

**KANSAS HEALTH POLICY AUTHORITY
LEGISLATIVE COORDINATING COUNCIL STUDY #5
Medicaid Reform and State Experiences**

Background

On July 9, 2008, the Legislative Coordinating Council (LCC) approved a number of studies to be conducted during the Interim by the Kansas Health Policy Authority (KHPA). Identification of these studies was in response to a May 2008 request made by the Conference Committee on H. Sub. for SB 81. Reporting on the experiences of other states in reforming Medicaid was one of the studies identified.

Overview of State Reform

During the past several years, a number of states have begun planning, enacting, or implementing a broad array of reform efforts. These efforts vary, and are often dependent upon the political and fiscal environment; demographic characteristics, insurance market dynamics, and other economic variables that impact a state's capacity to act.¹ Examples of the types of reform being implemented or planned include:

- Comprehensive coverage expansions;
- Strategies that focus on health system issues such as cost, quality and health insurance market reform;
- Chronic care management initiatives;
- Support for health information technology; and
- Creation of new purchasing pools.

Recently, the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) conducted a survey of Medicaid officials in all 50 states and the District of Columbia. Results of the survey are for fiscal years 2007 and 2008. Findings from the survey help illustrate the variation and the extent to which states are engaging in Medicaid reform. Some of the general findings of the survey are:

- More states than in any of the last seven years, removed restrictions or adopted policies to improve or expand their Medicaid programs in FY 2007 and FY 2008.
 - Every state implemented some type of provider rate increase in 2007 and 49 states planned to increase rates for at least one provider group in 2008.
 - More than half of all states in 2007 and in 2008 made positive eligibility changes such as increasing the income limit for eligibility, expanding eligibility for a new group (e.g., foster children, persons with disabilities who are working), or streamlining or simplifying the application or renewal process.
- Few states have taken advantage of new options to change benefits or impose new cost sharing requirements allowed through the Deficit Reduction Act of 2005 (DRA). As of October 2007:
 - Eight states used, or reported plans to use, the new DRA options related to benefits (Kentucky, West Virginia and Idaho are using the flexibility for comprehensive redesign);
 - Virginia converted its existing disease management program from a voluntary "opt-in" program to a voluntary "opt-out" DRA benchmark program;
 - Washington implemented a chronic care management pilot program under DRA authority;

¹ Academy Health. *State of the States*, January 2007.

- Kansas added personal assistance services for participants in the state's Ticket-to-Work Medicaid buy-in program;
- South Carolina planned a voluntary one-county pilot "Health Savings Account" using the State Employee High Deductible Health plan as the benchmark;
- Wisconsin planned to offer a modified benefit package adapted from its largest commercial, low-cost health care plan to the BadgeCare Plus expansion population; and
- Kentucky used the DRA authority to impose higher than nominal cost sharing amounts and to make co-payments enforceable.
- States are continuing to expand home and community-based long-term care (LTC) services.
 - In FY 2007, 35 states expanded LTC services while in FY2008 46 states planned to do so.
 - The most commonly reported LTC expansion during both years was expanding existing home and community-based services (HCBS) waivers or adopting new ones. (In Kansas, an Autism Waiver was approved in September 2007 and became effective January 1, 2008. This waiver provides support services to caregivers of children with autism spectrum disorders and early intensive intervention treatment for children with autism.)
 - States are also adding Programs for the All-Inclusive Care for the Elderly (PACE). (Currently in Kansas there is a PACE program serving Sedgwick County and one serving Topeka/Shawnee County and the six surrounding counties.)
 - Thirty-one states are using the DRA "Money Follows the Person" initiative which encourages states to transition people living in institutions to the community which supports HCBS efforts. (In May of 2007, CMS awarded Kansas a \$37 million five year demonstration grant for this initiative.)
 - Nearly half (24) of the states surveyed indicated they had plans to implement a LTC Partnership Program in 2008 to help increase the role of private long-term care insurance. (In Kansas, the LTC Partnership Program was approved to become effective April 1, 2007. The initiative encourages Kansans to partner with the state-based program as they purchase qualified private long-term care insurance policies).
- States are focusing more on Medicaid quality and improvement initiatives to get better value from Medicaid expenditures – in 2008 44 states will be using HEDIS® and or CAHPS® performance data from managed care organizations to measure and provide incentives for improved performance. (In Kansas HEDIS measures are used to annually assess the HealthWave program and are reported by the managed care organizations (MCOs); KHPA and MCOs use CAHPS data to evaluate patient-centered care, assess access to care, report performance, compare the results to local, regional, and national trends, and improve quality of care.)
- At the time of this report (October 2007), 42 states were moving forward with or were developing plans to expand health insurance coverage, almost all relying extensively on Medicaid to support and finance the plans, in order to address a growing number or uninsured individuals. (The authors of this report note that the outlook for state revenue growth as well as the outcome of the reauthorization of SCHIP and federal support for these expansions will determine how far states can go in expanding coverage.)

