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STATES IN ACTION: A Bimonthly Look at Innovations in Health Policy

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Coverage Gains and Budget Challenges

The U.S. Census Bureau reported recently that both the percentage and number of people without health insurance decreased in 2007, from 47.0 million (15.8 percent) in 2006 to 45.7 million (15.3 percent) in 2007. The percentage of people covered by private health insurance actually *decreased,* but the drop in private coverage was more than offset by an increase in coverage through government health insurance programs.

Meanwhile, the economy took a turn for the worse, threatening to undo gains in health insurance coverage and straining state budgets.

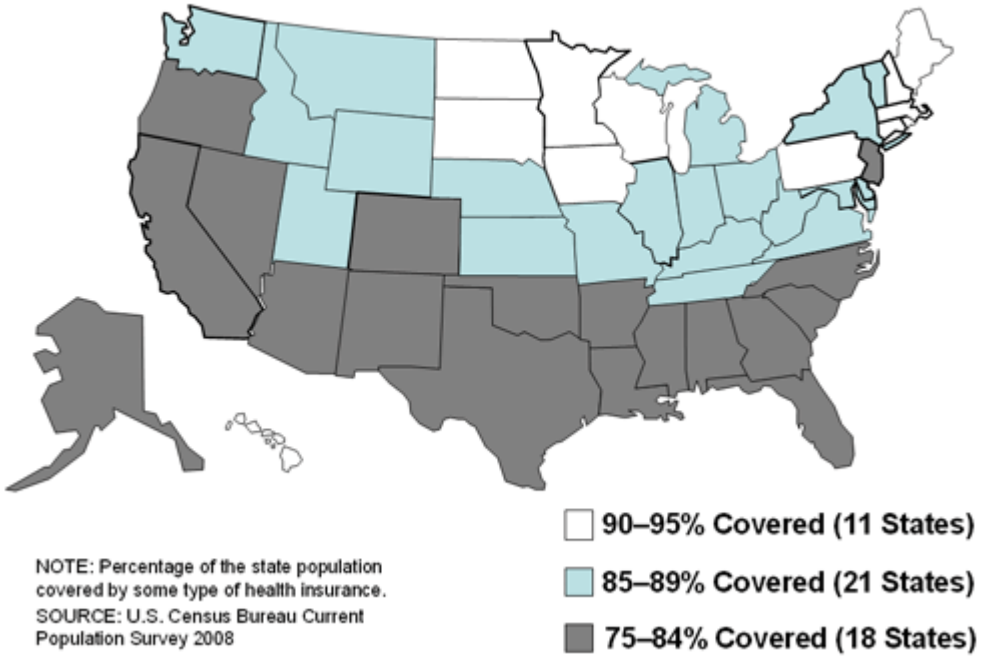
Even before the Wall Street financial crisis, the Center for Budget and Policy Priorities reported that 29 states were facing budget shortfalls in 2009, raising serious doubts about their ability to sustain gains in health coverage or consider additional reforms.

This issue of *States in Action* takes a close look at the Census Bureau's health insurance coverage data, considering how coverage changed by state, and describes ways in which states are trying to stay the course to cover the uninsured in a worsening economy.

Extent and Source of Coverage Vary by State

In 2007, 84.7 percent of the U.S. population was covered by some type of health insurance. But national statistics mask great differences in rates and sources of coverage from state to state; some states have much further to go to close gaps in coverage. Among the states, coverage rates ranged from 74.9 percent to 94.6 percent, with the highest rates in the Northeast and Upper Midwest and the lowest rates in the South and Southwest (Figure 1). States with large populations, including California, Florida, Georgia, North Carolina, and Texas, tend to have coverage rates below the national average. Among the 10 largest states, only Pennsylvania covers more than 90 percent of its population. Among the 15 smallest states, only Alaska's coverage rate (81.7 percent) is less than the national average.

