Maine obtained an 1115 waiver to expand eligibility to noncategorical adults. However, with 24,000 noncategorical individuals enrolled, Maine is reaching the limit of total federal dollars that can be spent under the waiver.³⁸⁶ This current freeze will affect plans to expand eligibility for noncategorical individuals to 125 percent of FPL on April 1. According to one news report, Republican leaders in Maine also want to eliminate April's scheduled expansion from 150 to 200 percent for parents.³⁸⁷

Dirigo Choice Enrollment

During the first year of operations, the state's plan was to enroll up to 31,000 Maine residents through their employers and 4,500 self-employed or unemployed individuals.³⁸⁸ Anthem Blue Cross & Blue Shield of Maine was named the insurance carrier for the Dirigo Choice plan in October 2004. Marketing began on October 1, 2004, and enrollment of small businesses and self-employed individuals began on January 1, 2005.³⁸⁹ Coverage for other individuals will begin April 1, 2005. The category of "other individuals" includes the unemployed, individuals who do not work more than 20 hours a week for any single employer, and individuals employed in an eligible business of two to 50 employees where the employer has not offered health insurance in the last 12 months.³⁹⁰

As of January 1, 2005, Dirigo Choice has enrolled and is providing benefits for 133 small businesses and 612 sole proprietors for a total of 1,800 members. The Dirigo Health Agency anticipated a similar enrollment rate for the February 1, 2005, coverage effective date.³⁹¹

Minnesota

State Demographics

Minnesota had a population of slightly over 5 million in 2003. Nine percent of the population had incomes under 100 percent of the federal poverty level, and an additional 15 percent had incomes that were 100 to 199 percent FPL.³⁹² Minnesota has a higher percentage of residents with employer-sponsored insurance than the national average, and lower percentages of uninsured people and people on Medicaid and Medicare. In Minnesota, 65 percent of the population had employer-sponsored insurance; 6 percent had individual insurance; 10 percent had Medicaid, SCHIP, or other public insurance (including dual eligibles with Medicaid and Medicare); 10 percent had Medicare; and 8 percent were uninsured in 2003.³⁹³

Medicaid Eligibility

Medicaid eligibility for pregnant women is at an income at 275 percent FPL or less. Medicaid eligibility for working and non-working parents is also 275 percent FPL. There are different eligibility criteria for several other Medicaid groups: 70 percent FPL for people on Supplemental Security Income (SSI), 85 percent FPL for people on State Supplementary Payments (SSP; an expansion group), and 95 percent FPL for the Aged, Blind, and Disabled group.³⁹⁴ Medicaid eligibility for children ages 0 to 1 is 280 percent FPL. Eligibility for children ages 1 to 19 is 275 percent FPL.³⁹⁵

Medicaid Financing Method

Minnesota's federal matching rate for Medicaid is 52.95 percent for fiscal year 2004, and 50 percent for fiscal years 2005 and 2006.³⁹⁶ The state portion of Medicaid funding comes from sliding-scale premiums and copayments, with the rest (the majority) coming from the Health Care Access Fund, a special revenue state fund that is funded through a 2 percent provider tax; a 1 percent premium tax on health maintenance organizations, nonprofit health service plan corporations, and community integrated service networks; and other funds to a lesser extent, including general revenue.^{397,398}

Total Medicaid spending in Minnesota in FY 2003 was \$4,921,224,346. The average Medicaid spending per enrollee in FY 2000 was \$5,418. This varied from an average of \$1,667 spent on each child to an average of \$16,754 spent per enrollee in the blind and disabled group.³⁹⁹

Medicaid Benefits

Medicaid in Minnesota offers outpatient hospital services and services at freestanding ambulatory surgery centers, public and mental health clinics, federally qualified health centers, and rural health clinics. It also offers inpatient hospital services. The following are types of benefits offered:

- Dental services, dentures, eyeglasses, hearing aids and services for speech, hearing and language disorders.
- Laboratory and X-ray services.
- Medical equipment and supplies, prosthetic and orthotic devices.
- Early and periodical screening, diagnosis and treatment services; family planning services; rehabilitation services (mental health and substance abuse).
- Services by these health care providers: certified registered nurse anesthetist, chiropractor, other medical and remedial care practitioners, dentists providing medical surgical services, nurse midwife, nurse practitioner, optometrist, physician, podiatrist, psychologist.
- Prescription drugs.
- Physical and occupational therapy services.
- Ambulance services, non-emergency medical transportation services.
- Home health services, hospice services, personal care services, private duty nursing services, targeted case management.
- Institutional services: inpatient psychiatric services under age 21, inpatient hospital nursing facility and intermediate care facility services for mental disease age 65 and older, institutions for mental disease, intermediate care facilities for the mentally retarded, nursing facility services.⁴⁰⁰

SCHIP Characteristics

Minnesota has a combined Medicaid and SCHIP program. The federal share for SCHIP is 65 percent for FFY2005 and the state share is 35 percent of each dollar spent.⁴⁰¹ Minnesota spent \$99.5 million on SCHIP in FY 2004, including both federal and state funds.⁴⁰² As of December 2003, there were 2,731 children enrolled in SCHIP in Minnesota.⁴⁰³ To qualify for SCHIP, a child must be younger than 19, a U.S. citizen or legal resident, not eligible for Medicaid or state employee coverage, not have private insurance, and have a family income below 200 percent of

the federal poverty level.⁴⁰⁴ Since Minnesota's SCHIP is a Medicaid expansion, the benefits are the same as the Medicaid benefits listed above, and SCHIP funds are used to raise the eligibility levels for children above that of the Medicaid program.⁴⁰⁵

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.⁴⁰⁶ It currently has about 30,000 enrollees.⁴⁰⁷ 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.⁴⁰⁸

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 \$100,000.⁴⁰⁹ As of October 2004 it was considered inactive.⁴¹⁰

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.⁴¹¹ 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.⁴¹² 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.⁴¹³

MinnesotaCare is a managed care program administered by the Minnesota Department of Human Services that expands eligibility for parents and relative caretakers of Medicaid and SCHIP-eligible children, and other selected groups of people. It includes a Medicaid 1115 Waiver to extend eligibility to parents and children under age 19 up to 275 percent FPL, and a SCHIP 1115 Waiver covering parents with incomes 100-200 percent FPL.⁴¹⁴ Childless adults can qualify if their gross household incomes are less than 175 percent FPL and they meet other guidelines, as can children and pregnant women up to 275 percent FPL without access to other insurance.⁴¹⁵

There are three levels of benefits in MinnesotaCare. Pregnant women and children have the most benefits and do not pay copayments, and parents and childless adults with incomes less than 75 percent FPL can receive most services but have limits and copayments. Childless adults with incomes 75-175 percent FPL receive fewer benefits, must pay copayments, and have a \$10,000 annual limit on inpatient services and a \$5,000 annual limit on all other services.⁴¹⁶ MinnesotaCare is funded through federal funds, sliding-scale premiums and copayments, a 2 percent provider tax, and a 1 percent premium tax on health maintenance

organizations, nonprofit health service plan corporations, and community integrated service networks.⁴¹⁷

Other Health Insurance Reforms/Initiatives

Minnesota is a national leader in efforts to cover low-income uninsured people. Besides Medicaid (called Medical Assistance) and SCHIP, the state has MinnesotaCare, which extends insurance to low-income working individuals without access to affordable employer-sponsored insurance and their families, and 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 and is totally funded with state funds; \$245.6 million was spent on GAMC in FY 2004.⁴¹⁸ There are two program options: full coverage GAMC for adults with incomes under 75 percent FPL, and catastrophic GAMC for adults at 75 to 175 percent FPL. Full coverage GAMC offers similar benefits to Medicaid, while catastrophic GAMC covers only inpatient hospitalizations, with a \$1,000 deductible per stay and no monthly premiums.⁴¹⁹

Conclusions and Recommendations for 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, and there are a variety of steps that Texas could take to better address the issue. Regarding covering more people through Medicaid and SCHIP, see our list of expansion options for Texas on pages 36-38 of “Medicaid and the State Children’s Health Insurance Program in Texas: History, Current Arrangements, and Options” by Warner, Jahnke, and Kimbell (April 2005). One of these recommendations is using Section 1931 to cover more low-income people under Medicaid, like a majority of other states do. This option is relatively straightforward and does not require a federal waiver to implement.

Lessening Hardship and Bankruptcy from Medical Bills

An issue related to the unaffordability of health insurance is the rate of personal bankruptcies stemming from unpaid medical bills. Mitigating these bankruptcies should be a related goal of any reform effort. Reasons for bankruptcies are not tracked, but the only in-depth study of bankruptcies from medical reasons, published by Harvard researchers in 2005 from 2001 data, estimated that half of the almost 1.5 million personal bankruptcies filed in the U.S. in 2001 were due to illness and unpaid medical bills. About 75 percent of filers were found to have health insurance when filing (though some coverage was inadequate, and some people subsequently lost coverage), but as the sample was taken in federal judicial districts in states other than Texas (which has the highest rate of uninsurance), and Texas no longer has the Medically Needy spend-down program in Medicaid, we can assume that the proportion of bankruptcy filers in Texas without insurance would be greater than the national estimate of 25 percent. Also, as this study points out, most people filing for bankruptcy owned homes and were considered middle class by occupation and education levels. Medical bills cause hardship or financial ruin to many other people besides those who formally file for bankruptcy, since poorer people do not need to file if they have no assets to protect from creditors.⁴²⁰

Providing health insurance alone will not stop the bankruptcy problem, if the insurance is not adequate for some medical conditions or has higher deductibles and out-of-pocket costs than people can afford. Many people lose income and even their jobs when they or a family member have a serious illness, when this is precisely the time that they need more money for bills and

need their jobs as a source of employer-based insurance. A system of insurance that is not tied to employment would be the ideal solution to ameliorate this problem.⁴²¹ One immediate step that could be taken in Texas would be to restore the Medicaid Medically Needy spend-down program for non-pregnant people (now the only group covered), so anyone with a major medical condition facing large medical bills could get emergency coverage if needed.

Changing and Regulating Small Groups

Another option for the state to consider is letting sole proprietors (self-employed small business owners who may not have any employees) buy into small group plans, such as some other states do. In this case, “small groups” would be considered to be 1 to 50 people, or whatever the states’ upper limit is, instead of 2 to 50 people, for example. Most states also regulate small group rates more than Texas does by limiting the range of manual rating. Texas could regulate rate-setting for small groups, though this can sometimes have unintended consequences. If rates cannot vary as much, and rates are lowered for the high-risk people, then rates must be raised for the lower-risk people, which may cause them to drop out of the group and seek lower-cost insurance, leaving the insurer with only higher-risk people and the need to raise rates.

Subsidizing the High-Risk Pool

The Texas high-risk pool is an option open to anyone who cannot obtain coverage elsewhere for medical reasons, but since many if not most uninsured people cannot afford the premiums, another way to insure more people would be to increase funding for the high-risk pool for premium subsidies. If the pool had more revenue from the state and from provider assessments, it could lower its premiums, which have gradually increased to 200 percent of the standard rate for the person being insured. Assessments are made on most regulated private health insurance, but this does not include small group policies or ERISA plans in the assessment base. Including small group policies would only change the assessments if small group policies are written proportionately differently by insurance companies or if there are some firms that just write such policies. Rather than tax employers it might be possible to tax third-party administrators, reinsurers or other entities that make ERISA plans viable.

It would probably be reasonable to try to find a way to subsidize the high-risk pool so that the premiums could be lowered to 150 percent of the standard premium or perhaps be made to vary depending on the beneficiary’s income or wealth. One potential source of income could either be a provider tax (proposed by some insurance companies as an alternative and an indirect way to get at ERISA plans) or a tax on all employers that do not offer some minimum level of health insurance coverage — perhaps \$100 per employee per month to fund both the high-risk pool and possibly some of the match for either SCHIP or a 1931 expansion.

