California and Other States' Expansion Efforts to Cover the Uninsured

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OREGON

The state of Oregon has a population of 3.2 million (in 1997), approximately $1/10^{th}$ the size of California. While California and many other state rates of the uninsured are increasing, Oregon's number of uninsured is decreasing. From 1990 to 1998, the state's uninsured residents have decreased from 18% to approximately 11%. This decline in number has occurred despite the state's inability to implement an employer mandate or even to pay into a state established program that would provide health coverage for these working poor. Medicaid enrollment increased from 260,000 in 1994 to 395,000 in 1995 as a result of the state's §1115 Medicaid waiver.

The three potential factors behind this impressive low rate of the uninsured are:

- Medicaid expansions provide health coverage to those with incomes below FPL. Oregon has a Medicaid program that covers low-income adults under a federal §1115 waiver.
- A series of reform efforts pertaining to Oregon's small-group insurance market.
- The increasing strength of the state economy, which has provided new jobs and employer sponsored health coverage.

However during the past couple of years, the number of residents who are uninsured is slowly beginning to increase again. From 1997 to 1998 the number has increased from 340,000 to 363, 000 (from 10.6% to 11.1% of the state's population), an increase of .5%. This is due to welfare reform (Medicaid enrollment fell to 330,000 as TANF/AFDC enrollees fell from 128,000 to 68,000) as well as the impact of the Asian economic crisis on Oregon's export economy.

To stop the growth of the uninsured, the state implemented two new programs, the Children's Health Insurance Program (CHIP) and the Family Health Assistance Program (FHIAP). The state CHIP program provides health coverage to children below the age of six, in families with income between 133% and 170% of the FPL and to children ages 6 to 18 between 100% and 170% of FPL. As of February 2000 there were over 15,000 new enrollees in CHIP.

FHIAP was established in 1997 through an increase in the state tobacco tax. It subsidizes the cost of private health insurance for those with incomes less than 170% of FPL. Due to the downturn in the state economy, the program's funding has been capped; there are about 5,000 adults enrolled and 20,000 on a waiting list.

In spite of the recent increase of uninsured, the state of Oregon is considered one of the leaders in developing programs to reduce the number of uninsured. The leading reason for this is a series of programs that form the Oregon Health Plan (OHP).

The OHP was enacted in 1989 and contains five main provisions. First Medicaid eligibility was extended to cover all persons with income below 100% of the FPL (previously was 57% of the FPL). Next, nearly all Medicaid beneficiaries were required to enroll in managed care. Third, employers were required to either provide health coverage to all their workers (who worked for more than 17.5 hours a week) or to pay into a state program that would provide coverage. Fourth, the Oregon Medical Insurance Pool (OMIP) was formed to develop a subsidized insurance pool for those excluded from or priced out of the regular insurance market

because they suffered from preexisting medical condition. Lastly, the Oregon Health Services Commission (OHSC) was formed to prioritize health services.

By the summer of 1995, after the implementation of Medicaid expansion, there were approximately 395,000 Medicaid beneficiaries. Roughly 76,000 of these enrollees are adults without children (equivalent to California's Medically Indigent Adult population). Since the implementation of federal welfare reforms, Medicaid enrollment has slowly and consistently decreased. By August of 1998 the number of Medicaid enrollees was down to approximately 330,000.

The decrease in enrollment is due in part to legislative restrictions enacted in 1995. Two new requirements have been added: a new $5000 liquid asset test and requirements to submit three months of income statements.

Oregon mandates that most Medicaid beneficiaries enroll in managed care. About 82-87% of the state's Medicaid beneficiaries are enrolled in managed care. Per member per month costs are much higher than in California, $132 for family members and $236 for adults without families.

There are 13 fully capitated health plans within the state's Medicaid managed care system. Four are commercial HMOs and the remaining nine are provider-sponsored organizations that enroll only Medicaid and other publicly insured beneficiaries.

WISCONSIN

Wisconsin has a population of approximately 5 million people with nearly 90% non-Hispanic white. It has the second lowest rate of the uninsured in the US, 8.6% in 1995 compared to the national average of 15.5%.

Nearly 80% of the population has health coverage through an employer. This high rate of coverage was achieved without any significant state intervention. Wisconsin also has a relatively generous Medicaid program with liberal eligibility criteria and a rich benefit package. The extensive Medicaid program, low numbers of uninsured, and strong base of private insurance make Wisconsin's health care and safety net system one of the strongest in the nation.

