Health Policy for Low-Income People: Profiles of 13 States

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The Urban Institute

Occasional Paper Number 57
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Assessing the New Federalism
An Urban Institute Program to Assess Changing Social Policies

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This paper is part of the Urban Institute’s *Assessing the New Federalism* project, a multiyear project to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, the project studies child and family well-being.


The nonpartisan Urban Institute publishes studies, reports, and books on timely topics worthy of public consideration. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders.
Assessing the New Federalism is a multiyear Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states, focusing primarily on health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. In collaboration with Child Trends, the project studies changes in family well-being. The project aims to provide timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute’s web site (http://www.urban.org). This paper is one in a series of occasional papers analyzing information from these and other sources.
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Health Policy for Low-Income People: Profiles of 13 States

Introduction

The past five years have given states new opportunities in health policy for low-income people, yet also put new pressures on policy formulation. State flexibility increased as a result of many developments, including welfare reform and the delinking of Medicaid from cash assistance, new funding for children’s health insurance coverage under the State Children’s Health Insurance Program (SCHIP), repeal of federal minimum standards for nursing home and hospital reimbursement that had constrained states’ control over Medicaid payments, and federal willingness to grant waivers under Medicaid (and now under SCHIP as well). Fiscal capacity also rose—the result of booming revenues during the long economic expansion of the 1990s and new tobacco settlement funds.

But new pressures on revenues and state policy have arisen—from recent federal economizing under Medicaid and Medicare, including cuts in safety net support that some states were believed to have abused; from political pressures for state tax cuts; and, starting in 2001, from a recession. New pressures were also generated by the Supreme Court’s *Olmstead vs. L.C.* decision, which detailed a limited right to home- and community-based services under the Americans with Disabilities Act; rapid growth in spending on pharmaceuticals; and by the difficulties encountered by Medicaid managed care. Political demands for public action sprang from developments such as the rise in numbers of uninsured people, the growth in private and public managed care, increases in the costs of pharmaceuticals, and many hospitals’ fiscal woes, as well as from events specific to each state.

To learn how states have responded to federal constraints and state flexibility during the past three years, the *Assessing the New Federalism* (ANF) project of the Urban Institute examined state priority-setting and program operations in health policy affecting the low-income populations in 13 states: Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. A series of case study reports were developed that focus on changes in health care policy in each state, building on earlier baseline studies in the same states. Information for the case studies was obtained from publicly available documents, newspapers, web sites, and interviews with state officials, provider organizations, consumer advocates, and other stakeholders. In-person interviews in state capitals were conducted from February through June 2001. Questions were asked using an open-ended interview protocol, and state officials were given the
opportunity to comment on the draft reports. Additional information was obtained to update the status of each state through roughly the end of 2001.

Four major sets of issues are addressed in this set of reports. First, how have the political and fiscal circumstances of the states changed over the past several years? Second, has the state expanded public or private health insurance coverage, whether through Medicaid, SCHIP, Medicaid research and demonstration waivers, or state-funded programs? Third, how have Medicaid managed care and other acute care issues changed? For example, has access been affected by managed care plan withdrawals from Medicaid or backlash against plans by providers or beneficiaries? Fourth, how are states responding to pressures to expand home- and community-based services for disabled persons, their new freedom to set nursing home reimbursement rates, and the labor shortage?

This report provides brief summaries of the findings from each state. Not surprisingly, states differ considerably in terms of their long- and short-term fiscal circumstances as well as their policy objectives. Therefore, it is difficult to draw conclusions that would apply in all states. Nonetheless, the following key points emerge from the state summaries.

State Fiscal Conditions and Health Policy

- From 1995 to 2000, state economies were expanding, inflation and unemployment were low, and state revenues increased rapidly. As a result, states were able to increase spending, cut taxes, and increase the size of their “rainy day” funds. Medicaid state general revenue spending increased at only about 5 percent a year as a result of low rates of medical care inflation, falling enrollment due to welfare reform and a strong economy, cost savings from the expansion of managed care, and, arguably, repeal of federal minimum standards on Medicaid nursing home reimbursement. Many states used their good fiscal status to expand health programs, among others.

- The national economy started to slow in 2000; by March 2001, the country was in a recession that reduced state revenues and caused state expenditures to climb. As states reexamine their already enacted fiscal year (FY) 2002 budgets and begin to plan their FY 2003 budgets, the ANF states generally do not appear to be planning major Medicaid cutbacks. Although growth in Medicaid and SCHIP spending was regarded as a major contributor to their fiscal problems, states generally do not appear to include significant cuts in these programs as a way to balance their budgets, although trimming optional benefits and cuts (or freezes) in provider reimbursement rates are likely. The loss of federal matching funds was often cited as a constraint on Medicaid cuts. If the recession deepens or is prolonged, this stance could change. But so far, the primary effect of the economic slowdown is likely to be the failure to take advantage of new coverage expansion opportunities, such as parent coverage under Section 1931(b) of the Social Security Act or SCHIP waivers.
Health Care Coverage

- Medicaid rolls fell between 1995 and 1998 because of the improved economy and welfare reform. Welfare reform allowed states to expand eligibility in new ways, but because of confusion on the part of beneficiaries and caseworkers, Medicaid enrollment fell, though not as much as Temporary Assistance for Needy Families (TANF) rolls. States responded to the unintended declines in Medicaid enrollment by reforming state outreach and enrollment practices, and Medicaid rolls rebounded to some extent over the following couple of years. States are now anticipating additional increases in enrollment as a result of the recession.

- Welfare reform created a new category under Section 1931(b) in the Social Security Act that allowed states to expand Medicaid eligibility to families with much higher incomes than was previously allowed. Only two of our thirteen states, New Jersey and California, elected to expand coverage using Section 1931(b). Massachusetts, Minnesota, Wisconsin, and New York had substantial Medicaid coverage expansions under Section 1115 research and demonstration waivers during the same period.

- SCHIP was enacted in 1997 and began to be implemented in 1998. States responded strongly by expanding coverage for children in families with relatively high income levels, even in states with historically very restrictive Medicaid eligibility levels. Most states adopted programs separate from Medicaid, seeking to establish programs that were not open-ended entitlements and that did not have a welfare stigma. States have embarked on ambitious outreach campaigns, and many developed innovative strategies to streamline the eligibility determination process. By December 2000, SCHIP had enrolled 2.7 million children; the number who were previously uninsured is not known.

- In 2000, three ANF states—Minnesota, New Jersey, and Wisconsin—received Section 1115 waivers under SCHIP to expand coverage to parents. California was granted a waiver in early 2002. States argue that expanding coverage for parents increases participation by children. There has been less interest in premium assistance programs that use Medicaid or SCHIP funds to subsidize employer-sponsored insurance because of the administrative complexity and the limited benefits of many employer health plans compared with Medicaid or SCHIP.

Acute Care Issues

- Medicaid managed care remains strong in most states; the exceptions are Alabama and Mississippi, where it was tried but quickly abandoned. But expectations of the ability of Medicaid managed care to control costs and improve care have diminished. Most states have experienced plan withdrawals, usually over issues of rate adequacy, administrative burdens, and difficulty maintaining...
provider networks. Capitation rates have often been increased in response. As a result, Medicaid programs are not finding the same levels of new savings from managed care as they had in previous years.

- Disproportionate share hospital (DSH) payments and upper payment limit (UPL) programs remain an important part of Medicaid financing. States have used considerable energy and creativity in developing arrangements that bring in substantial federal funds with little or no new state expenditures. The extent to which providers benefit from these initiatives varies. States are expanding these programs when they can, but they are seriously concerned about the fiscal consequences of federal cutbacks in DSH payments and new restrictions on the use of UPL programs.

- Prescription drug outlays are a major issue for all states, with recent Medicaid expenditures for prescription drugs increasing by 14 percent to 18 percent per year. Federal rules limit the states’ ability to restrain drug prices and utilization. However, some states (Florida and Michigan) are developing innovative approaches that offer the potential to obtain greater discounts from manufacturers.

- Several ANF states have adopted new programs to subsidize prescription drug coverage for the low-income elderly and disabled populations. These programs vary in the income groups that are covered and the structure of the subsidies.

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**Long-Term Care**

- The long-term care sector, including nursing homes and community-based services, faces severe workforce shortages. Several states have responded with rate increases that must be used to raise workers’ wages. The labor shortage has serious short- and long-term implications for quality of care and program expenditures.

- Several states have responded to concerns about the quality of care in nursing homes by raising reimbursement rates, tightening regulatory oversight, increasing staffing requirements, and providing consumers with more information.

- States continue to expand home- and community-based services. These include expansions of home care through the Medicaid personal care option, but increasingly they depend on extensive use of Medicaid and home- and community-based services waivers. Efforts to expand home- and community-based services are driven in part by the Supreme Court’s 1999 *Olmstead* decision, which ruled that inappropriate institutionalization was discrimination against people with disabilities. However, some states have not yet responded to *Olmstead* because they believe their extensive range of home- and community-based services makes further actions unnecessary.
Alabama

Barbara Ormond and Alyssa Wigton

The past three years have seen renewed attention to health care in Alabama. The current governor, Donald Siegelman, elected in November 1998, was the driving force behind the state’s SCHIP expansion when he was lieutenant governor. Alabama’s SCHIP, the first to be approved nationally, began in February 1998 as a Medicaid expansion, and added a second phase that included a private insurance option starting in September 1998. Since he became governor, Siegelman has turned his attention to long-term care for the elderly, particularly those with dementia. In addition, he has stated his commitment to expanding home- and community-based long-term care services for older people and younger persons with disabilities.

Political and Fiscal Circumstances

Improving the health of Alabama’s citizens, particularly the elderly, was a key focus of Democrat Siegelman’s campaign. Structurally, the state government is characterized by a strong executive and a relatively weak legislature; therefore, the change in governor had the potential to significantly influence policy. Democrats are the majority political party in both houses of the state legislature. Both the legislature and the governor, however, favor conservative fiscal policies. Reflecting this conservative philosophy, the state’s social programs are relatively limited, designed primarily to meet minimum federal requirements.

Alabama is facing serious budget pressures. The slowing economy over the past year led to mid-2001 budget cuts in some programs, notably education. The state reports that expenditures for state programs are on target for 2002 and that neither tax cuts nor tax increases are likely. Alabama’s general fund revenues are growing at about $20 million a year and are consistent with the estimates on which FY 2001 budgets were built. The Medicaid Trust Fund, established with tobacco settlement revenues, is expected to protect the Medicaid program from both the economic downturn and the budget shortfalls that have plagued it in recent years and also to cushion the program from the effects of changes in the DSH and UPL programs. These changes are likely to hit Alabama particularly hard because, in addition to the changes in these programs at the federal level, serious questions have been raised about how they have been implemented in Alabama.

Coverage Expansions

On January 30, 1998, Alabama became the first state to receive federal approval of its SCHIP proposal. The first phase of this plan expanded Medicaid eligibility to children up to age 19 in families with incomes up to 100 percent of the federal poverty...
level (FPL). Before this expansion, older adolescents in the state were eligible only up to the state’s Aid to Families with Dependent Children (AFDC) level of 15 percent of FPL—the lowest in the nation. In August 1998, Alabama received federal approval to expand eligibility for all children up to 200 percent of FPL through a newly created program called ALL Kids.

Alabama’s aggressive and effective outreach program for SCHIP has resulted not only in strong SCHIP enrollment but also in increased enrollment of children in Medicaid. The state streamlined the enrollment and recertification process for Medicaid and other insurance programs for the uninsured poor to improve the take-up rate and enrollee retention and to reduce administrative costs. In addition, it has raised Medicaid reimbursement rates for physicians and dentists in an effort to increase provider participation and improve access for enrollees.

**Acute Care**

Historically, Medicaid managed care has not been a large part of health care in Alabama. Commercial managed care penetration is low and much of the state is rural, hindering the development of provider networks. In 1997, under a Section 1115 waiver, Alabama instituted capitated managed care in Medicaid, the Better Access for You (BAY) Health Plan, in Mobile County. However, in October 1999, the community health centers, which felt they were not getting a fair share of the patients or adequate reimbursement for their services, withdrew from the plan network. This withdrawal left the state in violation of the terms of the program’s waiver and the program ended.

Alabama’s primary care case management program, Patient First, also began in 1997 under a Section 1915(b) waiver. Within two years the program was expanded throughout the state, with the exception of Mobile County, where the BAY Health pilot project was operating. When BAY Health ended, its enrollees were transferred first to fee-for-service, and then in the spring of 2000 to Patient First, in what was said to have been a smooth transition.

A significant issue affecting acute care providers in Alabama is the impact of changes in the DSH and UPL programs. The federal Balanced Budget Act of 1997 (BBA) had a negative impact on hospital operating budgets in Alabama by reducing both Medicare reimbursement rates and DSH spending. Although the state was granted a waiver to fold DSH payments into capitation payments—allowing it to maintain its hospital reimbursement system (Partnership Hospital Program or PHP) and avoid the hospital-specific caps on DSH payment—the waiver is up for renewal in early 2002 and is facing serious scrutiny from the Centers for Medicare and Medicaid Services (CMS, formerly HCFA). Furthermore, Alabama’s DSH allotment was reduced by the BBA. While the reduction was postponed by subsequent legislation, allotments are scheduled to fall again after 2002. Because the state retains a large share of the federal payments, as its DSH allotments are reduced Alabama is losing an important source of the financing for its Medicaid program.
In 2001 the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services issued reports on Alabama’s PHP, DSH, and UPL programs in which it said that the state had made no actual outlay of its own funds for the PHP program, contrary to the “spirit” of the matching arrangement, and that it had changed the method for calculating the UPL in ways that were not always consistent with the state plan. If the OIG’s findings are upheld, Alabama will be required to reimburse the federal government for the federal share of the allegedly excessive payments to hospitals, which the OIG calculated to be $168.3 million. In addition, the OIG wants the state to either justify retroactive payments made to hospitals by the state after the OIG audit period or repay the federal share of these payments, an additional $68.7 million. Alabama disputes the OIG findings and believes that its payments to hospitals were made in accordance with federal regulations.

Long-Term Care

The governor has identified increased access to home- and community-based services as a priority for his administration. Despite this public commitment, long-term care is heavily skewed toward institutional care, with policy strongly influenced by the nursing home industry. Eligibility criteria are strict, and the supply of services, both institutional and community-based, is controlled to help contain costs. Nursing home bed supply is relatively low and reimbursement relatively generous. Although the nursing home industry does not oppose expansion of home- and community-based services or see home care as competition, its annual rate increases take a large share of any Medicaid funding increases, leaving little to direct toward new services in the community.

The labor shortages seen across the country are also affecting Alabama. Although officials do not think the problem is as severe in Alabama as in other states, they do see some shortages in direct care workers, particularly skilled workers such as LPNs and RNs. Reimbursement for home health is below the average for southern states, and Medicaid officials would like it raised to allow better pay for direct care workers. They may also consider raising the pay of private duty nurses in an effort to address staff shortages.

Quality of long-term care in Alabama emerged as a key issue following a number of deaths in Alabama’s assisted living facilities. The Department of Public Health has adopted revised rules that provide stricter state oversight and regulation relating to licensure, administration, personnel and training, storage of medications, care of residents, and physical requirements for facilities.

Other Developments

Nearly a third of Alabama’s population live in rural areas. The proportion of the rural population covered by insurance is lower than in urban areas, and the proportion in
poor or fair health is higher. In spite of their poorer health status, rural residents are less likely to have seen a physician or other health professional. Several initiatives are under way to address these disparities. The Robert Wood Johnson Foundation is providing financial support to improve access to primary care through matching funds to rural communities for health care facilities improvement and equipment purchases. In addition, to address the problem of provider recruitment and retention, the state legislature created the Family Practice Rural Health Board to enhance training and preparation of family physicians for rural areas. Efforts to improve provider availability in rural areas include merit scholarships and loan forgiveness and repayment programs for health professions students.

Conclusion

Alabama is characterized by political and fiscal conservatism, and historically it has taken a minimalist approach to public health and welfare programs. Under Governor Siegelman, there has been renewed attention to health, but the cost of expanding public programs means that progress is likely to come in small increments. The ability to generate revenues is the biggest constraint the state faces. Alabama has a regressive tax structure with a heavy reliance on sales taxes and very low property taxes. The state is currently facing serious budget pressures. The slowing economy over the past year led to mid-year budget cuts in some programs, notably education, although health programs were spared. However, problems may be on the horizon for Alabama’s Medicaid program. Medicaid enrollment is rising, and if economic conditions deteriorate further, the number of Medicaid eligibles could increase. Without fundamental reform of the structure of its tax system, Alabama’s ability to increase revenues will remain very limited. Moreover, for a Medicaid program that is perennially near financial crisis, the OIG’s rulings on DSH and UPL, the phase-out of these programs, and the questions about the continuation of the PHP program represent the most important current threats to the program.
Health policymakers in California are challenged to meet the needs of a population that has very low rates of employer-sponsored health insurance and, as a result, high rates of uninsurance. Policy choices are further complicated by the fact that the state has a large immigrant population, many of whom are undocumented and therefore not eligible for most publicly funded programs. California’s basic strategy for addressing the needs of its low-income population is to maintain reasonably broad eligibility for its publicly funded health insurance system while providing support for a county-based system of indigent care for those uninsured and not eligible for public coverage. Historically, the state has kept reimbursement rates in its public programs low relative to national averages as a means of keeping broad eligibility affordable. After a period of robust economic growth, a slowdown in state revenues may make some policy options unaffordable.

**Political and Fiscal Circumstances**

With the shift in 1998 from Republican Governor Pete Wilson to Democratic Governor Gray Davis, some hoped for swift and progressive health care reform. However, Davis’s preference for fiscally conservative policymaking, coupled with his interest in keeping education his top priority, has yielded somewhat restrained reforms in spite of substantial growth in state revenues. Since 1998, California’s health policy has embodied moderate eligibility expansions and enrollment simplification, provider and health plan payment rate increases, a number of initiatives aimed at improving quality of care in nursing homes, and the creation of a new state department aimed at improving patient protections for those enrolled in managed care.

California avoided any major cuts in the Health and Human Services budget, but it adopted a “cost avoidance” strategy for Health and Human Services, meaning that efforts are being made to control costs without cutting covered services or eligibility. In the 2001–02 budget, “cost avoidance” efforts included freezing provider payments, exploring pharmacy rebate options, and expanding Medi-Cal (California’s Medicaid program) antifraud initiatives.