Using SCHIP Funds

Texas could also implement an employer buy-in and a full-cost buy-in for SCHIP insurance, as several other states have done. Texas already has an employer buy-in program for Medicaid (premium assistance, where the state pays part or all of an employer-sponsored plan for a person eligible for Medicaid, if it is more cost-effective for the state to do so). Not many people are enrolled in this Medicaid option since it is rare to have a person who is both financially eligible for Medicaid and has a job offering employer-sponsored insurance. These SCHIP options may help more people, since the eligibility levels for SCHIP are higher and there could be more enrollees with working parents who could potentially qualify for premium assistance with SCHIP funds, as well as parents who could afford to buy SCHIP for their uninsured children at full cost. Also, if SCHIP funds are not going to be entirely drawn down by SCHIP in Texas it would seem rational to find a way to cover parents of Medicaid children at some level with

SCHIP funds or at least cover Medically Needy spend-down to a certain extent since the match rate in SCHIP is much higher than in Medicaid.

Lessening the Cost of EMTALA

The legal obligation imposed by federal legislation requiring Medicare-participating hospitals to provide care to individuals with “reasonable emergencies” regardless of their ability to pay results in significant fiscal losses to most hospitals. The Emergency Medical Treatment and Labor Act (EMTALA) of 1985 requires hospitals participating in Medicare to medically screen *all* persons seeking care in hospital emergency departments, and to provide the treatment necessary to stabilize those determined to have an emergency condition, regardless of income, insurance, or immigration status.⁴²²

Currently, hospitals and other providers must absorb the costs associated with this care for the uninsured or underinsured. Hospitals serving a “disproportionate share” of medically indigent people receive Disproportionate Share Hospital (DSH) funds to help offset lost revenues. The Medically Needy Medicaid program also offers participating states some relief to this financial burden. The program allows additional individuals, including adults with children under the age of 18 years, to receive Medicaid coverage to assist with high medical bills after “spending down” to Medicaid eligibility by having their medical expenses offset their excess income.

In 2003, the 78th Texas Legislature elected to discontinue participation in the spend-down program. Reinstating the Medicaid Medically Needy program could offer help to reduce the cost of EMTALA to hospitals. Reinstating the program for the “1931” population (parents of children under 18 years of age) could be done with little difficulty. Including non-parent adults might require additional review to establish revenue neutrality. Revenue neutrality could potentially be compromised if the inclusion of the non-parents limited the amount of DSH funds available.

Future Study

One area for future study is the possibility of modifying the asset test in Medicaid — especially for Medically Needy spend-down, if reinstated, but also more broadly. Another area needing more study is the nature of both the small group and individual health insurance markets. There is little information about the individual market in Texas in terms of rates, margins, characteristics of those insured and other factors. Study of this market may well be warranted. Similarly, in the small group market the potential impact on rates and availability of insurance or reducing the extent to which rates can vary with manual adjustments needs to be investigated. Texas has many opportunities to cover more uninsured people and remedy its place as the worst state in the nation for the percentage of people with health insurance, but there are many complex issues involved and doing so will take compromise and perseverance.

Acknowledgments

The authors wish to thank the following people for their help with this project: Kristine Niemeyer (Senior Program Coordinator, LBJ School of Public Affairs) for contributing the profile of Maine, Kelly Shanahan (LBJ School graduate student) for contributing the profile of Colorado, and the members of the Task Force on Access to Health Care in Texas for their feedback.

Endnotes

- ¹⁹¹ Deborah Chollet, *Issue Brief: The Role of Reinsurance in State Efforts to Expand Coverage* (State Coverage Initiatives, October 2004, p. 1), available at <http://www.statecoverage.net/pdf/issuebrief1004.pdf>, accessed March 14, 2005.
- ¹⁹² State Coverage Initiatives, *SCHIP Employer Buy-In*, available at <http://www.statecoverage.net/employer.htm>, accessed March 14, 2005.
- ¹⁹³ State Coverage Initiatives, *Medicaid HIPP*, available at <http://www.statecoverage.net/hipp.htm>, accessed March 14, 2005.
- ¹⁹⁴ State Coverage Initiatives, *SCHIP Full Cost Buy-In*, available at <http://www.statecoverage.net/fullcost.htm>, accessed March 14, 2005.
- ¹⁹⁵ Deborah Chollet, *Issue Brief: The Role of Reinsurance in State Efforts to Expand Coverage* (State Coverage Initiatives, October 2004, p. 2, p. 5, endnote 1), available at <http://www.statecoverage.net/pdf/issuebrief1004.pdf>, accessed March 14, 2005.
- ¹⁹⁶ Isabel Friedenzohn, *Issue Brief: Limited-Benefit Policies: Public and Private-Sector Experiences* (State Coverage Initiatives, July 2004, p. 4), available at <http://www.statecoverage.net/pdf/issuebrief704.pdf>, accessed March 30, 2005.
- ¹⁹⁷ AISHealth.com, *Insurers, Enrollees Show Little Interest in State 'Mandate-Light' Laws* (Business News of the Week, May 18, 2005), available at <http://www.aishealth.com/bnow/051805a.html>, accessed May 18, 2005.
- ¹⁹⁸ Mila Kofman, *Issue Brief: Group Purchasing Arrangements: Issues for States* (State Coverage Initiatives, April 2003, p. 1), available at <http://www.statecoverage.net/pdf/issuebrief403.pdf>, accessed March 30, 2005.
- ¹⁹⁹ Texas Department of Insurance, *Working Together for a Healthy Texas, Interim Report, State Planning Grant Project* (September 2004, pp. 53-54), available at <http://www.tdi.state.tx.us/general/PDF/spgint04.pdf>, accessed April 2, 2005.
- ²⁰⁰ State Coverage Initiatives, *State-Only High Risk Pool*, available at <http://www.statecoverage.net/highrisk.htm>, accessed March 29, 2005.
- ²⁰¹ Claudia L. Schur, Marc L. Berk, and Jill M. Yegian, "Workers' Perspectives on Mandated Employer Health Insurance," *Health Affairs* (Web Exclusive, March 17, 2004, p. 128), available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.128v1.pdf>, accessed April 3, 2005.
- ²⁰² Employee Benefit Research Institute, *An Employer Mandate: What's Known and What Isn't* (November 1993, p. 1), available at <http://www.ebri.org/srpdfs/sr19.pdf>, accessed April 3, 2005.
- ²⁰³ The Commonwealth Fund, *California: Health Insurance Act of 2003*, available at http://www.cmwf.org/tools/tools_show.htm?doc_id=235062, accessed April 3, 2005.
- ²⁰⁴ Patricia A. Butler, *Revisiting Pay or Play: How States Could Expand Employer-Based Coverage within ERISA Constraints* (National Academy for State Health Policy, May 2002), available at http://www.nashp.org/Files/ERISA_pay_or_play.PDF, accessed April 3, 2005; and Patricia A. Butler, *ERISA Implications for Employer Pay or Play Coverage Laws* (California HealthCare Foundation, March 2005), available at <http://www.chcf.org/documents/insurance/ERISAPayPlayImplications.pdf>, accessed April 3, 2005.
- ²⁰⁵ State Coverage Initiatives, *State-Only Tax Incentives*, available at <http://www.statecoverage.net/tax.htm>, accessed March 29, 2005.
- ²⁰⁶ Texas Department of Insurance, *Working Together for a Healthy Texas, Interim Report, State Planning Grant Project* (September 2004, pp. 51-52), available at <http://www.tdi.state.tx.us/general/PDF/spgint04.pdf>, accessed April 2, 2005.
- ²⁰⁷ U.S. General Accounting Office, *Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses* (Washington, D.C., September 2003), Appendix III, pp. 41-43.

-
- ²⁰⁸ Georgetown University Health Policy Institute, *Summary of Key Consumer Protections in Individual Health Insurance Markets* (April 2004), available at http://www.healthinsuranceinfo.net/newsyoucanuse/discrimination_limits.pdf, accessed April 3, 2005.
- ²⁰⁹ Advantage Insurance and Financial Services, Inc., *Guaranteed Issue HIPAA Coverage*, available at http://www.aifsi.com/hipaa_plans.htm, accessed April 3, 2005.
- ²¹⁰ The Council for Affordable Health Insurance, *What Were these States Thinking? The Pitfalls of Guaranteed Issue* (May 2002), available at <http://www.cagionline.org/cahidoc.pdf>, accessed April 3, 2005; and Scott Garrett and Jeb Bradley, *Been There, Done That, Let's Steer Clear of Guaranteed Issue* (Letter to Republican Congress, March 3, 2003), available at <http://www.cagionline.org/garrettltr.pdf>, accessed April 3, 2005.
- ²¹¹ State Coverage Initiatives, *Profiles in Coverage: Healthy New York* (January 2005), available at <http://www.statecoverage.net/newyorkprofile.htm>, accessed April 20, 2005.
- ²¹² *Ibid.*
- ²¹³ *Ibid.*
- ²¹⁴ Embry Howell, Ruth Almeida, Lisa Dubay, and Genevieve Kenney, *Early Experience with Covering Uninsured Parents Under SCHIP* (The Urban Institute, No. A-51, May 2002), available at <http://www.urban.org/url.cfm?ID=310498>, accessed April 20, 2005.
- ²¹⁵ Gwendolyn L. Harris, Commissioner, New Jersey Department of Human Services, Letter to Dennis Smith, Centers for Medicare and Medicaid Services (July 15th, 2002), available at <http://www.cms.hhs.gov/hifa/njhifacvrltr.pdf>, accessed April 20, 2005; and Thomas A. Scully, Centers for Medicare and Medicaid Services, Letter to Gwendolyn L. Harris, New Jersey Department of Human Services (January 31, 2003), available at <http://www.cms.hhs.gov/hifa/njstandardapprovlet.pdf>, accessed April 20, 2005.
- ²¹⁶ Cindy Mann, Samantha Artiga, and Jocelyn Guyer, *Assessing the Role of Recent Waivers in Providing New Coverage* (Kaiser Commission on Medicaid and the Uninsured, Issue Paper, December 2003, p. 2), available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=28336>, accessed April 26, 2005.
- ²¹⁷ Isabel Frieden-zohn, *Issue Brief: States' Experience with Benefit Design* (State Coverage Initiatives, April 2003, p. 4), available at <http://www.statecoverage.net/pdf/issuebrief403benefits.pdf#search='utah%20medicaid%20benefit%20reduced>, accessed April 26, 2005.
- ²¹⁸ Cindy Mann, Samantha Artiga, and Jocelyn Guyer, *Assessing the Role of Recent Waivers in Providing New Coverage* (Kaiser Commission on Medicaid and the Uninsured, Issue Paper, December 2003, p. 7), available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=28336>, accessed April 26, 2005.
- ²¹⁹ Centers for Medicare and Medicaid Services, *Utah Primary Care Network Demonstration Fact Sheet* (updated April 4, 2005), available at <http://www.cms.hhs.gov/medicaid/1115/utpcnfs.pdf>, accessed April 26, 2005.
- ²²⁰ Isabel Frieden-zohn, *Issue Brief: States' Experience with Benefit Design* (State Coverage Initiatives, April 2003, p. 4), available at <http://www.statecoverage.net/pdf/issuebrief403benefits.pdf#search='utah%20medicaid%20benefit%20reduced>, accessed April 26, 2005.
- ²²¹ KaiserNetwork.org, *HHS Approves Utah's First-in-Kind Medicaid Waiver Proposal To Extend Coverage to 25,000 While Reducing Other Benefits* (Daily Health Policy Report, Feb 11, 2002), available at http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=9405, accessed April 25, 2005.
- ²²² Centers for Medicare and Medicaid Services, *Utah Primary Care Network Demonstration Fact Sheet* (updated April 4, 2005), available at <http://www.cms.hhs.gov/medicaid/1115/utpcnfs.pdf>, accessed April 26, 2005.
- ²²³ William R. Brody, "A New Vision for Maryland Hospitals" (originally published in the *Baltimore Sun*, December 10, 2002), available at <http://www.jhu.edu/~president/news/sundec10.html>, accessed April 21, 2005.
- ²²⁴ Maryland Health Services Cost Review Commission, *About HSCRC*, available at http://www.hscrc.state.md.us/about_us/about_us.html, accessed April 21, 2005.