Figure 1.
Health Insurance Coverage by State in 2007



NOTE: Percentage of the state population covered by some type of health insurance.
SOURCE: U.S. Census Bureau Current Population Survey 2008

Sources of coverage also vary considerably across states. For example, the percentage of people covered by employer-based and individually purchased private insurance ranges from lows of 56 to 57 percent in Texas, Mississippi, and New Mexico to highs of 78 to 80 percent in Minnesota,

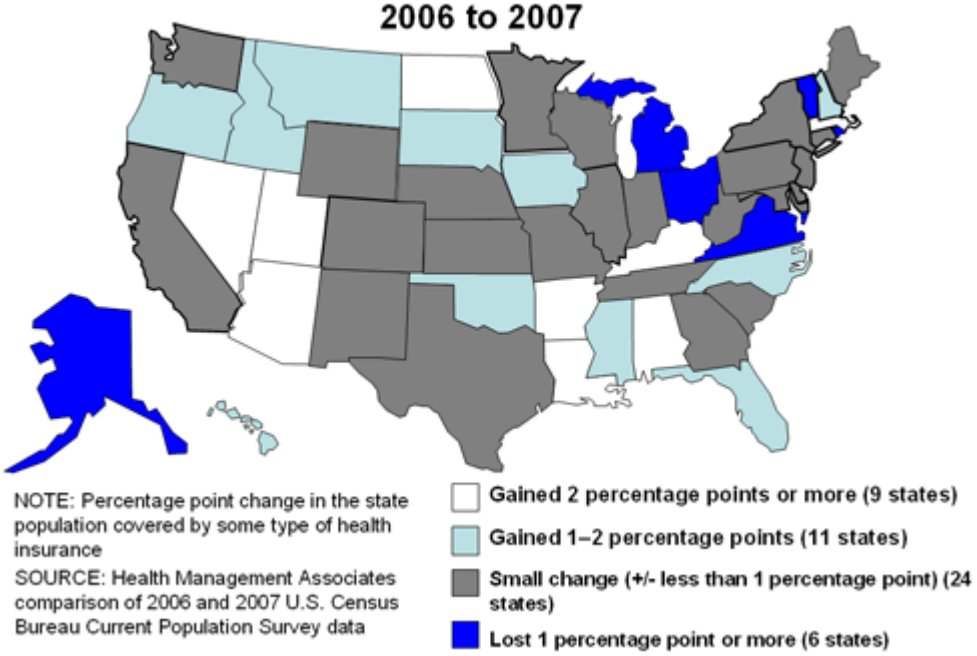
New Hampshire, North Dakota, and Iowa. Medicaid covers less than 7 percent of the population in New Hampshire and Nevada and more than 20 percent in Mississippi and the District of Columbia.

Some Coverage Gains, Some Losses

Across the nation, increases in health insurance premiums are outpacing wage growth, causing some employers to scale back benefits, require greater cost sharing by employees, or drop coverage altogether. Employer-sponsored health coverage dropped from 59.7 percent in 2006 to 59.3 percent in 2007. In 2007, this loss of employer-based coverage was more than offset by gains in government health insurance programs, including Medicare, Tricare, and, most important, Medicaid. Medicaid alone added 1.3 million people to its rolls in 2007. As a result, the percentage of people with some type of health insurance in the U.S. increased from 84.2 percent in 2006 to 84.7 in 2007.

After seven years of steady increases in the number of uninsured Americans, coverage gains in 2007 were widely reported as good news. But not all states shared in the gains: in 20 states, there were significant increases in the percentage of the population covered by some type of health insurance, while in six states there were significant coverage losses (Figure 2).

Figure 2.
Health Insurance Coverage Net Change by State
2006 to 2007



Within states, the interplay between private coverage and Medicaid was important. In 2007, additions to Medicaid rolls offset private coverage losses in 18 states. In 15 states the reverse was true: private coverage expanded and Medicaid enrollment fell. These trends suggest that Medicaid is functioning as intended, responding to economic conditions state by state and entitling more

citizens to enroll as personal income drops during an economic downturn. In this way, the program minimizes the effects of economic downturns on the overall coverage rate.

Medicaid Fills Gaps Left by Declining Private Coverage

Following the economic downturn of 2001 to 2004, state revenues grew 8.9 percent in 2005 and 2006, significantly above the historical average of 6.7 percent.[1] The boost in revenues enabled many states to expand public health insurance programs, resulting in the increased coverage rates seen in 2007 that helped to offset drops in private coverage. States implemented an array of changes to Medicaid programs, including: increasing provider payment rates, expanding eligibility and simplifying enrollment processes, improving or restoring targeted benefits, and expanding community-based long-term care.[2]

Medicaid directors did not take the upturn in state revenue for granted. While pursing coverage expansions, they also aimed to control spending growth, honing strategies that held Medicaid cost growth to a record low of 1.3 percent in 2006. In light of the current economic downturn, their caution was clearly warranted. The National Association of State Budget Officers began warning states in 2007 that "the housing market downturn could lead to slowing revenue growth in the near future."[3]