**Coverage Expansions**

Beginning under Governor Wilson, California took a two-pronged approach in response to SCHIP and the opportunity to improve children’s health insurance coverage. First, the state expanded Medi-Cal eligibility to all children in families earning up to 100 percent of FPL. Second, the state created Healthy Families, a separate children’s health insurance program which provides coverage to children age 1 through
Healthy Families has been in the spotlight since its implementation in 1998 and is one of the governor's top health policy priorities—in part because of the program's potential to cover uninsured children, but also because it is a nonentitlement program and allows for greater administrative flexibility and a better federal matching rate than Medi-Cal. During his first year in office, Davis increased eligibility limits for Healthy Families to 250 percent of FPL. In January 2001, California also submitted an SCHIP waiver proposal to expand the Healthy Families program to parents with incomes up to 200 percent of FPL. The state received approval in January 2002 and hopes to implement the program as early as summer 2002.

Although initially criticized for low and slow-building enrollment, Healthy Families has been gaining momentum, and California has implemented a number of strategies to simplify children’s enrollment in Healthy Families and Medi-Cal. These simplification strategies include shortening the joint Healthy Families/Medi-Cal application, piloting an electronic application (Health-e-App), and implementing 12 months of continuous coverage for children in Medi-Cal to make it consistent with Healthy Families.

Medi-Cal has also been changing under Governor Davis. In 2000, California expanded eligibility for Medi-Cal under a 1931(b) program by making all parents with incomes up to 100 percent of FPL eligible for coverage (the previous limit was roughly 74 percent of FPL). In addition, California increased the Medically Needy eligibility level for the aged, blind, and disabled to 133 percent of FPL (up from a maintenance need level of 84 to 90 percent of FPL). As part of the federal Ticket to Work and Work Incentives Improvement Act, California has extended Medi-Cal benefits to working individuals with disabilities earning below 250 percent of FPL.

**Acute Care**

In addition to changes resulting from the recent eligibility expansions, the state’s Medi-Cal managed care program continues to evolve. Although actual Medi-Cal managed care enrollment fell short of projections, as a result of welfare reform and the improving economy, approximately 52 percent of Medi-Cal beneficiaries are currently enrolled in managed care and 26 of 58 counties enroll some or all of Medi-Cal beneficiaries into managed care. To improve access and quality within the Medi-Cal program, and in part because California has long been known for having among the lowest Medicaid payment rates in the country, the state adopted a broad package of rate increases for Medi-Cal providers totaling $800 million in the Budget Act 2000–01. As part of these increases, California increased capitation rates by 9.2 percent for plans participating in the “two-plan” model, a managed care model implemented in 12 large counties that includes a county-developed plan (e.g., a local initiative) and a commercial plan.

California operates one of the largest DSH programs in the country under Medi-Cal, with state and federal expenditures of about $2.5 billion in 1998. In the mid-1990s there was some concern that California’s DSH program would collapse. Pub-
lic hospitals were frustrated that despite financing the program through their provision of intergovernmental transfers (IGTs), their net payments were declining while private hospitals’ payments were increasing. This effect was attributed to the increase in the number of private hospitals qualifying for DSH and the federally imposed cap on hospitals’ gross Medi-Cal DSH payments. This situation was resolved after the passage of the BBA, which contained a special exemption that allowed California to make gross DSH payments to its public hospitals up to 175 percent of their uncompensated-care levels and to pay public hospitals 50 percent of the aggregate net DSH benefit. Since fall 1997, this 50/50 distribution of net federal Medi-Cal DSH funds has been state law.³

California also has a supplemental hospital payment program, the Emergency Services and Supplemental Payment Fund, commonly referred to as the “1255” program after the legislative bill that created the program. The 1255 program grew substantially in the 1990s, with gross 1255 payments quintupling between fiscal years 1992–93 and 1997–98.⁴ As in other states, California is uncertain about how federal regulations on UPLs will affect its supplemental payment program. Because 1255 payments will count against the federal UPL, there could be actual limits on the total amount of 1255 payments that are available to hospitals.

The rise in pharmaceutical costs has been another acute medical care issue on the state policymakers’ agenda, and it was considered a major cost driver in Medi-Cal budget increases in FY 2000–2001 and FY 2001–2002. The state’s response, thus far, is to explore pharmacy rebate options. There has also been concern about the out-of-pocket costs prescription drugs pose for California’s senior citizens. In February 2000, California implemented a new program that offers Medicare recipients the opportunity to use any California pharmacy that accepts Medi-Cal and to receive prescriptions at the Medi-Cal rate. Potentially, this program provides seniors with a 10 to 24 percent discount on what they might otherwise pay.

### Long-Term Care

Under the Davis administration, a number of developments have addressed the long-term care system’s fragmentation, poor nursing home quality, and low provider reimbursement, in addition to furthering more community-based alternatives to institutional care. In order to improve policy and program coordination across state-level agencies, the Long-Term Care Council was established in January 2000.⁵ The Council has also been assigned the central role in Olmstead planning, and thus far it has established an Olmstead planning work group, solicited public input through stakeholder meetings, and developed a proposal to pilot a new assessment and transition process for nursing home residents seeking placement in other care settings. To address the quality of long-term care in California, the governor’s Aging with Dignity Initiative included a provider rate increase as well as a series of measures to increase oversight of nursing home facilities. The initiative also included measures to promote community-based care such as a $500 tax credit for taxpayers who are eligible caregivers for individuals with long-term care needs.
As with many other states, California’s health care systems, particularly those providing long-term care, have been challenged with a health care workforce shortage. To address the high turnover rate among long-term care workers, the broad package of rate increases in the 2000–01 budget included a 7.5 percent increase in nursing home rates that was to be used to increase wages by the same percentage for workers in nursing homes. The state also passed a law in 1999 mandating that each county establish an entity to serve as the employer of record for independent providers within California’s In-Home Supportive Services (IHSS) program by January 2003. The intent of this legislation is to provide a mechanism for collective bargaining over wages, hours, and benefits. IHSS independent providers also benefited from a $0.50 minimum wage increase, effective January 1, 2001, and an additional $0.50 wage increase effective January 1, 2002.

Other Developments

California has also implemented a number of managed care reforms to provide patient protection and education for its 23.5 million citizens enrolled in managed care plans. In 1999, California passed a law that allows patients to hold health plans accountable in court when a health maintenance organization (HMO) causes “substantial harm” to a patient. Another significant development, particularly in light of the national debate on a patient’s bill of rights, is the creation of the California Department of Managed Health Care. Launched in July 2000, the Department has an HMO Help Center where consumers can go 24 hours a day, 7 days a week, for assistance in dealing with their health plan. In addition to the Help Center, the Department of Managed Health Care is responsible for licensing all plans (including SCHIP and Medi-Cal plans), providing an annual HMO report card, and monitoring the financial solvency of the state’s health plans and medical groups—in response to recent medical group insolvencies that challenged plans’ abilities to maintain continuity of care.

Conclusion

In light of the recent economic downturn, Davis feels that his fiscally conservative approach to policymaking has been vindicated. By not having committed to large spending increases, and by dedicating the state’s sizable tobacco settlement to health programs, the governor’s 2001 budget revision—which reflects lower revenue projections—avoided major cuts in Health and Human Services spending. Nevertheless, the future course of California health policy is far from certain. California does not yet know how its supplemental payment program, which subsidizes many safety net hospitals, will be curtailed as federal regulations limiting Medicaid payments are phased in. In addition, with Medicaid enrollment expected to increase as a result of eligibility expansions, simplified enrollment procedures, and an uncertain economy, California may face some difficult policy tradeoffs in the coming year.
**Colorado**

*Jane Tilly and Julie Chesky*

Colorado policymakers have taken advantage of some of the opportunities available under federal-state programs, particularly Medicaid and SCHIP, to piece together a safety net for people with low incomes who lack private health coverage. In addition, Colorado has used regulation of the state’s small-group health insurance market to try to ensure affordability and accessibility of these policies. Nevertheless, the state’s safety net is strained because of the slowing economy and the state’s constitutional limits on revenues and increases, known as the Taxpayer’s Bill of Rights (TABOR), that force an annual examination of health care programs for ways to contain costs.

**Political and Fiscal Circumstances**

Although Colorado is a conservative state, Bill Owens was the first Republican to be elected governor in Colorado in 28 years; his four-year term began in 1999. He succeeded former Governor Roy Romer, a three-term Democrat, whose priorities included the expansion of children’s health programs. At the time of the site visit, Republicans controlled the House and the Democrats narrowly controlled the Senate. Health care does not appear to be a prominent issue on Governor Owens’s agenda, taking a back seat to public education initiatives. The governor does not want to expand public programs to cover the uninsured, and he prefers to focus reform efforts on private-sector solutions such as vouchers or tax credits to help the uninsured buy insurance. The governor also does not advocate providing pharmaceutical benefits to Medicare beneficiaries through a publicly funded state program because he believes such coverage should come from the federal government. However, under Governor Owens, enrollment in Colorado’s SCHIP program (CHP+) has been made easier. In addition, the governor brought the CHP+ board under Medicaid to improve communication between the two programs and agreed to use tobacco settlement funds to add a dental benefit to SCHIP.

Among the most contentious health care issues in the 2001 legislative session were the small-group insurance “reforms” that health plans supported. The proposals would have weakened the state’s community rating for parts of this market and the provider network adequacy requirements. However, the final legislation made only minor modifications to regulation of the small-group market.

Colorado faces a unique fiscal situation in that it has state constitutional limits on tax revenues and most public expenditures. TABOR, established in 1991, limits the state’s revenue growth in the current year to inflation plus population growth in the previous year; this is less than real growth in the state’s economy. State-funded public expenditures, with the exception of capital improvements such as new roads and prisons, are limited to 6 percent growth a year with no adjustment for inflation or population growth. Although earlier projections for FY 2002 indicated that allow-
able state revenues would exceed allowable state spending by about $253 million, state officials say that these projections are being revised downward because of increased expenditures and a slowing economy. In December 2001, state officials anticipated a $170.2 million shortfall in FY 2002, despite cuts of $390 million in September 2001. These reductions in the FY 2002 budget came primarily from capital and transportation projects, but there were some health care cost reductions including changes to Medicaid pharmaceutical payments. State officials also predict a budget shortfall in FY 2003.

Regardless of the state of the economy, these constitutional limits have had profound effects on efforts to improve or expand publicly funded health programs. These programs are in competition with one another and with other programs for funds. The pressures to contain Medicaid costs are particularly strong. Colorado’s total Medicaid expenditures grew quite rapidly at an average annual rate of 7.7 percent from 1995 through 1998, much higher than the national rate of 3.9 percent. Medicaid expenditures, excluding those for the Department of Human Services, grew 10.6 percent in FY 2000—the first double-digit increase in four years.1 Major public program expansions appear to be out of the question politically and financially, unless the state’s constitution is amended, which would require a statewide referendum.

Coverage Expansions

In 1998, Colorado implemented CHP+, which provides coverage to children through age 18 with family incomes up to 185 percent of FPL. It was preceded by the state-sponsored Colorado Child Health Plan, which provided primarily outpatient services to low-income children in rural areas. As of June 2001, 32,588 of the estimated 70,000 potentially eligible children were enrolled in Colorado’s CHP+ program.2 Imposition of relatively high premiums (up to $360 annually) and the method by which they were collected were thought by state officials to be partially responsible for preventing Colorado from reaching enrollment goals. As of April 2000, about 4,800 or 37 percent of the 13,000 families enrolled in CHP+ were behind in paying their premiums and faced disenrollment from the program.3 These 4,800 families represented about half of those required to pay premiums. Opposition to these premiums peaked in the summer of 2000, and Governor Owens responded by declaring a premium holiday from September through December 2000. In 2001, premiums were replaced with a $25 annual premium for one child and $35 for two or more children in families with incomes above 150 percent of FPL.

Among the issues for future consideration are what type of mental health benefit CHP+ should offer and how best to enroll children whose parents are not used to dealing with public-sector programs. Colorado has no plans to provide full coverage to the parents of children in CHP+. Moreover, while Medicaid eligibility standards will not be expanded significantly in FY 2002, the Colorado Department of Health Care Policy and Financing (DHCPF) and the Department of Human Services are jointly developing the Colorado Benefits Management System to simplify the eligi-
ility determination process for public benefits. This computerized application system will allow people the opportunity to apply for the entire spectrum of public benefit programs with one application form and one interview.4

Acute Care

Colorado was one of the first states to obtain a federal waiver to mandate that most Medicaid beneficiaries enroll in primary care physician (PCP) programs. In 1997, Colorado began requiring PCP enrollees whose primary care physician belonged to a network of a Medicaid HMO to enroll in that HMO. Other Medicaid beneficiaries, including those who are disabled, have a choice between primary care case management and entering an HMO. In FY 2002, the state anticipates that 136,334 beneficiaries will receive care through five HMOs and 54,724 through the PCP program.5

The Medicaid program pays participating HMOs risk-adjusted capitated rates that are required by law to be limited to 95 percent of estimated fee-for-service costs. Colorado has a contentious history with HMOs regarding the fairness and timeliness of state payments. In May 2000, a judge awarded Rocky Mountain HMO $18 million in back payments, and the state and the HMO agreed to have independent actuaries analyze the state’s rate-setting mechanism.6 Likewise, the Kaiser Foundation Health Plan of Colorado filed suit in late 2000 to recover years of back payments that the DHCPF allegedly withheld.7 State officials concede that they have had “some ugly battles” over HMO rates. These battles have delayed state plans to begin a competitive bidding process for Medicaid managed care plans.

Despite disputes over rates, Medicaid beneficiary surveys indicate reasonable levels of satisfaction with managed care plans and the PCP program. Most observers say that the state’s shift to Medicaid managed care generally has been successful. The state cited improved access to care for enrollees in managed care plans and enrollee satisfaction rates comparable to those of beneficiaries in the PCP program.

Another part of the safety net—the state’s indigent care programs—is funded primarily through maximization of DSH payments under Medicaid. Most of these funds go to nine hospitals that operate primarily in the Denver metropolitan area. This portion of the safety net is under significant pressure because these payments are low for some providers and because availability of indigent care is inadequate in some areas outside the Denver metropolitan area. The state does not yet use the Medicaid UPL strategy to obtain indigent care funds, but it plans to do so in the future.

Long-Term Care

Colorado’s public programs for people with disabilities vary by type of disability. The state uses a single-point-of-entry system to manage home and community services
and nursing home care for older persons and younger persons with physical disabilities. Services for older persons are dominated by nursing home care, where quality issues have arisen. Those persons with mental health conditions or developmental disabilities primarily receive services in the home and community. Managed care dominates delivery of mental health care to Medicaid beneficiaries, and the state relies on community-centered boards to manage home and community services for persons with developmental disabilities.

Elimination in 1997 of the federal Boren amendment, which required that Medicaid pay providers reasonable and adequate rates “to meet the costs which must be incurred by efficiently and economically operated facilities,” has allowed the state to pursue a number of provider rate changes. The state capped certain cost centers for nursing homes and reduced annual cost increases from 9 to 10 percent a year to 3 to 4 percent a year. Further changes are in store for nursing home rates because a 2000 law requires establishment of a case-mix-adjusted reimbursement system for nursing facilities participating in Medicaid.8

As for future issues, state officials point to the need to address the labor shortage in home and community settings and resulting challenges to quality assurance. There have been several recent initiatives to address quality of care. In FY 2000, funding was allocated to the Department of Public Health and Environment to hire 11 new staff who are devoted to improving nursing home inspections.9 Legislation enacted in 2001 requires this department to implement a consumer satisfaction survey for nursing home residents and to respond within five working days to complaints about nursing home quality.

Conclusion

Colorado has a relatively stable but increasingly strained health care system for people with low incomes. Further expansions of public-sector health care programs do not appear likely because the economy is weakening, because the governor supports private-sector efforts to expand coverage, and because of TABOR, the state’s constitutional limits on revenues and public expenditures. Pressure on Medicaid to control its cost growth is likely to continue because of TABOR and will be exacerbated by rising Medicaid expenditures and the state’s revenue shortfalls. Although the modified community rating system for small-group health insurance plans remains in place, insurers who feel that it increases their expenses are likely to continue applying pressure for reform.
Florida

Alshadye Yemane and Ian Hill

Through the early and mid-1990s, Florida could be described as an innovator in health policy. Under the creative leadership of both executive and legislative branch officials, Florida proposed and/or implemented a wide array of progressive initiatives, including expanding health insurance coverage through the Florida Health Security Act, implementing managed competition in the small-group insurance market through the Community Health Purchasing Alliances, increasing health coverage of low-income children through Medicaid expansions and the Healthy Kids program, reducing infant mortality through the Healthy Start program, and improving efficiency and cost-management in the health system through the aggressive expansion of Medicaid managed care. Many of these efforts were viewed as “models” and were emulated by other states.

Political and Fiscal Circumstances

With the passing of the gubernatorial reins from Democrat Lawton Chiles to Republican Jeb Bush, and with Republican majorities elected to both houses of the legislature in 1998, Florida saw for the first time in recent history the complete political alignment of its executive and legislative branches within the Republican Party. This development, along with a slowing economy, has helped create an environment that is more fiscally conservative, embraces a less expansionary view of the role of state government, and sees solutions to health policy challenges involving the cooperative partnering of state and local governments and the private sector. Within this philosophical construct, innovations continue to emerge as the state works to serve vulnerable populations better.

During the past five years, budget shortfalls emerged in Florida, fueled by dramatic growth in Medicaid spending as a result of increases in enrollment, home- and community-based program funding, and health care costs (in particular, prescription drugs), as well as declines in general revenue funds due in part to the recent implementation of large tax cuts. Interestingly, however, even though they faced an estimated Medicaid shortfall of $1.5 billion, state officials avoided implementing significant program cuts during the regular 2001 legislative session. Instead, the state adopted policies that sought to control spending growth rates and find more efficiencies in current operations. Principal among the state’s strategies was the adoption of a new Medicaid prescription drug formulary that will allow Florida to restrict beneficiaries’ use of prescription drugs to medicines for which it has successfully negotiated the receipt of “supplemental manufacturer rebates”—that is, rebates that go beyond the federally mandated discounts it currently receives from manufacturers. Florida also instituted a prior-authorization policy for nonemergency inpatient admissions, developed several competitive bidding processes for the purchase of cer-
tain Medicaid services, and facilitated the increase in Medicaid capitated plan enrollment so as to take advantage of perceived cost efficiencies.