²²⁵ Ibid.

²²⁶ Maryland Health Care Commission, *News Release* (April 4, 2001), available at <http://www.dhmm.state.md.us/publ-rel/html/disco~1.htm>, accessed May 19, 2005.

²²⁷ U.S. Census Bureau, *Table 1: Annual Estimates of the Population for Counties of Texas: April 1, 2000 to July 1, 2004*, available at <http://www.census.gov/popest/counties/tables/CO-EST2004-01-48.xls>, accessed June 8, 2005.

²²⁸ Kaiser Family Foundation, State Health Facts, *Texas: Distribution of Total Population by Federal Poverty Level, State Data 2002-2003, U.S. 2003*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Texas&category=Demographics+and+the+Economy&subcategory=People+in+Poverty&topic=Distribution+by+FPL>, accessed March 11, 2005.

²²⁹ Kaiser Family Foundation, State Health Facts, *Texas: Population Distribution by Insurance Status, State Data 2002-2003, U.S. 2003*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Texas&category=Health+Coverage+%26+Uninsured&subcategory=Insurance+Status&topic=Distribution+by+Insurance+Status>, accessed March 11, 2005.

²³⁰ Kaiser Family Foundation, State Health Facts, *Texas: Medicaid Eligibility, 2004*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Texas&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Eligibility>, accessed March 11, 2005; and E-mail from Anne Dunkelberg to Kristie Kimbell, "Re: FPL Question," March 24, 2005.

²³¹ Kaiser Family Foundation, State Health Facts, *Texas: Income Eligibility Levels for Children under Medicaid, as a Percent of Federal Poverty Level, 2004*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Texas&category=Medicaid+%26+SCHIP&subcategory=Children%27s+Medicaid+and+SCHIP+Eligibility&topic=Income+Eligibility%2d%2d+Medicaid>, accessed March 11, 2005.

²³² Kaiser Family Foundation, State Health Facts, *Texas: Federal Matching Rate (FMAP) for Medicaid*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Texas&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Spending&topic=Federal+Matching+Rate+%28FMAP%29>, accessed March 11, 2005.

²³³ Anne Dunkelberg, Center for Public Policy Priorities, *Medicaid and State Budgets: A Case Study of Texas* (Kaiser Commission on Medicaid and the Uninsured, March 2002, p. 18), available at <http://www.cppp.org/files/6/getfile.pdf>, accessed April 25, 2005.

²³⁴ Texas Legislative Budget Board, *Fiscal Note for SB1839, Enrolled Version, 77th Legislative Session* (May 26, 2001), available at <http://www.capitol.state.tx.us/cgi-bin/tlo/textframe.cmd?LEG=77&SESS=R&CHAMBER=S&BILLTYPE=B&BILLSUFFIX=01839&VERSION=5&TYPE=F>, accessed April 27, 2005.

²³⁵ Kaiser Family Foundation, State Health Facts, *Texas: Medicaid Spending*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Texas&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Spending>, accessed March 11, 2005.

²³⁶ Kaiser Commission on Medicaid and the Uninsured, *Medicaid Benefits, as of January 2003*, available at <http://www.kff.org/medicaidbenefits/state-TX.cfm>, accessed March 11, 2005.

²³⁷ Texas Health and Human Services Commission, *Texas Medicaid in Perspective, 5th ed.* (2004, p. 2-8), available at <http://www.hhsc.state.tx.us/medicaid/reports/PB5/PinkBookTOC.html>, accessed April 4, 2005.

²³⁸ Texas Health and Human Services Commission, "FY 05 Federal Alloc LAR" (Excel spreadsheet, January 2005).

²³⁹ Texas Health and Human Services Commission, *Children's Health Insurance Program*, available at <http://www.hhsc.state.tx.us/chip/index.html>, accessed April 4, 2005.

²⁴⁰ Anne Dunkelberg and Molly O'Malley, *Children's Medicaid and SCHIP in Texas: Tracking the Impact of Budget Cuts* (Kaiser Commission on Medicaid and the Uninsured, July 2004, p. 2), available at <http://www.kff.org/medicaid/7132.cfm>, accessed April 18, 2005.

-
- ²⁴¹ Centers for Medicare and Medicaid Services, *A Profile of Medicaid: Chartbook 2000* (p. 72), available at <http://www.cms.hhs.gov/charts/medicaid/2Tchartbk.pdf>, accessed November 14, 2004.
- ²⁴² Texas Health and Human Services Commission, *CHIP Assets Test Policy: Summary of Final Rules*, available at http://www.hhsc.state.tx.us/chip/reports/042304_AssetTestPolicySum.html, accessed June 8, 2005.
- ²⁴³ Texas Health and Human Services Commission, *A Consumer Guide to Better Healthcare: Your 2004 Road Map to Understanding the Health Care System in Texas*, pp. 47-50, available at <http://www.hhsc.state.tx.us/chip/reports/ConsumerGuideEnglish.pdf>, accessed November 30, 2004.
- ²⁴⁴ Kaiser Family Foundation, State Health Facts, *Texas: Managed Care & Health Insurance*, available at http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&category=Managed+Care+%26+Health+Insurance&subcategory=&topic=&link_category=&link_subcategory=&link_topic=&welcome=0&area=Texas¬es=show&printerfriendly=0#pagetopic8, accessed March 11, 2005.
- ²⁴⁵ Texas Department of Insurance, *Texas Health Insurance Risk Pool Expansion Options* (January 2005, pp. 3, 4), available at <http://www.tdi.state.tx.us/general/pdf/lhlRiskPoolRept.pdf>, accessed May 20, 2005.
- ²⁴⁶ *Ibid.*, p. 4, appendices.
- ²⁴⁷ *Ibid.*, pp. 4, 5, 16.
- ²⁴⁸ Texas Department of Insurance, *Working Together for a Healthy Texas, Interim Report, State Planning Grant Project* (September 2004, pp. 43, 49, 53-54), available at <http://www.tdi.state.tx.us/general/PDF/spgint04.pdf>, accessed April 4, 2005.
- ²⁴⁹ Texas Department of Insurance, *Rules, Subchapter D, Health Group Cooperatives*, available at <http://www.tdi.state.tx.us/commish/rules/0811AA-059.html>, accessed April 4, 2005.
- ²⁵⁰ Texas Department of Insurance, *Listing of Coalition and Purchasing Cooperatives* (March 23, 2005), available at http://www.tdi.state.tx.us/company/lhcoop_lst_incl.html, accessed April 26, 2005.
- ²⁵¹ Texas Department of Insurance, *Biennial Report of the Texas Department of Insurance to the 79th Texas Legislature* (December 2004, Section D, Issue 9), available at <http://www.tdi.state.tx.us/commish/reports/finalbie05.html#thrs>, accessed April 4, 2005.
- ²⁵² Texas Department of Insurance, *Working Together for a Healthy Texas, Interim Report, State Planning Grant Project* (September 2004, pp. 51-52), available at <http://www.tdi.state.tx.us/general/PDF/spgint04.pdf>, accessed April 26, 2005.
- ²⁵³ Kaiser Family Foundation, State Health Facts, *Texas: Medicaid Managed Care Enrollees as a Percent of State Medicaid Enrollees, 2003*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Texas&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Managed+Care&topic=MC+Enrollment+a+s+a+%25+of+Total+Enrollment>, accessed March 11, 2005.
- ²⁵⁴ Texas Health and Human Services Commission, *Texas Medicaid in Perspective, 5th ed.* (2004, p. 3-13), available at <http://www.hhsc.state.tx.us/medicaid/reports/PB5/PinkBookTOC.html>, accessed March 13, 2005.
- ²⁵⁵ State Coverage Initiatives, *Medicaid HIPP*, available at <http://www.statecoverage.net/hipp.htm>, accessed March 14, 2005.
- ²⁵⁶ State Coverage Initiatives, *Medicaid TMA*, available at <http://www.statecoverage.net/tma.htm>, accessed March 14, 2005.
- ²⁵⁷ Paper commissioned by the Task Force on Access to Health Care in Texas, website available at <http://www.utsystem.edu/hea/taskforce/homepage.htm>.
- ²⁵⁸ Kaiser Family Foundation, State Health Facts, *Florida: Distribution of Total Population by Federal Poverty Level, State Data 2002-2003, U.S. 2003*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Florida&category=Demographics+and+the+Economy&subcategory=People+in+Poverty&topic=Distribution+by+FPL>, accessed April 17, 2005.

-
- ²⁵⁹ Kaiser Family Foundation, State Health Facts, *Florida: Population Distribution by Insurance Status, State Data 2002-2003, U.S. 2003*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Florida&category=Health+Coverage+%26+Uninsured&subcategory=Insurance+Status&topic=Distribution+by+Insurance+Status>, accessed April 17, 2005.
- ²⁶⁰ Kaiser Family Foundation, State Health Facts, *Florida: Medicaid Eligibility, 2004*, available at http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Eligibility&topic=&link_category=&link_subcategory=&link_topic=&welcome=0&area=Florida¬es=show&printerfriendly=0#pagetopic1, accessed April 17, 2005.
- ²⁶¹ Kaiser Family Foundation, State Health Facts, *Florida: Income Eligibility Levels for Children under Medicaid, as a Percent of Federal Poverty Level, 2004*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Florida&category=Medicaid+%26+SCHIP&subcategory=Children%27s+Medicaid+and+SCHIP+Eligibility&topic=Income+Eligibility%2d%2d+Medicaid>, accessed April 17, 2005.
- ²⁶² Kaiser Family Foundation, State Health Facts, *Florida: Federal Matching Rate (FMAP) for Medicaid*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Florida&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Spending&topic=Federal+Matching+Rate+%28FMAP%29>, accessed April 17, 2005.
- ²⁶³ Kaiser Family Foundation, State Health Facts, *Florida: State Medicaid Expenditures (in millions), SFY 2003*, available at http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&category=Medicaid+%26+SCHIP&subcategory=State+Medicaid+Spending&topic=State+Medicaid+Spending%2c+SFY2003&link_category=&link_subcategory=&link_topic=&welcome=0&area=Florida, accessed April 17, 2005.
- ²⁶⁴ Kaiser Family Foundation, State Health Facts, *Florida: Medicaid Spending*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Florida&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Spending>, accessed April 17, 2005.
- ²⁶⁵ Kaiser Commission on Medicaid and the Uninsured, *Medicaid Benefits, as of January 2003*, available at <http://www.kff.org/medicaidbenefits/state-FL.cfm>, accessed April 17, 2005.
- ²⁶⁶ Kaiser Family Foundation, State Health Facts, *Florida: Income Eligibility Levels for Children Under SCHIP, as a Percent of Federal Poverty Level, 2004*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Florida&category=Medicaid+%26+SCHIP&subcategory=Children%27s+Medicaid+and+SCHIP+Eligibility&topic=Income+Eligibility%2d%2d+Separate+SCHIP>, accessed April 17, 2005.
- ²⁶⁷ Florida KidCare, *Florida KidCare*, available at <http://www.floridakidcare.org>, accessed April 17, 2005.
- ²⁶⁸ Kaiser Family Foundation, State Health Facts, *Florida: SCHIP*, available at http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&category=Medicaid+%26+SCHIP&subcategory=SCHIP&topic=&link_category=&link_subcategory=&link_topic=&welcome=0&area=Florida¬es=show&printerfriendly=0#pagetopic1, accessed April 17, 2005.
- ²⁶⁹ Centers for Medicare and Medicaid Services, *A Profile of Medicaid: Chartbook 2000* (p. 72), available at <http://www.cms.hhs.gov/charts/medicaid/2Tchartbk.pdf>, accessed November 14, 2004.
- ²⁷⁰ National Governor's Association, *Florida: NGA Summary, State Children's Health Insurance Program*, available at <http://www.nga.org/cda/files/FLSCHIP.pdf>, accessed April 17, 2005.
- ²⁷¹ Florida Agency for Health Care Administration, *Florida KidCare, A Briefing for Governor Jeb Bush on September 12, 2003* (Powerpoint Presentation, September 12, 2003), available at http://www.fdhc.state.fl.us/Medicaid/MediKids/kidcare_governor_9_03.ppt, accessed April 17, 2005.
- ²⁷² Kaiser Commission on Medicaid and the Uninsured, *Update on the Florida SCHIP Enrollment Freeze* (July 23, 2004), available at <http://www.statecoverage.net/statereports/fl41.pdf>, accessed April 18, 2005.
- ²⁷³ Kaiser Family Foundation, State Health Facts, *Florida: Managed Care & Health Insurance*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Florida&welcome=1&category=Managed+Care+%26+Health+Insurance>, accessed April 17, 2005.

