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Leading the Way: State Health Reform Initiatives

EXECUTIVE SUMMARY

Governors are proposing ambitious health reform initiatives to improve the current health care system. The continually rising cost of health care and ever increasing number of uninsured individuals has increased momentum for reform to contain costs and increase coverage for the uninsured, particularly at the state level.

The source of insurance and the quality of care for Americans varies significantly. Most Americans (60 percent) receive their health insurance through their employer.¹ Over a quarter of the U.S. population receive their health care through public programs—fourteen percent of Americans receive health coverage from Medicare,² and 13 percent through Medicaid.³ Nearly 4 percent of Americans are covered by military-related health care.⁴ An additional 5 percent of Americans obtain insurance through the individual health insurance market.⁵ Over 15 percent of individuals have no insurance coverage and are left to seek care on their own.⁶

Governors cannot wait for federal solutions to the rising cost of health care and the growing number of the uninsured. As a result, health care reform efforts at the state level have been a priority for governors in recent years. States are approaching health care reform broadly and are aiming to improve cost containment efforts through quality improvement and measurement, incorporating prevention and wellness into their health plans, and using information technology to further improve care delivery.

Type of Health Insurance	Coverage Rate (percent)
Employer-Based	60.2
Uninsured	15.3
Medicare	13.0
Medicaid/SCHIP	13.7
Military Health Care	3.8

Source: U.S. Census Bureau, 2006

Governors are proposing health system reforms that encompass both coverage and health system improvements that are aimed at enhancing the overall health care system, including:

- **Innovative coverage approaches using both public and private expansions.** State public program expansions use the Medicaid and State Children’s Health Insurance Program (SCHIP) programs to increase coverage to additional individuals, particularly children. States are expanding access to private insurance through small business incentives, premium assistance programs to help workers buy their employer-sponsored health insurance, and health savings accounts (HSAs).
- **Reforming the private insurance marketplace.** States are approaching reforms through participation requirements to encourage employers and individuals to obtain health insurance. States are also encouraging employers to set up Section 125 plans to allow their workers to deduct their health insurance premiums pre-tax, and are utilizing a “connector” model, which provides access to more affordable and portable insurance. Additionally, states are using a state-defined benefit package to allow individuals to receive basic health services through private insurers.

- **Improving the health care system.** States are using quality improvement and measurement, such as pay-for-performance evaluations, quality measures, and the development of electronic data exchange, to improve the efficiency and quality of patient care in the health care system. States are also using prevention and wellness benefits, such as the early treatment of preventable diseases, to contain costs and improve the value of coverage.

This issue brief explores the innovative ways states are approaching health reform to expand access to affordable coverage and improve the health care system and the health of the population. In addition, a snapshot of many state health reforms is included in the appendix.

CURRENT STATUS OF THE HEALTH CARE SYSTEM

Governors are proposing and implementing ambitious health reform initiatives to improve the health care system. The United States spends more in its health care system than any other country, yet ranks near the bottom of industrialized nations in the quality and scope of care delivered.⁷ Because of the fragmented nature of the health care system, reforms are often difficult to implement. However, the continually rising cost of health care and ever increasing number of individuals without insurance has increased momentum for reform to contain costs and increase coverage for the uninsured, particularly at the state level.

The health insurance system in the United States is primarily based upon coverage provided through employers. In 2005, 60 percent of the U.S. population had employer-sponsored health insurance.⁸ Large employers are significantly more likely to offer health insurance to their workers than small firms, primarily because large employers are better able to cover the expense of providing benefits.⁹

The individual insurance market is available for those who do not have access to or choose not to participate in other employer-based or public health insurance. However, the share of the insured covered through the individual market is comparatively small. Insurance products sold in this market tend to be more expensive than in the small group market, especially for those with chronic conditions and complex health needs. Only 5 percent of Americans participate in the individual health insurance market.¹⁰

While a majority of Americans receive their health care through the private insurance market, state and federal programs provide health coverage for many who are unable to obtain it on their own. Fourteen percent of Americans receive health coverage from Medicare,¹¹ and an additional 13 percent are provided health insurance through Medicaid, the program jointly funded by the federal and state governments.¹² Nearly 4 percent of the U.S. population are covered by military-related health care.¹³

The Uninsured

There are nearly 45 million—just over 15 percent of the population—uninsured individuals in the United States.¹⁴ Sixty-six percent of the uninsured are individuals or families with incomes below 200 percent of poverty.¹⁵ The uninsured are likely to be working individuals. Nearly 70 percent of the uninsured live in families with one or more full-time workers.¹⁶ In addition, racial and ethnic minorities account for half of the uninsured in America.¹⁷