Source: *As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2007 and 2008*, Kaiser Family Foundation <http://www.kff.org/medicaid/kcmu101007pkg.cfm>

Summary of State Reform Efforts

The *State of the States* (January 2008) report, published by Academy Health provides a closer examination of reform efforts currently being advanced by various states. The report categorizes state reform efforts as being:

- Comprehensive – reform efforts aim to provide residents with universal or near universal coverage;
- Substantial - expand coverage, include private market reforms, and launch new purchasing mechanisms; and
- Incremental - expand health coverage for subpopulations within the uninsured.

The following summaries are provided within this framework.

Comprehensive Reforms

State of Massachusetts Reform Highlights

The State of Massachusetts enacted legislation in April 2006 aimed to provide near universal health coverage for state residents. Components of the legislation included:

- *The Commonwealth Care* program to provide subsidized coverage for people with incomes up to 300% of the federal poverty level (FPL);
- *The Commonwealth Health Insurance Connector* to “connect” individuals to insurance by offering affordable, quality insurance products;
- *MassHealth* (Medicaid program) expansion to children up to 300% of the FPL;
- An individual mandate that all adults in the state purchase health insurance by 12/31/07; and
- A requirement that employers with 11 or more employees provide health insurance coverage or pay a “fair share” contribution of up to \$295 annually per employee.

Other aspects of reform that have been implemented but not specified in legislation are:

- Minimum creditable coverage (needed in order to meet the individual mandate requirement) has been defined to include “preventive and primary care, emergency services, hospitalization benefits, ambulatory patient services, hospitalization benefits, ambulatory patient services, mental health services and prescription drug coverage.”
- Affordability standards have been established to determine the subsidy levels for people enrolled in Commonwealth Care and the premium amounts for families with incomes above 300% of FPL. About 2% of the population has been exempted from the individual mandate because insurance policies that meet the affordability standards set by the Commonwealth Connector Authority are not available.
- S.2526 was signed in August 2008 in an effort to control rising health care costs. The legislation establishes a commission to develop uniform billing and coding standards, sets a goal of adopting electronic health records by 2015, emphasizes educating providers on lower-cost drugs and medical treatments, and develops measures to increase the number of primary care doctors.
- During August 2008, the Governor signed H.5022 which increases state funding for health reform.

State of Massachusetts Reform Impact

Impact on Access	Impact on Cost	Impact on Quality	Challenges
<ul style="list-style-type: none"> • Dramatic: As of March 2008, 439,000 (or 67%) of an estimated 650,000 people who were previously uninsured are now insured. 	<ul style="list-style-type: none"> • Due to the successful enrollment into the Commonwealth Care program, the costs have exceeded previous estimates. • The Governor’s budget request of \$869 million for 2009 is about \$400 million more than for 2008; this funding may still fall short. • Options being considered for raising additional revenue include increasing the tobacco tax and legislation aimed at constraining health care cost growth overall. 	<ul style="list-style-type: none"> • Goals for improving quality were identified in April 2008 and include adopting a standard measurement of annual health care spending for the state and developing a website to provide consumers with cost and quality information. 	<ul style="list-style-type: none"> • The costs of reform have been higher than expected. • As health care costs continue to rise, keeping insurance affordable will be increasingly difficult.