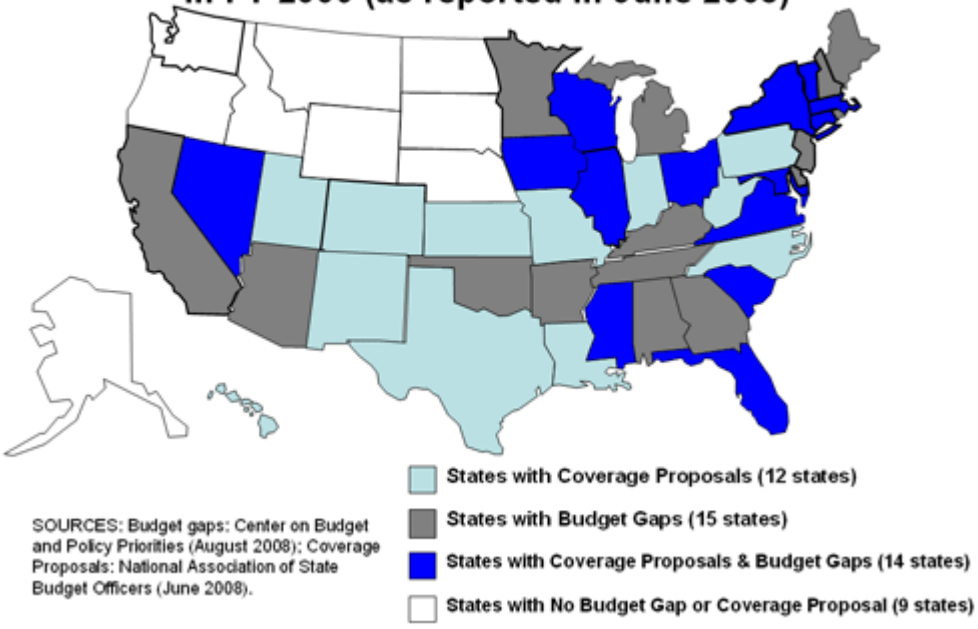
Despite Budget Restraints, States Aim to Cover Uninsured

Much has changed since the 2007 Census data were collected. In just the past six weeks, the economy has worsened on a scale not seen in a lifetime. Even before the bottom fell out of the U.S. housing and credit markets, state budget officials were predicting only a 1 percent increase in overall state general fund spending for fiscal 2009—the third lowest spending increase in the past 31 years.[4] According to the Center for Budget and Policy Priorities, revenues are expected to fall short of proposed spending in 29 states in 2009 (Figure 3). Medicaid directors in two-thirds of states report that there is at least a 50 percent likelihood of a Medicaid budget shortfall in their state in 2009.[5]

Despite budget challenges, more than half of the states have enacted plans to increase coverage for the uninsured in 2009 (Figure 3). Governors' plans vary, from proposals to cover all of the uninsured to targeted expansions for specific groups such as uninsured children and small business employees. Most state plans to reduce the number of uninsured use Medicaid as a building block for additional coverage and financing. All of the coverage expansion proposals were enacted prior to the credit crunch—before states understood how difficult it would be for them to issue bonds to cover spending until personal income tax revenues are collected next spring; and before they revised their 2009 revenue estimates downward to reflect the worsening economy.

"States want to stay on course with coverage reforms," says Anne Kohler, director of the National Association of State Medicaid Directors, "but the sudden inability to borrow or meet revenue projections, and concerns about employee pension programs, create a perfect storm of budget challenges—this is happening now, and it's not yet clear which states will be in a position to expand coverage."

Figure 3.
States with Budget Gaps and Health Coverage Proposals in FY 2009 (as reported in June 2008)



Conclusion

The good news about the decreased number of uninsured Americans in 2007 was quickly overshadowed by the worsening economy. Yet, covering the uninsured remains a high priority and has bipartisan support across many state governments. Many states hope to leverage their Medicaid programs to fill gaps in coverage resulting from the continued erosion of private coverage. However, the current economic crisis will test the resolve of governors and legislators who want to sustain recent coverage gains and further expand coverage to the 47 million Americans who are still uninsured.