The catastrophic events of September 11, 2001, however, precipitated a significant downturn in the state’s economy, which created huge unexpected deficits in the state’s FY 2002 budget. As a result, the governor was forced to convene two special legislative sessions late in 2001 during which several cost-cutting measures were enacted, including the elimination of the Medically Needy program for adults, which effectively ends coverage for almost 19,000 Medicaid beneficiaries. The state also reduced income eligibility thresholds for the state’s elderly and disabled Medicaid expansion program, causing an additional 1,500 beneficiaries to lose coverage, and eliminated Medicaid coverage of dental, vision, and hearing services for adults, restricting access for approximately 190,000 beneficiaries who use at least one of these services. It remains to be seen whether the cost efficiencies the state has invested in will prevent future cuts to Medicaid and other health care programs in the event of a prolonged economic recession.

Coverage Expansions

Problems of uninsurance continued to loom large, fueled by continually low rates of employer-sponsored insurance and very low Medicaid income eligibility levels for adults. Yet, by the end of the regular 2001 session, policymakers had no plans to pursue public coverage expansions through such avenues as Section 1931 Medicaid expansions or SCHIP “family coverage” waivers. Rather, the state promoted expanded private-sector coverage through such strategies as the creation of the Small Employer Health Alliance to permit group pooling/purchasing by small employers, and the governor’s proposed HealthFlex program, which would allow insurers, HMOs, and community-based organizations to offer low-end policies that would cover major medical and preventative services on a pilot basis in selected portions of the state with relatively high uninsurance. State officials, however, admit that these policies would have only a marginal effect on the uninsured rate.

Addressing the problem of uninsurance among Florida’s children has been a policy priority for the state. KidCare was officially established in 1998—though its roots date back to 1990 with the creation of the school-based child health insurance initiative called Healthy Kids. Today, the KidCare program represents a relatively complex “combination program”; that is, it comprises both Medicaid and separate program components, including (1) a Medicaid program expansion that extends coverage to infants with family income between 185 percent and 200 percent of FPL and teens age 15 to 18 under 100 percent of FPL; (2) Medikids, which is a nonentitlement Medicaid “look-alike” program that offers Medicaid benefits to children age 1 through 4 with family income between 133 and 200 percent of FPL; (3) Healthy Kids (which was grandfathered into the Title XXI program and builds on the original child health insurance program), a joint venture between the government and private industry that provides coverage for kids age 5 through 6 with family income between 133 and 200 percent of FPL and kids age 7 through 18 with

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family income between 100 and 200 percent of FPL; and (4) the CMS program, a separate and specialized health care delivery system that is extended to all SCHIP-eligible children with special health care needs. The complex structure of the KidCare program is the result of strong political sentiment against a pure Medicaid expansion and the desire to implement a program utilizing the state’s existing infrastructure.

Although KidCare has generally achieved high rates of enrollment—Florida has the third largest CHIP program in the nation—participation in the program was initially slowed by backlogs and delays in the enrollment process and, more recently, by shortfalls in some counties that could not provide the local match resources required by the Healthy Kids model. State officials report that a number of steps have been taken to streamline the application process and expedite enrollment, including building more sophisticated linkages between the state’s Department of Children and Families and the Healthy Kids eligibility systems. The state was expected to expand its capacity for enrollment even further with the additional funding provided by the 2000 state legislature during its regular session, but the recent economic downturn may weaken its ability to sustain enrollment increases.

Acute Care

Acute care systems—primarily managed care organizations (MCOs) and hospitals—have weathered turbulent times. In the managed care sector, tighter regulations in the aftermath of quality-of-care scandals, coupled with intense competition, have caused numerous plans to leave the state entirely, and other plans to stop participating in Medicaid. Yet many policymakers describe the managed care market as “healthier” in light of these developments, with financially sound plans and better state oversight more firmly in place. At the same time, recent years have seen the development of an alternative model called the “Provider Service Network” that is built around provider groups that traditionally serve low-income and vulnerable populations. As with the HMO industry, the hospital sector has experienced some financial difficulty in the past few years. Significant reductions in Medicare reimbursement after the BBA, coupled with steady increases in uncompensated-care provision, weakened the financial position of hospitals. More recently, however, hospitals’ financial circumstances have improved, partly because of the numerous mergers and acquisitions that have strengthened their market position when negotiating payment arrangements with insurers. Although Florida had a relatively small DSH program throughout the 1990s, plans call for enhancing the state’s drawdown of federal matching dollars through the UPL flexibility, an effort that could potentially bolster hospital operations; but new proposed Center for Medicaid and Medicare Services guidelines that will lower the rate at which the federal government will match a state’s UPL payments to providers will undoubtedly limit UPL funding opportunities for Florida in the future.

To address the impact of rising prescription costs on Florida’s residents, the legislature has also sought to develop a pharmaceutical expense assistance program for
Florida’s senior citizens who are eligible for both Medicaid and Medicare. In 2000, the legislature passed the Senior Prescription Affordability Act (SPAA) to provide assistance for dually eligible low-income seniors in the amount of an $80 monthly benefit for prescription drugs with a 10 percent copayment requirement. Eligible recipients must have an income between 90 and 120 percent of FPL and not be enrolled in a Medicare HMO that provides a pharmacy benefit. The SPAA also includes provisions that allow Medicare recipients, regardless of income, to receive discounts on prescription drugs at Medicaid-participating pharmacies. As a condition of participating in the Medicaid or SPAA low-income assistance programs, pharmacies must agree to cap drug prices for Medicare beneficiaries at the average wholesale price minus 9 percent with a dispensing fee of $4.50. Recent news about this phase of the program indicates that in some cases the pharmacies’ standard senior discount rates are lower than the wholesale-based rate participants are required to pay under this program.

**Long-Term Care**

A full-blown crisis has emerged within Florida’s long-term care system, one that threatens to further undermine the quality of the nursing home system. A complex set of interrelated factors have “domino-ed” to create this situation: chronic staffing shortages, which led to an erosion in quality of care, which led to lawsuits that resulted in extremely large awards for complainants and skyrocketing liability insurance rates for the industry. The situation is further compounded in the long term by the lack of home- and community-based alternatives to nursing home care in a state that already has a very high proportion of older people and is projected to see dramatic increases in the size of that population in the future.

In contrast to the state of home- and community-based services programs for the elderly, Florida has made tremendous strides in its efforts to implement community-based alternatives for younger Floridians with developmental disabilities. Governor Bush has surprised many with his efforts to focus resources on this population and, using the *Olmstead* decision as leverage, has successfully argued with federal officials for the approval of pending Medicaid home- and community-based services waivers and state plan amendments.

**Conclusion**

Though the past few years have seen clear innovation in state policymaking, uncertainty still exists about the impact of these innovations. As Florida’s budget reached crisis levels partly because of the tragic events of September 11, 2001, it remains to be seen whether the current policies of cost containment will be able to minimize the need for future budget cuts to health programs for low-income populations in the event of a prolonged economic slowdown. Although the size and scope of problems with the uninsured have stabilized, the limited potential for “public/private partner-
ship” proposals such as the Small Employer Health Alliance and HealthFlex to significantly reduce rates of uninsurance, coupled with Medicaid cutbacks and the problems experienced in local SCHIP funding that have inhibited program enrollment, could cause Florida to lose the gains it has made in addressing the problem of high uninsurance rates. Questions also surround the ability of the recent long-term care reforms to improve the quality of care received by patients and control the long-term care costs incurred by the state.
Massachusetts

Randall R. Bovbjerg and Frank C. Ullman

Major expansions of public coverage for low-income people have dominated Massachusetts health policy from the mid-1990s through calendar year 2001. In 1997, the state redesigned and significantly expanded its MassHealth coverage under a Medicaid waiver. The expansions plus high rates of employer-sponsored insurance have dramatically reduced uninsurance. Only 6 percent of Massachusetts residents and only 3 percent of children lacked coverage in 2000. The state also recently increased pharmaceutical coverage for seniors; continued to expand community services in mental health, developmental disabilities, and long-term care; dealt with the insolvency of the state’s largest HMO, which also owns the largest Medicaid HMO; and convened a high-level, bipartisan task force to systematically reconsider state health policies.

A dramatic drop in state revenues since June 2001 has forced budget cuts, but despite worsening times, Massachusetts continues to support an expansive health care safety net, especially through Medicaid. The program has made some moderate economizing measures, but not unusually large ones, and some expansions continue. Medicaid has done better than the rest of state government under cutback budgeting.

Political and Fiscal Circumstances

By tradition and voter registration, Massachusetts is a heavily Democratic state, long noted for liberal support of health coverage, high taxes, and strong regulation. Under Republican governors and Democratic legislatures since 1991, the state cut taxes and regulation while expanding state health care coverage, especially after 1997. There is bipartisan backing for incremental expansions, private health advocacy groups are numerous and influential, and state agencies compete to share in coverage-promoting programs. Unlike politics in almost any other state, Massachusetts politics also features strong popular support for mandatory universal coverage.

Three consecutive Republican governors have succeeded Democratic Governor Michael Dukakis, who decided not to seek a fourth term in 1991 after he presided over a failed presidential campaign and a recessionary economy. William Weld won a narrow victory that year, running as a fiscal conservative and a social liberal, and policy shifted markedly, although Democrats continued to dominate the legislature, as they still do. Weld and Lieutenant Governor Paul Cellucci were easily reelected in 1994. In July 1997, just after the start of MassHealth expansions, Weld resigned in an unsuccessful bid to become ambassador to Mexico. Cellucci became acting governor and won election in his own right in 1998. In April 2001, he followed Weld’s example by resigning a year and a half early to become ambassador to Canada. Lieutenant Governor Jane Swift became the state’s first female governor. She, like her predecessors, has made a no-new-taxes pledge but supports health care expansion.
Massachusetts’s economy performed robustly after emerging from an especially deep recession in the early 1990s. FY 2001 revenues ended strong, leaving a $453 million surplus—quite unlike many states’ shortfalls—which Acting Governor Swift proposed to split between a modest tax cut and social priorities, including $40 million for distressed hospitals. Collections worsened thereafter because of the national recession, especially after the attacks of September 11. The governor froze state hiring and took other measures, but also announced an increase in health care support for the newly unemployed. The fiscal 2002 budget was not agreed upon until early December. Some health-related programs have been cut, but core Medicaid as well as pharmaceutical assistance for the elderly was little affected. More changes may occur if the downturn is prolonged.

Massachusetts Medicaid spending has always been high, but its growth was held to only 1.5 percent a year between 1995 and 1998, well below half of the national average rate. Expenditures rose faster after that because of the MassHealth expansions. In FY 2001 Medicaid needed a supplemental appropriation to cope with a $258 million deficit, and expenditures have been predicted to increase 7.5 percent for FY 2002. Recent cost drivers include increases in provider rates and pharmaceutical costs, as well as higher utilization.

Coverage Expansions

Coverage has expanded markedly since the state began implementing its large Section 1115 Medicaid waiver in July 1997. Overall, the state increased the number of enrollees by almost a third between 1997 and 2001. The state has also moved from a patchwork of programs toward a jointly administered family of coverages known as MassHealth and from different income ceilings toward more consistent targeting of low-income residents. The recent expansions are among the largest in the nation in terms of income ceilings for eligibility, categories of beneficiaries, and comprehensiveness of benefits provided. Taken together, the programs now offer some form of assistance to all low-income children (those with household incomes up to 200 percent of FPL), almost all parents to 133 percent of FPL (with some help to up to 200 percent), and many childless adults to 133 percent as well.

MassHealth has six main constituent programs—MassHealth Standard, CommonHealth, Basic, Family Assistance, Limited, and Buy-in.

- **MassHealth Standard** is essentially traditional Medicaid plus SCHIP. Coverage is available up to 200 percent of FPL for pregnant women and infants, to 150 percent for children, to 133 percent for parents of covered children and for disabled adults below age 65, and to 100 percent for seniors and refugees (meeting asset tests), as well as to all Supplemental Security Income (SSI) recipients and some others. Standard includes about 85 percent of all MassHealth enrollees and produced most of the rapid early growth under the waiver. Growth was especially high among disabled enrollees, while the senior component remained flat.
• MassHealth CommonHealth offers comprehensive Medicaid benefits to disabled individuals ineligible for Standard. There is no income ceiling, but cost sharing on a sliding scale is required above 200 percent of FPL, so most enrollees’ incomes are below that level but above Standard’s ceilings. CommonHealth includes only about 1 percent of MassHealth enrollees, even after rapid growth, but they are largely nonworking disabled adults with high costs per person.

• MassHealth Basic offers less comprehensive benefits (not long-term care services or nonemergency transportation) to long-term unemployed adults who are uninsured or underinsured, are below age 65, and have incomes below 133 percent of FPL. Basic enrolls almost 8 percent of MassHealth members after higher than expected postwaiver growth.

• MassHealth Family Assistance has three parts: (1) direct coverage or premium assistance to children, (2) premium assistance to some working adults unable to qualify for Standard or CommonHealth coverage, and (3) employer incentives to certain small employers of qualified workers. Eligibility extends to children age 1 through 18 and their parents between 150 and 200 percent of FPL, as well as to childless adults from 0 to 200 percent of FPL whose employers and ESI (employer-sponsored insurance) plans also qualify. Children get direct coverage from the state if they lack access to ESI or premium subsidy if they do have ESI access. Parents and other adults get premium subsidy. Family Assistance enrolls fewer than 4 percent of the MassHealth total, mainly children with direct coverage. Premium assistance and employer incentives had inherently greater start-up difficulties, but they are expected to grow more in the near future.

• MassHealth Limited covers emergency services, including labor and delivery, for people who are ineligible for other MassHealth coverage only because of immigration status. Limited enrolls only about 2 percent of MassHealth members, but numbers are expected to increase.

• MassHealth Buy-in resembles Basic and is available to Medicare-eligible applicants, subsidizing enrollees’ premiums, deductibles, and copayments. Seniors or persons with disabilities whose income or assets exceed MassHealth eligibility ceilings may be eligible. About 1 percent of MassHealth members receive Buy-in benefits.

In the aftermath of September 11, the administration began trimming much state spending, but not in health coverage. Indeed, the governor announced expansions of state support for unemployed workers’ health coverage.

Acute Care

In the mid-1990s, Massachusetts officials had expected to move more beneficiaries from primary care case management into capitated MCOs. In practice, capitated enrollment has been allowed to decline, and market consolidation and Medicaid
withdrawals cut the number of participating MCOs from 13 in 1992 to 4 today. Only one of the remaining plans has significant commercial membership, and conflicts are emerging among the four because of the higher rates paid to the two MCOs run by safety net hospitals.

Most MassHealth beneficiary groups are required to enroll in either the Primary Care Clinician Plan (PCCP), a primary care case management system, or MCOs. About one-fourth of the MassHealth population is exempt from mandatory participation—individuals dually enrolled in Medicaid and Medicare, individuals with commercial health insurance, and residents in health care institutions. Managed care is slowly being extended to the disabled population. More than 70 percent of managed care enrollees are in PCCP; the balance are in one of the four MCOs.

The state’s unusual uncompensated-care pool pays for medically necessary services at hospitals and community health centers (CHCs) for uninsured and underinsured residents with low or moderate income. Hospitals and CHCs screen applicants for MassHealth eligibility, and if the applicant has no other funding, the pool will pay for free care for those with family income up to 200 percent of FPL. Beneficiaries up to 400 percent of FPL get partial free care; they must meet a per-family annual deductible. People with even higher incomes may qualify for “medical hardship” eligibility if they have very high medical expenses—similar to Medicaid “spend down” eligibility. Eligibility lasts one year, and some hospitals issue insurance-like cards.

The pool was created in 1985 to spread the cost of uncompensated care across hospitals. Funds initially came from uniform hospital surcharges on private payers under rate regulation. Hospitals with more collections than uncompensated care paid in; hospitals in deficit drew out. The state later got federal Medicaid support by qualifying the pool for DSH payments, but the pool’s size was capped. Under price competition after 1991, payouts were limited to charity care, and hospitals found it harder to pass through assessments to payers. Most hospitals also lost ground because the pool was capped while costs were not, and because the two big safety net hospitals were given ever larger support. A 1997 reform raised funds by assessing health care payers and adding Medicaid funds earmarked for the two hospitals while cutting hospital assessments. For a time all hospitals got full payment, but free care again exceeded the available funds by 2001; more state funds were added in the 2002 budget, and hospital assessments were cut again.

To assist seniors with rising pharmaceutical costs, Massachusetts created ever more generous pharmaceutical programs—in 1997, 1999, and 2001. The first pharmaceutical assistance program offered limited benefits to seniors earning 133 percent of FPL, and when enrollment lagged, benefits were boosted and eligibility raised to 150 percent. The program was renamed and expanded in 1999, adding disabled beneficiaries and going up to 188 percent of FPL. Further, a new unlimited benefit was added on a trial basis for most elders as well as younger persons with disabilities with high prescription costs relative to their incomes. The program was expanded and renamed again in April 2001. “Prescription Advantage” is touted as the nation’s first universally available drug coverage for the elderly and younger disabled persons. It offers unlimited benefits and imposes no income ceilings, although enrollees pay premiums of up to $82 a month (graduated by income) as well as deductibles and
copayments up to an annual out-of-pocket ceiling of $2,000 or 10 percent of household income. As of July 2001, about 41,000 people had enrolled. The initial budget of about $100 million a year was maintained through 2002’s budgetary cuts.

A simultaneous concern has been control of drug spending for Medicaid and for the general population. The state’s fastest growing acute care cost since the mid-1990s has been prescription drugs, a cost that more than doubled between 1995 and 2000, from $300 million to $686 million. New Medicaid controls were announced in autumn 2001 that lowered the maximum days per prescription, limited the number of refills per prescription, required prior approval for brand-name drugs when generic equivalents are available, and modified pricing for pharmacies. The legislature has also long supported a broad bulk purchasing pool for pharmaceuticals, going beyond Medicaid, but disagreements with the governors have delayed serious planning.