Wisconsin's Medicaid eligibility criteria are among the most generous in the country. In 1994-5 Medicaid covered 640,000 persons -- 76% of the state's low income population (i.e. people in families with incomes below 150% of the FPL). The year 2000 data shows 450,000 enrolled of whom over 53,000 are on BadgerCare

Wisconsin has been a leader in welfare reform. It replaced its AFDC (Aid to Families with Dependent Children) with the nationally prominent Wisconsin Works or W-2 program.

Declining caseloads under W-2 and the state's strong economy caused Medicaid rolls to fall dramatically. Medicaid enrollment of TANF/AFDC persons fell 22% (from 203,500 to 158,800). This decrease raised concerns that the number of uninsured is increasing. The state

proposed to use the State Children's Health Insurance Plan (S-CHIP) and the Medicaid §1931 option to expand Medicaid eligibility for adults and children.

The state Medicaid budgets for 1997-98 ($910 million) and 1998-99 ($929 million) represented a decrease in state dollars budgeted for Medicaid. One reason for this decline is the expanded use of county funds instead of state dollars for matching federal Medicaid funds. The decline in Medicaid caseloads was the other factor. Most of the caseload decline occurred in the family related categories.

The state initiated BadgerCare. This initiative was prompted by concern regarding the significant decline (by 22% or nearly 45,000 recipients between January and September 1997) in the Medicaid AFDC caseload due to W-2.

BadgerCare covers 53,622 children and adults. BadgerCare operates separately from Medicaid, even though it is run through the Medicaid program. The program uses federal funds from the State Children's Health Insurance Program (S-CHIP) and the Medicaid §1931 option to help fund the program.

Health insurance is offered to all children and adults in families with incomes below 185% FPL. Families enrolled in BadgerCare would remain in the program until their income level reaches 200% FPL. BadgerCare is a heavily subsidized program. Premiums are required only of those families with incomes above 150% of FPL and the cost would not exceed 3% of income. It provides for family coverage buy in with employers with premium contributions between 60 and 80% of premium.

In August of 1998, BadgerCare was initially denied by HCFA due to its financing components. Wisconsin planned to use part of S-CHIP's federal funding to increase coverage for adults, even though S-CHIP is aimed at expanding health insurance for children. It also sought to use premium payments by beneficiaries as part of the state match. Wisconsin now funds parents in BadgerCare under the Medicaid §1931 option.

Wisconsin had a small general relief medical program to fund health services for low-income adults who are not eligible for Medicaid, especially adults without children and who have lived in Wisconsin for at least 60 days. Counties were required to operate a general relief program for both cash and medical care.

In 1995 Wisconsin reduced its funding for the general relief medical program. Mandatory General Assistance (GA) was eliminated and replaced with an optional County Relief Block Grant program where state general-fund expenditures are capped. State funding was cut by one-third from $27.9 million in 1995 to $19.6 million in 1996. In Milwaukee County, the funds may be used only for health services. In other counties, the funds can be used for cash assistance if medical care is also provided. In 1997, about 26,000 people were enrolled. Under the revised program, Milwaukee County receives $16.6 million of state funds while the remaining 71 counties are left with $2 million.

WisconCare is a small program that provides limited outpatient primary care and inpatient maternity and delivery services to eligible individuals in the 17 counties with high unemployment. The recipients must be ineligible for Medicaid and private health insurance,

have low incomes, and be unemployed or underemployed. There is no asset test. The program serves about 1,500 persons a year. The program is financed with revenue from hospital assessments and volunteer services of providers.

Wisconsin is a low-DSH (Disproportionate Share Hospital) state. It had about a $12 million DSH allotment in 1996, which accounted for less than 1% of the state's total Medicaid spending that year. Wisconsin runs two DSH programs. The first, established in 1986, has funding of about $6 million. Payments are funded with state general funds and a federal Medicaid match. The payments are issued as an add-on to regular Medicaid inpatient payment rates. The other DSH program was established in 1993, when the state began to make Medicaid DSH payments to county-owned hospitals that provided "significant" services to General Assistance patients. In 1996, two Milwaukee hospitals received about $6 million under GA (General Assistance) DSH program.

In 1996, Wisconsin spent more on Medicaid supplemental payments to qualified providers (hospitals and other providers) than on DSH. The state's share of the supplemental payments is funded with intergovernmental transfers provided by facilities receiving the additional payments. The payments are targeted to publicly owned hospitals and nursing homes, including state, county, and municipal facilities.

Wisconsin initiated a statewide expansion of Medicaid managed care program that was completed in mid 1997. In 1998, 85% of family eligibles were enrolled in managed care; the program served nearly 190,000 recipients. Wisconsin Medicaid's family coverage appears to cost $150 pmpm (per member per month).