Source: *States Moving Toward Comprehensive Health Care Reform*. The Kaiser Commission on Medicaid and the Uninsured, http://www.kff.org/uninsured/kcmu_statehealthreform.cfm, accessed August 19, 2008.

State of Maine Reform Highlights

- The Dirigo Health Reform Act was signed into law in June, 2003; it was a comprehensive reform effort aimed at providing affordable, quality health care to every Maine resident by 2009.
- At the center of Maine's health reform was the creation of DirigoChoice, a voluntary health care plan for businesses with 50 or fewer employees, the self-employed and eligible individuals without access to employer-sponsored insurance.
- Initially, DirigoChoice was made available through Anthem; effective January 2008 Maine began contracting with Harvard Pilgrim Health Care. The program offers discounts on monthly premiums and reductions in deductibles and out-of-pocket maximums on a sliding scale fee to enrollees with incomes below 300% FPL.²
- Funding for the program includes a combination of:
 - Employer contributions
 - Individual contributions
 - One-time appropriation of state general funds
 - Federal Medicaid matching funds for Medicaid eligible individuals
 - A "savings offset payment (SOP)", a key but controversial mechanism through which assessments are issued to insurers based on savings generated by the program.

² Academy Health. *State of the States*, January 2007.

State of Maine Reform Impact

Impact on Access	Impact on Cost	Impact on Quality	Challenges
<ul style="list-style-type: none"> Enrollment was voluntary and has fallen short of what was anticipated by policy makers. As of February 2008, 23,000 individuals and a small percentage of businesses (i.e., over 725) were enrolled in Dirigo Choice.³ When compared to the estimated 124,000 uninsured Maine residents, this number is considered modest. Additionally, for low income residents, the fully subsidized Medicaid program has been more attractive than the partially subsidized DirigoChoice plan.⁴ 	<ul style="list-style-type: none"> SOP is based on savings, identified by Dirigo Health Reform, including savings associated with a reduction in uncompensated care. The state determines the savings offset payment based on “aggregate measureable cost savings.” The aggregate cost savings approved have been lower each year than expected, and revenues available to fund subsidies through DirigoChoice have been negatively impacted. The SOP payment mechanism triggered a court challenge – in June 2007, the Maine Supreme Court upheld the SOP. In April 2008, the Governor signed legislation that replaces the SOP with taxes on beer, wine, soda, and a surcharge on insurers. New funding sources are being targeted for repeal. 	<ul style="list-style-type: none"> Efforts are being made to reduce hospital costs and improve management of chronic conditions Maine’s three largest health care systems are collaborating to make electronic health records (EHR) accessible across the three systems, share information about critically ill patients in rural hospitals, and launch preventive health programs for chronic conditions (e.g., obesity, substance abuse) to reduce high cost medical interventions. Dirigo Health’s Maine Quality Forum was created to improve the quality of care. The Forum serves as a clearinghouse for best practices and information and is a resource to providers and consumers. 	<ul style="list-style-type: none"> Sustainability of the program, especially DirigoChoice Geographic and demographic characteristics – Maine has large rural, elderly and low-income populations, with many experiencing chronic health conditions. There are many small and seasonal businesses – fewer employers offer health insurance compared to other states. The program has struggled to offer broad choices of coverage due to the availability of major carriers The SOP funding mechanism has been controversial. The new funding mechanism is targeted for repeal.

Sources:

States Moving Toward Comprehensive Health Care Reform. The Kaiser Commission on Medicaid and the Uninsured, http://www.kff.org/uninsured/kcmu_statehealthreform.cfm, accessed August 19, 2008.

State of the State January 2008. Academy Health, <http://statecoverage.net/pdf/StateofStates2008.pdf>

³ The Kaiser Commission on Medicaid and the Uninsured. *States Moving Toward Comprehensive Health Care Reform.*, http://www.kff.org/uninsured/kcmu_statehealthreform.cfm accessed August 19, 2008.

⁴Academy Health. *State of the States*, January 2008.