For More Information

See:

- Health Insurance Coverage 2007, U.S. Census Bureau, August 26, 2008.
- The Fiscal Survey of States National Association of State Budget Officers and National Governors Association, June 2008.
- Final estimate of gaps in projected FY2009 state budgets, Center on Budget and Policy Priorities, August 5, 2008.
- V. Smith et al., Headed for a Crunch: An Update on Medicaid Spending, Coverage and Policy Heading into an Economic Downturn, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2008 and 2009, Kaiser Commission on Medicaid and the Uninsured, September 2008.

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[1] National Association of State Budget Officers (NASBO) and National Governors Association (NGA), "The Fiscal Survey of States," June 2008.
[2] V. Smith et al., Headed for a Crunch: An Update on Medicaid Spending, Coverage and Policy Heading into an

Economic Downturn, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2008 and 2009, Kaiser Commission on Medicaid and the Uninsured, September 2008.
[3] NASBO and NGA, "The Fiscal Survey of States," June 2007.
[4] NASBO and NGA, "The Fiscal Survey of States," June 2008.
[5] V. Smith et al., September 2008.

Snapshots

State Coverage Expansions, Despite Economic Downturn

Despite the economic downturn, a few states are continuing to pursue coverage expansions. States such as Indiana are expanding Medicaid and the State Children's Health Insurance Program (SCHIP) by extending program eligibility up the income ladder. Other states are taking more unusual approaches, such as mandating children's coverage (New Jersey) or extending dependent coverage for children to young adults (Illinois and many other states)

Indiana's SCHIP Expansion

Beginning October 1, Indiana raised the income eligibility for its SCHIP program, Hoosier Healthwise, from 200 percent of the federal poverty level (FPL) to 250 percent of the FPL, about $53,000 for a family of four. Indiana estimates that nearly 10,000 children up to age 19 have become newly eligible, and state officials expect a little more than half will enroll in the first year. Other additions to the plan for children ages 0 to 3 with family income from 200 to 250 of FPL include: year-round eligibility, regardless of changes in a family's income, and the addition of telemedicine as a benefit.

"Thanks to tremendous bipartisan support from the Indiana General Assembly, we are able to continue our commitment to health care in this state," says Family and Social Services Administration Secretary Mitch Roob.

Families newly eligible for Hoosier Healthwise must contribute to the premiums on a sliding scale: those earning between 200 to 225 percent of the FPL pay $42 per month for one child and $53 for two or more children. Families earning 226 to 250 percent pay $53 for one child and $70 for two or more children. As the result of program savings in other areas, the state was able to cover the additional children without new appropriations, beyond the 5 percent annual increase in the amount allotted from general revenues.

Though the Indiana legislature approved a plan last year to extend SCHIP eligibility to 300 percent of the FPL, the Centers for Medicare and Medicaid Services (CMS) denied the extension to those above 250 percent of the FPL under federal rules set forth in August 2007 (see Federal Activity).

This expansion is one component of Indiana's 2007 "Check-Up Plan," which also includes the Healthy Indiana Plan (HIP), a major Medicaid expansion for low-income adults through the creation of health savings accounts (see previous article in *States in Action*). More than 27,000

people have enrolled in HIP; state officials are pleased with the response, particularly among childless adults.

Other components of the Check-Up Plan include: a Medicaid expansion to pregnant women with incomes up to 200 percent of FPL, expanded child immunizations, provider payment increases, tobacco cessation programs and other health initiatives, extension of dependent coverage to age 24, a small business qualified wellness program tax credit, and a tax credit for small employers to establish Section 125 plans.

As of mid-October, state officials do not expect the current economic crisis to affect Indiana's ability to sustain its programs.

For More Information
Contact: Elizabeth Surgener, Deputy Director of Communications and Media, Indiana Family and Social Services Administration, Elizabeth.Surgener@fssa.in.gov.

New Jersey's Children's Mandate and Coverage Expansion for Parents

In July, New Jersey Governor Jon Corzine signed into law comprehensive health reform that helps the state move toward universal access to health coverage. A key feature is a "Kids First" mandate: beginning July 2009, all state residents up to age 19 will be required to have health coverage.