²⁷⁴ Florida Agency for Health Care Administration, *Florida Health Insurance Study 2004, The HRSA State Planning Grant Program Interim Report* (September 30, 2004, pp. 9-10), available at http://ahca.myflorida.com/Medicaid/Research/Projects/fhis2004/PDF/HRSA-SPG_INTERIM_Report_FINAL_.pdf, accessed April 18, 2005.

²⁷⁵ Florida Agency for Health Care Administration, *HRSA State Planning Grant: Project Abstract* (2003, p. 1), available at http://ahca.myflorida.com/affordable_health_insurance/PDFs/hrsa_state_planning_grant.pdf, accessed April 18, 2005.

²⁷⁶ Health Management Associates, *Final Report of the Governor's Task Force on Access to Affordable Health Insurance* (February 15, 2004, p. 64), available at <http://www.statecoverage.net/statereports/fl38.pdf>, accessed April 18, 2005.

²⁷⁷ Kaiser Family Foundation, State Health Facts, *Florida: Medicaid Managed Care*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Florida&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Managed+Care>, accessed April 17, 2005.

²⁷⁸ Kaiser Family Foundation, State Health Facts, *Medicaid Waiver to Cover Family Planning, 2005*, available at http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Florida&category=Medicaid+%26+SCHIP&link_category=Women%27s+Health&link_subcategory=Medicaid+Policy&link_topic=Family+Planning+Waiver, accessed April 17, 2005.

²⁷⁹ State Coverage Initiatives, *Medicaid Section 1931 Waiver*, available at <http://www.statecoverage.net/medicaid-1931.htm>, accessed April 17, 2005.

²⁸⁰ State Coverage Initiatives, *SCHIP Full Cost Buy-In*, available at <http://www.statecoverage.net/fullcost.htm>, accessed April 17, 2005.

²⁸¹ Centers for Medicare and Medicaid Services, *Florida*, available at <http://www.cms.hhs.gov/medicaid/waivers/flwaiver.asp>, accessed April 17, 2005.

²⁸² "Gov. Bush Proposes Medicaid Revamp," *St. Petersburg Times* (January 12, 2005), available at http://www.sptimes.com/2005/01/12/State/Gov_Bush_proposes_Med.shtml, accessed January 12, 2005.

²⁸³ *Ibid.*

²⁸⁴ Florida Agency for Health Care Administration, *Empowered Care: A Proposed Concept for Florida Medicaid* (draft, March 14, 2005), available at http://www.empoweredcare.com/docs/empoweredcare_proposed_concept.pdf, accessed March 23, 2005.

²⁸⁵ Florida House of Representatives, Health Care General Committee, "Committee Meeting Packet for March 16, 2005" (including draft legislation of "Medicaid Reform Act of 2005," March 14, 2005).

²⁸⁶ Florida Senate, *Senate Bill 0838ER* (Enrolled, 3rd Engrossed, 2005 Legislature), available at http://www.flsenate.gov/cgi-bin/view_page.pl?Tab=session&Submenu=1&FT=D&File=sb0838er.html&Directory=session/2005/Senate/bills/billtext/html, accessed May 23, 2005.

²⁸⁷ Diane Hirth, "Medicaid Measure Passes: Compromise Comes Through," *The Mercury News* (May 7, 2005), available at <http://www.mercurynews.com/mld/tallahassee/news/politics/11586417.htm?template=contentModules/printstory.jsp>, accessed May 23, 2005.

²⁸⁸ Kaiser Family Foundation, State Health Facts, *Arkansas: Distribution of Total Population by Federal Poverty Level, State Data 2002-2003, U.S. 2003*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Arkansas&category=Demographics+and+the+Economy&subcategory=People+in+Poverty&topic=Distribution+by+FPL>, accessed March 11, 2005

²⁸⁹ Kaiser Family Foundation, State Health Facts, *Arkansas: Population Distribution by Insurance Status, State Data 2002-2003, U.S. 2003*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Arkansas&category=Health+Coverage+%26+Uninsured&subcategory=Insurance+Status&topic=Distribution+by+Insurance+Status>, accessed April 17, 2005

²⁹⁰ Kaiser Family Foundation, State Health Facts, *Arkansas: Total Medicaid Spending, FY2003*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Arkansas&category=Medicaid+%26+>

SCHIP&subcategory=Medicaid+Spending&topic=Total+Medicaid+Spending%2c+FY2003, accessed March 10, 2005.

²⁹¹ State Coverage Initiatives, *Health Cost Concerns Intensify in Little Rock* (Summer 2003), available at <http://www.statecoverage.net/statereports/ar4.pdf>, accessed April 22, 2005.

²⁹² Kaiser Family Foundation, State Health Facts, *Arkansas: Total Medicaid Spending, FY2003*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Arkansas&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Spending&topic=Total+Medicaid+Spending%2c+FY2003>, accessed March 10, 2005.

²⁹³ Heather Sacks, Todd Kutyla, and Sharon Silow-Carroll, Economic and Social Research Institute, *Toward Comprehensive Health Coverage for All: Summaries of 20 State Planning Grants from the U.S. Health Resources and Services Administration* (Commonwealth Fund, November 2002, p. 61), available at <http://www.statecoverage.net/statereports/ar3.pdf>, accessed on March 10, 2005.

²⁹⁴ State Coverage Initiatives, *Health Cost Concerns Intensify in Little Rock* (Summer 2003), available at <http://www.statecoverage.net/statereports/ar4.pdf>, accessed April 22, 2005.

²⁹⁵ Kaiser Commission on Medicaid and the Uninsured, *Medicaid Benefits, as of January 2003*, available at <http://www.kff.org/medicaidbenefits/state-MN.cfm>, accessed March 10, 2005.

²⁹⁶ Kaiser Family Foundation, State Health Facts, *Arkansas: SCHIP Federal Matching Rate (FMAP), FFY2005*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Arkansas&category=Medicaid+%26+SCHIP&subcategory=SCHIP&topic=Federal+Matching+Rate>, accessed April 12, 2005.

²⁹⁷ Kaiser Family Foundation, State Health Facts, *Arkansas: SCHIP Expenditures, FFY 2002*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Arkansas&category=Medicaid+%26+SCHIP&subcategory=SCHIP&topic=SCHIP+Expenditures>, accessed April 12, 2005.

²⁹⁸ Kaiser Family Foundation, State Health Facts, *Arkansas: Managed Care & Health Insurance*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Arkansas&category=Managed+Care+%26+Health+Insurance&subcategory=State+Continuation+Coverage&topic=State+COBRA+Expansions>, accessed March 10, 2005.

²⁹⁹ State Coverage Initiatives, *Assessing State Strategies for Health Coverage Expansion: Profiles of Arkansas, Michigan, New Mexico, New York, Utah, and Vermont* (February 2003), available at <http://www.statecoverage.net/statereports/multi3.pdf>, accessed April 22, 2005.

³⁰⁰ Kaiser Family Foundation, State Health Facts, *Arkansas: Women's Health*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Arkansas&category=Women%27s+Health&subcategory=Medicaid+Policy&topic=Family+Planning+Waiver>, accessed March 10, 2005.

³⁰¹ State Coverage Initiatives, *Medicaid Section 1931 Waiver*, available at <http://www.statecoverage.net/medicaid-1931.htm>, accessed March 8, 2005.

³⁰² Centers for Medicare and Medicaid Services, *Arkansas Waiver and Demonstration Programs, Fact Sheet*, available at <http://www.cms.hhs.gov/medicaid/1115/ar1115tefra.asp>, accessed April 23, 2005.

³⁰³ Ibid.

³⁰⁴ State Coverage Initiatives, *Assessing State Strategies for Health Coverage Expansion: Profiles of Arkansas, Michigan, New Mexico, New York, Utah, and Vermont*, available at <http://www.statecoverage.net/statereports/multi3.pdf>, accessed April 22, 2005.

³⁰⁵ U.S. Census Bureau, *U.S. Census 2000, Colorado QuickFacts*, available at <http://quickfacts.census.gov/qfd/states/08000.html>, accessed November 30, 2004.

³⁰⁶ Kaiser Family Foundation, State Health Facts, *Colorado: Distribution of Total Population by Federal Poverty Level, State Data 2002-2003, U.S. 2003*, available at: www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Colorado&category=Demographics+and+the+Economy&subcategory=People+in+Poverty&topic=Distribution+by+FPL, accessed March 25, 2005.

-
- ³⁰⁷ Kaiser Family Foundation, State Health Facts, *Colorado: Population Distribution by Insurance Status, state data 2002-03, U.S. 2003*, available at www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Colorado&category=Health+Coverage+%26+Uninsured&subcategory=Insurance+Status&topic=Distribution+by+Insurance+Status, accessed March 25, 2005.
- ³⁰⁸ The Bell Policy Center, “Ten Years of TABOR: A Study of Colorado’s Taxpayer’s Bill of Rights,” (2003), pp. 12-14.
- ³⁰⁹ Ibid. The index used is the Denver-Boulder-Greeley Consumer Price Index.
- ³¹⁰ Donnell-Kay Foundation, “Amendment 23 and Public School Financing in Colorado” (March 2003), p. 5, available at <http://www.headfirstcolorado.org/A23FINAL.pdf>, accessed November 28, 2004.
- ³¹¹ Head First Colorado, “Amendment 23 Background,” available at http://www.headfirstcolorado.org/factsheets/Amendment_23.php, accessed November 28, 2004.
- ³¹² The Bell Policy Center, “Ten Years of TABOR: A Study of Colorado’s Taxpayer’s Bill of Rights.”
- ³¹³ Kaiser Family Foundation, State Health Facts, *Colorado: Medicaid Eligibility, 2004*, available at www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Colorado&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Eligibility&topic=Income+Eligibility%2d%2d+Pregnant+in+Medicaid, accessed March 27, 2005.
- ³¹⁴ Kaiser Family Foundation, State Health Facts, *Colorado: Income Eligibility Levels for Children Under Medicaid, as a Percent of the Federal Poverty Level (FPL), 2004*, available at www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Colorado&category=Medicaid+%26+SCHIP&subcategory=Children%27s+Medicaid+and+SCHIP+Eligibility&topic=Income+Eligibility%2d%2d+Medicaid, accessed March 27, 2005.
- ³¹⁵ Kaiser Family Foundation, State Health Facts, *Colorado: Federal Matching Rate (FMAP) for Medicaid*, available at www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Colorado&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Spending&topic=Federal+Matching+Rate+%28FMAP%29, accessed March 27, 2005.
- ³¹⁶ Colorado Department of Health Care Policy and Financing (HCPF), “Strategic Plan, FY 05-06 Budget Request,” p. L-4; and HCPF, “Part II: Summary Tables—FY 2004-05 Appropriations by Department and Fund Source,” p. 15.
- ³¹⁷ Kaiser Family Foundation, State Health Facts, *Colorado: Total Medicaid Spending, FY2003*, available at www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Colorado&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Spending&topic=Total+Medicaid+Spending%2c+FY2003, accessed March 27, 2005.
- ³¹⁸ Kaiser Family Foundation, State Health Facts, *Colorado: Distribution of Medicaid Spending per Enrollee by Enrollment Group, FY2000*, available at www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Colorado&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Spending&topic=Spending+per+Enrollee+by+Group%2c+FY2000, accessed March 27, 2005.
- ³¹⁹ Kaiser Commission on Medicaid and the Uninsured, *Medicaid Benefits, as of January 2003*, available at www.kff.org/medicaidbenefits/state-CO.cfm, accessed March 27, 2005.
- ³²⁰ Kaiser Family Foundation, State Health Facts, *Colorado: Children’s Medicaid and SCHIP Eligibility*, available at www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Colorado&category=Medicaid+%26+SCHIP&subcategory=Children%27s+Medicaid+and+SCHIP+Eligibility, accessed April 22, 2005.
- ³²¹ Colorado Medical Services Board, *Children’s Basic Health Plan Annual Report State Fiscal Year 2004*, p. 8.
- ³²² Kaiser Family Foundation, State Health Facts, *Colorado: SCHIP*, available at www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&category=Medicaid+%26+SCHIP&subcategory=SCHIP&topic=&link_category=&link_subcategory=&link_topic=&welcome=0&area=Colorado, accessed April 22, 2005.
- ³²³ National Academy for State Health Policy, *State Experience with Enrollment Caps in Separate SCHIP Programs* (February 2004, p. 5), available at www.statecoverage.net/statereports/multi30.pdf, accessed April 22, 2005; and Colorado Medical Services Board, *Children’s Basic Health Plan Annual Report State Fiscal Year 2004*, p. 8.
- ³²⁴ Colorado Medical Services Board, *Children’s Basic Health Plan Annual Report State Fiscal Year 2004*, p. 6.