State of Vermont Reform Highlights

- In June 2006, comprehensive health reform legislation was passed with the goal of achieving near universal coverage by 2010 and improving health care for people with chronic conditions. Primary components of the reform are:
 - The *Catamount Health Program* – a health insurance plan for people without access to employer-sponsored insurance. Within Catamount Health:
 - Premium assistance, on a sliding scale, is provided to individuals and their dependents with incomes below 300% of the federal poverty level;
 - The monthly premium assistance cost for individuals and their dependents range from \$60 per month for those with incomes under 200% of the FPL and \$135 per month for those with incomes between 275% and 300% of the FPL;
 - Premiums for those with incomes above 300% of the FPL are \$393 for an individual and \$1100 for a family.
 - *Employer-Based Premium Assistance* – for individuals with incomes below 300% FPL, to help them pay for their employer's insurance plan.
 - *Employer Requirement* – an assessment fee of \$365 for employees who are not offered or who do not take up health care coverage and are uninsured; there is an exception for small employers.
 - *Blueprint for Health* – is a statewide initiative to improve health and health care; the premise of the initiative is that prevention and support of chronic conditions (e.g., timely and effective treatment) will result in a healthier population and reduce demand for medical services.
- Reform financing comes from multiple sources:
 - Premium collections
 - Employer fees
 - Tobacco tax increase
 - Federal matching funds through the Medicaid program
- Implementation of the plan began in October 2007.

State of Vermont Reform Impact

Impact on Access	Impact on Cost	Impact on Quality	Challenges
<ul style="list-style-type: none"> • Catamount Health was implemented Oct. 1, 2007 and will be phased in over 5 years. A major education, outreach, and enrollment campaign for all of the insurance options available has been launched. As of 12/31/07, 1,352 individuals were enrolled in Catamount Health; the enrollment target was 4,245. 	<ul style="list-style-type: none"> • In 2010, the plan is expected to cost \$60.6 million. • The original financing called for nearly half of the funding to come from the state's Medicaid "Global Commitment to Health" waiver. • The Centers for Medicare and Medicaid Services (CMS) decided to only allow federal matching funds to be used to finance premiums for individuals up to 200% FPL (instead of all Catamount enrollees up to 300% FPL). As a result, Vermont had to commit additional General Fund revenues to fund the plan. • Additional funds are being raised by the increase in the tobacco tax and remaining funds will come from the employer assessment and individual contributions. 	<ul style="list-style-type: none"> • Prevention and chronic care management are focal points of the Blueprint for Health. • These two components are considered by Vermont as being critical to slowing the rate of health care and cost growth. • Other states can look to Vermont to see if improving chronic care management can reduce the growth of health care costs and improve quality over the long-term. 	<ul style="list-style-type: none"> • Will the Catamount Health Plan prove to be affordable for low and moderate income individuals and families (especially those not eligible for premium subsidies)? • Is financing sustainable over the long-term (the state had to commit more state funds than originally planned)? • The Blueprint Health Plan focuses on prevention and chronic care management. The plan will require significant financial investment and commitment of all stakeholders.

Sources:

States Moving Toward Comprehensive Health Care Reform. The Kaiser Commission on Medicaid and the Uninsured, http://www.kff.org/uninsured/kcmu_statehealthreform.cfm, accessed August 19, 2008

Kaiser Commission on Medicaid and the Uninsured. *Vermont Health Care Reform Plan*, December 2007, <http://www.kff.org/uninsured/upload/7723.pdf>, accessed August 19, 2008.

Other States that Considered Comprehensive Proposals

- California
- Pennsylvania
- New Mexico

Substantial Reforms

State of Washington Reform Highlights

- Reform legislation was enacted in 2007.
- The legislation reflects certain aspects of the comprehensive reform enacted by other states, in particular that of Massachusetts.
- The plan aims to provide access to health care coverage for all residents by 2012.
- Key features of the reform are:
 - Funding to provide health insurance for all children by 2010.
 - SCHIP expansion from 251 to 300% FPL; full-cost-buy-in to public coverage for those above 300% FPL.
 - Creating a statewide connector, the Health Insurance Partnership, scheduled to make health insurance products available for purchase in September 2008.
 - Directing the Health Care Authority to provide grants to community health centers that work with local hospitals to reduce unnecessary emergency room visits.
 - Creating the Washington Quality Forum to address disparities in care.
 - Expanding chronic care management.
 - Directing state health agencies to change contracts and reimbursement for pay-for-performance.
 - Promote prevention.