**Long-Term Care**

Institutional costs are the largest single line item of Medicaid spending for long-term care services for elderly, mentally ill, and developmentally disabled persons. However, the key recent concern has not been high spending, but rather the adequacy of payment rates. Massachusetts nursing home margins are among the worst in the country, and the percentage of nursing homes running at a loss was expected to rise from about 50 percent in 1997 to about 75 percent in 2001. Concern was expressed that homes could not attract and retain qualified staff and that there is “potential” for quality deterioration. The task force’s working groups have recommended increasing Medicaid payment rates but tying new resources to quality of care, better staffing, and improved planning and data collection, especially on access and quality. As of December 2001, rates were scheduled to rise modestly in the traditional January update, then more in June as the state shifts updates to match its July–June fiscal year.

Another priority is continuing the shift from institutional to community-based care. Massachusetts funds a broad array of home- and community-based services for the elderly. Many of the services that other states provide under home- and community-based waivers, such as personal care attendants, are covered as optional services under MassHealth, Massachusetts’s regular Medicaid program. State data show that community spending has risen much faster than facility spending since at least FY 1996. The annual rise has been especially large starting in FY 2000. That year, community spending growth outpaced facility growth by 16 percent to 2 percent. As a percentage of long-term-care spending, community services are projected to increase from 19 percent in FY 1998 to 24 percent in 2002. However, despite increased funding for community-based care, waiting lists for noninstitutional mental health care have developed, prompting two recent lawsuits. In response to this litigation and the 1999 *Olmstead* ruling on inappropriate institutionalization of disabled Americans, Health and Human Services Secretary Bill O’Leary and Attorney General Tom Reilly announced, in December 2000, a five-year, $114 million plan to...
eliminate the waiting list for services to individuals with mental retardation. In the 2002 budget, the legislature cut support for community placement, but most was restored after the governor’s veto.

Other Developments

The HMO market has drawn attention because of increased concentration and the near-failure in January 2000 of the then-largest HMO, Harvard-Pilgrim Health Care. That crisis drew heavy media coverage and required major state intervention. Along with provider-patient backlash against managed care, the insolvency also helped generate more regulation of managed care. Managed care concerns also fueled the campaign for a government-led system of universal coverage, which was narrowly defeated in a ballot initiative of November 2000.

Conclusion

Massachusetts is almost uniquely supportive of health care, especially for low-income residents. Tradition, political ideology, the influential nonprofit hospital industry, ample state revenues, and a generous federal 1115 waiver have all combined to create very strong support for expansions. Through the end of FY 2001 in June, state policy remained resolutely expansionist, despite increasing concerns over the economy and the phasing in of a very large tax cut. The most prominent health policy issues included raising provider rates, implementing expanded prescription drug coverage for aged and disabled persons, expanding long-term care alternatives, and further strengthening the state’s uncompensated-care pool, as well as implementing newly strengthened oversight of health plans and patient protections. The state budget ended the 2001 year in unexpected surplus, a share of which was earmarked as aid to distressed hospitals. Agreement on a fiscal 2002 budget was delayed until December 2001, by which time revenue projections were down dramatically. Nonetheless, through the end of calendar 2001, Massachusetts continued providing generous support for health care as cutbacks fell more heavily on other public programs. Future developments depend heavily on the depth and duration of recessionary shortfalls in revenue.4
Michigan

Jane Tilly, Frank Ullman, and Julie Chesky

Since the late 1990s, Michigan has expanded and implemented changes in its publicly funded health care programs by creating a new health care program for children, implementing a relatively generous prescription drug program for its senior residents, and expanding Medicaid managed care. For most of this period, Michigan had the financial resources to support these efforts.

Fewer adults and children lived in poverty in Michigan than in the nation as a whole in the late 1990s. And employer-sponsored health insurance played a larger role in health care coverage for Michigan’s low-income population than in the rest of the country. As a result, only 7 percent of the state’s children and 11 percent of its adults were uninsured, compared with roughly 13 percent of children and 16 percent of adults nationally.

However, by the fall of 2001 the state’s economy began deteriorating, partly because of the terrorist attacks of September 11. The resulting projected revenue shortfalls are likely to affect state health programs, including Medicaid, because Michigan is considering serious budget cuts.

Political and Fiscal Circumstances

Republicans set health policy in Michigan as they control both houses of the state legislature and the governor’s office. Health care was not at first a notable priority for Governor John Engler after his election in 1990. Over time, though, health has gained prominence, especially providing health care coverage to children, prescription drug coverage to older Medicare beneficiaries, and home and community services to the state’s Medicaid population with disabilities.

Michigan’s budget remained in the black during the latter half of the 1990s, benefiting from increases in the state sales tax, constitutional limits on spending current-year revenue, and the state’s overall robust economy. But the budgetary situation began changing in 2001. Although Michigan’s reserves rose to $1.3 billion in state fiscal year 2000, the state’s May 2001 revenue estimates were $592 million below levels forecast in January 2001. Projected revenue shortfalls in FY 2002, resulting from the softening economy, prompted state policymakers to consider increasing short-term borrowing for capital improvements, accessing monies from the state’s rainy day fund, and restraining increases in governmental spending. The Department of Community Health decreased its budget by $193 million in state and federal funds by reducing payments to hospitals and nursing homes, cutting funds for a number of small health care programs, and implementing a preferred drug list for Medicaid.
The state has become more focused on controlling the growth of Medicaid costs. In recent years, average annual Medicaid expenditure growth has been about 5 percent. To contain Medicaid costs, during the late 1990s Michigan undertook a shift from fee-for-service delivery of health care services to a system dominated by HMOs. Though Medicaid cost increases have moderated under managed care, state officials worry about growth in pharmaceutical expenditures, which currently absorb 15 percent of the Medicaid budget and are increasing more rapidly than any other service. Pressures to contain Medicaid costs are likely to increase because the state projects a budget shortfall of about $800 million in FY 2003.

**Coverage Expansions**

Although Medicaid is the primary source of public health care coverage, Michigan implemented a new program for children in 1998. Using Title XXI or SCHIP funds, Michigan created MIChild, which covers children through age 18 with family incomes between 150 and 200 percent of FPL. The state relies on HMOs and the Blue Cross/Blue Shield Preferred Provider Organization network to deliver services to MIChild enrollees.

The state also used SCHIP funds to expand Medicaid to include children ages 16 through 18 in families with incomes up to 150 percent of FPL. Medicaid, however, was not the major focus of expansion under SCHIP because such an expansion would have created a new entitlement and policymakers wanted to give children access to a program resembling mainstream health insurance. SCHIP enrollment and expenditures were initially lower than anticipated but they have grown over time. In December 1998, total SCHIP enrollment was 10,949. According to state officials, by June 2001, 21,691 children were enrolled in MIChild and 29,626 in the SCHIP Medicaid expansion. The increase in enrollment is attributed, in part, to the state’s outreach efforts, which have included major media campaigns, grants to local agencies, and the involvement of numerous state agencies. In addition to state efforts, the Blue Cross Blue Shield of Michigan Foundation introduced an initiative called Seek-Find-Enroll: Reducing the Number of Uninsured Children in Michigan, which awarded grants to community coalitions to conduct outreach activities, identify and reduce barriers to enrollment, and enroll eligible children in Medicaid and MIChild. Three Michigan communities—Detroit/Wayne County, Muskegon County, and the Upper Peninsula—also benefit from a $1 million grant from The Robert Wood Johnson Foundation to help fund outreach. In January 2002 the governor announced Michigan’s plans to submit a waiver to expand health coverage to 200,000 adults. The plan would increase income eligibility limits under Medicaid to expand coverage to more low-income and disabled people but also would cut some services to current beneficiaries.
Acute Care

Michigan has taken a number of steps to change its delivery of acute care services, including increasing reliance on Medicaid managed care. In 1997, Michigan received a Medicaid freedom-of-choice waiver that required Medicaid beneficiaries, except nursing home residents, those dually eligible for Medicare and Medicaid, and the medically needy, to enroll in HMOs. About 70 percent of Medicaid beneficiaries are currently enrolled in managed care.

Payment rates to participating HMOs have been a controversial issue in Michigan’s Medicaid managed care program. In response to complaints from health plans and other providers, the state increased HMO rates by 4 percent in FY 2000 and by 11.7 percent in FY 2001 and eliminated the requirement that plans be financially responsible for the cost of psychotropic medications. As a result of these changes, plans are expected to show a profit on their Medicaid contracts in FY 2001.

The state has used its role as a purchaser of services to improve its quality assurance for HMOs. Plans must report Health Employment Data Information Set (HEDIS) quality data and must have certification from either the National Committee on Quality Assurance or the Joint Commission on the Accreditation of Health Care Organizations by the summer of 2002. Medicaid-only plans are experiencing the most difficulty with this requirement, according to state officials, because of the inherent complexity and lack of prior experience with this type of reporting. However, these HMOs are now engaging in more quality assurance activities. Since 1999, the state has produced reports on HMO performance, which show generally good levels of consumer satisfaction but substantial variation among plans related to certain service delivery issues such as customer service and access to specialists. The state encourages HMOs to use established clinical standards for diabetic, AIDS, cardiac, and asthma patients, among others.

Medicaid DSH and UPL strategies are significant sources of funds for acute care services, amounting to about $1 billion a year. DSH payments to hospitals are primarily payments to public hospitals that serve large numbers of people with low incomes. These payments also help finance county-based indigent care programs. For example, in Ingham and Wayne counties, Medicaid DSH funds are used to provide health care services to low-income residents not eligible for other public programs. In addition to financing public hospitals and several county health care programs for the indigent, Michigan has UPL programs that make payments to nursing facility units—county-owned medical care facilities and hospital chronic care units. These payments are based on the difference between what Medicaid pays and what Medicare would have paid. Michigan also provides UPL funding to Hurley Hospital, one of the state’s largest public hospitals.

Recent federal legislation has imposed some limits on Michigan’s ability to use the DSH program to increase state revenues. However, DSH and UPL payments continue to be significant. To date, state officials have been able to absorb declines in DSH and UPL payments with minimal difficulty, but future reductions will be more difficult to absorb.
Michigan is among those states implementing a relatively generous prescription drug coverage program for its older citizens; it replaces two programs that relied on tax credits and vouchers. In October 2001, Michigan began enrolling people age 65 and over with incomes below 200 percent of FPL in the Elder Prescription Insurance Coverage (EPIC) program, which receives funding from state general revenues and tobacco settlement funds. Beneficiaries pay a sliding-scale premium to enroll in EPIC.

**Long-Term Care**

Michigan has two large Medicaid home and community services programs and several much smaller state-funded programs that provide services to qualified persons with disabilities. The MI Choice Waiver for the Elderly and Disabled provides home care agency-based services to about 14,000 people who would otherwise be eligible for nursing home care. The Medicaid Home Help program (an optional personal care service), which began in the 1970s, provides personal care services using a consumer-directed model, where most beneficiaries hire and fire individual workers.

In 2001, the Michigan Department of Community Health (MDCH) created a new administrative entity—the Long-Term Care Initiative—to coordinate all long-term care programs serving older persons and younger adults with physical disabilities, including the Medicaid MI Choice waiver and the Home Help program. The Initiative is also responsible for developing and implementing a new, comprehensive long-term care system based on models designed to contain costs through capitated payment and to offer more choice to beneficiaries.

Michigan moved to managed care for persons with developmental disabilities and mental health conditions in 1998 because the state and consumer advocates wanted more flexibility for participants than was possible under the old system. In 1998, Michigan received approval for a Medicaid waiver to establish a statewide Medicaid managed care program for long-term recipients of mental health, substance abuse, and developmental disability services. The MDCH contracts with local or regional Community Mental Health Service Programs to manage and provide Medicaid mental health, substance abuse, and developmental disability services and supports under a prepaid, shared-risk arrangement.

**Conclusion**

Since the late 1990s, the state has implemented two major expansions of health care coverage: SCHIP and EPIC. The program for children had slow initial enrollment, but the state has tackled that issue with increased outreach efforts. The prescription drug program was implemented in October 2001, and the program’s experience with prescription drug cost increases will be instructive given recent rapid escalation in use of this health care service in the Medicaid program.
The shift to Medicaid managed care has also been a key health policy issue in recent years. Although implementation of this effort was controversial, the situation has stabilized with increased payment rates and protections for enrollees. The state is now moving toward a capitated system to deliver long-term care services to aged and disabled Medicaid beneficiaries. The effects of this pronounced trend toward Medicaid managed care will be a key issue for the state, as will managed care’s effects on cost growth. Medicaid cost containment is likely to remain a priority for state policymakers, particularly in light of the softening economy.
Minnesota

Sharon K. Long and Stephanie Kendall

Minnesota boasts one of the lowest uninsurance rates in the nation, and it has long been a national leader in state efforts to expand health insurance to the low-income population. The state supports a comprehensive Medicaid program, characterized by liberal eligibility policies and a rich set of benefits, as well as a subsidized health insurance program for the low-income population (MinnesotaCare) and a generous General Assistance Medical Care program. The state has continued to invest in its health care programs over the past few years.

Political and Fiscal Circumstances

The most notable political development in Minnesota over the past five years has been the election of Jesse Ventura (I), a third-party candidate, fiscal conservative, social liberal, and former pro-wrestler, to replace Governor Arne Carlson (R) in 1998. The state house of representatives also changed hands, from the Democratic Farmer-Labor (DFL) Party to the Republicans. The state senate remains under the control of the DFL. This unusual tripartisan government has complicated state politics, with each legislative chamber and the governor often maintaining divergent views on the distribution of funding and the nature of sustainable tax cuts.

Minnesota had significant budget surpluses every year from 1996 to 2001. The surplus grew steadily larger over that period, reaching a projected $5 billion for the biennium of 1999–2001 (fiscal years 2000 and 2001). Although the state’s economy began to slow in 2001 and into 2002, the state’s recovery is predicted to be faster than that of the nation as a whole. Nevertheless, Minnesota is beginning 2002 with a projected deficit of nearly $2 billion in FY 2002–03.

Coverage Expansions

Minnesota has established generous eligibility standards for its health insurance programs. Between Medicaid and MinnesotaCare, the state offers coverage for children, their parents, and pregnant women with family incomes up to 275 percent of FPL. In recent years, the state has continued to expand coverage around the margins within its SCHIP and Medicaid programs.

In part because of its long commitment to covering its low-income population under Medicaid and MinnesotaCare, Minnesota operates only a small SCHIP program. In 1997, Minnesota already received Medicaid matching funds for children up to 275 percent of FPL under MinnesotaCare. Because the SCHIP legislation required that funds be used on new programs rather than supplementing programs
already in place,³ Minnesota had little opportunity to use its federal SCHIP allotment. Consequently, Minnesota submitted and received approval in 1998 for a small SCHIP program that would serve as a “placeholder” to prevent the state from losing its allotted SCHIP funds. Minnesota’s SCHIP program offers coverage to children under age 2 with family incomes between 275 and 280 percent of FPL. The program covers about 20 children.⁴

In December 2000, Minnesota applied for an amendment to its existing 1115 waiver under new Health Care Financing Administration (HCFA) guidelines that would allow it to use SCHIP funds to improve its existing programs. The state received HCFA approval in June 2001 to, among other things, receive SCHIP funds with an enhanced federal match for parents or relative caretakers of children enrolled in MinnesotaCare with incomes between 100 and 200 percent of FPL. Although Minnesota already receives Medicaid matching funds for this population, SCHIP provides a higher percentage match than Medicaid.⁵

Eligibility for Medicaid in Minnesota has historically been very extensive, and the state has continued to expand eligibility around the margins. Recent expansions of coverage include a small adjustment for inflation in the income standards for Medicaid under Section 1931 provisions,⁶ an increase in the income standards for aged, blind, and disabled individuals from 70 to 100 percent of FPL, the removal of an asset test for pregnant women and children, and the extension of Medicaid benefits to higher-income employed disabled persons.⁷ The state has also garnered Medicaid matching funds for adults enrolled in its MinnesotaCare program under its Section 1115 waiver. Federal matching funds were extended to include the parents and caretakers of children⁸ enrolled in MinnesotaCare with incomes up to 175 percent of FPL in 1999 and up to 275 percent of FPL in 2001.⁹ In addition, beginning in July 2002, the income limit for children under Medicaid will be raised to 170 percent of FPL, while the income limit for parents will be raised to 100 percent of FPL, increasing continuity of coverage and raising the income threshold at which the family is subject to premiums under MinnesotaCare.

A particularly significant expansion has been the extension of the Medicaid program to working persons with disabilities at higher income levels. In 1999, Minnesota enacted the Medical Assistance for Employed Persons with Disabilities program, which offers Medicaid coverage to employed disabled persons under 65 at any income level but with assets below $20,000. Enrollment under the program, at 5,500 in December 2000, has exceeded state expectations, and proposals to address higher-than-expected program costs are being considered.¹⁰

### Acute Care

Minnesota is also known for its innovation in health care delivery. Starting in 1985, the state began moving its Medicaid population into capitated managed care under one of the first Section 1115 Medicaid competition demonstrations—the Prepaid Medical Assistance Program (PMAP). By early 2001, Minnesota had successfully established PMAP in nearly all of its counties, and it continues its efforts to intro-
duce either PMAP or alternative versions of Medicaid managed care in the remaining counties. Under the waiver, savings generated under PMAP are used to support Medicaid eligibility expansions.

Though hospitals in Minnesota have been quite stable over the past several years, they are beginning to show some of the strains of rising health care costs. Recent bond downgrades and dips in profit margins are cause for concern among hospital administrators and state officials. Several factors have contributed to the current environment, including uncompensated-care increases in urban areas (attributed in part to growing immigrant populations), concern about reimbursement rates, and the shortage of health care workers.

The state has attempted to address the health care worker shortage through several initiatives, including funding a two-year worker training and retention program run by the Minnesota Job Skills Partnership program, relaxing certification requirements for some workers, and establishing loan forgiveness and scholarship programs to reduce education barriers to increasing the supply of health care workers. Employers in the private sector are also taking steps to ease the shortage—hospitals have joined with the state and some business groups to form a coalition called the Health Care Administrative Partnership to provide appropriate training in areas with the most severe shortages of trained workers. Despite these efforts, however, respondents noted little evidence of improvement.