-
- ³²⁵ Kaiser Family Foundation, State Health Facts, *Colorado: Managed Care & Health Insurance*, available at www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Colorado&category=Managed+Care+%26+Health+Insurance, accessed March 27, 2005.
- ³²⁶ Colorado Health Institute (CHI) “The Small Group Health Insurance Market in Colorado” (White Paper, pp. 25-26), available at http://coloradohealthinstitute.org/publications/Sm_grp_mkt.pdf, accessed April 26, 2005.
- ³²⁷ CHI, “The Small Group Health Insurance Market in Colorado,” pp. 25-26.
- ³²⁸ Kaiser Family Foundation, State Health Facts, *Colorado: Medicaid Managed Care Enrollees as a Percent of State Medicaid Enrollees, 2003*, available at www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Colorado&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Managed+Care&topic=MC+Enrollment+as+a+%25+of+Total+Enrollment, accessed March 28, 2005.
- ³²⁹ Centers for Medicare and Medicaid Services, *Colorado 1915(b) Fact Sheet—Primary Care Physicians Program*, available at www.cms.hhs.gov/medicaid/1915b/copcpps.pdf, accessed March 28, 2005; and HCPF, “Assumptions and Calculations FY 05-06 Budget Request,” November 1, 2004, p. M-69.
- ³³⁰ Centers for Medicare and Medicaid Services, *Colorado 1915(b) Fact Sheet—Primary Care Physicians Program*, available at www.cms.hhs.gov/medicaid/1915b/copcpps.pdf, accessed March 28, 2005.
- ³³¹ HCPF, “Assumptions and Calculations FY 05-06 Budget Request,” November 1, 2004, p. M-24. Telephone interview with Elizabeth Arenales, Esq., Health Care Program Director, Colorado Center on Law and Policy, by Kelly Shanahan, March 6, 2005.
- ³³² Arenales interview.
- ³³³ HCPF, “Assumptions and Calculations FY 05-06 Budget Request,” November 1, 2004, p. M-79.
- ³³⁴ Centers for Medicare and Medicaid Services, *Colorado*, available at <http://www.cms.hhs.gov/medicaid/waivers/cowaiver.asp>, accessed March 28, 2005.
- ³³⁵ Centers for Medicare and Medicaid Services, *Colorado §1115 Demonstration Fact Sheet—Consumer Directed Attendant Support*, available at <http://www.cms.hhs.gov/medicaid/1115/cocdasfct.pdf>, accessed March 28, 2005.
- ³³⁶ Centers for Medicare and Medicaid Services, *Colorado §1115 Demonstration Fact Sheet—Alternatives in Medicaid Home Care*, available at <http://www.cms.hhs.gov/medicaid/1115/coamhcsfct.pdf>, accessed on March 28, 2005.
- ³³⁷ HCPF, “Assumptions and Calculations FY 05-06 Budget Request,” November 1, 2004, pp. M85-86.
- ³³⁸ Colorado State Constitution, Article X, Section 21 “Tobacco Taxes for Health Related Purposes.”
- ³³⁹ As of April 22, 2005, HB05-1262 has passed the House of Representatives, the Senate Health and Human Services Committee, and as of this writing awaits debate in the Senate Appropriations Committee.
- ³⁴⁰ Colorado Legislative Council Staff, “HB05-1262 State and Local Revised Fiscal Impact,” Drafting Number LLS 05-0339, Prime Sponsors Rep. Boyd and Sen. Hagedorn; Bill Status: House Third Reading, April 5, 2005, pg. 3.
- ³⁴¹ Colorado General Assembly, House of Representatives, Second Reading of HB05-1262, testimony of House bill sponsor, Representative Betty Boyd, D-Jefferson County, April 5, 2005.
- ³⁴² Colorado General Assembly, First Regular Session, Sixty-fifth General Assembly, HB05-1262 Engrossed (this version includes all amendments adopted on Second Reading in the House of Introduction), House Sponsorship: Boyd and Buescher, Senate Sponsorship: Hagedorn, Sandoval, Tochtrop, Williams, and Windels.
- ³⁴³ Colorado Legislative Council Staff, “HB05-1262 State and Local Revised Fiscal Impact,” Drafting Number LLS 05-0339, Prime Sponsors Rep. Boyd and Sen. Hagedorn; Bill Status: House Third Reading, April 5, 2005; Colorado General Assembly, House of Representatives, Second Reading of HB05-1262, testimony of House bill sponsor, Representative Betty Boyd, D-Jefferson County, April 5, 2005.
- ³⁴⁴ HCPF, “Assumptions and Calculations FY 05-06 Budget Request,” November 1, 2004, p. M-86.

-
- ³⁴⁵ Kaiser Family Foundation, *Maine: Population Distribution by Insurance Status, state data 2002-03, U.S. 2003*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Maine&category=Health+Coverage+%26+Uninsured&subcategory=Insurance+Status&topic=Distribution+by+Insurance+Status>, accessed March 2, 2005.
- ³⁴⁶ Kaiser Family Foundation, *Maine: Population Distribution by Insurance Status, state data 2002-03, U.S. 2003*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Maine&category=Health+Coverage+%26+Uninsured&subcategory=Insurance+Status&topic=Distribution+by+Insurance+Status>, accessed March 2, 2005.
- ³⁴⁷ Kaiser Family Foundation, *Maine: Distribution of Total Population by Federal Poverty Level, state data 2002-03, U.S. 2003*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Maine&category=Demographics+and+the+Economy&subcategory=People+in+Poverty&topic=Distribution+by+FP+L>, accessed March 2, 2005.
- ³⁴⁸ Rachel Garfield, *Understanding MaineCare: A Chartbook about Maine's Medicaid Program* (Governor's Office of Health Policy and Finance, Augusta, Maine, January 2005, p. 11), available at <http://www.dirigohealth.maine.gov/MaineCare%20Chartbook%201-6-05.pdf>, accessed April 6, 2005.
- ³⁴⁹ Kaiser Family Foundation, *Maine: Medicaid Spending*, available at http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&category=Medicaid+%26+CHIP&subcategory=Medicaid+Spending&topic=&link_category=&link_subcategory=&link_topic=&welcome=0&area=Maine, accessed April 6, 2005.
- ³⁵⁰ Kaiser Family Foundation, *Maine: Medicaid Spending*, available at http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&category=Medicaid+%26+CHIP&subcategory=Medicaid+Spending&topic=&link_category=&link_subcategory=&link_topic=&welcome=0&area=Maine, accessed April 6, 2005.
- ³⁵¹ Rachel Garfield, *Understanding MaineCare: A Chartbook about Maine's Medicaid Program* (Governor's Office of Health Policy and Finance, Augusta, Maine, January 2005, p. 11), available at <http://www.dirigohealth.maine.gov/MaineCare%20Chartbook%201-6-05.pdf>, accessed April 6, 2005.
- ³⁵² Kaiser Family Foundation, *Maine: Medicaid Spending*, available at http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&category=Medicaid+%26+CHIP&subcategory=Medicaid+Spending&topic=&link_category=&link_subcategory=&link_topic=&welcome=0&area=Maine, accessed April 6, 2005.
- ³⁵³ Kaiser Commission on Medicaid and the Uninsured, *Medicaid Benefits, as of January 2003*, available at <http://www.kff.org/medicaidbenefits/state-ME.cfm>, accessed April 6, 2005.
- ³⁵⁴ Kaiser Family Foundation, *SCHIP Matching Rate*, available at <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=Maine&category=Medicaid+%26+CHIP&subcategory=CHIP&topic=Federal+Matching+Rate>, accessed April 6, 2005.
- ³⁵⁵ Kaiser Family Foundation, *SCHIP Expenditures, FFY2002*, available at <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=Maine&category=Medicaid+%26+CHIP&subcategory=CHIP&topic=CHIP+Expenditures>, accessed April 6, 2005.
- ³⁵⁶ Kaiser Family Foundation, *Current Monthly SCHIP Enrollment, January 2003*, available at <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=Maine&category=Medicaid+%26+CHIP&subcategory=CHIP&topic=Enrollment>, accessed April 6, 2005.
- ³⁵⁷ State Coverage Initiatives, *State of the States: Finding Alternate Routes* (Academy Health, January 2005, p. 17), available at <http://www.statecoverage.net/pdf/stateofstates2005.pdf>, accessed March 30, 2005.
- ³⁵⁸ Centers for Medicare and Medicaid Services, *Health Insurance Flexibility and Accountability (HIFA) Initiative Fact Sheet*, November 12, 2002, available at <http://www.cms.hhs.gov/hifa/mecarefs.pdf>, accessed April 26, 2005.
- ³⁵⁹ Centers for Medicare and Medicaid Services, *Maine HIV/AIDS Demonstration Fact Sheet*, November 24, 2003, available at <http://www.cms.hhs.gov/medicaid/1115/mehivfct.pdf>, accessed April 26, 2005.
- ³⁶⁰ Jill Rosenthal and Cynthia Pernice, *Dirigo Health Reform Act: Addressing Health Care Costs, Quality, and Access in Maine* (Portland, ME: National Academy for State Health Policy, June 2004), p. 1.

³⁶¹ State Coverage Initiatives, *State of the States: Finding Alternate Routes* (Academy Health, January 2005, p. 15), available at <http://www.statecoverage.net/pdf/stateofstates2005.pdf>, accessed March 30, 2005.

³⁶² Rosenthal and Pernice, p. 10.

³⁶³ *Ibid.*, pp. 10-11.

³⁶⁴ *Ibid.*, p. 10.

³⁶⁵ State Coverage Initiatives, *State of the States: Finding Alternate Routes* (Academy Health, January 2005, p. 15), available at <http://www.statecoverage.net/pdf/stateofstates2005.pdf>, accessed March 30, 2005.

³⁶⁶ Rosenthal and Pernice, p. 10.

³⁶⁷ *Ibid.*, p. 11.

³⁶⁸ *Ibid.*

³⁶⁹ *Ibid.*, p. 13.

³⁷⁰ *Ibid.*, p. 10.

³⁷¹ *Ibid.*

³⁷² *Ibid.*, p. 5.

³⁷³ *Ibid.*, p. 7.

³⁷⁴ *Ibid.*

³⁷⁵ *Ibid.*, p. 6.

³⁷⁶ State of Maine statute requires that benefits be provided at the same benefit level provided for medical treatment for the following listed mental illnesses: psychotic disorders, including schizophrenia, dissociative disorders, mood disorders, anxiety disorders, personality disorders, paraphilias, attention deficit and disruptive behavior disorders, pervasive developmental disorders, tic disorders, eating disorders, including bulimia and anorexia, and substance abuse-related disorders.