MASSACHUSETTS

Massachusetts has a population of 6 million making it the 13th largest in the nation. It has a large, high quality and high cost health care system with a strong public sector commitment to supporting health services for the low-income population. The state is a high income state, ranked 4th in the state. It has relatively high rates of health insurance coverage with only 12.6% (756,000) of the nonelderly uninsured compared to 15.5% for the rest of the nation.

The Massachusetts Medicaid program spent $5.7 billion in 1995 on 806,400 eligibles. On a per enrollee basis, Massachusetts spends $6,189, more than any other state with the exception of New York which spends $6,194. Spending per low-income person is $4,254 compared to $2,041 for the rest of the nation. New York and Connecticut are the only others who spent more per low-income person.

State government plays the predominant role in administration and funding of the Medicaid program. Local governments do not contribute to the cost of the program aside from intergovernmental transfers used for Medicaid DSH payments to city hospitals.

Medicaid eligibility income standards are higher than the national average and the state has adopted most federal optional eligibility categories. Medicaid enrollment for the low income population is extensive with the state covering 64% of the population below 150% of poverty.

Massachusetts Medicaid's growth rates (1.8% annually between 1992 and 1995) were well below the national average (5.2% annually 1992-5). In addition there has been a decline (11%) in AFDC participation due to an improved economy and the state's welfare reform efforts.

In 1976, the state of Massachusetts discontinued its health coverage of the indigent adult population (no federal match) due to a state fiscal crisis. However, slowly it restored coverage beginning with prescriptions and outpatient care, then funding for public hospitals and finally all public and private hospitals. Now, the General Relief (equivalent to California's MIA, non-categorically linked, medically indigent adult) population is covered as a part of Medicaid through a federal 1115 waiver.

Medicaid extends coverage to 200% of the federal poverty level under the federal waiver. The federal waiver extends FFP for the MIA population and provides mandatory managed care for all Medicaid eligibles.

The Waiver

The waiver program called MassHealth will extend coverage to new population groups and absorb two of the formerly state-funded programs, the CommonHealth program for the disabled and the Medical Security program for the short term unemployed.

MassHealth expands Medicaid coverage to all children through the age of 18 to 133% of poverty, as well as retaining current coverage of pregnant women and infants up to 185% of FPL. It establishes a New State Benefit Plan which will also extend coverage to long term unemployed individuals and other adults whose gross incomes are not above 133% FPL.

The Insurance Reimbursement Program provide premium subsidies to low income workers with incomes below 200% of FPL, and provides subsidies to employers in small firms with fewer than 50 workers that contribute at least 50% of the cost of premiums of plans that meet state standards.

Uncompensated Care Pool

In the early 1980's, an uncompensated care pool was initiated to pay for hospitals' bad debts and charity care to the uninsured. The program was part of state rate setting but survived its eventual downfall. The uncompensated care pool ($330 million) is by far the largest non-Medicaid subsidy program in the state. After a legislative change in 1990, clinics were paid from the hospital uncompensated care pool as well.

Massachusetts distributes its funds from the uncompensated care pool as DSH payments and receives federal Medicaid matching payments. The hospital portion of the pool is $315 million but only 15 of the 84 hospitals in Massachusetts are net receivers from the pool. The bulk of payments (about $150 million) go to two public hospitals, Cambridge Hospital and Boston City Hospital.

Other Programs for the Uninsured

Massachusetts has other programs covering those ineligible for Medicaid.

- Healthy Start is for pregnant uninsured women ineligible for Medicaid.
- Under CHIP, uninsured children above Medicaid levels are covered.

- Medical Security provides transitional coverage for those laid off or changing jobs by paying for COBRA coverage. The program is funded through the UI program and charges a $16 annual individual surcharge. The plan covers 16,000 people (March 1997) receiving state and federal unemployment benefits. Individuals can be eligible with incomes up to 400% FPL.
- Center Care allocates $4 million ($35 pmpm) for outpatient care through community clinics for uninsured adults who are not eligible for any other program.

Subsidized insurance programs include: the Children's Medical Security Plan (Healthy Children Plan), prescription drug coverage for seniors, and CommonHealth. The Children's Medical Security Plan provides primary care and preventive services to about 33,000 uninsured children not eligible for Medicaid and CHIP. There are no premiums for those below 200% FPL and premiums rise as incomes rise.

Common Health provides health insurance to working adults with disabilities and to children with disabilities who are not eligible for Medicaid. The program provides full or supplemental health benefits to about 3,500 enrollees depending on their insurance coverage and requires a monthly premium according to an income-related sliding fee scale. The benefits are comparable to Medicaid coverage with the exception that long-term care services are limited.