Affordable health care services for individuals without health insurance are difficult to find in the private market. More than 40 percent of non-elderly uninsured adults have no regular source of health care, compared with 9 percent of their counterparts who have insurance coverage.¹⁸ And, nearly half (47 percent) of uninsured adults delayed seeking medical care due to cost.¹⁹

Health Care Spending

In 2005, the United States spent more on health care than any other industrialized country²⁰—nearly \$2 trillion (\$6,697 per person),²¹ a 7 percent increase in spending from the previous year.²² Health care spending accounted for 16 percent of gross domestic product (GDP) in 2005.²³ While spending rates continue to rise, the rate of the spending increase in 2005 was the slowest since 1999,²⁴ which may offer a hint at the effectiveness of some cost containment measures implemented in recent years.

Medical expenditures for uncompensated medical care in the United States were estimated at \$40.7 billion in 2004.²⁵ Of this amount, at least \$36.6 billion, or 85 percent, came from local, state, and federal governments.²⁶

Delivery of Care

Until recently, doctors and hospitals have been reimbursed by public and private insurance programs on a per-service-provided fee schedule. The emphasis has not traditionally been on providing the best, most effective care; rather the emphasis has been on delivering the services the providers believe are warranted to treat the immediate illness or condition. Providers have had to function with few system supports or incentives for selecting effective services, managing chronic conditions, utilizing appropriate preventive services, and avoiding errors. The United States ranks lowest among other industrialized countries for providing quality care.²⁷

STATE HEALTH REFORM EFFORTS

Lack of federal action, as well as the desire to get a greater value from the health care system, have spurred state health care reform efforts in recent years. Currently, most states are experiencing a period of increased revenue and a better fiscal situation than they were three or more years ago. As a result, several states are enacting health care program enhancements and expansions, many of which were cut during the recent budget crisis. In fact, state spending increased by nearly 9 percent in fiscal year 2006.²⁸

Nevertheless, governors are cautious about moving forward, knowing that state budgets are likely to experience a downturn again at some point in the future. Governors are aware that they must pursue controlled program expansions, and that increasing coverage alone will not control the rising cost of health care. As a result, states are exploring three main areas of reform to improve coverage and care within their health care systems:

- **Innovative coverage approaches using both public and private expansions.** Public expansions involve using the Medicaid and SCHIP programs to expand coverage to populations that would otherwise likely be uninsured, particularly children with slightly higher incomes. The private expansions use state dollars to provide incentives and subsidies for small businesses to make it more feasible for them to provide health insurance to their employees. States are also using premium assistance programs to help low-income workers buy their employer-sponsored health insurance, and are setting up and contributing to health savings accounts (HSAs) to allow individuals to purchase their own health care services.
- **Reforming the private insurance marketplace.** States are approaching reforms by requiring employer participation to discourage employers from dropping the health insurance they offer to their workers, and individual requirements mandate that individuals have health insurance or face a penalty. Through tax incentives, states are encouraging employers to set up Section 125 plans to allow their workers to deduct their health insurance premiums with pretax dollars. States are also utilizing a connector model, which provides access to more affordable and portable insurance, as well as allowing a greater choice of insurance products for those not receiving their insurance through their employer. The creation of a state-defined benefit package is another option states are using to ensure individuals are receiving basic health services through private insurers.

- **Improving the health care system.** Through quality improvement and measurement, states are using methods, such as pay-for-performance, adoption of standard quality measures, and development of electronic data exchange, to improve the efficiency and quality of patient care in the health care system. States are also incorporating prevention and wellness benefits into their reform plans and insurance regulations in order to improve the cost effectiveness of care by treating preventable diseases earlier and improving the value of coverage.

This issue brief explores the various innovative ways states are approaching health reform. While states are using many strategies to improve health outcomes, including reforming their Medicaid programs and promoting healthier living, this brief is limited to reforms related to health insurance. The brief highlights state examples of each mechanism described. The issue brief is followed by an appendix that provides a more extensive snapshot of the current reform initiatives in states.

INNOVATIVE COVERAGE APPROACHES

The most publicly recognized component of state-led reforms focuses on increasing access to health care coverage. Many states have taken steps to expand coverage to populations that would otherwise not qualify for public programs and would not be able to afford private insurance either through their employer or by directly purchasing insurance in the individual market. States are using several approaches to expand coverage to the uninsured, including expanding public programs, increasing access to affordable private health insurance by subsidizing the cost of the insurance, and combining public and private expansions.