³⁷⁷ Anthem, *Dirigo Choice Health Plan 2—Group [B, C, D, E, or F]*, available at <http://www.dirigohealth.maine.gov/DHA%20Agreement%20-Sch%20B-4%20FINAL%209-12-04.pdf>, accessed April 6, 2005.

³⁷⁸ Rosenthal and Pernice, p. 7.

³⁷⁹ Maine Office of the Governor, Office of Health Policy and Finance, *Proposals to “Reform” Insurance: Less Coverage at Higher Cost for Most Mainers* (March 15, 2005), available at http://www.maine.gov/governor/baldacci/healthpolicy/news/3_15_05.htm, accessed March 30, 2005.

³⁸⁰ *Ibid.*

³⁸¹ Maine Office of the Governor, Office of Health Policy and Finance, *Dirigo Health has Successful First Year*, available at http://www.maine.gov/governor/baldacci/healthpolicy/news/9_13_04.htm, accessed March 30, 2005.

³⁸² Rosenthal and Pernice, p. 9.

³⁸³ “MaineCare and the Federal Budget,” *Maine Health News and Views* (Portland, Maine, January 2005, pp. 1-2), available at http://www.mainehealth.org/mh_about/newsviewsjan.pdf, accessed March 3, 2005.

³⁸⁴ *Ibid.*

³⁸⁵ “Health Care for All Tough in the Early Going: A New MaineCare Program Has Reached its Limits, Highlighting the Challenge of Universal Coverage” (www.IthicaTimes.com, February 20, 2005) available at http://www.zwire.com/site/news.cfm?newsid=14000131&BRD=1395&PAG=740&dept_id=226958&rfti=6, accessed March 3, 2005; and “Brief on MaineCare Cuts for ‘Noncategorical’ Adults,” *Maine Equal Justice* (Augusta, Maine, February 17, 2005), available at http://www.mejp.org/PDF/mainecare_cuts.pdf, accessed March 3, 2005.

-
- ³⁸⁶ “Brief on MaineCare Cuts for ‘Noncategorical’ Adults,” *Maine Equal Justice* (Augusta, Maine, February 17, 2005), available at http://www.mejp.org/PDF/mainecare_cuts.pdf, accessed March 3, 2005.
- ³⁸⁷ Josie Huang, “Baldacci Halts Expansion of Health Program,” *Portland Press Herald* (February 18, 2005), available at <http://pressherald.maintoday.com/news/statehouse/050218mainecare.shtml>, accessed March 3, 2005.
- ³⁸⁸ State Coverage Initiatives, *State of the States: Finding Alternate Routes* (Academy Health, January 2005, p. 16), available at <http://www.statecoverage.net/pdf/stateofstates2005.pdf>, accessed March 30, 2005.
- ³⁸⁹ Maine Office of the Governor, Office of Health Policy and Finance, *Dirigo Health has Successful First Year*, available at http://www.maine.gov/governor/baldacci/healthpolicy/news/9_13_04.htm, accessed March 2, 2005.
- ³⁹⁰ “Residents Can Enroll in State Health Plan,” *York Weekly* (February 9, 2005), available at <http://www.seacoastonline.com/news/yorkweekly/02092005/business/63728.htm>, accessed March 2, 2005.
- ³⁹¹ State Coverage Initiatives, *State of the States: Finding Alternate Routes* (Academy Health, January 2005, p. 16), available at <http://www.statecoverage.net/pdf/stateofstates2005.pdf>, accessed March 30, 2005.
- ³⁹² Kaiser Family Foundation, State Health Facts, *Minnesota: Distribution of Total Population by Federal Poverty Level, State Data 2002-2003, U.S. 2003*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Minnesota&category=Demographics+and+the+Economy&subcategory=People+in+Poverty&topic=Distribution+by+FPL>, accessed March 8, 2005.
- ³⁹³ Kaiser Family Foundation, State Health Facts, *Minnesota: Population Distribution by Insurance Status, State Data 2002-2003, U.S. 2003*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Minnesota&category=Health+Coverage+%26+Uninsured&subcategory=Insurance+Status&topic=Distribution+by+Insurance+Status>, accessed March 8, 2005.
- ³⁹⁴ Kaiser Family Foundation, State Health Facts, *Minnesota: Medicaid Eligibility, 2004*, available at http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Eligibility&topic=&link_category=&link_subcategory=&link_topic=&welcome=0&area=Minnesota¬es=show&printerfriendly=0#pagetopic1, accessed March 8, 2005.
- ³⁹⁵ Kaiser Family Foundation, State Health Facts, *Minnesota: Income Eligibility Levels for Children under Medicaid, as a Percent of Federal Poverty Level, 2004*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Minnesota&category=Medicaid+%26+SCHIP&subcategory=Children%27s+Medicaid+and+SCHIP+Eligibility&topic=Income+Eligibility%2d%2d+Medicaid>, accessed March 8, 2005.
- ³⁹⁶ Kaiser Family Foundation, State Health Facts, *Minnesota: Federal Matching Rate (FMAP) for Medicaid*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Minnesota&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Spending&topic=Federal+Matching+Rate+%28FMAP%29>, accessed March 8, 2005.
- ³⁹⁷ Randall Chun, *MinnesotaCare* (Information Brief, Minnesota House of Representatives, November 2003, p. 12), available at <http://www.house.leg.state.mn.us/hrd/pubs/mncare.pdf>, accessed March 8, 2005.
- ³⁹⁸ Minnesota House of Representatives, Fiscal Analysis Department, *Health Care Access (HCAF) Transfer Issues* (Issue Brief, revised June 9, 2004), available at <http://www.house.leg.state.mn.us/fiscal/files/ibhctxfr.PDF>, accessed April 14, 2005.
- ³⁹⁹ Kaiser Family Foundation, State Health Facts, *Minnesota: Medicaid Spending*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Minnesota&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Spending>, accessed March 8, 2005.
- ⁴⁰⁰ Kaiser Commission on Medicaid and the Uninsured, *Medicaid Benefits, as of January 2003*, available at <http://www.kff.org/medicaidbenefits/state-MN.cfm>, accessed March 8, 2005.
- ⁴⁰¹ Kaiser Family Foundation, State Health Facts, *Minnesota: SCHIP Federal Matching Rate (FMAP), FFY 2005*, available at <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&category=Medicaid+%26+SCHIP&subcategory=SCHIP+Federal+Matching+Rate>

SCHIP&subcategory=SCHIP&topic=Federal+Matching+Rate&link_category=&link_subcategory=&link_topic=&welcome=0&area=Minnesota, accessed April 11, 2005.

⁴⁰² Kaiser Family Foundation, State Health Facts, *Minnesota: SCHIP Expenditures, FFY 2002*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Minnesota&category=Medicaid+%26+SCHIP&subcategory=SCHIP&topic=SCHIP+Expenditures>, accessed April 11, 2005.

⁴⁰³ Kaiser Family Foundation, State Health Facts, *Minnesota: Current Monthly SCHIP Enrollment, December 2003*, available at <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=Minnesota&category=Medicaid+%26+SCHIP&subcategory=SCHIP&topic=Enrollment>, accessed April 11, 2005.

⁴⁰⁴ Centers for Medicare and Medicaid Services, *A Profile of Medicaid: Chartbook 2000* (p. 72), available at <http://www.cms.hhs.gov/charts/medicaid/2Tchartbk.pdf>, accessed November 14, 2004.

⁴⁰⁵ National Governor's Association, *Minnesota, NGA Summary, State Children's Health Insurance Program*, available at <http://www.nga.org/cda/files/MNSCHIP.pdf>, accessed April 11, 2005.

⁴⁰⁶ Kaiser Family Foundation, State Health Facts, *Minnesota: Managed Care & Health Insurance*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Minnesota&welcome=1&category=Managed+Care+%26+Health+Insurance>, accessed March 8, 2005.

⁴⁰⁷ Minnesota Comprehensive Health Association, *Minnesota Comprehensive Health Association*, available at <http://www.mchamn.com>, accessed April 17, 2005.

⁴⁰⁸ Kaiser Family Foundation, State Health Facts, *Minnesota: Managed Care & Health Insurance*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Minnesota&welcome=1&category=Managed+Care+%26+Health+Insurance>, accessed March 8, 2005.

⁴⁰⁹ Heather Sacks, Todd Kutyla, and Sharon Silow-Carroll, Economic and Social Research Institute, *Toward Comprehensive Health Coverage for All: Summaries of 20 State Planning Grants from the U.S. Health Resources and Services Administration* (Commonwealth Fund, November 2002, p. 61), available at <http://www.statecoverage.net/statereports/mn30.pdf>, accessed March 8, 2005.

⁴¹⁰ Deborah Chollet, *The Role of Reinsurance in State Efforts to Expand Coverage* (State Coverage Initiatives, Issue Brief, October 2004, p. 5, endnote 1), available at <http://www.statecoverage.net/pdf/issuebrief1004.pdf>, accessed March 11, 2005.

⁴¹¹ Kaiser Family Foundation, State Health Facts, *Minnesota: Medicaid & SCHIP*, available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Minnesota&welcome=1&category=Medicaid+%26+SCHIP>, accessed March 8, 2005.

⁴¹² State Coverage Initiatives, *Medicaid Section 1931 Waiver*, available at <http://www.statecoverage.net/medicaid-1931.htm>, accessed March 8, 2005.

⁴¹³ Centers for Medicare and Medicaid Services, *Minnesota*, available at <http://www.cms.hhs.gov/medicaid/waivers/MNwaiver.asp?state=MN>, accessed March 8, 2005.

⁴¹⁴ State Coverage Initiatives, *Medicaid Section 1115 Waiver*, available at <http://www.statecoverage.net/medicaid-1115.htm>, and *SCHIP Section 1115 Waiver*, available at <http://www.statecoverage.net/schip-1115.htm>, accessed March 8, 2005.

⁴¹⁵ Randall Chun, *MinnesotaCare* (Information Brief, Minnesota House of Representatives, November 2003, p. 3), available at <http://www.house.leg.state.mn.us/hrd/pubs/mncare.pdf>, accessed March 8, 2005.

⁴¹⁶ Ibid.

⁴¹⁷ Ibid.

⁴¹⁸ Minnesota Department of Human Services, *Minnesota Health Care Programs* (March 2005), available at http://www.dhs.state.mn.us/main/groups/publications/documents/pub/DHS_id_048802.pdf, accessed April 11, 2005.

⁴¹⁹ Children, Youth and Family Consortium and the Children's Defense Fund Minnesota, *Covering All Families* (February 20, 2004), available at <http://www.cyfc.umn.edu/coveringallfamilies/programsfaq.html>, accessed April 11, 2005.

⁴²⁰ David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, "Illness and Injury As Contributors to Bankruptcy" (*Health Affairs*, Web Exclusive, February 2, 2005), available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.63v1>, accessed May 27, 2005.

⁴²¹ Ibid.

⁴²² Centers for Medicare and Medicaid Services, Emergency Medical Treatment and Labor Act (EMTALA) Resource, available at <http://www.cms.hhs.gov/providers/emtala/default.asp>, accessed March, 25, 2004.