Although DSH payments have not been a significant source of funds for the Medicaid program in Minnesota (only $56 million in 1998), Minnesota’s small program was dramatically cut when the BBA reduced the state’s $33 million federal allotment to roughly $16 million because of an error in federal and state reporting. Congressional action resulted in a reinstatement of the full $33 million in federal funding for fiscal years 1998 and 1999; however, federal funding for fiscal years 2000–2002 remained at $16 million. Minnesota congressional members are working to reinstate the full amount of funding.11

In response to rising prescription drug prices, Minnesota has focused on helping low-income elderly and disabled persons through a new state program, Minnesota’s Prescription Drug Program (PDP), originally called the Senior Drug Program. The program, which began in 1999, serves elderly persons age 65 or older with income at or below 120 percent of FPL and assets of $10,000 or less for an individual or $18,000 or less for a couple.12 In January 2002, the income standard for the program increased to 135 percent of FPL. The program pays for most prescription drugs after the enrollee pays the $35 monthly deductible. As of January 2001, about 5,600 seniors had enrolled in PDP. The PDP program is set to expand in July 2002 to include disabled people under age 65 with income less than 120 percent of FPL.

Long-Term Care

Minnesota is in the early stages of a major restructuring of its long-term care system to address the health care needs of its aging population more efficiently. The state is
investing heavily in home- and community-based care (with a growing emphasis on consumer-directed care), while reducing institutional care for its elderly and disabled populations. Because of the scope of Minnesota’s home- and community-based services, state officials have not felt it necessary to prepare a specific plan that addresses the Olmstead decision.

Minnesota operates six home- and community-based care waiver programs under Section 1915 of the Social Security Act. Five of those waivers provide home- and community-based services to specific populations at risk for institutionalization. Minnesota’s sixth waiver represents a major innovation in care delivery—the Minnesota Senior Health Options Program (MSHO). MSHO provides coordinated primary, acute, and long-term care services under Medicaid and Medicare services for dually eligible persons age 65 or older, and represents the first of only four joint Medicaid and Medicare waivers granted by the HCFA. As of 2001, MSHO was operating in seven counties in the Twin Cities metropolitan area and three rural counties, with enrollment totaling 4,138 as of April 2001. The state is also moving forward with a new program to enroll younger disabled Medicaid beneficiaries into managed care, called the Minnesota Disability Health Options (MnDHO) program. Like MSHO, MnDHO integrates primary, acute, and long-term services under Medicaid and Medicare.

In addition to Minnesota’s efforts under the Medicaid program, the state also supports the Alternative Care Program (ACP), which is aimed at increasing home- and community-based care for elderly persons who do not qualify for Medicaid. ACP serves state residents age 65 or older who are at risk of nursing home placement but do not have personal income or assets to cover 180 days in a nursing facility. In 2000, the ACP served 10,696 people at a cost of more than $49 million.

Like other sectors of the health care industry, long-term care providers have been struggling with the worker shortage. Some nursing homes have been forced to eliminate beds or even close entire wings because of an inability to meet minimum staffing levels. This has contributed to waiting lists for some nursing homes in the state. The legislature has taken a number of steps to try to address the shortage of long-term care workers. Most notably, every year since 1997 the state has approved reimbursement rate increases to support increases in salaries for health care workers.

**Conclusion**

Minnesota continues to build on its strong health care system, both by expanding coverage to new populations and by refining its service delivery strategies. Most notably, Minnesota has efforts under way to expand health care coverage for elderly and disabled persons, to reshape its long-term care system to meet the needs of an aging population at lower costs, to control prescription drug costs for elderly and disabled persons, and to implement quality initiatives for health plans participating in public programs. Minnesota’s health care efforts into 2001 were bolstered by a strong economy and high levels of employer-sponsored health insurance coverage, a
substantial tobacco settlement, and a commitment from elected officials and the public to the state’s considerable health care system.

However, there are signs of increasing stress in the health care system, including rising health care costs (particularly prescription drug costs), a severe shortage of health care workers, and increasing uncompensated care in urban areas. In addition, Minnesota must deal with the needs of a growing immigrant population. How these issues are resolved in the future will be shaped by both the state’s economic downturn in 2001–2002 and the political environment in Minnesota, which has shifted to the right in recent years. Moreover, the health policy agenda may be affected by a proposal to shift funding for MinnesotaCare from taxes on providers, HMO premiums, and drug wholesalers to either the general budget or tobacco settlement funds. The resolution of this issue could have a lasting impact on program funding, given rising health care costs and competing demands on the state budget and tobacco funds.
State health policy in Mississippi evolves slowly because funding constraints generally limit opportunities for new initiatives. In recent years, when funding has been made available, the state has acted. The state’s proceeds from the tobacco settlement have been dedicated to health activities. The availability of new federal funding under SCHIP in the late 1990s resulted in swift response as attention focused on the design and implementation of Mississippi’s SCHIP, the Mississippi Health Benefits program. Other current health policy issues include maximizing federal dollars for the state’s health programs in an era of emerging fiscal constraints; implementing coverage expansions for children and the aged, blind, and disabled; and expanding long-term care options for people with mental illness or developmental disabilities.

Political and Fiscal Circumstances

Mississippi’s U.S. congressional delegation is majority Republican, including both senators. In contrast, at the state level, Democrats control both the legislature and the governor’s office. Governor Ronnie Musgrove, formerly the state’s lieutenant governor, replaced the two-term Republican Kirk Fordice, who could not succeed himself. Although health care has not been a high priority in Musgrove’s administration, the governor has been supportive of many health initiatives, particularly increasing enrollment in the Mississippi Health Benefits program. Health care issues may be rising as a priority, as evidenced by a series of health care summits in 2001. The strength of political support for state health spending appears to be strong, driven by the generous federal matching rates for both Medicaid and SCHIP, currently 76.8 and 83.8 percent, respectively.

Although Mississippi’s economy performed well throughout the latter half of the 1990s, the state still ranks last in per capita income—$20,993 in 1999, about $9,000 below the national average. When Governor Fordice took office in 1992 in the aftermath of recession, the state’s rainy day fund was nearly depleted. When he left in January 2000, the state’s rainy day fund was about 7.5 percent of appropriations. Improvement in the operating budget came from strong growth in revenues, due in part to the increase in revenues from the growing gaming industry. More recently, the state has been under severe budget pressure (in FY 2001). In response to a revenue shortfall, two rounds of budget cuts were announced, in November 2000 and February 2001. Medicaid was spared these cuts, which fell primarily on nonhealth programs and on health programs not receiving federal matching funds, such as public health and mental health.

All of Mississippi’s tobacco settlement funds are targeted for health, and the use of those funds has helped mitigate the budget crunch for health-related programs. The budget problems are expected to worsen in the coming year, and whether Med-
icaid will continue to be protected is an important question. The rate of increase in Medicaid expenditures has been rising, driven in part by the rising cost of pharmaceuticals and rising expenditures on nursing homes. Increased enrollment has also fueled expenditure growth, with expansions for children under SCHIP that have increased participation in Medicaid and, more significantly, for high-cost groups such as those with disabilities or with HIV. Although proposals in the current (January 2002) legislative session do not include cutbacks in eligibility, officials are seeking to limit enrollment by eliminating outreach under both Medicaid and SCHIP. Cuts in services and reimbursement have also been proposed.

Mississippi has a relatively large DSH program ($136 billion in federal payments in 2000) and has recently begun to take advantage of the UPL program to bring additional federal funds into Medicaid. The state’s DSH allotments were cut somewhat by the BBA and are scheduled to decrease again after 2002. The state share is funded through intergovernmental transfers, and participating hospitals keep a percentage of the federal payments; the rest is returned to the state. Mississippi began its first UPL program for nursing homes in fall 2000 and, encouraged by the hospital association, expanded participation to hospitals in summer 2001. Reductions in these federal payments will add to the problems the state is facing because of the recession.

Coverage Expansions

While Mississippi’s expansion for poverty-level aged and disabled adults is noteworthy as the most generous in the nation, the bulk of policymakers’ attention has been focused on children. The first phase of the state’s SCHIP, undertaken in October 1998, effectively accelerated the federally mandated phase-in of Medicaid coverage for older children with family incomes up to 100 percent of FPL. In February 1999, Mississippi received federal approval to offer private, non-Medicaid coverage to children in families with incomes up to 133 percent of FPL (subsequently increased to 200 percent). This non-Medicaid phase of Mississippi’s SCHIP was implemented on December 20, 2000. The two phases of the program are known jointly as the Mississippi Health Benefits Program, which also encompasses Medicaid coverage for pregnant women and children. A joint application covers all three components of the Mississippi Health Benefits Program.

Both phases of Mississippi’s SCHIP started slowly. Consequently, enrollment and total expenditures were initially lower than anticipated. Enrollment has grown over time. In December 1998, enrollment was 5,968; by June 2000 enrollment had reached 21,217.1 Of these enrollees, about half were in the Medicaid SCHIP expansion and half in the non-Medicaid component. According to state figures, 41,542 children were enrolled in May 2001. Nonetheless, Mississippi had spent only 50 percent of the state’s 1998 federal allotment by the end of 2000—$29 million out of $56 million.2 To boost enrollment and draw down the allotment, the state eased eligibility rules and eliminated the required six months with no insurance before eli-
Recertification has been a problem, so the state stopped disenrolling children who had failed to recertify until the recertification process could be fixed.

**Acute Care**

In 1995, the legislature created a program of capitated managed care for Medicaid as a way to control rising expenditures. The HCFA (now CMS) approved a model HMO contract and capitation rates in January 1996. Medicaid managed care was originally envisioned as a statewide program, but negative publicity surrounding managed care in neighboring Tennessee and the lack of a base of commercial managed care on which to build quickly led to reduced support for the program. The legislature decided to scale back from a statewide to a pilot program in 11 counties and to make enrollment voluntary rather than mandatory.

By 2000, all of the participating HMOs had either withdrawn or been placed in receivership because of several factors. First, the removal of service restrictions (i.e., limits on inpatient care days, physician visits, and prescription drugs) in managed care introduced the potential for adverse selection into the program. Second, there is very little commercial managed care in Mississippi, so neither providers nor beneficiaries had had much experience with managed care. Finally, Mississippi is a predominantly rural state, making the development of provider networks difficult.

As the program folded, Medicaid HMO enrollees were easily shifted back to fee-for-service Medicaid and then, if they were eligible, to the state’s primary care case management program, HealthMACS. HealthMACS was implemented in October 1993 and currently covers almost 65 percent of the eligible population. While Medicaid officials have not achieved cost savings commensurate with their original expectations, they see the program as worthwhile in its establishment of medical homes for beneficiaries. Currently, only TANF-related beneficiaries are eligible for HealthMACS, but officials are considering expanding the program to the elderly and disabled once remaining issues with the TANF population are resolved.

**Long-Term Care**

Demand for alternatives to institutional care is growing. Medicaid officials envision a system in which people needing long-term care would be screened to determine both eligibility and level of care (whether home- or community-based services were enough or whether nursing facility care was required). They are hopeful that such a system will come out of the task force that has been set up to draft the state’s responses to the *Olmstead* decision. In November 2000, Governor Musgrove ordered the Division of Medicaid to take the lead on *Olmstead*. In response, Mississippi Access to Care, a working group with open membership, was created. The working group is to develop a plan to provide (1) an estimate of the number of disabled residents who need or will need services, (2) an estimate of the cost to imple-
ment the plan, and (3) a proposal for funding. The long-range goal is make community-based services available to all persons with disabilities by June 30, 2011.

Other Developments

Eighty percent of the state’s hospitals, representing two-thirds of total beds, are located in rural areas. To assist rural hospitals, the state enacted the Mississippi Rural Hospital Flexibility Act of 1998 to strengthen rural hospital systems by designating certain rural hospitals as “critical access hospitals” in accordance with the federal Medicare Rural Hospital Flexibility Program. This federal program allows small rural hospitals to operate as less than full-service institutions and still receive cost-based Medicare reimbursement. However, the program is not as attractive to rural hospitals as its designers had hoped. In response to dwindling inpatient revenues in the 1990s, rural hospitals have diversified their activities, often tailoring their service offerings not only to need but also to the availability of preferential reimbursement for skilled nursing facilities and distinct part geriatric psychiatry units. The hospitals would have to close these units in order to qualify for critical access status.

In addition to the wider nursing shortage, rural areas face major challenges in the recruitment and retention of physicians. The state recently established a loan repayment program for medical graduates and began allowing physician assistants to practice throughout the state, not just in urban areas, to help ease the health professional shortage in rural areas.

Conclusion

Mississippi suffers from the dual problem of a large poor population with significant health care needs and a small state budget with which to meet these needs. The recent change in governor in Mississippi has brought a new approach to addressing the problem—looking to Medicaid as a way to bring federal dollars into the state to help meet the needs of Mississippi’s poorer citizens—although the state has yet to fully implement this strategy. In addition, the tobacco settlement funds, which the state has chosen to devote almost entirely to health, and the SCHIP have provided new opportunities for the state to expand its public programs. However, the current economic downturn may exacerbate Mississippi’s woes with potentially rising Medicaid rolls coupled with stagnating state revenues.
New Jersey

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In recent years, New Jersey substantially expanded its role in health financing. Public coverage increased, especially for low- and moderate-income children, and so did public oversight of private coverage. This was a marked shift from the previous era of active public retrenchment and downsizing. During the early to mid-1990s, the state had been implementing hospital deregulation, major reductions in support for hospital uncompensated care, cuts in hospital and nursing home rates, and mandatory Medicaid managed care for cash-assistance beneficiaries. Such downsizing had been prompted both by economic downturn and by a shift in political philosophy as Republicans assumed control of the governorship and both houses of the legislature in the early 1990s. The expansionary era ended in September 2001 because a preset ceiling was reached for covering adults not eligible for traditional Medicaid. Simultaneously, state revenues began to decline markedly. As a new Democratic governor took office in January 2002, New Jersey seemed to face the largest deficit of any state in percentage terms. Further cuts are expected, although health care appears less threatened than most state programs.

Political and Fiscal Circumstances

Republicans dominated state politics from 1992 until 2002. They gained complete control of the legislature in 1992 and the governorship in 1994. Voters elected Christie Whitman over incumbent Governor Jim Florio, who was discredited after breaking clear campaign promises by pushing through a large tax increase in 1990 to maintain services during the recession. Tax cutting and economic development were Governor Whitman’s key priorities. Health care was not a prominent issue, and the key health policy shift of the early 1990s—deregulation of hospital rates—had already begun. Over time, she gave health care higher priority, especially for coverage expansions beyond conventional Medicaid, through NJ KidCare and then NJ FamilyCare. Whitman won a second term in 1997, although narrowly, then resigned a year early, leaving in January 2001 to run the federal Environmental Protection Agency in the Bush administration. Senate President Donald DiFrancesco then became acting governor as well, but withdrew from campaigning for the office. Democrat Jim McGreevey won the gubernatorial election of November 2001, Democrats regained control of the assembly, and the senate was split evenly, 20-20. Health policy was not prominent in the campaign.

New Jersey’s economy performed robustly after a difficult emergence from the early 1990s recession. The state ranked second among states in per capita income—$35,551 in 1999, about $7,000 above the national average. Governor Whitman took office in 1994 in the aftermath of the recession, when annual expenditures exceeded base revenue by roughly $1.59 billion. As she left in January 2001, the
state was projecting a $1 billion surplus in the $22 billion budget proposed for 2002, of which about two-thirds constituted a formal rainy day fund whose use is restricted. In addition, control over Medicaid spending has consistently been a key priority and has met with considerable success. Starting from a high spending base, Medicaid grew only 3 percent a year from 1995 to 2000, compared with 5 percent nationally.

Budgetary pressures were building, however. In 2000, state expenditures slightly outgrew projections for the fiscal year, but so did revenues. The state had also accumulated a high level of debt, which it was able to finance. Supplemental appropriations were needed in mid-2000, for instance, to deal with damage from Hurricane Floyd. The HMO bailout legislation also needed a supplemental appropriation, but Medicaid and other health programs did not. NJ FamilyCare enrollment grew far faster than expected once fully implemented early in calendar 2001, but extra costs were met with slack elsewhere in the budget. As the FY 2002 budget was adopted in June 2001, revenues were still expected to grow, but much more slowly than had been assumed by Whitman’s proposals in January. The final budget raised revenues and cut spending by nearly $1 billion. More adjustments quickly became needed as revenues began falling well below projections. The administration deferred much capital and other spending, announced a hiring freeze, cut administrative funding across the board, and asked departments to prepare program cuts. Adjustments largely spared Medicaid, however, whose FamilyCare expansion had already reached its target ceiling and been curtailed.

Governor-elect McGreevey called for even more drastic measures, estimating even higher shortfalls. As he took office in January 2002, yet higher estimates of deficit were publicized.

### Coverage Expansions

In the late 1990s, public coverage expanded incrementally to quite generous levels. By early 2001, New Jersey offered coverage to children with family incomes up to 350 percent of FPL, parents up to 200 percent, and childless adults up to 100 percent, funded by a mix of funding streams. Some state funding is contributed with no federal match, using a large portion of the tobacco settlement funds—more of which goes to health care in New Jersey than in the average state. The state’s income eligibility levels are among the highest in the nation. Medicaid, children’s, and adult coverages now operate as varying benefit packages within a single program, dubbed NJ FamilyCare.

New Jersey’s SCHIP expansion for children is the most generous in the nation, whether measured as the highest income eligibility threshold or the largest rise in threshold after SCHIP. SCHIP expanded in several phases. The first expansion, in February 1998, covered children up to age 19 in families with incomes up to 133 percent of FPL, who were enrolled in Medicaid. This group included older children, age 6 to 18, who were not already eligible for Medicaid. A month later, New Jersey began offering non-Medicaid coverage to children with family incomes between 133 and 200 percent of FPL. In July 1999, the state expanded non-Medicaid coverage
to children in higher income families (200 to 350 percent of FPL). Despite the state’s ambitious expansions, enrollment and expenditures for children were initially lower than anticipated, but then grew over time. To boost enrollment, the state eased eligibility rules and administration. The Medicaid-style face-to-face interview was dropped in favor of a mail-in application. The state also shortened the required “waiting period” of uninsurance before granting eligibility to poor children (below 200 percent of FPL). The period was cut from 12 to 6 months for children who had had employer-sponsored coverage and was completely eliminated for children who had had individual coverage and those who were involuntarily disenrolled by employers.