"This is a 'soft' mandate, with carrots, not sticks," says Suzanne Esterman, spokeswoman for New Jersey's Department of Human Services. There are currently no penalties for non-compliance, but there are many opportunities to obtain affordable coverage. NJ FamilyCare, the state's SCHIP program, is available to children in families with income up to 350 percent of the FPL, or $74,200 per year for a family of four.[1] Families with incomes above 350 percent of FPL can buy into reasonably priced insurance for their children through NJ FamilyCare ADVANTAGE (see previous article in *States in Action*). Families will be asked to indicate on their New Jersey tax returns whether their dependents have health insurance coverage. The state will send applications and conduct outreach to families identified as having uninsured children who may be eligible for Medicaid or NJ FamilyCare. Task forces are currently developing strategies to enhance outreach and enrollment activities.

Another key feature of the health reform is an expansion of NJ FamilyCare to parents with incomes from 133 to 200 percent of FPL, with premiums and copayments tied to a sliding scale as income rises above 150 percent of the FPL. The expansion began September 1, and officials expect that, by the end of state fiscal year 2009, an additional 17,500 parents and 10,000 children will enroll. (Experience nationwide indicates that coverage expansions to parents result in having more children enroll as well.) Additional state costs are estimated at $11.3 million for the year, coming from general revenues, with the federal government providing matching funds.

New Jersey's health reform also makes changes intended to make individual health insurance more affordable to young adults and to increase insurer participation in the small group market.

At this point, officials do not expect that the national economic crisis will lead them to scale back the health reforms. "New Jersey's cost of living is so high that we'll do what we can to help alleviate additional stress on our families' finances," says Esterman.

For More Information

See: Senate Bill 1557
Contact: Suzanne Esterman, Spokeswoman, New Jersey Department of Human Services, suzanne.esterman@dhs.state.nj.us.

Reference

[1] The federal government is currently continuing to provide the match, having backed away from enforcing its August 2007 directive that it would not approve matching funds for families with incomes above 250 percent of the FPL, unless 95 percent of a state's eligible children in families with incomes under 200 percent of FPL are already enrolled (see Federal Activity for discussion).

Illinois Joining Other States in Extending Age for Dependent Coverage

Beginning January 1, 2009, Illinois parents will be able to keep their unmarried children on their health insurance plans until they reach age 26, or age 30 if they are military veterans. This could allow up to 300,000 young adults to stay on their parents' insurance plans. This provision is part of Governor Rod Blagojevich's "Rewrite to Do Right" campaign, in which he used amendatory veto power to revise a prior proposal that had a more modest dependent coverage extension.[1]

About 30 percent of Americans ages 19 through 29—13.7 million individuals in 2006—do not have health coverage.[2] No longer considered dependents, they often lose coverage at age 19 or upon high school or college graduation. In fact, 38 percent of high school graduates who do not attend college and one-third of college graduates are uninsured for some period of time during the year after graduation.[3]

Illinois is among a growing cadre of states trying to reduce the number of uninsured young adults by extending the time they can remain on their parents' insurance policies. Twenty-four states have moved from allowing insurers to set their own dependent age limits to defining dependent to include older children.[4] Most commonly, these states have extended the dependent age limit to "up to" age 24, 25, or 26. All states require the dependent to be unmarried. Some states set two age limits; for example, Idaho defines dependent as up to age 21 if unmarried, and from ages 21 to 25 if unmarried, a full-time student, and financially dependent on parents. New Jersey has set the highest age limit: young adults can retain coverage as dependents through age 30 if they are unmarried, uninsured, have none of their own dependents, and are either a resident of the state or a full-time student. To protect against the potential for young adults to wait to join their parents' plan until they need health services, New Jersey requires that young adults apply to continue coverage within 30 days from when they would have previously aged off of a policy, or during an open enrollment period.

While some insurers and business representatives fear that premiums may rise quickly when very sick young people remain on their parents' plans, supporters view these coverage expansions as a

positive trend that promotes access to care and adds greater numbers of young, healthy individuals to the insurance pool. It is also a way for states to expand coverage without making public expenditures.

For More Information

See:

- J. L. Kriss, S. R. Collins, B. Mahato, E. Gould, and C. Schoen, Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help, 2008 Update, The Commonwealth Fund, May 2008.
- National Conference of State Legislatures
- Kaiser Family Commission State Health Facts

References

[1] Under a previous version of Illinois House Bill 5285, insurers would have been required to continue offering coverage for one year to dependent, full-time college students who leave school or reduce school participation due to catastrophic illness or injury.
[2] National Conference of State Legislatures, www.ncsl.org/programs/health/dependentstatus.htm.
[3] J. L. Kriss, S. R. Collins, B. Mahato, E. Gould, and C. Schoen, Why Young Adults Become Uninsured and How New Policies Can Help, 2008 Update, The Commonwealth Fund, May 2008.
[4] Insurers commonly set limits at age 18 or 19, extended to 21 or 22 if child is a full-time student.