Funding for several of the state's health initiatives have come from cigarette taxes, the favored means of financing. In 1992, the state's voters passed the Massachusetts Tobacco Control Program, which raises $56 million annually towards public health and tobacco education programs. The tax was increased again in 1996 to fund individual health care coverage instead of the population-based tobacco prevention programs. The $100 million per year increase in the tobacco tax is marked for expansion of the Medicaid program, the Children's Medical Security Plan, and a prescription drug coverage program for seniors.

Massachusetts Medicaid has had statewide mandatory enrollment in managed care for select populations since 1992 when it received a Section 1915 (b) waiver. 378,000 Medicaid beneficiaries are subject to mandatory managed care enrollment. Those required to enroll in managed care must choose a primary care clinician or enroll in one of several HMOs.

The largest share of Medicaid HMO enrollment is in the Neighborhood Health Plan, a plan formed by community health centers. In 1995, 29,905 of the 87,288 Medicaid enrollees in HMOs (34%) were with Neighborhood Health Plan.

ARIZONA

Over the past decade, Arizona experienced a large increase in population; from 1990 to 1998, the number of residents grew to 4.6 million (21% increase). Much of the state's growth is concentrated in Maricopa County (Phoenix and its suburbs). As the state's population has grown, the number of residents without health insurance grew as well. The percentage of uninsured nonelderly residents has increased from 20.8% in 1989-90 to 28.1% in 1996-97. Arizona now has the highest percentage of uninsured persons in the nation.

There are several reasons for the state's growing health care crisis. The most important is the state's economy. While unemployment is low (less than 4%), most recent job growth is in the service sector, especially in the tourist industry. These jobs are generally low paying and do not provide health insurance. Arizona ranks 48th in the nation in the percentage of persons with employer-based health insurance coverage. Nor have most former welfare beneficiaries enrolled in the state's transitional Medicaid initiative; most have joined the ranks of the uninsured.

Arizona is unique in that it was the last state to enact Medicaid in 1982. Its §1115 waiver was then considered controversial. It required nearly all beneficiaries to enroll in managed care, covered the poor regardless of categorical linkage and had its entire Medicaid program run as a demonstration initiative, long before either was common. Other states now emulate much of its model.

Its Medicaid program, called the Arizona Health Care Cost Containment System (AHCCCS), began in 1982 as a Medicaid demonstration pilot, exempt from many of the federal rules that govern other state programs. Up to 1982, county government was a payor until the state took over indigent care and established AHCCCS. AHCCCS differed in three important ways from what was permissible under a traditional Medicaid program. First, it required nearly all beneficiaries to enroll in a competitively bid managed care system. Second, it did not cover long term care services, and third, it did not cover behavioral health services.

AHCCCS enrollment grew rapidly from the mid-1980s until the mid 1990s, increasing from 144,450 enrollees in July 1985 to 476,117 in July 1996. The increase was primarily due to eligibility expansions for children and pregnant women. Since then there has been a steady decline in program enrollment. By July 1998, the number of beneficiaries had fallen to 431,047. This decrease is primarily due to reductions in welfare caseloads and the strong economy.

The number of Medicaid beneficiaries has declined, as has the growth rate of the state's Medicaid expenditures. Between 1992 and 1995, for example, AHCCCS expenditures grew at an average of 12% annually. Between 1995 and 1997, expenditures grew by only 4%.

AHCCCS has developed three separate managed care systems: 1) the first and largest is made up of 11 health plans that provide primary and acute care services to beneficiaries who do not receive long term care services 2) group of five behavioral health firms that provide mental health services to this same population 3) eight health plans that care for just over 25,000 recipients of long term care services.

Arizona uses a system of competitive bidding to select health plans for the AHCCCS market. The state scores the bids on four factors 1) provider network (35% of the overall score), 2) capitation rate (30%), 3) programs and services (20%) and 4) organizational structure (15%).

Arizona's allotment of the Child Health Insurance Program (CHIP) budget is $114 million annually. To receive the full allotment, the state contributes $36 million in state general revenues. The federal government will pay 75% of the Arizona CHIP.

The goal for KidsCare was to phase in coverage over a two-year period to about 72,000 children. During phase one (November 1998 until October 1999), the program will cover children in families with incomes less than 150% FPL. The income criteria increases to 200% in

phase two (October 1999). Children in families with incomes above 150% will be required to pay premiums.

Arizona decided to create a separate state CHIP rather than financing a Medicaid expansion. This option allowed the state greater discretion to set program policy. At the same time, the state agreed that AHCCCS would administer nearly all of the CHIP initiative. There is a single CHIP/Medicaid application, and only clients not eligible for Medicaid are considered for CHIP. Most CHIP beneficiaries enroll in the AHCCCS managed care network.