In December 1999, Governor Whitman proposed a new coverage expansion, NJ FamilyCare.2 The original plan was to use new tobacco settlement funds to extend the NJ KidCare model to parents and childless adults. Once the legislature enacted FamilyCare in June 2000, NJ FamilyCare subsumed NJ KidCare. NJ FamilyCare also raised income ceilings for pregnant women. The new program attempts to create a single, seamless system for families, combining different sources of funding for various types of enrollees. In January 2001, New Jersey (along with Rhode Island and Wisconsin) received the first federal Section 1115 SCHIP waiver for this type of expansion. The state uses SCHIP funds to pay for parents with income up to 200 percent of FPL whose children already qualify for either Medicaid or SCHIP. The state began operations a few months earlier, using state funds in expectation of the waiver. NJ FamilyCare also covers childless adults, using state dollars without federal matching. Childless adults with income below 50 percent of FPL are eligible for Medicaid-like benefits, and childless adults with income between 50 and 100 percent of FPL are eligible for a managed care package.

All New Jersey interviewees spoke with pride of creating NJ FamilyCare, which they see as a high-quality program. Fiscal support for the program was available because of the tobacco settlement funds and controlled growth in Medicaid and elsewhere. But support was capped and eligibility was understood not to be an entitlement. Enrollment greatly exceeded expectations. The state planned for 125,000 enrollees in three years, but reached 75,000 within three months, and 123,285 by early August. In June, the final FY 2002 budget added modest new state funding to help cope with the unexpectedly rapid enrollment, but did not add enough funds to maintain high eligibility ceilings and authorized administrators to do whatever was needed to stay within budget. In mid-August, officials drastically curbed eligibility for new adult applicants and delayed benefits until enrollees actually enter a managed care plan.3 Prior eligibility was maintained for existing enrollees and applicants in the queue before September. Further cuts had not been announced through December 2001, although officials warned in January that up to 15,000 FamilyCare participants might be disenrolled for ignoring repeated notices to re-enroll at the end of a year’s eligibility.
Acute Care

New Jersey relies heavily on managed care, which enrolls most Medicaid recipients and all enrollees under the NJ FamilyCare expansion. Medicaid managed care enrollment declined somewhat in the late 1990s as state welfare and Medicaid rolls declined, but it has since rebounded to an all-time high and was expected to grow further as NJ FamilyCare implementation continued. Since 1995, virtually all TANF and TANF-related Medicaid enrollees have been required to enroll in MCOs. Other eligibility groups could voluntarily enroll in managed care, but few did. In October 2000, after long planning, the state began phasing in mandatory enrollment for aged, blind, and disabled recipients. Implementation began in three counties and should be statewide by the end of calendar 2001.

Cuts in federal DSH payments appear to have affected state policy very little. Between 1995 and 1998, DSH declined 7.4 percent per year, almost precisely the national average. State officials said the shift was absorbed within the state budget without much difficulty. Much of DSH spending is in the state’s long-standing uncompensated-care pool. With hospital rate deregulation in 1993, the pool was cut and focused on charitable services only, with increased assistance for higher-need hospitals. In FY 2001, pool funding rose by $36.3 million, to $356.3 million, mainly through a new supplemental program for hospitals providing lesser amounts of charity, intended to ensure that every facility receives at least $0.20 of support for each dollar of charity.

As in many other states, the rising cost of prescription drugs greatly increases New Jersey’s Medicaid costs. Some initiatives are under way, but New Jersey seems constrained in holding down drug prices within Medicaid; the pharmaceutical industry is very important to the state. Beyond Medicaid, New Jersey has long aided low-income seniors with prescription costs through Pharmaceutical Assistance to the Aged and Disabled (PAAD). PAAD has subsidized low-income elderly and disabled residents since 1975, reaching nearly 200,000 beneficiaries. As of January 1, 2001, annual income limits were $19,238 for singles and $23,589 for married couples. PAAD spending has risen rapidly—about 9 percent annually since 1995—well beyond the annual 3 percent rise in casino revenues, the program’s primary funding source. Administrators initially sought to respond with new controls, but the political response was new spending. The legislature expanded PAAD into a new Senior Gold program in May 2001, with eligibility income limits raised about $10,000, though with somewhat higher cost sharing.

Long-Term Care

Policy on long-term care is dominated by continuing shifts from institutional to community-based care, along with ongoing containment of institutional spending. Community care is increasing for the elderly, people with mental illness, and people with developmental disabilities. Consumer-directed personal assistance services are
being implemented for persons with chronic physical disabilities. Officials speak warmly of relations with HCFA over program issues, including waiver requests. This congeniality is seen as a change, a result more of federal than of state developments. The state is seeking cooperative implementation of the Supreme Court’s 1999 Olmstead ruling on inappropriate institutionalization of disabled Americans. It is recognized that more home- and community-based support is needed, so state policymakers are meeting with various advocacy and other constituencies to help set policy and, unlike many other states, New Jersey does not expect litigation.

As have other states, New Jersey has also given high priority to holding down nursing home payment rates. The state cut rates in 1995, but still ranked high nationally in nursing home payments. In 1999, the state again modified its payment system, phasing in reforms during the year ending July 2000. The reforms cut allowances for administrative costs and reduced rates for facilities with vacancy rates above 10 percent for two years. Observers agree that federal repeal of Boren Amendment requirements was not a factor in state policymaking, as the state had already cut rates under prior law and won in Boren litigation. Nursing home associations lobbied against the changes—one association citing losses of nearly $40 million, or more than $1,000 per patient each year—and policymakers have shelved plans for additional adjustments.

The quality of nursing home care is a long-standing concern in New Jersey, as in the nation. The key recent state initiative is report cards based on federal standards, started in January 1998. The industry complains that, although the state’s homes do well by national standards, state and federal surveyors in New Jersey keep looking until they find problems. Homes feel constrained by a tight labor market, high staff turnover, and increasing severity of patients’ conditions because of earlier discharges from hospitals and the loss of healthier patients to assisted living.

Other Developments

Upheavals in insurance markets renewed attention to state oversight. The key stimulus was HMO insolvencies; market consolidation and losses among HMOs are other concerns. In the late 1990s, state regulators had to take over two insolvent HMOs and one other insurer. The state had long had conventional regulatory protections (solvency and reporting requirements) for both HMOs and conventional health insurers, but the insolvencies showed shortcomings in officials’ authority to oversee HMO risk bearing and cope with insolvencies. New legislation was needed both to deal with the insolvencies’ immediate financial and medical shortfalls and to increase regulatory powers to try to avoid future problems. Other managed care oversight included strong new patient protection legislation.
Conclusion

Currently prominent health policy issues include maintaining the downsized coverage expansion for children and families, implementing Medicaid managed care for the disabled, closing institutions for the people with mental illness and people with developmental disabilities, and expanding long-term care alternatives, as well as implementing the recently strengthened state financial oversight of health plans and patient protections, including potential for-profit conversion of the state’s large Blue Cross plan. Other 1990s initiatives seem stable and hence less salient concerns, including reorganization of the health department, administration of Medicaid managed care for poverty-related beneficiaries, expansion of state subsidies for prescription drugs for aged and disabled persons, redesign of the hospital uncompensated-care pool, and most quality regulation of HMOs. New Jersey is broadly supportive of health care for the indigent, but cautious with its own funds.

As of the end of 2001, two new developments were creating considerable uncertainty. The first is a dramatic drop in state revenues, the worst in 20 years. The FY 2002 budget required $1 billion in adjustments between the governor’s proposal of January 2001 and the enacted budget of June. The adjustments included minor revenue enhancements in the collection of business taxes, but there is major political resistance to broad tax increases. As FY 2002 progressed, additional cuts proved necessary, but under Republican control largely spared health programs.

Second, Democrats won the November 2001 elections. New Governor McGreevey campaigned against Republican overspending and has promised large cuts in government to avoid raising taxes as Democrat Jim Florio did during the last recession. Health care has not been a target, but given the fiscal outlook, the future challenge seems not to be crafting further growth in public activities but rather just maintaining past expansions, notably for children.
New York

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New York has a tradition of funding an extensive health care system for its low-income population. By almost any measure—eligibility, provider payment, services covered—the state operates one of the most comprehensive Medicaid programs in the country, as well as a generous SCHIP expansion. In addition, New York has in place some of the most far-reaching small-group and individual insurance reforms, and it has a number of well-funded subsidy programs to help support safety net providers.

Political and Fiscal Circumstances

Little has changed in New York’s political environment in recent years: George Pataki, a Republican, started his second four-year term as governor in January 1999, and Democrats still maintain the majority of seats in the assembly while the Republicans maintain the majority of seats in the senate. With this political leadership, New York has continued to address challenging issues facing the health care market through a variety of ambitious health care reforms, most recently and notably the Health Care Reform Act (HCRA) of 2000—a sweeping piece of legislation that includes funding for several new programs to expand coverage to the uninsured. Moreover, although the state has become more fiscally conservative, with tax cuts enacted in each year of Pataki’s leadership and a slowdown in year-to-year state budget growth, New York’s reputation for sponsoring well-financed health care programs (particularly Medicaid) has not changed much in recent years.

New York was able to undertake progressive HCRA reforms because of tobacco settlement money in 2000, monies from a cigarette tax increase, and a good economy. However, New York’s fiscal circumstances have changed substantially in recent months. Although many state budgets have been affected by the national economic downturn, the terrorist attacks of September 11 have had a direct and significant impact on New York state. Revenue losses attributed to the terrorist attacks alone are projected to be at least $1.63 billion during the 2001–02 fiscal year.

Coverage Expansions

This study reveals that during the late 1990s, New York’s policy attention on health care issues was principally aimed at addressing the state’s large and growing uninsured population. Coverage expansions during this time focused on extending coverage to children through the Child Health Plus (CHPlus) program and Medicaid expansions, and more recently to adults with the passage of HCRA 2000.
Though most SCHIP programs were newly developed under Title XXI of the Social Security Act in 1997, New York has been providing health insurance coverage to children since 1991 through the state-sponsored CHPlus program. With the passage of Title XXI, New York applied for SCHIP funding for CHPlus and received federal approval in April 1998. In 1999, CMS approved an amendment to New York’s SCHIP waiver as well as an expansion of Medicaid coverage for children. Under SCHIP, New York expanded Medicaid to cover children age 15 to 18 with family incomes up to 100 percent of FPL and expanded CHPlus to cover children up to age 19 living in households with income up to 250 percent of FPL. New York’s pre-SCHIP CHPlus program provided a strong foundation for rapid implementation of the expansions. By June 2000, CHPlus enrollment totaled 522,058, accounting for nearly a quarter of SCHIP enrollment nationwide.1

Although CHPlus has a relatively large enrollment, concern has been growing about simplifying the program’s eligibility determination processes. State efforts to improve the enrollment process have included allowing SCHIP applicants to mail in their applications, eliminating the asset test, and making presumptive eligibility available to all applicants. In addition, New York established a “facilitated enrollment” process in spring 2000 to improve eligibility screening for Medicaid and CHPlus and to make the process more user-friendly for applicants. Under facilitated enrollment, families are assisted with the joint application and enrollers determine which program the child appears eligible for and helps the family collect the required documentation. Retention of children in Medicaid and CHPlus has also been a growing concern, with some health plans estimating that as many as 25 to 50 percent of children are disenrolled because they fail to complete the eligibility redetermination process.2

In addition to expanding coverage for children, recent initiatives have addressed the state’s adult uninsured population through HCRA 2000—the centerpiece of New York’s health policy legislation that addresses virtually all dimensions of the state’s health care system, from indigent care to graduate medical education to poison control. In addition to reauthorizing a number of established programs, HCRA 2000 contained funding for several new programs, including Family Health Plus (FHPlus) and Healthy New York. Together, these programs are designed to extend coverage to about 1 million previously uninsured New Yorkers, at a cost to the state of nearly $500 million over three and half years.

FHPlus expands coverage through Medicaid to parents with incomes up to 150 percent of FPL and single adults and childless couples with incomes up to 100 percent of FPL.3 Estimates suggest that about 600,000 individuals will qualify for the program. The impetus for FHPlus came from a range of health care stakeholders, including the hospital industry and health care unions, as well as community groups. Designed to build on CHPlus, FHPlus offers participants comprehensive acute care health benefits. FHPlus participants will also receive services through managed care plans, just like the state’s CHPlus and Medicaid programs. New York received federal approval to implement FHPlus on May 30, 2001, and implemented the program in October 2001.

The Healthy New York initiative was spearheaded by Governor Pataki and is intended to address the significant and growing number of working uninsured indi-
individuals in New York. The program provides state-subsidized health coverage for small employers and for individual workers. To be eligible for the program, employers must have 50 or fewer eligible employees, have offered no employer-based coverage for the past 12 months, have one-third of employees make less than $30,000 per year, and be willing to pay at least 50 percent of employee premiums. Uninsured workers and their families who work for firms that do not provide coverage and whose incomes are below 250 percent of FPL are able to purchase direct coverage under Healthy New York. Healthy New York became operational January 2001, and as of mid-2001, the program had roughly 900 enrollees.

In the wake of the September 11 attacks, New York established the Disaster Relief Medicaid program, which enables applicants to sign up for four months of “on the spot” Medicaid coverage if they complete a single-page, streamlined application form. The new program has resulted in a surge in Medicaid enrollment, with more than 75,000 New Yorkers enrolling in Medicaid in the first six weeks of the program. The program was implemented because the September 11 attacks on the World Trade Center damaged the city’s computer system that processes Medicaid applications and because of the increased number of New Yorkers eligible for Medicaid—New York City lost more than 100,000 jobs as a result of the terrorist attacks.

**Acute Care**

The state’s rollout of its Partnership Plan Section 1115 Medicaid waiver program is high on the agenda of policymakers and advocates. New York’s Partnership Plan calls for the phased-in enrollment of more than 2 million Medicaid recipients into managed care on a mandatory basis. When implemented, the waiver program will include the TANF, TANF-related, and Supplemental Security Income (SSI) populations, as well as special programs—called special needs plans—for selected high-need/high-cost recipients. The waiver also includes an expansion of Medicaid to New York’s general assistance program—the Safety Net program—which allows the state to receive federal Medicaid matching dollars for program recipients. As of May 2001, about 700,000 adults and children statewide were enrolled in managed care, approximately 34 percent of all Medicaid recipients eligible for managed care under the waiver program. Implementation of the waiver has moved more slowly than anticipated because of several factors, including a decline in Medicaid enrollment, sensitivity around past marketing abuses in New York City, and the exit of several Medicaid managed care health plans and lack of support from hospitals—related to plans’ and hospitals’ perception that the Medicaid capitation rates are too low.

New York operates a relatively large Medicaid DSH program with spending totaling $1.8 billion in 1998. Unlike many other states, New York does not “retain” federal DSH funds to be used for other purposes, but rather provides the bulk of federal DSH dollars to qualifying hospitals. The state’s Medicaid DSH expenditures dropped substantially in the late 1990s, from $2.9 billion in 1995 to $1.8 billion in 1998. This decline is related to the “budget neutrality” provisions of New York’s 1115 Partnership Plan waiver. New York essentially traded some of its DSH spend-
ing to be allowed to receive a federal match for the Safety Net population and still maintain budget neutrality. The decline in DSH spending also relates to the BBA, which cut New York's federal DSH allotment nearly $239 million over the 1998 to 2002 period. To date, the drop in DSH funding has not been a major issue for policymakers or hospitals, primarily because of the Community Health Care Conversion Demonstration Project, which provides $1.25 billion in federal funds (no state match is required) over the five-year period of the Partnership Plan waiver.

New York also operates a Medicaid UPL program, which is targeted to the state’s nursing homes. The program consisted of approximately $1 billion in Medicaid funds (federal and state) in 2000. According to respondents, as much as $950 million of the $1 billion program is potentially in jeopardy with the passage of the federal Beneficiary Information and Protection Act of 2000. It is unclear how the state will respond if nursing homes lose UPL funds.

Another important acute care issue relates to prescription drug coverage. With pharmaceuticals one of the fastest growing costs in Medicaid, the governor has proposed establishing an independent Pharmacy and Therapeutics Committee to make recommendations regarding drug formularies, utilization policies, and options to achieve price discounts on drugs. In response to the impact of rising prescription drug costs on New York’s senior citizens, policymakers expanded the state-sponsored prescription drug coverage program for low-income seniors, called Elderly Pharmaceutical Insurance Coverage (EPIC) program. EPIC is a cost-sharing program for senior citizens over age 65 who are not enrolled in Medicaid. Initially, program eligibility was limited to individuals with annual incomes up to $18,500 or married couples with annual incomes up to $24,400. As part of HCRA, EPIC was expanded to include singles with annual incomes up to $35,000 and couples with combined incomes of up to $50,000. It is expected that the expansion will boost enrollment from approximately 120,000 to roughly 200,000 seniors.

Long-Term Care

New York’s commitment to a strong health care system extends to the provision of long-term care. In 1998, the state spent more than $12 billion on Medicaid long-term care—accounting for nearly 45 percent of the state’s total Medicaid spending. On a per-enrollee basis, New York’s spending for elderly, blind, and disabled beneficiaries is double the national average. New York’s high long-term care costs are related to the state’s comprehensive benefits, innovative programs, a prevalence of Medicaid estate planning attorneys that guide elderly in how to divest their assets, and a system that is fragmented and difficult to regulate.5

As part of a strategy to curtail long-term care costs, the governor has attempted to reduce nursing home spending. In his 2001 State of the State address, the governor proposed several provisions to cut state Medicaid funding for nursing homes by a total of approximately $330 million (federal, state, and local). However, both the assembly and senate budget resolutions restored these proposed cuts because of concerns about the impact on quality of care as well as labor shortage issues in the nurs-
ing home sector. The shortage of health care workers, especially in the nursing home market, is almost universally acknowledged among key stakeholders as being one of the biggest health care issues New York currently faces.

Quality of care in New York’s long-term care system has been a key issue in recent years. In 2000, additional funding was set aside to hire at least 80 additional nursing home inspectors, and lawmakers enacted legislation that requires an applicant for licensure as a nursing home administrator to pass an examination before receiving a license. In 2001, Governor Pataki proposed further nursing home quality improvement measures, including criminal background checks for all nursing home employees and increased fines for providers found to be noncompliant.

Historically, New York has been considered a model in its provision of home- and community-based services, thanks to its extensive provider network, generous benefits, and innovative programs. New York has not made any major changes to its community-based care system in response to the Olmstead decision. Though New York officials are “aware of the decision” and are examining the state’s long-term care system to make sure it complies with the decision, they are not actively undertaking new initiatives. State officials view New York as a national leader in offering a wide range of home- and community-based services to their residents.