Source:

State of the States January 2008. Academy Health, <http://statecoverage.net/pdf/StateofStates2008.pdf>

State of Washington Reform Impact

Because implementation of the reform is so new and still in progress, the impact has not yet been determined.

State of Oregon Reform Highlights

- The Healthy Oregon Act was signed in June 2007, providing a detailed timeline for developing a full-scale health reform plan for consideration during the 2009 legislative session.
- The bill established the Oregon Trust Board, tasked with gathering public input and creating a comprehensive health care plan.
- The seven member Board, appointed by the governor and confirmed by the Senate, is composed of experts in the areas of consumer advocacy, management, finance, labor and health care.
- Five subcommittees are to make recommendations on financing, delivery system reform, benefit definition, eligibility and enrollment, and federal policy issues and opportunities.
- Existing state commissions and committees are responsible for compiling data and conducting research to inform the subcommittees' decision making.
- Per a legislative mandate, the Oregon Health Trust Board must present a plan to the legislative assembly by February 1, 2008 on the potential design and implementation of a Health Insurance Exchange.
- The Exchange is to serve as the central forum for uninsured individuals and businesses to purchase affordable health insurance.
- Public meetings for stakeholders across the state are scheduled between February 2007 and October 2008.

- A comprehensive plan is to be submitted to the Governor, the Speaker of the House and President of the Senate on October 1, 2008.
- The plan will be submitted to the Legislative Assembly during the 2009 legislative session.
- Also during 2007, the governor signed the Health Kids Plan, expanding eligibility to children. Funding for the plan was made contingent upon an 84 cent increase in the state tobacco tax. The ballot initiative was not approved by voters on the November 2007 ballot. Unless an alternative source of funding can be agreed upon, the plan will not be implemented.

Sources:

States Moving Toward Comprehensive Health Care Reform. The Kaiser Commission on Medicaid and the Uninsured, http://www.kff.org/uninsured/kcmu_statehealthreform.cfm, accessed August 19, 2008

State of the State January 2008. State Coverage Initiatives, <http://statecoverage.net/pdf/StateofStates2008.pdf>

State of Oregon Reform Impact

The reform has yet to be implemented.

State of Illinois Reform Highlights

- In March 2007, Governor Blagojevich proposed “Illinois Covered” to provide affordable and quality health care to all residents.
- The proposal builds on the success of his All Kids program, the first program in the country to provide health care for all children.
- Key features of the “Illinois Covered” are:
 - A statewide purchasing pool through which small businesses and individuals without access to employer-sponsored insurance can purchase insurance coverage.
 - Premium subsidies for individuals with incomes between 100 and 400 percent of the FPL, to help them purchase insurance.
 - A new program to cover adults under poverty and an expansion of health care coverage to families up to 400% of the FPL.
- Proposed financing of the plan was through a new Illinois Covered Trust Fund, with a 3% employer assessment as the primary revenue source.
- A bill incorporating the provisions of the Governor’s proposal was introduced during the 2007 legislature session, but was not passed.
- Because the bill was not approved, the Governor sought to use his executive authority to expand health care including:
 - In October 2007, Illinois became the first state to provide free mammograms, breast exams, pelvic exams, and Pap tests to all uninsured women.
 - The Governor implemented the FamilyCare expansion through administrative order, despite legal efforts to stop the expansion (3,300 individuals have been enrolled since November 2007).

State of Illinois Reform Impact

- On April 15, 2008, a judge issued a preliminary injunction that prohibits the Governor from continuing the FamilyCare expansion.
- It is not clear whether the 3,300 enrolled individuals will be able to continue to receive health coverage.