The legislature agreed that not all KidsCare beneficiaries had to participate in AHCCCS. Instead parents could choose to enroll their children in the direct services program or sign them up with a health plan in the state employee health insurance plan. Under the direct services program, children can receive care from any participating provider and the provider is paid on a fee for service basis by the state.

The initiative received federal approval in September 1998 and the state began implementation in November 1998. Enrollment is much lower than expected. The state expected that more than 20,000 youngsters would sign up during the first few months, but as of February 1999, there were fewer than 10,000 CHIP enrollees.

Two initiatives target working adults. The Premium Sharing Program provides subsidized insurance for persons with income below 200% FPL. The Health Care Group provides low cost insurance to small businesses around the state. These programs are struggling with low enrollment.

The main sources of care for the uninsured are the public hospitals in Phoenix and Tucson, the 28 community health centers (with 80 sites) around the state, and the public health clinics in every county.

In the early 1990's the safety net seemed in danger of falling. But a turnaround began in November 1994, when Arizona voters enacted Proposition 200, which increased the state's tobacco tax by 40 cents thereby generating between $120 million and $125 million per year in additional revenue. The referendum also required that 70% of the tax revenue generated be spent on programs to aid the state's uninsured.

MINNESOTA

In 1995 Minnesota has a population of 4.6 million. Of its population, relatively few Minnesotans are members of racial or ethnic minority groups. 11.2% of the state's population has an income that falls below the FPL.

Minnesota has the fourth lowest uninsured rate in the country with 9.2% (423,200) insured in 1995. Several factors contribute to Minnesota's high insurance rate: broad Medicaid program, large state subsidized health insurance program, and a high rate of coverage by employer-based health insurance (74%).

The state has low levels of hospital uncompensated care (bad debt and charity care); its hospitals provide uncompensated care equal to 2.9% of their expenses, almost half the national rate and about the same rate as in California.

In 1992, the state enacted the HealthRight legislation, now called MinnesotaCare, which called for changes in how health care was delivered and financed in the state. MinnesotaCare is actually a series of laws that have two main goals: to broaden access to health care and to contain the increase in health care costs. In order to achieve these goals, legislation included cost-containment measures with state and regional health care spending targets, health insurance reforms for employers with fewer than 30 workers, and provisions aimed at expanding access to the uninsured. It mandated that all publicly funded populations shift to managed care.

The legislation created a subsidized health insurance program called MinnesotaCare (formerly the Children's Health Plan) for the low income population. It provides limited health insurance benefits to uninsured families and single adults who meet income and other eligibility guidelines. The program provides health insurance to more than 100,000 Minnesotans.

Income eligibility extends to 275% of FPL for families and 175% for all other adults. MinnesotaCare is coordinated with Medicaid and utilizes the same MCOs. The program is funded by a provider tax and enrollee premiums.

Monthly premiums are based on family size and income. In 1997 an asset limit of $30,000 total net assets for a household of two or more and $15,000 for a household of one, was established.

Eligibility criteria include having no access to employer-sponsored health insurance for the previous 18 months, being uninsured for the past 4 months, and living in the state for at least 6 months prior to application.

MinnesotaCare enrollees were initially served on a fee-for-service basis, but beginning in July 1996, they were enrolled into mandatory managed care programs.

As of July 1996, MinnesotaCare had a $300 million surplus. Two main factors have contributed to the surplus. First, the cost of serving families with children who enrolled in the program was lower than expected due to lower than predicted utilization rates. Second, adults without children have been enrolling at lower-than-expected rates.

Two eligibility deterrents are involved with Minnesota Care: a long application form and high monthly sliding fee scale premiums. These premiums can be as high as $200-300 per family per month. In addition, benefits are less than Medicaid (MA) ($10,000 limit on hospital care) thus creating an incentive to apply for MA.

Minnesota's principal health care programs are administered by two departments, the Department of Human Services (DHS) and the Department of Health (MDH). DHS is responsible for the majority of direct service health programs such as Medicaid, General Assistance Medical Care, and the MinnesotaCare program.

In 1995 Medicaid, called Medical Assistance (MA) the program covered nearly 550,000 individuals at a cost of $3 billion. MA offers many Medicaid optional benefits, and medically needy recipients receive the same benefit package as the categorically needy.

For the most part, the state treats MA and Minnesota's General Assistance Medical Care (GAMC) as the same program. GAMC is a state-funded program that covers acute health care for Minnesota residents who are not categorically eligible for Medicaid but who meet income and asset requirements comparable to the Medicaid medically needy standards. GAMC clients are enrolled in the same managed care plans as the MA population and are being phased into managed care at the same time as MA clients.