**An Analysis of Reform Options Developed by Other States Appendix
A. State Coverage Matrix: Strategies for Health Insurance Expansion**

State	Medicaid					SCHIP			State-Only		
	1115	1931	HIPP	TMA*	HIFA	Employer Buy-In	1115	Full-Cost Buy-In	Coverage Program	High-Risk Pool	Tax Incentives
Alabama										✓	
Alaska		✓								✓	
Arizona	✓	✓		✓	✓						
Arkansas	✓	✓								✓	
California		✓	✓		✓				✓	✓	✓
Colorado					✓					✓	✓
Connecticut		✓						✓		✓	
Delaware	✓			✓							✓
District of Columbia	✓	✓							✓		
Florida		✓						✓		✓	
Georgia			✓								✓
Hawaii	✓										
Idaho										✓	✓
Illinois					✓					✓	✓
Indiana										✓	
Iowa		✓	✓							✓	✓
Kansas		✓								✓	✓
Kentucky										✓	
Louisiana									✓	✓	
Maine					✓						✓
Maryland		✓				✓				✓	
Massachusetts	✓		✓			✓			✓		
Michigan					✓				✓		
Minnesota	✓	✓					✓		✓	✓	
Mississippi						✓				✓	
Missouri	✓		✓						✓	✓	✓
Montana		✓								✓	
Nebraska		✓		✓						✓	
Nevada		✓									
New Hampshire		✓								✓	
New Jersey			✓		✓	✓	✓				✓
New Mexico	✓	✓			✓					✓	✓
New York	✓	✓						✓	✓		
North Carolina								✓			✓
North Dakota		✓								✓	
Ohio		✓									
Oklahoma		✓								✓	
Oregon	✓	✓			✓				✓	✓	

State	Medicaid				HIFA	SCHIP			State-Only		
	1115	1931	HIPP	TMA*		Employer Buy-In	1115	Full-Cost Buy-In	Coverage Program	High-Risk Pool	Tax Incentives
Pennsylvania		✓	✓						✓		
Rhode Island	✓		✓			✓	✓		✓		
South Carolina		✓		✓						✓	
South Dakota										✓	
Tennessee	✓			✓							
Texas			✓	✓						✓	
Utah	✓									✓	✓
Vermont	✓	✓									
Virginia			✓			✓			✓		
Washington		✓							✓	✓	
West Virginia											
Wisconsin	✓	✓	✓			✓	✓			✓	✓
Wyoming		✓								✓	
ALL STATES	16	27	11	6	9	7	4	4	13	32	15

Source: State Coverage Initiatives, *State Coverage Matrix: Strategies Used to Expand Health Insurance Coverage Across the U.S.* (updated March 2004), available at <http://www.statecoverage.net/matrix.htm>, accessed March 14, 2005.

*TMA is Transitional Medicaid Assistance, and a check in this column means that the state has extended eligibility for TMA beyond the 12 months required after a family loses eligibility for welfare due to increased earnings.

References

- Advantage Insurance and Financial Services, Inc., *Guaranteed Issue HIPAA Coverage*. Available at http://www.aifsi.com/hipaa_plans.htm.
- AISHealth.com, *Insurers, Enrollees Show Little Interest in State ‘Mandate-Light’ Laws*. Business News of the Week, May 18, 2005. Available at <http://www.aishealth.com/bnow/051805a.html>.
- Anthem. *Dirigo Choice Health Plan 2—Group [B, C, D, E, or F]*. Available at <http://www.dirigohealth.maine.gov/DHA%20Agreement%20-Sch%20B-4%20FINAL%209-12-04.pdf>.
- Arenales, Elizabeth, Esq., Health Care Program Director, Colorado Center on Law and Policy, Telephone interview by Kelly Shanahan, March 6, 2005.
- “Brief on MaineCare Cuts for ‘Noncategorical’ Adults.” *Maine Equal Justice*. Augusta, Maine, February 17, 2005. Available at http://www.mejp.org/PDF/mainecare_cuts.pdf.
- Brody, William R. “A New Vision for Maryland Hospitals.” Originally published in the *Baltimore Sun*, December 10, 2002. Available at <http://www.jhu.edu/~president/news/sundec10.html>.
- Butler, Patricia A. *ERISA Implications for Employer Pay or Play Coverage Laws*. California HealthCare Foundation, March 2005. Available at <http://www.chcf.org/documents/insurance/ERISAPayPlayImplications.pdf>.
- Butler, Patricia A. *Revisiting Pay or Play: How States Could Expand Employer-Based Coverage within ERISA Constraints*. National Academy for State Health Policy, May 2002. Available at http://www.nashp.org/Files/ERISA_pay_or_play.PDF.
- Centers for Medicare and Medicaid Services. *A Profile of Medicaid: Chartbook 2000*. Available at <http://www.cms.hhs.gov/charts/medicaid/2Tchartbk.pdf>.
- Centers for Medicare and Medicaid Services. *Arkansas Waiver and Demonstration Programs, Fact Sheet*. Available at <http://www.cms.hhs.gov/medicaid/1115/ar1115tefra.asp>.
- Centers for Medicare and Medicaid Services. *Colorado 1915(b) Fact Sheet—Primary Care Physicians Program*. Available at www.cms.hhs.gov/medicaid/1915b/copcpps.pdf.
- Centers for Medicare and Medicaid Services. *Colorado §1115 Demonstration Fact Sheet—Alternatives in Medicaid Home Care*. Available at <http://www.cms.hhs.gov/medicaid/1115/coamhcsfct.pdf>.
- Centers for Medicare and Medicaid Services. *Colorado*. Available at <http://www.cms.hhs.gov/medicaid/waivers/cowaiver.asp>.
- Centers for Medicare and Medicaid Services. *Emergency Medical Treatment and Labor Act (EMTALA) Resource*. Available at <http://www.cms.hhs.gov/providers/emtala/default.asp>.
- Centers for Medicare and Medicaid Services. *Florida*. Available at <http://www.cms.hhs.gov/medicaid/waivers/flwaiver.asp>.

- Centers for Medicare and Medicaid Services. *Health Insurance Flexibility and Accountability (HIFA) Initiative Fact Sheet*. November 12, 2002. Available at <http://www.cms.hhs.gov/hifa/mecarefs.pdf>.
- Centers for Medicare and Medicaid Services. *Maine HIV/AIDS Demonstration Fact Sheet*. November 24, 2003. Available at <http://www.cms.hhs.gov/medicaid/1115/mehivfct.pdf>.
- Centers for Medicare and Medicaid Services. *Minnesota*. Available at <http://www.cms.hhs.gov/medicaid/waivers/MNwaiver.asp?state=MN>.
- Centers for Medicare and Medicaid Services. *Utah Primary Care Network Demonstration Fact Sheet*. Updated April 4, 2005. Available at <http://www.cms.hhs.gov/medicaid/1115/utpcnfs.pdf>.
- Children, Youth and Family Consortium and the Children's Defense Fund Minnesota. *Covering All Families*. February 20, 2004. Available at <http://www.cyfc.umn.edu/coveringallfamilies/programsfaq.html>.
- Chollet, Deborah. *Issue Brief: The Role of Reinsurance in State Efforts to Expand Coverage*. State Coverage Initiatives, October 2004. Available at <http://www.statecoverage.net/pdf/issuebrief1004.pdf>.
- Chun, Randall. *MinnesotaCare*. Information Brief, Minnesota House of Representatives, November 2003. Available at <http://www.house.leg.state.mn.us/hrd/pubs/mncare.pdf>.
- Colorado Department of Health Care Policy and Financing. "Assumptions and Calculations FY 05-06 Budget Request." November 1, 2004.
- Colorado Department of Health Care Policy and Financing. "Strategic Plan, FY 05-06 Budget Request," "Part II: Summary Tables—FY 2004-05 Appropriations by Department and Fund Source."
- Colorado General Assembly. First Regular Session, Sixty-fifth General Assembly, HB05-1262 Engrossed. Includes all amendments adopted on Second Reading in the House of Introduction.
- Colorado General Assembly, House of Representatives. Second Reading of HB05-1262, testimony of House bill sponsor, Representative Betty Boyd, D-Jefferson County, April 5, 2005.
- Colorado Health Institute. "The Small Group Health Insurance Market in Colorado." White Paper. Available at http://coloradohealthinstitute.org/publications/Sm_grp_mkt.pdf.
- Colorado Legislative Council Staff. "HB05-1262 State and Local Revised Fiscal Impact." Drafting Number LLS 05-0339. Prime Sponsors Rep. Boyd and Sen. Hagedorn. Bill Status: House Third Reading, April 5, 2005.
- Colorado Medical Services Board. *Children's Basic Health Plan Annual Report State Fiscal Year 2004*. 2004.
- Colorado State Constitution. Article X, Section 21. "Tobacco Taxes for Health Related Purposes."

- Donnell-Kay Foundation. “Amendment 23 and Public School Financing in Colorado.” March 2003. Available at <http://www.headfirstcolorado.org/A23FINAL.pdf>.
- Dunkelberg, Anne, and Molly O’Malley. *Children’s Medicaid and SCHIP in Texas: Tracking the Impact of Budget Cuts*. Kaiser Commission on Medicaid and the Uninsured, July 2004. Available at <http://www.kff.org/medicaid/7132.cfm>.
- Dunkelberg, Anne. Center for Public Policy Priorities. *Medicaid and State Budgets: A Case Study of Texas*. Kaiser Commission on Medicaid and the Uninsured, March 2002. Available at <http://www.cppp.org/files/6/getfile.pdf>.
- Employee Benefit Research Institute. *An Employer Mandate: What’s Known and What Isn’t*. November 1993. Available at <http://www.ebri.org/srpdfs/sr19.pdf>.
- Florida Agency for Health Care Administration. *Empowered Care: A Proposed Concept for Florida Medicaid*. Draft, March 14, 2005. Available at http://www.empoweredcare.com/docs/empoweredcare_proposed_concept.pdf.
- Florida Agency for Health Care Administration. *Florida Health Insurance Study 2004, The HRSA State Planning Grant Program Interim Report*. September 30, 2004. Available at http://ahca.myflorida.com/Medicaid/Research/Projects/fhis2004/PDF/HRSA-SPG_INTERIM_Report_FINAL_.pdf.
- Florida Agency for Health Care Administration. *Florida KidCare, A Briefing for Governor Jeb Bush on September 12, 2003*. Powerpoint Presentation, September 12, 2003. Available at http://www.fdhc.state.fl.us/Medicaid/MediKids/kidcare_governor_9_03.ppt.
- Florida Agency for Health Care Administration. *HRSA State Planning Grant: Project Abstract*. 2003. Available at http://ahca.myflorida.com/affordable_health_insurance/PDFs/hrsa_state_planning_grant.pdf.
- Florida House of Representatives, Health Care General Committee. “Committee Meeting Packet for March 16, 2005.” Including draft legislation of “Medicaid Reform Act of 2005” March 14, 2005.
- Florida KidCare. *Florida KidCare*. Available at <http://www.floridakidcare.org>.
- Florida Senate. *Senate Bill 0838ER* (Enrolled, 3rd Engrossed, 2005 Legislature). Available at http://www.flsenate.gov/cgi-bin/view_page.pl?Tab=session&Submenu=1&FT=D&File=sb0838er.html&Directory=session/2005/Senate/bills/billtext/html.
- Friedenzohn, Isabel. *Issue Brief: Limited-Benefit Policies: Public and Private-Sector Experiences*. State Coverage Initiatives, July 2004. Available at <http://www.statecoverage.net/pdf/issuebrief704.pdf>.
- Friedenzohn, Isabel. *Issue Brief: States’ Experience with Benefit Design*. State Coverage Initiatives, April 2003. Available at <http://www.statecoverage.net/pdf/issuebrief403benefits.pdf#search='utah%20medicaid%20benefit%20reduced..>
- Garfield, Rachel. *Understanding MaineCare: A Chartbook about Maine’s Medicaid Program*. Governor’s Office of Health Policy and Finance, Augusta, Maine, January 2005. Available at <http://www.dirigohealth.maine.gov/MaineCare%20Chartbook%201-6-05.pdf>.