Federal Activity

CMS Directive Limits State Coverage Expansions

In August 2007, the Centers for Medicare and Medicaid Services (CMS) issued a directive that limits states' ability to expand the State Children's Health Insurance Program (SCHIP) to cover children in families with income above 250 percent of the federal poverty level (FPL). According to the directive, states would be allowed to increase SCHIP eligibility above 250 percent of poverty only if they could first prove that 95 percent of children in families with income below 200 percent of poverty were enrolled in Medicaid or SCHIP. Twenty-three states have been directly affected by this directive—10 that had already implemented coverage expansions beyond 250 percent of FPL and another 14 that had been planning to do so (Washington State fits both categories).

New Jersey, California, and eventually five other states filed lawsuits to challenge the authority of the directive. The U.S. Government Accountability Office and Congressional Research Service also examined it and concluded the directive exceeded the scope of the Administration's power and was therefore illegal.

On September 29, 2008, lawyers for CMS told a U.S. District Court judge the directive was only meant to be "policy guidance" and repeated an earlier announcement that CMS does not plan to take compliance actions against states if they fail to meet the requirements in the directive. However, the directive has not been rescinded, leaving states uncertain about how to plan for the future. Whether or not the directive is ever enforced, it has already resulted in a number of states limiting or delaying their plans to expand coverage for children. The judge who heard the case called it "complex" and reserved his judgment. The situation remains uncertain, and will likely

emerge as an early test of the next administration's thinking about how to use—or not use—Medicaid and SCHIP to cover uninsured Americans.

For More Information

See:

- CMS Directive to State Health Officials, August 17, 2007.
- Congressional Review Act: Applicability to CMS Letter on State Children's Health Insurance Program, U.S. General Accounting Office, May 15, 2008.
- R. Schwaneberg, NJ and Feds Tangle in Court over Kids' Health Care Rules," *The New Jersey Star-Ledger,* September 30, 2008.

Commission Corner

The Commonwealth Fund Commission on a High Performance Health System took its mission overseas this fall to learn about the Dutch health care system. Commission research director Cathy Schoen and three Commission members—Dallas Salisbury, Sandra Shewry, and Mary Wakefield—participated in AcademyHealth's five-day tour of multiple sites in the Dutch health system, including: the Ministry of Health, Welfare, and Sport; the Health Care Insurance Board; the Dutch Care Authority; a large university medical center; and a local primary care center. The tour focused on the role of government and quasi-governmental structures, the impact of an individual mandate, risk equalization in insurance markets, benefit design, and payment reform. It informed and provided insight for the Commission's forthcoming policy recommendations for a new presidential administration and Congress, as well as an forthcoming issue brief on the Dutch health care system.

In September, the Commission hosted a briefing on Capitol Hill for congressional and Administration staff to discuss the value of patient-centered medical homes and the challenges that must be surmounted to strengthen the U.S. primary care infrastructure through this model of care delivery.

In November, watch for the Commission's latest report, a synthesis of 10 case studies of high-performing organized health care systems, as well as a briefing on Massachusetts' health reform efforts. The Commission will hold its final meeting of 2008 in Washington, D.C., to finalize recommendations for the new president and Congress and set priorities for work in 2009, taking into account the results of the election.

For more information, please visit the Commission page on the Fund's Web site.

Related Publications

S. K. Long, Who Gained the Most Under Health Reform in Massachusetts? The Urban Institute, October 16, 2008.

S. K. Long, The Impact of Health Reform on Underinsurance in Massachusetts: Do the Insured Have Adequate Protection? The Urban Institute, October 16, 2008.

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L. J. Conwell, M. Neuman, M. Gold, State Efforts to Address *Healthy People 2010* Goals to Eliminate Health Disparities: Two Cases, Mathematica Policy Research, Inc., September 29, 2008.

M. B. Rosenthal, Beyond Pay for Performance—Emerging Models of Provider-Payment Reform, *New England Journal of Medicine,* September 19, 2008, 359(12):1197–1200.

R. A. Berenson, T. Hammons, D. N. Gans et al., A House Is Not a Home: Keeping Patients at the Center of Practice Redesign, *Health Affairs,* September/October 2008 27(5):1219–30.