To be eligible for GAMC, a household must have income not in excess of 120% of AFDC eligibility maximums and no more than $1,000 in household assets. GAMC eligibility standards allow disregards for work income.

In 1995, GAMC served about 51,000 Minnesotans but between 1993 and 1995, enrollment decreased by 20%; this trend was expected to continue through 1997. Officials cite the strong economy and the introduction of MinnesotaCare as the key factors to the enrollment decrease.

Through a 1902 (r)(2) expansion adopted in 1993, MA extends coverage to pregnant women and infants less than two years old in families whose income is below 275% FPL. The maximum income allowed for the state's medically needy program is 65% FPL (compared with 48% nationally).

Under the state's § 1115 waiver, granted in April 1995, Minnesota receives Medicaid federal financial participation (FFP) for children below age 21 who are enrolled in the MinnesotaCare program. The expansion population is estimated at 68,000 children statewide. The expansion group of children is provided the full Medicaid benefit package rather than the more restrictive benefits offered under the MinnesotaCare program.

Minnesota sponsors a high-risk insurance pool called the Minnesota Comprehensive Health Association (MCHA). MCHA, established in 1976, is the nation's oldest high-risk pool and subsidizes health insurance for individuals who cannot obtain coverage from other sources. Minnesotans are eligible to purchase MCHA coverage if they meet the following requirements: have lived in the state for at least six months and have been refused coverage or had an offer of coverage at higher than the standard premium or have been treated within the past three years for at least one of the "presumptive conditions" (i.e. AIDS, stroke, etc.) listed in the authorizing statute.

MCHA is financed by enrollee premiums and by assessments on all insurers. Premiums are limited to 125% of the standard commercial premium for an average person. Enrollment has decreased from a peak of 35,000 in 1993 to 29,000 in 1995. The decline may have been due to health insurance reforms and the MinnesotaCare program.

WASHINGTON

The state of Washington has a population of 5.3 million, making it the eighteenth largest state in the US. It has lower than average elderly and young populations yet its overall population has been growing at more than twice the national rate since 1990. This growth may be due to the in-migration of working-age adults.

A smaller percentage of the low-income population is uninsured in Washington than in the rest of the country. This is the result of broad Medicaid coverage for pregnant women and children and the Basic Health Plan's targeting of the working low-income population.

Its low uninsurance rate of 12.9% for the nonelderly is largely due to a higher percentage of private coverage than in other states. Washington also has a Medicaid program that is relatively broad toward the near-poor (those between 100% and 200% of poverty and a state-only subsidized plan (BHP) that targets this population as well.

About 12.3% of the nonelderly population and 57.9% of the poor are insured through Medicaid. Approximately 15% of the population have state-subsidized health insurance, mostly through Medicaid or the Basic Health Plan.

Medicaid spending in Washington was $3 billion in 1995, approximately half financed by the federal government. On a per enrollee basis, Washington spends 8% less than the national average. Medicaid spending has been growing faster than other components of state spending increasing from 9% to 13% of state general fund expenditures between 1990 and 1995. The main reason for this expenditure growth has been enrollment expansions.

Washington pursued an effective Medicaid maximization strategy; substituting federal dollars for state dollars in many areas. The federal share of state medical assistance budget increased from 46% in fiscal year 1986 to 56% in 1996.

From 1992 to 1995, Washington's Medicaid enrollment levels grew about 3 percentage points faster than the national average rate, and the rate of growth for non-cash children in Washington was 2.6 times the national average rate. The major reason of this enrollment growth was the state's 1994 expansion of Medicaid eligibility for children under the age of 19 up to 200% of FPL by using a 1902(r)(2) state plan amendment. The expansion for children was enacted as part of the 1993 Health Services Act and is funded through the Health Services Account. The state has conducted active outreach to children.

In January 1996, Washington eliminated AFDC-related medically needy eligibility. This legislative change was made to reduce Medicaid spending, and it was expected that most would enroll in BHP.

The state has broad Medicaid eligibility limits, especially for pregnant women (up to 185% FPL) and children under 19 (up to 200% FPL). The state's AFDC and medically needy income criteria are higher than the national average. Also, the state extends family planning eligibility to poverty-related pregnant women for 12 months postpartum, as compared to the standard 60-day postpartum eligibility.

The Department of Social and Health Services (DSHS) is an umbrella human services agency that houses both Medicaid and the majority of the state's health services programs. The

Medicaid budget in the state is split across several subunits of DSHS one of which the Medical Assistance Administration or MAA (53% of total Medicaid funds) administers the medical care component of Medicaid and related insurance programs.