Public Program Expansions

Numerous states have implemented or are considering expanding the Medicaid and SCHIP programs to include those uninsured individuals who would otherwise not qualify for the programs. Generally using both federal and state dollars, states have expanded eligibility by increasing income and asset levels or expanding the categories of individuals that qualify for the programs. Other states have offered buy-in programs to allow the uninsured with slightly higher incomes to purchase health insurance coverage through the Medicaid or SCHIP programs.

The All Kids program in **Illinois** was implemented to offer affordable health insurance with a Medicaid-like benefit package to all children in the state. Subsidized premiums are available on a sliding scale with a maximum premium of \$300 per month per child. In order to qualify, individuals must have been without health insurance for 12 months. Cost-sharing amounts are also based on a sliding scale, with the exception of preventive care, for which there are no copayments.

Wisconsin's health reform proposal, BadgerCare Plus, focuses on covering all children, providing coverage and enhanced benefits for pregnant women, making the program simple, and promoting prevention and healthy behaviors. BadgerCare Plus combines several existing programs into one comprehensive program. The plan also expands coverage to seven new groups, including children with family incomes greater than 185 percent of poverty, pregnant women with incomes between 185 percent and 300 percent of poverty, parents with incomes between 185 percent and 200 percent of poverty, and farmers and self-employed parents with incomes less than 200 percent of poverty. The proposal also emphasizes preventive care.

Private Insurance Expansions

Low-income workers are frequently not offered insurance through their employers or are unable to afford the coverage they are offered. Sixty percent of employers offered health insurance to their employees, and the average cost of employer-sponsored family coverage is \$11,480 annually.²⁹ As the employee's share of the premium increases, individuals are less likely to take up their employers' insurance because of the cost.³⁰

A number of state initiatives are aimed at increasing access to affordable health coverage in the private insurance market, mainly through employer-sponsored insurance. Several state plans provide incentives to small businesses to offer coverage to their employees and subsidize premiums for low-income workers. Other states offer premium assistance to allow low-income workers to buy their employer-sponsored insurance. Some states are setting up and contributing to health savings accounts (HSAs) for low-income individuals, while others are providing incentives to small businesses that set up HSAs for their employees.

Small Business Programs

The small group insurance market is generally expensive, making it difficult for small employers to offer their workers affordable health insurance. As a result, a number of states have implemented efforts to help employees of small businesses gain access to the health insurance market. To address the needs of small employers, states are providing subsidies and tax incentives to small business owners to encourage them to offer health insurance to their workers.

States are also providing subsidized premiums and defined benefit packages to employees of small businesses to ensure they have access to affordable and comprehensive health insurance. Generally, for a business to participate in these programs, a certain percentage of employees must accept the insurance offered—and in cases where the state contributes to the premium, the employer must contribute, as well.

The **Oklahoma** Employer/Employee Partnership for Insurance Coverage (O-EPIC) program was created to assist small businesses in offering their employees health insurance. Participating employers with 50 or fewer employees must contribute 25 percent of the employee's premium and must offer a qualified O-EPIC plan. Qualifying O-EPIC plans are required to cover state-defined basic benefits and have maximum out-of-pocket spending limits. The state subsidizes the cost of the coverage to ensure affordability.

In **New York**, the Healthy NY program offers affordable health insurance options to small employers, providing businesses with 50 or fewer employees access to state-defined benefit packages. The costs of the plans are subsidized by the state to ensure affordability. Employers must have a 50 percent participation rate in the program and must contribute at least 50 percent of the employee's premium. The Healthy NY plans are offered by any of the health maintenance organizations (HMOs) in the state.

Under the Insure **Montana** initiative, tax credits and subsidies to make health coverage more affordable are available for both small business employees and employers. A tax credit is available for small businesses with fewer than 10 employees who currently offer and contribute toward their employees' health insurance costs. On average, participating small businesses receive a credit of up to \$100 per month per employee.

Premium Assistance Programs

Many states offer premium assistance as a method for expanding coverage to uninsured individuals. By contributing to the cost of the premium, premium assistance programs enable individuals to purchase employer-sponsored insurance that they would otherwise be unable to afford. A portion of the premium is paid by the state, while an affordable amount is paid by the employee.

States often manage their premium assistance programs through the Medicaid and SCHIP programs, providing premium assistance to individuals at the higher end of the programs' eligibility levels—and allowing the state to access federal matching funds to provide the premium subsidies. Premium assistance programs do not put the state at risk for providing health benefits, because participating individuals receive their insurance through their employers, making it a cost-effective option for states.