R. A. Paulus, K. Davis, and G. D. Steele, Continuous Innovation in Health Care: Implications of the Geisinger Experience, *Health Affairs,* September/October 2008 27(5):1235–45.

D. R. Rittenhouse, L. P. Casalino, R. R. Gillies et al., Measuring the Medical Home Infrastructure in Large Medical Groups, *Health Affairs,* September/October 2008, 1246–58.

C. Burke and J. Shin, From Access to Affordability: A Summary of State Strategies to Provide Private Health Insurance Coverage to Small Groups, The Nelson A. Rockefeller Institute of Government Health Policy Research Center, August 2008.

D. L. Spencer and L. Blewettt, Individual High Risk Pools: A Case Study of the Minnesota Comprehensive Health Association, The Nelson A. Rockefeller Institute of Government Health Policy Research Center, August 2008.

C. D. Baker, A. Caplan, K. Davis et al., Shattuck Lecture: Health of the Nation—Coverage for All Americans, *The New England Journal of Medicine,* August 21, 2008 359:777–780.

State Health Access Data Assistance Center, A Needed Lifeline: Chronically Ill Children and Public Health Insurance Coverage, A State-by-State Analysis, The Robert Wood Johnson Foundation, August 2008.

T. A. Coughlin and S. Zuckerman, State Responses to New Flexibility in Medicaid. *The Milbank Quarterly,* June 2008 86(2):209–240 (subscription required).

J. Holahan and G. M. Kenney, Health Insurance Coverage of Young Adults: Issues and Broader Considerations, The Urban Institute, June 2008.

C. A. Berry, G. S. Krutz, B. E. Langner et al., Jump-Starting Collaboration: The ABCD Initiative and the Provision of Child Development Services Through Medicaid and Collaborators, *Public Administration Review,* May/June 2008 68(3):480–90 (subscription required).

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S. Silow-Carroll, Iowa's 1st Five Initiative: Improving Early Childhood Developmental Services Through Public–Private Partnerships, The Commonwealth Fund, September 2008.

M. M. Doty, S. R. Collins, S. D. Rustgi, and J. L. Kriss, Seeing Red: The Growing Burden of Medical Bills and Debt Faced by U.S. Families, The Commonwealth Fund, August 2008.

S. R. Collins, J. L. Kriss, M. M. Doty, and S. D. Rustgi, Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007, The Commonwealth Fund, August 2008.

J. L. Kriss, S. R. Collins, B. Mahato, E. Gould, and C. Schoen, Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help, 2008 Update, The Commonwealth Fund, May 2008.

Upcoming Meetings

American Public Health Association's Annual Meeting
San Diego, CA
October 25–29, 2008
www.apha.org/meetings

National Association of State Medicaid Directors' Fall Meeting
Washington, D.C.
November 12–14, 2008
www.nasmd.org/conferences/conferences.asp

Greater New York Hospital Association/United Hospital Fund Annual Symposium
New York, NY
November 19, 2008
www.uhfnyc.org/calendar_contact3160/calendar_contact_show.htm?doc_id=707395

Institute for Healthcare Improvement's Annual National Forum
Nashville, TN
December 8–11, 2008
www.ihi.org/IHI/Programs/ConferencesAndSeminars/20thNationalForumonQualityImprovement.htm

National Conference of State Legislatures' Fall Forum
Atlanta, GA
December 10–13, 2008
www.ncsl.org/calendar/showNCSLCalendarDate.cfm?day=10&Month=12&Year=2008&id=10764

Families USA Health Action 2009 Conference
Washington, D.C.
January 29–31, 2009
www.familiesusa.org/conference

About the Newsletter

The *States in Action* bimonthly newsletter describes innovative state health programs from across the country. It is intended to help policymakers, administrators, and researchers as they work to stretch health care dollars and meet the needs of their residents.

States in Action is part of a Commonwealth Fund program on state innovations. For more information, contact Rachel Nuzum, Senior Policy Director, Policy and State Innovations, at rn@cmwf.org.

We welcome those involved in state efforts to expand coverage and improve care and efficiency to send an e-mail about their efforts to stateinnovations@cmwf.org.

Editorial Advisory Board 2008

The *States in Action* Editorial Advisory Board includes experts from various aspects of state health policy. Members of the Editorial Advisory Board help to shape the newsletter by providing technical expertise, suggesting state innovations for inclusion, and assisting in the reviewing of each issue.

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