The Health Care Authority (HCA) has administrative responsibility for the state's own program for uninsured lower income working families, called the Basic Health Plan (BHP). The program interacts with Medicaid to create seamless coverage for pregnant women and children. The Basic Health Plan is comparable to California's Healthy Families with the exception that it covers adults as well as children.

BHP subsidizes individuals, families, or employers to purchase managed care plan coverage, with plans selected in a managed competition framework. Adults pay a minimum of $10 per month to join, and there is also sliding fee scale so that persons above 200% of FPL pay the full age-adjusted premium, which was $116 to $242 per month in 1996. Employers can sponsor BHP participation for their employees by paying $45 per month per worker.

Persons over age 65 can join BHP if they are not eligible for Medicare coverage. Children under age 19 who are eligible for coverage may join BHP *Plus*, which enrolls the children in Medicaid with no premium, although they are assigned to the same BHP health plans as their parents. Medicaid pays the BHP premium costs for these children.

BHP is not an entitlement program and funding levels are capped. In November of 1996 the existing appropriation was exhausted and in December 1996 more than 60,000 people were on the waiting list. Funding for 8,000 more subsidized enrollees was appropriated during the 1997 legislative session.

BHP participation has grown substantially since 1994 because of deliberate policy changes. Total participation nearly tripled from 69,000 in July 1995 to 195,000 in December 1996. Before this increase, the state was concerned that BHP participation levels were lower than expected so it reduced premium levels to boost participation. The state wanted to increase participation in employer-sponsored BHP plans but has found that employers were slower to join.

Of the total 195,000 BHP participants, about 130,000 are subsidized exclusively by the state. The remainder individuals pay the full premium (13,000) or are children who are eligible for and financed by Medicaid (52,000).

The state created a high-risk pool in 1987 that allows individuals denied coverage to buy standard policies at 150% of the average premium charged by the six largest carriers. All carriers are assessed in proportion to their total premium revenue to cover the losses in this high-risk pool. The enrollment in this high risk pool has dropped from more than 4,000 to fewer than 1,000 persons since the 1994 expansions of the BHP and the underwriting reforms in the individual market.

Washington's CHIP program covers uninsured children above BHP levels between 200-250% of FPL. Washington has other "gap-filling" programs that serve special populations. The programs include:

- General Assistance-Unemployable (GA-U) and Alcoholism and Drug Abuse Treatment and Support Act (ADATSA) medical assistance programs that provide basic medical services to General Assistance clients.
- Medically Indigent program, which provides emergency reimbursement for uninsured people who are not eligible for other programs, with high medical expenses incurred in hospitals. Essentially this program is an uncompensated care program for hospitals.
- State Children's Health Program, which provides Medicaid-type coverage to children under age 18 in households who are not otherwise eligible for Medicaid, primarily undocumented children.

The total number of people served in these programs was modest (28,000 in 1996). The GA-U program assumed greater importance since elderly and disabled immigrants who lose SSI benefits under the federal welfare reform law are generally eligible for GA-U cash assistance and medical coverage. These programs are largely funded by additional federal funds earned in the state's disproportionate share hospital (DSH) program.

Washington uses the Medicaid DSH program to address various needs. Its goals have been to assist certain hospitals and to generate surplus funds for the state to support non-Medicaid medical services, including the state-only Medically Indigent and GA-U programs.

The decision to move most Medicaid enrollees into managed care plans was made in the early 1990's with actual implementation beginning in 1993. Today there are 380,000 Medicaid enrollees in fully capitated, closed-panel managed care organizations (MCOs). Another 195,000 residents are insured through MCOs participating in BHP. 225,000 public employees, dependents, and retirees are enrolled in MCOs through the state's Public Employees Benefits Board, and 59,000 are enrolled in the state's own self-insured PPO.

More than 800,000 Washington residents are in more than 25 managed care plans purchased or administered by the state. This compares with approximately 3.7 million residents covered in the Washington commercial insurance market overall, and a total state population of 5.3 million.

While most Medicaid beneficiaries, such as mothers and children, are in managed care plans, most Medicaid expenditures still take place in fee-for-service (FFS) arrangements.

The state of Washington initiated mandatory managed care for Medicaid eligibles through a 1915(b) waiver it applied for in 1986 in three counties, with approximately 14,000 enrollees. Washington decided in 1992 to expand Medicaid managed care to all counties for the AFDC, pregnant women and children expansion groups.

As of 1997 there were 16 managed care vendors with 19 plans in the Healthy Options program and at least two plans are in each of Washington's 39 counties (the average is four). Washington clinics operate the largest Medicaid managed care plan in the state.