**Conclusion**

New York has continued its long-standing practice of providing comprehensive health coverage to low-income residents. But considerable work is needed to turn the many new initiatives into successful programs. In particular, the state will be faced with the important challenge of enrolling and retaining eligible populations in the new insurance coverage programs. If the new programs do not meet their enrollment goals, New York and its providers will continue to confront the pressures of a sizable uninsured population (estimated at more than 2 million nonelderly individuals in 1999). At the same time, the state is facing revenue losses attributed to the terrorist attacks of September 11 and the national recession, coupled with projected increases in Medicaid spending: In 2001, Medicaid expenditures were expected to increase 6 percent, about three times the annual growth rate over the period from 1995 to 2000. Although the economic downturn could have resulted in significant health care cuts in the FY 2002–03 budget, the legislature passed a major health care package in January 2002 that includes funding for hospital and nursing home worker recruitment and retention, expands Medicaid eligibility for disabled workers, and further streamlines Medicaid and CHPlus enrollment and redetermination processes. The package, estimated to cost $3.5 billion over three years, will be financed by the conversion of Empire Blue Cross Blue Shield into a for-profit entity, an increase in cigarette taxes, and a yet-to-be-approved increase in New York’s Medicaid matching rate by the federal government.
Texas

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Texas is a big, diverse state with a large low-income population, high levels of uninsurance, and many foreign-born residents, largely from Mexico. Politically, it is very conservative, with fairly minimal health and welfare programs beyond what is required to draw down a federal match. Taxes are low, limiting the funds that are available for health and human service programs. Cash welfare is highly unpopular, but health care is viewed more favorably, and there is some interest in expanding eligibility if the state can afford it or if it can get the federal government to pay the incremental costs.

Political and Fiscal Circumstances

Texas has new political leadership and is facing a very different fiscal environment from that in the late 1990s. With the departure of Governor George W. Bush to become president of the United States, the new governor is Rick Perry, a conservative Republican, whose main interests lie outside of health care. After booming in the late 1990s, the state’s economy deteriorated in 2001, and a modest surplus turned into a substantial budget deficit. Despite this, the two-year budget passed by the legislature in the spring included several health care initiatives, including Medicaid eligibility simplification for children, funding for SCHIP, increased reimbursement for nursing homes, and establishment of a new system of health insurance for public school teachers and a pharmaceutical assistance program for older people and persons with disabilities (although no funding was provided). The declining economy, which has been exacerbated by the terrorist attacks of September 11, 2001, may curtail further expansions. So far, however, expenditures and revenues are close to projections.

Coverage Expansions

Texas has one of the highest rates of uninsurance in the country, largely because of a low rate of private insurance coverage and a large poverty population, leaving the state with a large gap to fill with public programs. The Texas Medicaid program is fairly limited in terms of covered services and eligibility for nondisabled adults. Because of the strong economy and welfare reform, Medicaid enrollment fell during the late 1990s, especially for nondisabled adults, although it is rising again and is projected to continue to increase for the next several years. There is strong upward pressure on the Medicaid budget as a result of increasing enrollment, prescription drug costs, and provider efforts to increase payment rates. A major concern within Medicaid is the very large number of children who are eligible for the program but are
not enrolled. In 2001, the legislature enacted an initiative to address this issue by funding outreach and simplifying the application process. The state is not actively pursuing existing federal legislative mechanisms to expand eligibility for adults. The legislature did pass a bill in 2001 that would have sought federal Medicaid waivers for the expansion of eligibility for adults using local funds as the federal match, but the governor vetoed this bill. Smaller pilot projects are being explored.

The Texas SCHIP had a slow start, but it has now enrolled more than 400,000 children and is projected to continue to grow. The program is very politically popular, and the success of SCHIP inspired the Medicaid eligibility changes for children that were enacted in 2001. The state has made the SCHIP application process very simple and invested in outreach. SCHIP eligibility is family income up to 200 percent of FPL. Texas SCHIP is primarily a non-Medicaid program that uses MCOs. In part because there are so many uninsured children in the state, Texas has not pursued using SCHIP funds to provide health insurance for adults. For budgetary reasons, the state is examining options to slow expenditure growth.

**Acute Care**

Texas Medicaid and SCHIP depend heavily on managed care for children and nondisabled adults. Medicaid managed care is in all of the major urban areas, and all SCHIP enrollees are in some form of managed care. Although older people and people with disabilities are not required to join MCOs, the state is operating an innovative demonstration in Houston that integrates some acute and long-term care services. State officials believe that managed care has the potential to provide a “medical home” for enrollees, improve quality, and contain costs. Many providers, however, have never liked managed care and find the system to be very administratively complicated and burdensome. Medicaid has primarily contracted with commercial HMOs; though some health plans have dropped out of the program, the withdrawals have largely been limited to specific markets. Responding to concerns by consumers and providers, in 1999 the legislature imposed a moratorium on expansion of Medicaid managed care, which has now been lifted. Despite the ambivalence in the legislature and elsewhere about managed care, the 2001 budget includes its expansion as one possible strategy of saving money.

Many of the Medicaid managed care concerns are mirrored in the commercial market and in the state’s insurance regulations. Overall, commercial managed care has had a difficult time in Texas, with many HMOs losing money throughout much of the 1990s, leading to some mergers and consolidations. Texas has been a leader in state regulation of MCOs, with laws providing a patients’ bill of rights that includes the ability to sue HMOs.

A major source of health care for the low-income population in Texas is public hospitals, which compensate in part for the low Medicaid eligibility levels for adults. Though mostly supported by local property tax assessments, hospitals providing health care to the Medicaid and uninsured populations benefit from the Medicaid DSH payment adjustment. Expenditures for these payments are quite large in Texas,
accounting for about 14 percent of total Medicaid spending in 1998. Though federal law has mandated some cuts, the program has not changed much in recent years. The state is now pursuing similar strategies—supplemental payment or so-called UPL programs—which are designed to provide facilities with higher-than-normal Medicaid rates, using local government funds for the state match.

The costs of prescription drugs have been increasing for both Medicaid and consumers. In 2001, the state created a small prescription drug program for low-income elderly and disabled persons but did not provide funding for it. The upper-income limit for eligibility is to be determined after a more thorough analysis of projected costs. The goal is to get the program started and to expand eligibility over time, as state finances permit. The program, which is not an entitlement, will have a formulary and encourage the use of generic drugs. The state also established a discount retail program and created a bulk purchasing arrangement for state programs, but these are yet to be implemented.

Long-Term Care

Long-term care, especially nursing homes, is under substantial pressure in Texas. Both nursing homes and noninstitutional providers have been affected by a shortage of workers. The state has historically set low levels of Medicaid reimbursement for nursing homes, and many facilities were adversely affected by the changes to Medicare skilled nursing facility reimbursement enacted as part of the federal BBA. In addition, liability insurance costs have skyrocketed, and many facilities have dropped coverage. The nursing home industry contends that the cost pressures make it difficult for them to provide high-quality care. The 2001 legislature partially addressed these issues with a significant rate increase and with an initiative to allow for-profit nursing homes to participate in the state-run high-risk medical liability pool.

Through its Medicaid program, Texas provides a range of home- and community-based services, although there are large waiting lists for Medicaid waiver services. The state has responded to the Supreme Court’s Olmstead decision by actively engaging in a planning process. Texas home health agencies were very adversely affected by the changes to the Medicare home health reimbursement system that were part of the BBA.

Other Developments

Texas policymakers have recently addressed three other health care issues. First, in a highly controversial opinion, the state’s attorney general argued that the provision of nonemergency health services to undocumented immigrants is illegal under federal law without new authorization, which has not occurred in Texas, an interpretation from which public hospitals and consumer advocates have strongly dissented.
Second, the state has started a small initiative to improve health and human services in the colonias, which are areas without basic infrastructure, such as potable water or sewage systems. Third, not all public school teachers in Texas have access to employer-sponsored health insurance, a problem that was largely remedied by the legislature in 2001.

Conclusion

Texas has a very large number of uninsured and an aging population, and the large number of immigrants complicates policymaking. Public programs to meet these needs are limited, in part because tax revenues are low and there is strong resistance to public programs. Nonetheless, over the past few years, the state has implemented a number of health policy initiatives including funding for SCHIP, increased reimbursement for nursing homes, and establishment of a new system of health insurance for public school teachers and a pharmaceutical assistance program for older people and persons with disabilities.

As Texas looks to the future, it faces four challenges. First, as with many other states, Texas’s fiscal condition deteriorated over the course of 2001, placing strong pressures on the state budget. If the economy does not improve, the state may face having to raise taxes or cut programs in the future. Second, the Texas Health and Human Services Commission is required to achieve Medicaid savings, which could have major impacts on the future of the program. Third, the state is considering expanding enrollment in Medicaid managed care, despite resistance from providers. Finally, the state’s long-term care system, especially nursing homes, is very much in flux. Nursing homes are in financial difficulty for a variety of reasons, and quality of care is a major concern. The state has invested a lot in planning home- and community-based services, in part to comply with the Olmstead decision, but waiting lists remain large.
Washington

John Holahan and Mary Beth Pohl

Washington is a state with a strong history of progressive social policy. It has been a leader in health reform with legislation in 1993 that included an employer mandate, an expansion of Medicaid coverage for low-income children and home- and community-based coverage for the elderly and disabled, and a major effort to reform its individual and small-group insurance markets. The state also expanded enrollment in its Basic Health Plan (BHP), an insurance program for low-income working families. In subsequent years, the state repealed several of these measures. It also enacted a ballot initiative, I-601, that constrains state spending growth to inflation plus population increases, less than the rate of growth in per capita income. Today the state is struggling to maintain several of the advances in health coverage it made in the early 1990s.

Political and Fiscal Circumstances

Control in Washington’s senate is narrowly in the Democrats’ hands, 25D–24R, and the house is split 49D-49R, with shared control of the rules and chairmanships. In mid-July 2001, the legislature ended a historically long session, with three back-to-back special sessions, caused at least in part by political gridlock. The Democratic governor, Gary Locke, who won reelection to his second term last year, replaced the retiring Mike Lowry in 1996. Governor Locke has not emphasized health, making little mention of it in his 2000, 2001, and 2002 State of the State addresses, and instead has focused on education, crime, transportation, water, and energy.

The state has had a strong economy throughout the 1990s. For example, per capita income grew by 16.4 percent between 1995 and 1999 versus 10.8 percent for the United States. Nonetheless, the state is consistently faced with budget crises as it attempts to enact its biennium operating budgets. The perennial budget crises stem from the stringent expenditure cap enacted as I-601 in 1994, which limits general fund spending growth to a three-year average of inflation and population growth. The 2002–03 problems were tied to the cap but were also precipitated by revenue shortfalls. The state does not have a personal income tax; rather, it relies on property taxes and sales and business taxes for its general revenues, making the state’s revenues highly vulnerable to economic fluctuations. In 2001 the state faced a downturn in its economy, water supply reduction due to a drought, an energy crisis, and an earthquake. These setbacks have led to increases in emergency spending together with reduced revenues.

Rising health care costs played a major role in the state’s serious budget problems. State and employee health benefits were expected to increase in the next biennium by 12 percent to 14 percent per year and the BHP costs by 10 percent and perhaps more. Medicaid spending was expected to grow by about 10 percent per year.
because of increases in managed care rates and rising fee-for-service expenditures for the disabled, principally prescription drugs. Caseload growth is forecasted to be about 3 percent per year and per capita expenditures 7 percent per year. Because of increased spending and declining revenues, the state faced a serious budget crisis, which required three special legislative sessions before it was resolved. Several cuts in Medicaid, BHP, and the state employees’ health plan were proposed, but opposition to most proposals was intense.

The solution to Washington’s 2002–03 budget dilemma came when state officials discovered a way to expand the UPL, ProShare, program. The state’s ProShare payments were made to 14 government-owned nursing homes. The state had been calculating the difference in Medicaid and Medicare UPLs for all 267 nursing homes and used this sum to determine the amount of the enhanced payments that could be made to the 14 nursing homes, which returned about half the money to the state.4 In the midst of the budget deadlock, the state discovered that if it used the Resource Utilization Group System to calculate what the Medicare UPL would have been, the limit could be increased. With the new methodology, the state would receive more than $450 million of new federal money in 2002 and 2003 and retroactive payments for 2000 and 2001. These funds increased the amount of revenue in the Health Services Account (HSA), which, because of new provisions permitting HSA funds to be transferred to the general fund, allowed the state to solve its budget problem. In the budget that was passed, cuts in health care spending were quite limited compared with the proposals that had been considered. There was a small cut in BHP enrollment and small increases in BHP copayments for prescription drugs.

In the second year of its biennium, Washington developed a $1.3 billion deficit out of an approximately $23 billion budget. The governor considered a range of options for reducing Medicaid spending. In the end, he proposed substantial cuts in reimbursement rates for both generic and brand name drugs and in nursing home reimbursement rates and elimination of interpreter services.

In late 2001 Washington also submitted a waiver proposal to CMS, which if granted would reduce outlays and increase federal revenues. Under the waiver proposal the state would impose premiums on children and pregnant women with incomes above 100 percent of FPL up to 5 percent of income, shift BHP parents into SCHIP, obtain the higher SCHIP match, and use the state’s SCHIP allotment. The state has asked for authority to impose cost sharing on optional services for all mandatory eligibles and on all nonpreventive services for optional groups, as well as authority to cap enrollment for all optional eligibility groups. It appears unlikely that CMS will approve this waiver in its current form.

**Coverage Expansions**

The aftershocks of Washington’s efforts to provide statewide universal health insurance in the early 1990s continue to affect health care policymaking eight years later. Although many of the most ambitious 1993 Health Services Act reforms, including the employer mandate, were repealed several years later, other reforms—such as the
expansion of the BHP, small-group and individual market reforms, and the increased Medicaid eligibility threshold—significantly influence today's health insurance coverage issues.

One major goal of the 1993 reforms was to adequately provide health insurance to the state's working poor residents, who often do not have access to employersponsored coverage. To accomplish this, the reforms expanded the BHP, a state-only funded health insurance program, from a small pilot project to a program that covered 60,000 individuals statewide by the end of 1995. The BHP provides a subsidy to families and individuals earning less than 200 percent of FPL, with sliding-scale premiums starting as low as $10 per month. In addition, the 1993 reforms extended BHP availability to families and individuals earning more than 200 percent of FPL, who could enroll without a subsidy but would bear the full cost of coverage. In 2001, about 130,000 people received coverage through the BHP. To further increase coverage of Washington's poor, a third health reform expanded the Medicaid eligibility threshold. Beginning in 1994, Washington extended Medicaid coverage for children up to 200 percent of FPL, which was one of the highest levels in the nation at that time.

Washington established a separate SCHIP program, for non-Medicaid-eligible children between 200 and 250 percent of FPL. Washington's SCHIP implementation occurred in 2000, later than in most states. The state's reluctance to participate in SCHIP stemmed from its inability to obtain enhanced match for children below 200 percent of FPL because they were already covered under Medicaid. Medicaid and SCHIP, both administered under the Department of Social and Health Sciences Medical Assistance Administration (DSHS-MAA), have a joint Medicaid-SCHIP application with self-declaration of income. The state has incorporated innovative mechanisms to ensure coverage of eligible individuals who apply. Both programs use the same income counting methods, and an in-person interview is not required. Along with already high Medicaid eligibility levels, these measures have resulted in a large Medicaid spillover effect with 70 to 75 percent of those applying for SCHIP being determined eligible for Medicaid. Washington also has seen a significant growth in its wholly state-funded Children's Health Program, which provides medical coverage to noncitizen children in households below 100 percent of FPL.

In November a ballot initiative passed, allowing the state to increase its tobacco tax and use the proceeds to fund additional slots in the BHP, provided that the state maintained BHP enrollment funded through other HSA revenues at 125,000.

**Acute Care**

As of June 2000 there were 430,000 enrollees in the Healthy Options plan, Washington's Medicaid managed care program. This number represents about 60 percent of Medicaid enrollees. Premiums paid to managed care plans were $650.1 million in 2000 and were expected to rise to $876.7 million in 2003, an increase of 11.5 percent per year. Per enrollee costs are expected to increase 8 percent per year. Only TANF families and other nondisabled adults and children are in Medicaid managed
care. Washington had attempted to enroll the SSI population in managed care in the eastern part of the state. Managed care for the SSI population failed because of several factors, including a major withdrawal of health plans in eastern Washington, a consolidation of health carriers, and the fact that new enrollees entered with pent-up demand and the rates reportedly were not adequate.\(^7\)

Washington’s hospital payment system is a DRG (diagnostic-related groups)-based system, and rates have been increasing by about 5 percent per year. Hospital expenditures are expected to increase by 9.8 percent per year between 2000 and 2003.\(^8\) Hospital margins are quite low in the state, and hospitals are concerned about rates of payment. The state has reduced the burden on hospitals through its medically indigent program (for the uninsured) and its General Assistance for the Unemployed program (a program for the temporarily disabled). Both pay hospital bills for people who are otherwise uninsured, though both programs pay hospitals less than their full costs. The state also has a relatively large DSH program. Though scaled back in recent years because of the BBA, it is targeted to those hospitals that provide a large amount of care through Medicaid. DSH payments are projected to fall from $240 billion in 2000 to $193.3 billion in 2003. Hospitals are greatly concerned about these reductions because they are on top of the larger pressures coming from Medicare and private payers.

Prescription drug costs are high and increasing rapidly in the state. The MAA projects that drug spending will increase by 16.8 percent between 2000 and 2003. As part of the budget debate, Washington twice attempted to enact a joint purchasing program—Medicaid together with the state employees’ plan and BHP—to obtain discounts on top of those from the federal Medicaid rebate program. Physicians could opt to choose from a preferred drug list and avoid most requirements for prior authorization. Physicians not accepting the preferred drug list would face extensive prior authorization. These attempts were defeated in the legislature following heavy lobbying by the drug manufacturers. Instead, the legislature also directed MAA to achieve a 3 percent savings in program expenditures through various cost-containment and utilization initiatives. In response to the worsening budget environment, the MAA is now proposing to cut reimbursement rates.

Washington has also sought to provide some relief to seniors paying increasingly high prescription drug costs. In August 2000, the governor established the AWARDS program, a prescription drug “buyer’s club” (similar in concept to Sam’s Club or Costco), whereby seniors pay $15 a year (or $25 per family) to purchase reduced-price drugs. However, a group, mostly representing pharmacists, filed a motion to stop the implementation of the AWARDS rules, claiming that any “savings” seniors see would come solely from reducing pharmacists’ revenues. On May 25, a state court judge agreed and struck down the program.