Source: *States Moving Toward Comprehensive Health Care Reform*. The Kaiser Commission on Medicaid and the Uninsured, http://www.kff.org/uninsured/kcmu_statehealthreform.cfm, accessed August 19, 2008

State of Indiana Reform Highlights

- Adults began enrolling in Indiana's new Healthy Indiana Plan in January 2008.
- The plan, the first of its kind among the states, allows Indiana to offer a benefit package modeled after a high-deductible plan and health savings account to low-income people using Medicaid funds.
- The plan operates under a federally approved waiver.
- The plan covers:
 - Very poor and other low-income uninsured parents (22%-200% FPL).
 - Other adults (0-200% FPL) who do not have access to employer-based coverage, Medicare, or regular Medicaid.
- Benefits are provided through managed care plans and include:
 - *High-deductible coverage* – Individuals are covered for state-specific benefits up to a \$300,000 annual cap and a \$1 million lifetime cap after meeting a \$1,100 deductible.
 - *POWER Account* – This account is used to cover the \$1,100 deductible. The account consists of monthly contributions made by the enrollees in addition to a state contribution. The state's contribution varies according to a sliding scale based on the participant's financial ability to contribute. If any funds remain in the POWER Account at the end of the year, this balance rolls-over to the following year's contributions if the participant has received the preventative services required by the plan.
 - *Preventive care* – Individuals are covered for preventive care; this care is not subject to a deductible and does not draw from the POWER Account.
- Enrollees Contributions:
 - The monthly POWER Account contributions that enrollees make range from 2%-5% of their income and are based on a sliding scale.
 - The state (in addition to federal match funds) pays for the gap between the enrollees' contribution and the \$1,100 deductible for the POWER Account.
 - If the enrollee misses a monthly payment, he or she loses coverage, forfeits 25% of his or her contributions to the POWER Account, and is barred from re-enrolling for 12 months.
- Financing:
 - As a Medicaid waiver program, Indiana must demonstrate budget neutrality.
 - The state plans to offset the coverage expansion by:
 - Using a portion of their Disproportionate Share Hospital (DSH), and
 - Achieving savings in existing Medicaid coverage for pregnant women, children, and parents covered through Medicaid.
- In addition to the savings required for budget neutrality, the state has agreed to achieve further savings of \$15 million (state and federal) over the five-year waiver period.

State of Indiana Reform Impact

- Approximately 13,000 adults were enrolled as of June 2008.
- Enrollees tend to be:
 - Poor (69%)
 - Women (65%)
 - Age 40 or older (58%)
 - Without dependent children (59%)
- Enrollment for adults without dependent children is currently capped at 34,000.
- The state estimates it will eventually enroll 86,000 parents.
- Key issues for consideration are:
 - The affordability and adequacy of the coverage;

- Enrollees' understanding of the coverage;
- The plan's ability to promote personal responsibility, cost transparency, and preventive care;
- Cost-effectiveness; and
- The impact on already eligible Medicaid beneficiaries.

Source: Kaiser Commission on Medicaid and the Uninsured. *Summary of Healthy Indian Plan: Key Facts and Issues*, June 2008, <http://www.kff.org/medicaid/upload/7786.pdf> , accessed August 19, 2008.

State of Wisconsin Reform Highlights

- BadgerCare Plus was launched on February 1, 2008; it merges Family Medicaid, BadgerCare, and Healthy Start to form a comprehensive health insurance program for low income children and families.
- Under BadgerCare Plus, eligible populations are:
 - All children, regardless of income; sliding scale premiums will be required for those above 200% of the FPL;
 - Pregnant women with incomes up to 300% FPL;
 - Parents and relatives caring for a child up to 200% FPL;
 - Regardless of income, young adults in foster care who turn 18 on January 1, 2008, will be automatically eligible for BadgerCare Plus, until they turn 21;
 - Farm families and other families who are self-employed may be eligible if their income is under 200% FPL; and
 - Parents whose child/children are in foster care and have a reunification plan in place may be eligible if their income is below 200% FPL.
- Enrollee Costs:
 - Families with incomes that exceed 200% FPL will be able to purchase basic health care for their children for \$10 to about \$68 per child per month, depending on their income.
 - Premium costs for families with incomes up to 300% FPL will be subsidized.
 - CMS approved a waiver that allows federal match for children up to 250% FPL while those between 250 and 300% FPL will be subsidized with state-only funds.
 - Families with incomes above 300% FPL are required to contribute the full cost of coverage.