NEW YORK

New York is the third most populous state, with a population of 18.2 million. New York covers both Medicaid and Home Relief recipients, but it has an uninsured rate of 16.8% of the non-elderly population (3.1 million people). Its uninsured population is also growing.

New York has the largest Medicaid program in the country, with total expenditures more than $24 billion (1995). This was 30% greater than the next-highest spending state, California which spent $17 billion in 1995. In 1995, more than 3.3 million New Yorkers were enrolled in the Medicaid program.

15.6% of the state's population (2.8 million) is enrolled in Medicaid compared to the 13.0% for the rest of the country. An additional 447,000 are eligible through the Home Relief program, the state's general assistance program. The state's Medicaid eligibility criteria are higher than the national average.

The Home Relief program provides cash assistance and medical care to poor people who do not qualify for Medicaid (mainly because they are adults who do not have children). Total spending on medical services for the Home Relief population was $1.6 billion in 1995, covering approximately 338,000 people. Recipients receive the full Medicaid benefit package; the state receives federal matching contributions only through DSH payments for inpatient hospital care.

In December of 1999, the state legislature agreed to raise the state's cigarette tax to 55 cents a pack in order to provide health insurance coverage for almost one million uninsured residents. In 2002, $600 million provided from the tobacco tax, tobacco settlement and federal matching funds would insure families up to 150% FPL and individuals up to 100% of FPL. In addition, $77 million annually in state subsidies will help small businesses provide health coverage to their employees. $29 million will be allotted to help individuals buy their own health coverage from private insurance carriers.[1]

New York established a children's health insurance program, Child Health Plus that covers 124,000 children. The program is being expanded with federal S-CHIP funds to cover up to 251,000 children.

Child Health Plus (CHP) provides subsidized health insurance coverage for children from low-income working families who are not eligible for Medicaid. The program extends coverage to those up to 225% of the federal poverty level. Child Health Plus was initially financed entirely with state funds then enhanced with S-CHIP matching.

Families at 120% or less of poverty pay no premium. Families with incomes between 120 and 159% FPL pay $9 per covered child per month, up to $36 per month per family maximum. Families with incomes between 160 and 222% pay $13 per child and a $52 monthly family maximum.

CHP is transitioning into CHIP and will be 2/3 federally funded. There will be one application and seamless referrals with Medicaid.

[1] "New York Doubling Cigarette Tax to Pay for Health Care for Poor" by Raymond Hernandez, New York Times, December 18, 1999, A-1.

Hospitals and clinics also receive funds to help cover the cost of caring for the uninsured. The state allocates $1.2 billion to health insurance subsidy initiatives and to providers for uncompensated care. For many years the state has had a bad-debt and charity-care pool, a system of cross-subsidies to hospitals with high uncompensated care burdens from those with fewer non-paying patients.

The Medicaid program is the largest single item in the state budget and grew faster from 1990 to 1995 than all other expenditure areas in the budget. New York spends more per Medicaid beneficiary (excluding DSH payments), than any other state. It has a broad benefit package, full cost reimbursement of hospitals, high nursing home payment rates, and extensive coverage of personal care services.

The state has been one of the most successful states at Medicaid maximization, or structuring services to meet Medicaid standards and obtain federal funds. New York also has the highest aggregate DSH payments in the nation.

The state received approval of a Section 1115 waiver that will allow it to expand its use of mandatory managed care. The waiver, called the Partnership Plan, will enroll all AFDC and related populations, as well as SSI-eligibles and medically needy beneficiaries, in managed care on a mandatory basis. Managed care enrollment will be expanded from 645,000 to more than 2.4 million Medicaid beneficiaries.

The waiver will also include federal Medicaid matching funds for the Home Relief population and for hospitals and clinics requiring assistance with the transition to managed care.

Before implementation of the mandatory program the *voluntary* managed care program enrolled 645,000 of approximately 2.4 million adults and children who are Medicaid beneficiaries. Thirty-two percent of Medicaid beneficiaries who live in the 57 upstate counties were in managed care, compared to 22% in New York City. Eleven of those counties, predominately rural ones, have almost no managed care. The 1115 waiver would mandate managed care enrollment for most of the remainder (2.4 million).

Thirty percent of Medicaid beneficiaries in managed care plans are in Prepaid Health Service Plans (PHSPs), Medicaid only health plans that are predominately sponsored by clinics and nonprofit hospitals. New York will cover both Medicaid and Home Relief (equivalent to California's MIAs) eligibles through the same managed care.

Prepared by Roohe Ahmed/ITUP: 2/20/00 from Urban Institute *New Federalism* studies, ITUP phone interviews and other research