- Garrett, Scott, and Jeb Bradley, *Been There, Done That, Let's Steer Clear of Guaranteed Issue*. Letter to Republican Congress, March 3, 2003. Available at <http://www.cagionline.org/garrettltr.pdf>.
- Georgetown University Health Policy Institute. *Summary of Key Consumer Protections in Individual Health Insurance Markets*. April 2004. Available at http://www.healthinsuranceinfo.net/newsyoucanuse/discrimination_limits.pdf.
- "Gov. Bush Proposes Medicaid Revamp." *St. Petersburg Times*. January 12, 2005. Available at http://www.sptimes.com/2005/01/12/State/Gov_Bush_proposes_Med.shtml.
- Harris, Gwendolyn L. Commissioner, New Jersey Department of Human Services, Letter to Dennis Smith, Centers for Medicare and Medicaid Services. July 15th, 2002. Available at <http://www.cms.hhs.gov/hifa/njhifacvrltr.pdf>.
- Head First Colorado. "Amendment 23 Background." Available at http://www.headfirstcolorado.org/factsheets/Amendment_23.php.
- "Health Care for All Tough in the Early Going: A New MaineCare Program Has Reached its Limits, Highlighting the Challenge of Universal Coverage." www.IthicaTimes.com, February 20, 2005. Available at http://www.zwire.com/site/news.cfm?newsid=1400131&BRD=1395&PAG=740&dept_id=226958&rfl=6.
- Health Management Associates. *Final Report of the Governor's Task Force on Access to Affordable Health Insurance*. February 15, 2004. Available at <http://www.statecoverage.net/statereports/fl38.pdf>.
- Himmelstein, David U., Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler. "Illness and Injury As Contributors to Bankruptcy." *Health Affairs*, Web Exclusive, February 2, 2005. Available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.63v1>.
- Hirth, Diane. "Medicaid Measure Passes: Compromise Comes Through." *The Mercury News* (May 7, 2005). Available at <http://www.mercurynews.com/mlt/tallahassee/news/politics/11586417.htm?template=contentModules/printstory.jsp>.
- Howell, Embry, Ruth Almeida, Lisa Dubay, and Genevieve Kenney. *Early Experience with Covering Uninsured Parents Under SCHIP*. The Urban Institute, No. A-51, May 2002. Available at <http://www.urban.org/url.cfm?ID=310498>.
- Huang, Josie. "Baldacci Halts Expansion of Health Program." *Portland Press Herald*. February 18, 2005. Available at <http://pressherald.maintoday.com/news/statehouse/050218mainecare.shtml>.
- Kaiser Commission on Medicaid and the Uninsured. *Medicaid Benefits, as of January 2003*. Available at <http://www.kff.org/medicaidbenefits>.
- Kaiser Commission on Medicaid and the Uninsured. *Update on the Florida SCHIP Enrollment Freeze*. July 23, 2004. Available at <http://www.statecoverage.net/statereports/fl41.pdf>.
- Kaiser Family Foundation. *Arkansas: Women's Health*. Available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Arkansas&category=Women%27s+Health&subcategory=Medicaid+Policy&topic=Family+Planning+Waiver>.

- Kaiser Family Foundation. *Demographics and the Economy*. Available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&welcome=1&category=Demographics+and+the+Economy>.
- Kaiser Family Foundation. *Health Coverage and Uninsured*. Available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&welcome=1&category=Health+Coverage+%26+Uninsured>.
- Kaiser Family Foundation. *Managed Care and Health Insurance*. Available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&welcome=1&category=Managed+Care+%26+Health+Insurance>.
- Kaiser Family Foundation. *Medicaid and SCHIP*. Available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&welcome=1&category=Medicaid+%26+SCHIP>.
- Kaisernetwork.org. *HHS Approves Utah's First-in-Kind Medicaid Waiver Proposal To Extend Coverage to 25,000 While Reducing Other Benefits*. Daily Health Policy Report, Feb 11, 2002. Available at http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=9405.
- Kofman, Mila. *Issue Brief: Group Purchasing Arrangements: Issues for States*. State Coverage Initiatives, April 2003. Available at <http://www.statecoverage.net/pdf/issuebrief403.pdf>.
- Maine Office of the Governor. Office of Health Policy and Finance. *Proposals to "Reform" Insurance: Less Coverage at Higher Cost for Most Mainers*. March 15, 2005. Available at http://www.maine.gov/governor/baldacci/healthpolicy/news/3_15_05.htm.
- Maine Office of the Governor. Office of Health Policy and Finance. *Dirigo Health has Successful First Year*. Available at http://www.maine.gov/governor/baldacci/healthpolicy/news/9_13_04.htm.
- "MaineCare and the Federal Budget." *Maine Health News and Views*. Portland, Maine, January 2005. Available at http://www.mainehealth.org/mh_about/newsviewsjan.pdf.
- Mann, Cindy, Samantha Artiga, and Jocelyn Guyer. *Assessing the Role of Recent Waivers in Providing New Coverage*. Kaiser Commission on Medicaid and the Uninsured, Issue Paper, December 2003. Available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=28336>.
- Maryland Health Care Commission. *News Release*. April 4, 2001. Available at <http://www.dhmh.state.md.us/publ-rel/html/disclo~1.htm>.
- Maryland Health Services Cost Review Commission. *About HSCRC*. Available at http://www.hscre.state.md.us/about_us/about_us.html.
- Minnesota Comprehensive Health Association. *Minnesota Comprehensive Health Association*. Available at <http://www.mchamn.com>.
- Minnesota Department of Human Services. *Minnesota Health Care Programs*. March 2005. Available at http://www.dhs.state.mn.us/main/groups/publications/documents/pub/DHS_id_048802.pdf.

- Minnesota House of Representatives. *Fiscal Analysis Department, Health Care Access (HCAF) Transfer Issues*. Issue Brief, revised June 9, 2004. Available at <http://www.house.leg.state.mn.us/fiscal/files/ibhctxfr.PDF>.
- National Academy for State Health Policy. *State Experience with Enrollment Caps in Separate SCHIP Programs*. February 2004. Available at www.statecoverage.net/statereports/multi30.pdf.
- National Governor's Association. *Florida: NGA Summary, State Children's Health Insurance Program*. Available at <http://www.nga.org/cda/files/FLSCHIP.pdf>.
- National Governor's Association. *Minnesota, NGA Summary, State Children's Health Insurance Program*. Available at <http://www.nga.org/cda/files/MNSCHIP.pdf>.
- "Residents Can Enroll in State Health Plan." *York Weekly*. February 9, 2005. Available at <http://www.seacoastonline.com/news/yorkweekly/02092005/business/63728.htm>.
- Rosenthal, Jill, and Cynthia Pernice. *Dirigo Health Reform Act: Addressing Health Care Costs, Quality, and Access in Maine*. Portland, ME: National Academy for State Health Policy, June 2004.
- Sacks, Heather, Todd Kutyla, and Sharon Silow-Carroll. Economic and Social Research Institute. *Toward Comprehensive Health Coverage for All: Summaries of 20 State Planning Grants from the U.S. Health Resources and Services Administration*. Commonwealth Fund, November 2002. Available at <http://www.statecoverage.net/statereports/ar3.pdf>.
- Schur, Claudia L., Marc L. Berk, and Jill M. Yegian. "Workers' Perspectives on Mandated Employer Health Insurance." *Health Affairs*. Web Exclusive, March 17, 2004. Available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.128v1.pdf>.
- Scully, Thomas A. Centers for Medicare and Medicaid Services, Letter to Gwendolyn L. Harris, New Jersey Department of Human Services. January 31, 2003. Available at <http://www.cms.hhs.gov/hifa/njstandardapprovlet.pdf>.
- State Coverage Initiatives. *Assessing State Strategies for Health Coverage Expansion: Profiles of Arkansas, Michigan, New Mexico, New York, Utah, and Vermont*. February 2003. Available at <http://www.statecoverage.net/statereports/multi3.pdf>.
- State Coverage Initiatives. *Health Cost Concerns Intensify in Little Rock*. Summer 2003. Available at <http://www.statecoverage.net/statereports/ar4.pdf>.
- State Coverage Initiatives. *Medicaid HIPP*. Available at <http://www.statecoverage.net/hipp.htm>.
- State Coverage Initiatives. *Medicaid Section 1115 Waiver*. Available at <http://www.statecoverage.net/medicaid-1115.htm>.
- State Coverage Initiatives. *Medicaid Section 1931 Waiver*. Available at <http://www.statecoverage.net/medicaid-1931.htm>. April 17, 2005.
- State Coverage Initiatives. *Medicaid TMA*. Available at <http://www.statecoverage.net/tma.htm>.

State Coverage Initiatives. *Profiles in Coverage: Healthy New York*. January 2005. Available at <http://www.statecoverage.net/newyorkprofile.htm>.

State Coverage Initiatives. *SCHIP Employer Buy-In*. Available at <http://www.statecoverage.net/employer.htm>.

State Coverage Initiatives. *SCHIP Section 1115 Waiver*. Available at <http://www.statecoverage.net/schip-1115.htm>.

State Coverage Initiatives. *State of the States: Finding Alternate Routes*. Academy Health, January 2005. Available at <http://www.statecoverage.net/pdf/stateofstates2005.pdf>.

State Coverage Initiatives. *State-Only High Risk Pool*. Available at <http://www.statecoverage.net/highrisk.htm>.

State Coverage Initiatives. *State-Only Tax Incentives*. Available at <http://www.statecoverage.net/tax.htm>.

Texas Department of Insurance. *Biennial Report of the Texas Department of Insurance to the 79th Texas Legislature*. December 2004, Section D, Issue 9. Available at <http://www.tdi.state.tx.us/commish/reports/finalbie05.html#thrs>.

Texas Department of Insurance. *Listing of Coalition and Purchasing Cooperatives*. March 23, 2005. Available at http://www.tdi.state.tx.us/company/lhcoop_lst_incl.html.

Texas Department of Insurance. *Rules, Subchapter D, Health Group Cooperatives*. Available at <http://www.tdi.state.tx.us/commish/rules/0811AA-059.html>.

Texas Department of Insurance. *Texas Health Insurance Risk Pool Expansion Options*. January 2005. Available at <http://www.tdi.state.tx.us/general/pdf/lhlRiskPoolRept.pdf>.

Texas Department of Insurance. *Working Together for a Healthy Texas, Interim Report, State Planning Grant Project*. September 2004. Available at <http://www.tdi.state.tx.us/general/PDF/spgint04.pdf>.

Texas Health and Human Services Commission. *A Consumer Guide to Better Healthcare: Your 2004 Road Map to Understanding the Health Care System in Texas*. Available at <http://www.hhsc.state.tx.us/chip/reports/ConsumerGuideEnglish.pdf>.

Texas Health and Human Services Commission. *Children's Health Insurance Program*. Available at <http://www.hhsc.state.tx.us/chip/index.html>.

Texas Health and Human Services Commission. *CHIP Assets Test Policy: Summary of Final Rules*. Available at http://www.hhsc.state.tx.us/chip/reports/042304_AssetTestPolicySum.html.

Texas Health and Human Services Commission. *Texas Medicaid in Perspective, 5th ed.* 2004. Available at <http://www.hhsc.state.tx.us/medicaid/reports/PB5/PinkBookTOC.html>.

Texas Legislative Budget Board. *Fiscal Note for SB1839, Enrolled Version, 77th Legislative Session*. May 26, 2001). Available at <http://www.capitol.state.tx.us/cgi-bin/tlo/textframe.cmd?LEG=77&SESS=R&CHAMBER=S&BILLTYPE=B&BILLSUFFIX=01839&VERSION=5&TYPE=F>.

- Texas Health and Human Services Commission. "FY 05 Federal Alloc LAR." Excel spreadsheet, January 2005.
- The Bell Policy Center. "Ten Years of TABOR: A Study of Colorado's Taxpayer's Bill of Rights." 2003.
- The Commonwealth Fund. *California: Health Insurance Act of 2003*. Available at http://www.cmwf.org/tools/tools_show.htm?doc_id=235062.
- The Council for Affordable Health Insurance. *What Were these States Thinking? The Pitfalls of Guaranteed Issue*. May 2002. Available at <http://www.cagionline.org/cahidoc.pdf>.
- U.S. Census Bureau. *Table 1: Annual Estimates of the Population for Counties of Texas: April 1, 2000 to July 1, 2004*. Available at <http://www.census.gov/popest/counties/tables/CO-EST2004-01-48.xls>.
- U.S. Census Bureau. *U.S. Census 2000, Colorado QuickFacts*. Available at <http://quickfacts.census.gov/qfd/states/08000.html>.
- U.S. General Accounting Office. *Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses*. Washington, D.C., September 2003.