**Long-Term Care**

Washington has been known as a leader and innovator in long-term care services because of policy initiatives to shift Medicaid recipients out of nursing homes and

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expanded care options in community-based settings. Leaders in Washington continue to support and expand these shifts for the elderly and persons with mental illnesses and developmental disabilities and younger people with disabilities. Because of its substantial expansion of long-term care services, the state does not anticipate that the *Olmstead* decision, which requires states to move individuals to community-based settings to the extent possible, will have a major impact. However, as new care settings, such as adult family homes, assisted living facilities, and board and care homes, take on a larger share of long-term care recipients, concern has grown about the quality of care given in these facilities and the level of regulation necessary to ensure quality. In addition to regulation of facilities, concerns have been raised about training standards and wage levels for aides working in community-based facilities.

Washington, like the rest of the country, has struggled to fill the increasing number of positions available for long-term care providers resulting from a period of low unemployment rates combined with the low wages these workers typically receive. Though a general shortage of registered nurses has made recruiting skilled staff difficult, attracting lower-skilled aides has been an even more acute problem. There were concerns that the problem of the shortage of aides could not be solved with current nursing home rates, and the legislature has been unwilling to make significant adjustments. In fact, in response to recent budget problems, the governor is now proposing substantial cuts in nursing home rates. The legislature is not likely to fully accept these proposals, but nonetheless rates are expected to be cut, which could exacerbate the worker shortage problem.

**Conclusion**

Washington will confront many difficult issues in the near future. It seems inevitable that health care spending through the state employees’ plan, Medicaid, and the BHP will place ongoing pressure on the state budget. State spending will be limited by I-601, although the state has recently found ways of transferring funds from other sources to alleviate the I-601 constraints. But in the future these transfers will require new revenue sources. Thus state spending is also limited by the growth in state revenues, which in turn are dependent on the growth in the state’s economy. In the past two budget cycles the state solved its fiscal problems through tobacco settlement revenues and increased use of UPL mechanisms. Neither of these will be available in the future to enhance state revenues; even the current UPL program is in some jeopardy because of CMS concerns. In the past budget cycle the state avoided significant cuts in the BHP; it may not be able to do so in the future. The state also is not likely to enact further coverage expansions absent any new federal legislation. Washington has gone from being a leader among states in health reform to a state struggling to maintain its existing coverage programs.
Wisconsin

Brian K. Bruen and Joshua M. Wiener

Wisconsin is one of America’s leading “laboratories of reform.” Then-Governor Tommy Thompson was a motivating force for change throughout the 1990s, championing policies that favored work and self-reliance. Although health care was not a top priority of the state, Wisconsin implemented some major health care initiatives in the late 1990s. BadgerCare, the state’s publicly subsidized health program for low-income families with incomes too high to qualify for Medicaid, often is touted as a model for other states seeking to expand coverage. Wisconsin also has been a national leader in long-term care, especially in the development of flexible home- and community-based services. The latest major initiative is Family Care, which consolidates funding for long-term care through use of care management organizations.

Political and Fiscal Circumstances

Wisconsin has new political leadership and is facing a very different fiscal environment from that during the late 1990s. With the departure of Governor Thompson to head the U.S. Department of Health and Human Services, the new governor is Scott McCallum, a conservative Republican whose priorities are tax reduction and education. The economic slowdown has exacerbated a large structural budget deficit and created substantial financial pressures, which the state has solved temporarily by relying on a creative repackaging of tobacco settlement funds and vastly expanding its Medicaid intergovernmental transfer program. Despite the financial pressures, Medicaid and other health programs were cut only very slightly in the budget that passed in 2001, and new funds were found to create a new prescription drug assistance program for senior citizens.

Coverage Expansions

Wisconsin has one of the lowest rates of uninsurance in the country, mainly because of a very high rate of private insurance coverage, leaving the state with a smaller gap to fill with public programs. The Wisconsin Medicaid program is one of the country’s most extensive in terms of covered benefits and eligibility, although it is less than 14 percent of the state budget. Because of the strong economy and a strict welfare reform initiative (Wisconsin Works, or W-2), Medicaid enrollment fell sharply during the late 1990s, though it is beginning to rise again. Increasing enrollment, prescription drug costs, and provider pressure for increased rates have placed strong upward pressure on the Medicaid budget. In 2001, the legislature cut Medicaid payments for prescription drugs as its principal cost-containment initiative.
A major innovation in Wisconsin has been the implementation of BadgerCare, which is funded through a combination of a Medicaid research and demonstration waiver and an SCHIP waiver. In these waivers, the state proposed to cover parents as well as children through SCHIP rather than Medicaid (and receive the higher federal match), arguing that it would make enrollment of children easier because parents could benefit as well. Although the waivers were ultimately granted by the U.S. Department of Health and Human Services, the process of obtaining the waivers was politically contentious and difficult.

Families with dependent children qualify for coverage under BadgerCare if their incomes are at or below 185 percent of FPL and they are not eligible for Medicaid. Once enrolled, a family’s income may increase to 200 percent of FPL before the family is no longer eligible. There is no financial asset limit for eligibility. Participants with family incomes above 150 percent of FPL are required to pay a premium for coverage, a requirement that consumer advocates argue discourages enrollment. In addition, families with employer-provided and heavily subsidized health insurance are ineligible. Enrollment has grown quickly, exceeding projections, and was 83,000 individuals as of May 2001. Unlike Medicaid, BadgerCare is not an entitlement, though if the state chooses to reduce eligibility levels, the federal SCHIP waiver is automatically terminated and BadgerCare reverts to a Medicaid waiver, which has a much lower federal match rate. Covered services are identical to Medicaid’s. Most BadgerCare enrollees are in MCOs, which also are required to participate in Medicaid, easing the transition between the two programs.

**Acute Care**

Wisconsin has a well-established Medicaid and commercial managed care market. Enrollment in MCOs that participate in Medicaid or BadgerCare is mandatory for nondisabled adults and children who live in ZIP Codes with two or more participating MCOs. The state and MCOs have wrangled over rates, with managed care plans winning substantial increases in 2000. Medicaid and BadgerCare MCOs are commercial plans, with most of the state’s MCOs participating. The number of MCOs serving public beneficiaries has been relatively stable, though a few plans have dropped out.

Though the market is highly competitive, commercial managed care in Wisconsin has not experienced the turmoil that has characterized the market in much of the rest of the country. Penetration rates for MCOs have been relatively stable at about a third of the state’s population. Though two MCOs are national for-profit organizations, most of the state’s MCOs are Wisconsin-based, and nonprofit, provider-based organizations play a major role. State regulation of managed care is extensive and includes a patients’ bill of rights. Financially, HMOs had small losses in 1997 and 1998 and relatively large losses in 1999. In response, the HMOs raised premiums and turned a small profit in 2000.

Overall, Wisconsin hospitals are operating at a profit, though margins are down. Thanks to the low numbers of uninsured, hospital expenditures for uncompensated
care are a small percentage of gross patient revenue. Hospitals in Wisconsin are overwhelmingly private, nonprofit facilities; there is only one investor-owned facility and two public hospitals. Over the past few years, there have been some mergers, but few closings. Many hospitals are part of a health system. Hospitals are in a strong bargaining position with HMOs and have recently refused to give large discounts, reportedly because they do not believe that signing contracts with HMOs will increase their market share.

The Medicaid program has made little use of the DSH payment requirements to increase federal revenues or to provide aid to hospitals with large amounts of uncompensated care. Though Wisconsin did not aggressively use DSH payments, the state developed Medicaid supplemental payment programs that operate like some DSH programs. In these programs, Wisconsin claims the unreimbursed expenditures of publicly owned nursing facilities as the state match for federal Medicaid funds, a practice commonly referred to as the state’s intergovernmental transfer (IGT) program (see below).

Going into the 2001–2003 budget process, Wisconsin policymakers faced intense pressure to provide prescription drug coverage for older people. Governor McCallum’s proposal lacked specific funding and was viewed as too restrictive by consumer advocates and the legislature. After considerable political wrangling, the legislature enacted a new program that will be one of the most generous in the country, covering older people with incomes up to 240 percent of FPL. The program is funded by a $0.18 increase in the cigarette tax.

Long-Term Care

Long-term care has a high political and policy profile in Wisconsin, partly reflecting the fact that a majority of Medicaid expenditures are for these services. The state has a national reputation for flexible home- and community-based services through its Community Options Program (COP). The program funds services in nonmedical residential facilities, such as assisted living, and allows consumer direction of services, including payment of family members. COP has very long waiting lists, which have been politically controversial and make the state potentially vulnerable to lawsuits resulting from the Supreme Court’s *Olmstead* decision. Most observers, however, believe that the state’s substantial home- and community-based programs make them immune from legal problems. The state’s Family Care demonstration seeks to create incentives for increased use of home- and community-based services by capitating all state long-term care expenditures.

The state’s nursing home industry is under substantial stress, with a number of facilities in bankruptcy proceedings, falling occupancy rates, facilities closing, and beds being taken out of service. Recruitment and retention of staff is a major problem, and quality-of-care concerns are increasing. The nursing home industry blames low Medicaid reimbursement for its problems and has lobbied hard for rate increases. Though the impact of the repeal of federal minimum standards for Medicaid reim-
bursertainment of nursing homes is unclear, the state has clearly tightened reimbursement over the past few years.

To provide the funds for rate increases, the nursing home industry proposed and the governor and legislature agreed to a major restructuring of the state’s Medicaid IGT program. Under the approved plan, three counties borrow funds from a financial institution and transfer them to the state, which then returns the funds to the counties and certifies the returned funds as Medicaid expenditures for nursing facilities, enabling the state to claim federal matching funds equal to about 60 percent of the amount initially transferred. This new plan could potentially bring $604 million in federal funds to Wisconsin during the 2001–2003 biennium. A significant portion of these funds is slated to be used to increase payments to nursing facilities, particularly facilities that are run by counties. The IGT program is controversial, but even critics of the IGT approach admit that the state does not have any other politically viable options to generate the same level of funding for nursing facilities that the IGT affords.

**Conclusion**

Wisconsin provides an extensive range of services to the low-income population through Medicaid and BadgerCare. The state is also an innovator in long-term care, in both its COP and its Family Care demonstration. As Wisconsin looks to the future, it faces four major challenges. First, the state’s fiscal condition has deteriorated, placing strong pressures on the state’s budget. Creative financing with the state’s tobacco settlement funds and manipulation of intergovernmental transfers in Medicaid helped to prevent major health care program cutbacks in 2001. But if revenues continue to decline, the state may face having to raise taxes or cut programs in the future. Second, Medicaid and BadgerCare are under fiscal pressures to be more efficient while also maintaining a broad set of benefits and eligibility. Third, the state must implement its major new prescription drug program for older people. Enrolling large numbers of persons and controlling expenditures in the face of continued escalation in prescription drug costs may be difficult. Finally, in the area of long-term care, the state faces a number of challenges, including long waiting lists for home- and community-based services, labor shortages, and a fiscally unstable nursing home industry. The Medicaid rate increases this year may help stabilize the nursing home industry, but it is unclear whether the state will be able to get all of the federal Medicaid funds on which future rate increases depend. Furthermore, the state must decide whether Family Care is a success and should be expanded to the rest of the state.
Notes

Introduction
1. All of these reports are available from The Urban Institute, Washington, D.C.: Barbara Ormond and Alyssa Wigton, Recent Changes in Health Policy for Low-Income People in Alabama; Amy Westpfahl Lutzky and Stephen Zuckerman, Recent Changes in Health Policy for Low-Income People in California; Jane Tilly and Julie Chesky, Recent Changes in Health Policy for Low-Income People in Colorado; Alshadye Yemane and Ian Hill, Recent Changes in Health Policy for Low-Income People in Florida; Randall R. Bovbjerg and Frank C. Ullman, Recent Changes in Health Policy for Low-Income People in Massachusetts; Jane Tilly, Frank C. Ullman, and Julie Chesky, Recent Changes in Health Policy for Low-Income People in Michigan; Sharon K. Long and Stephanie Kendall, Recent Changes in Health Policy for Low-Income People in Minnesota; Barbara Ormond and Frank C. Ullman, Recent Changes in Health Policy for Low-Income People in Mississippi; Randall R. Bovbjerg and Frank C. Ullman, Recent Changes in Health Policy for Low-Income People in New Jersey; Teresa A. Coughlin and Amy Westpfahl Lutzky, Recent Changes in Health Policy for Low-Income People in New York; Joshua M. Wiener and Niall Brennan, Recent Changes in Health Policy for Low-Income People in Texas; John Holahan and Mary Beth Pohl, Recent Changes in Health Policy for Low-Income People in Washington; and Brian K. Bruen and Joshua M. Wiener, Recent Changes in Health Policy for Low-Income People in Wisconsin. A companion paper by John Holahan, Joshua M. Wiener, and Amy Westpfahl Lutzky, “Health Policy for Low-Income People: State Responses to New Challenges,” will be available as a web exclusive on the Health Affairs web site, http://www.healthaffairs.org, in May/June 2002.

Alabama
2. Alabama, like many other states, makes DSH and UPL payments to public hospitals and then receives some portion of the payment back from the hospitals through intergovernmental transfers. In Alabama these transfers are made through the Public Hospital Transfers and Alabama Health Care Trust Fund.

California
1. In summer 2001, the legislature raised the income eligibility to 250 percent of FPL—mirroring the eligibility threshold for children. When the state’s current proposal is federally approved, the state plans to submit an amendment to expand eligibility to 250 percent of FPL.
2. Given the state’s matching rate and its reliance on intergovernmental transfers to finance the state share of Medi-Cal DSH, less than half of this represents federal revenues that are available as supplemental payments to hospitals.
3. This approach offers an ongoing solution to the conflict among hospitals because the federal government made the 175 percent rule permanent for all public hospitals, not just those in California, with the passage of the Beneficiary and Improvement Act of 1999.
4. Given the Medi-Cal matching rate, net federal payments under 1255 were about 50 percent of these levels.
5. The Council consists of the directors of the Departments of Aging, Developmental Services, Health Services, Mental Health, Rehabilitation, Social Services, and Veteran Affairs and the Office of Statewide Health Planning and Development.

6. IHSS helps to pay for personal care and chore services for elderly individuals and people with disabilities who need assistance to remain in their own homes.

**Colorado**


**Florida**

1. States are allowed to develop formularies that restrict access to prescription drugs as long as they adhere to certain federal rules that require, for example, the creation of a prior authorization program to allow access to drugs excluded from the state’s formulary.


3. All cuts will be restored until July 1, 2002, with nonrecurring general revenue funds. Cost savings from the implementation of these cuts, therefore, pertain to the FY 2002-03 budget.


5. The Department of Children and Families handles Medicaid eligibility and Healthy Kids handles SCHIP eligibility.

**Massachusetts**


3. Also covered are disabled persons with federal QDWI status (qualified disabled and working individual), those who have lost their Medicare Part A benefits owing to their return to work. CommonHealth covers them up to 200 percent of FPL, with an asset test of double the limit for SSI eligibility.

**Michigan**


**Minnesota**

2. The state receives Medicaid matching funds for these populations, regardless of whether they are enrolled in Medicaid or MinnesotaCare.
3. The legislation required that funds be used on new programs rather than supplementing programs already in place, with the exception of three states (Florida, New York, and Pennsylvania) with existing children’s health insurance programs that were grandfathered into SCHIP.
6. The increase raised income base standards by 3 percent, increasing allowable monthly income by $14 for an individual and $17 for a family of two.
7. Although it is not an expansion in Medicaid coverage, Minnesota has also implemented a program allowing QWDIs to use Medicaid to pay Medicare Part A premiums.
8. Minnesota had been receiving Medicaid matching funds for children with incomes up to 275 percent of FPL in MinnesotaCare since 1995.
9. Parents and caretakers for whom the state receives matching funds receive a slightly reduced benefit package that includes copayments for prescription drugs and other services.
12. In addition, an eligible applicant must have been a Minnesota resident for six months, must not be living in a nursing home, must not have had drug coverage from other sources in the past four months, and must be enrolled in or applying for Medicare supplement programs.
14. Ibid.
15. MnDHO is Minnesota’s third attempt to enroll disabled Medicaid enrollees under age 65 into managed care programs. Blind and disabled individuals were included in the first three counties to implement PMAP in 1985. After one year the major participating health plan dropped the program, and disabled enrollees were returned to fee-for-services Medicaid. Almost 15 years later, the state moved forward with the
Demonstration Project for People with Disabilities (DPPD), under which counties were to operate their own mandatory managed care system for the disabled. Although enrollment was scheduled to begin in 2000, the project was put on hold after two of the four participating counties ended their participation because of concerns about the program's impacts on the disabled population and county providers.


Mississippi


New Jersey


3. After September 1, only single adults and childless couples eligible for WorkFirst/General Assistance will be able to enroll in NJ FamilyCare. Thus, childless couples earning more than $2,600 per year are no longer eligible. See http://www.njfamilycare.org/.


6. Following common usage, we often refer to “insurers” to include other health plans such as HMOs and hospital service corporations. The total number of HMOs statewide decreased as well as those on Medicaid.

**Washington**


4. The Beneficiary Improvement and Protection Act, enacted by the U.S. Congress in 2000, required states to calculate the difference between the Medicaid and Medicare UPLs for just the 14 hospitals. There was a transition to the lower limits depending on how long the state had used the program; Washington has a three-year transition period so eventually the use of this mechanism will be phased out.

5. Based on a site visit conducted on October 11, 2000, as part of the Urban Institute’s SCHIP Evaluation, *Assessing the New Federalism* project.


8. Data provided by the state of Washington Medical Assistance Administration.

**Wisconsin**

About the Editors

Amy Westpfahl Lutzky is a research associate with the Urban Institute’s Health Policy Center, where her work currently focuses on issues surrounding the implementation of the State Children’s Health Insurance Program (SCHIP). Ms. Lutzky has also studied the financing and organization of safety net ambulatory care systems, Medicaid DSH funding, and health care developments in California and New York as part of the Institute’s Assessing the New Federalism project. Before joining the Urban Institute, Ms. Lutzky served as an analyst for the Lewin Group.

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