State of Wisconsin Reform Impact

Wisconsin's reform plan has been in effect less than one year; the impact of the reform will take some time to realize. It is interesting to note, however, that six weeks after launching the program, 71,000 people were enrolled, far exceeding enrollment expectations.

Sources:

States Moving Toward Comprehensive Health Care Reform. The Kaiser Commission on Medicaid and the Uninsured, http://www.kff.org/uninsured/kcmu_statehealthreform.cfm, accessed August 19, 2008

State of the State January 2008. *Academy Health*, <http://statecoverage.net/pdf/StateofStates2008.pdf>

Incremental Reforms

During 2007, a number of states advanced reform to expand coverage for children, while others focused on parents, the aged and disabled. Listed below are brief descriptions of some of these reforms.

State(s)	Reform Focus	Brief Description
Oklahoma, Ohio, Louisiana	Expand coverage to children	Proposed reforms to expand coverage to children up to 300% FPL was denied by CMS.
Hawaii	Expand coverage to children	Two pilot programs were implemented to expand coverage to infants and children – the Hawaii Infant Health Program provides coverage to uninsured newborns up to 30 days of age for up to \$10,000 in health care assistance per infant.
Connecticut	Expand coverage to Children	The HUSKY program (Medicaid and SCHIP) was expanded to provide coverage for children from 300 to 400%FPL at a cost of \$6 MIL in 2008. Additionally, the state plans automatic enrollment of uninsured newborns in HUSKY and will pay the premium for the first two months; estimated cost - \$2.7 MIL.
Missouri	Expand coverage to children	2007 legislation restores coverage and benefits to some subpopulations whose services were eliminated two years ago including 6,000 children who lost coverage because their parents had access to employer-sponsored health insurance. Additionally, revisions to income eligibility requirements restore SCHIP coverage to about 20,000 children.
New York	Expand coverage to children	Governor Spitzer finalized a budget that would raise the eligibility requirement to the state's Child Health Plus program from 250% to 400% FPL; CMS denied the request.
Texas	Expand coverage to children	Legislation signed by Governor Perry that will: <ul style="list-style-type: none"> • Allow families below 185% FPL to undergo redetermination once rather than twice a year; • Revise a 90-day waiting period requirement so that it applies only to children with health insurance during the 90 days before applying for SCHIP. These revisions may result in the addition of 100,000 children to the SCHIP program. Nearly 25,000 children lost coverage during the first six months of 2007.
Connecticut	Increase Dependent Coverage	Enacted legislation requiring group comprehensive and health insurance policies to extend coverage to children until age 26.
Idaho	Increase Dependent Coverage	Expanded the definition of dependent under a new law; unmarried non-students can remain on their parents' insurance until age 21. Unmarried, financially dependent full-time students can remain on their parents' insurance until age 25.
Indiana	Increase Dependent Coverage	Requires commercial health insurers and HMOs to cover dependents until age 24 at the policy holder's request.
Maine	Increase Dependent Coverage	Passed legislation requiring insurers to continue coverage for dependents until age 25 as long as they remain dependent and do not have dependents of their own.

State(s)	Reform Focus	Brief Description
Maryland	Increase Dependent Coverage	Legislation allows young adults to remain eligible for insurance until age 25 if the individual resides with the insured policyholder and is not married.
Montana	Increase Dependent Coverage	Legislation was passed providing insurance coverage under a parent's policy for unmarried children under age 25.
Washington	Increase Dependent Coverage	Enacted a requirement that any commercial health plan offering insurance coverage must allow the option of covering unmarried dependents until age 25.
Other States	Increase Dependent Coverage	Other states that have increased the age limit for dependents to remain on their parent's policy are: Colorado, Delaware, Massachusetts, New Hampshire, New Jersey, New Mexico, Rhode Island, South Dakota, Texas and Utah.

Source: *State of the State January 2008*. Academy Health, <http://statecoverage.net/pdf/StateofStates2008.pdf>

Additional Strategies

States are increasingly looking at strategies that pair coverage expansions with strategies that incorporate chronic care management and coordination, wellness and prevention, safety, and transparency of data collection through public reporting.⁵ Examples of states proposing or attempting to advance these types of programs are California, West Virginia, Maryland, and Louisiana, among others.

Additional Strategies Specific to Kansas

Other strategies that Kansas implemented or attempted to implement include:

- A Medicaid Transformation Grant – Kansas was awarded a CMS Medicaid Transformation Grant in October of 2006 for \$906,664. The two year grant pilots the use of a predictive modeling tool to identify health needs and improve preventive health care for disabled Kansans enrolled in Medicaid.
- In Kansas a Premium Assistance Program, Kansas Healthy Choices was intended to be an extension of private health insurance to low-income families using a combination of federal, state, and employer funds. The program was authorized by the Legislature and Governor in May 2007 with the signing of Senate Bill 11. Though it was slated for implementation in January of 2009, it was removed from statute by the 2008 legislature. Kansas Healthy Choices was designed to help control state health care spending for the poverty level population by providing broader access to preventive care, and strengthening and expanding the private markets rather than replacing them.
- Community-Based Alternatives to Psychiatric Residential Treatment Facilities (PRTF) – The Department of Social and Rehabilitation Services (SRS), a sister agency to KHPA, was awarded a Community-Based Alternatives to PRTF demonstration grant. The total federal share of the award for the five year demonstration is \$17,406,672. The demonstration will allow the state to use Medicaid funds to provide home and community based services to children and adolescents under the age of 21, as an alternative to PRTF.

Conclusion

Many of the reform efforts summarized here are relatively new or have yet to be fully implemented. The full extent to which these reforms impact health care in their respective states is likely to require further time to evaluate. Exceptions include the Massachusetts program which has demonstrated a significant increase in providing coverage to previously uninsured individuals, and

⁵ Academy Health. *State of the States*, January 2008.

perhaps the preliminary results of Florida's program. Florida launched Medicaid reform pilots in Broward and Duval counties in July 2006 and began enrollment in September 2006. One year later, the pilots were expanded into three more counties. Under the reform, participating plans were allowed to offer different benefit packages, and impose different levels of cost sharing (for nonpregnant adult enrollees), contingent upon state approval. Due to these changes, enrollees were required to compare benefit packages and consider differences such as preferred drug lists, provider networks, and prior authorization requirements when making their choice. Although some of the reform changes have not yet been implemented, reports on the preliminary results have been mixed. Some sources (e.g., the James Madison Institute) point to improvements in access to services and benefit packages, while others (e.g., Georgetown University) indicate a reduction in provider participation and problems associated with beneficiaries not being aware of which plans would cover their medications or doctors.

Aside from the time required to evaluate the impact of state reform efforts, there are other factors that influence the extent to which reform can occur. In the report *The Decline in the Uninsured in 2007: Why Did It Happen and Can It Last?* (Kaiser Commission on Medicaid and the Uninsured, October 2008, <http://www.kff.org/uninsured/7826.cfm>) a number of these factors are cited and include the following:

- During an economic decline, states' revenues contract with less funding available for Medicaid and SCHIP budgets.
- At the same time less funding is available, the number of people qualifying for these programs increases.
- During the 2001 to 2004 recession, relief was provided to the states in the form of increased federal matching payment rates.
- To help ensure more people would be covered, the increase in federal funds was contingent upon maintaining existing income eligibility levels.
- During times of economic downturn, states may find it difficult to even maintain their current levels of health coverage let alone address the needs for increased coverage as unemployment increases.

Given our current economic downturn, circumstances such as those described above may have a negative impact on the extent to which states can continue to engage in Medicaid reform. It is possible, however, that a new economic stimulus package being considered at the federal level could include additional funding to state Medicaid programs. If the additional funding is approved, this could help address the collective \$50 billion shortfall the states are facing in fiscal year 2008-2009, and perhaps make cuts on Medicaid and other programs less likely.⁶

⁶ The Henry J. Kaiser Family Foundation. Kaiser Daily Health Policy Report: *Potential Second Economic Stimulus Package Could Include Money for State Medicaid Programs*, <http://www.kff.org/uninsured/7826.cfm>, October 21, 2008.