Utah's Premium Partnership for Health Insurance (UPP) program is designed to help residents pay for employer-based health insurance that would otherwise be too costly. UPP is available to employees with low-incomes who are eligible for their employer's plan but do not currently have health insurance. Eligible individuals can receive up to \$150 for their monthly premium and up to \$100 per month for each child. Enrolled children also have options for dental coverage. Utah law requires employers to pay half of their employees' premiums.

A major component of **Minnesota's** reform plan is a modernization of existing public programs—and includes increasing subsidies in private coverage rather than the state-managed MNCare program for children in families with incomes above 200 percent of poverty. For this option, a standard benefit package, called MNCare II, will be developed by the state and offered in the private market to ensure basic services are covered and coverage is affordable. The governor's plan requires insurers with more than 3 percent of individual market to offer the MNCare II. Insurers can modify the benefit in order to make it attractive to parents of children who may be enrolled.

Texas is proposing a premium assistance program to help low-income uninsured working adults gain access to affordable health insurance. The state will offer varying levels of premium assistance based on a sliding scale. Participating plans must be certified by the state. The plans include a minimal deductible and copayments, which can be paid for by individuals out of a health savings account that is set up by the state.

Health Savings Accounts

Some states have used health savings accounts (HSAs) as a way to expand coverage to the uninsured. Often paired with a catastrophic health insurance plan, some states are setting up and contributing to HSAs for low-income individuals to allow them to have access to private health services. This model focuses on consumer engagement and allowing the individual to be involved in the choice and payment of the services.

Other states are encouraging small businesses to offer HSAs to their workers by offering a tax credit for those businesses that have not previously offered their employees health insurance and choose to set up and contribute to HSAs. In both types of HSA programs, individuals are also expected to contribute to the HSA and toward the health care services they choose to receive.

Indiana has created a health insurance plan for adults and pregnant women with incomes below 200 percent of poverty. Under the Healthy Indiana plan, participating individuals will have a Personal Wellness Responsibility (POWER) Account, which acts as a health savings account, with \$1,100 to cover the deductible. A private health insurance plan approved by the state is available to individuals after they have met the deductible and includes services, such as preventive care and disease management. The plan also includes \$500 for preventive care, such as physicals, screenings, chronic disease management, and smoking cessation. In addition, the plan, which passed with overwhelming bipartisan support, includes a 44-cent increase on cigarettes that is estimated to discourage 40,000 fewer youth smokers and 23,400 fewer adult smokers. As a result, an extra \$11 million will go toward childhood immunizations.

In **Kansas**, the Small Employer Health Insurance credit offers small businesses a tax credit for offering and contributing to HSAs for their employees. The Small Employer Health Insurance credit is available to businesses with fewer than 50 employees that have not contributed to their employees' health insurance over the past two years. The enhanced credit for newly contributing employers is \$70 per member per month in the first year, phasing down to \$35 per member per month in the third year, and ending after the third year.

REFORMING THE PRIVATE INSURANCE MARKETPLACE

Many states are using private insurance market reforms to make health insurance more affordable. The reforms generally focus on the employer and individual insurance markets and are designed to bolster the marketplace to create less-expensive products. Some states are requiring employers to offer insurance to their employees, while other states are mandating that individuals have health insurance. By using these mechanisms, more individuals seek coverage through the private market and, as a result, spread the risk of the insurance pool across a larger number of individuals, thus driving down premiums.

In addition, many states are requiring or encouraging employers to use Section 125 of the federal tax code, which allows employees to have their health insurance premiums deducted from their paychecks on a pretax basis. Several states are creating a “connector” or an “exchange”—a mechanism that presents affordable and portable private health insurance options through a quasi-governmental authority. The connector model pools individuals together to spread the risk and connects people with insurance options.

Benefit packages designed by the state and offered by private insurance companies are another method by which states are able to offer affordable and comprehensive insurance options to their residents. The benefits included generally cover basic services to ensure individuals receive the medical care they need on a routine basis, as well as in the case of an emergency.

The majority of reform efforts to the private insurance marketplace include a combination of these mechanisms, in part because any solution in isolation would be unlikely to produce marked results. Therefore, states are often considering methods for combined reform initiatives.

Employer Participation

Some states are requiring employers to offer health insurance to their workers. Such requirements, which typically exempt small businesses, are generally used to discourage employers from dropping coverage, thus forcing their workers to seek insurance elsewhere.

With the employer requirement mechanism, employers not offering insurance are charged a fee determined by the state for each uninsured employee. In some state proposals, the fee can be assessed even if the employer is offering coverage, but not all employees are insured. Thus, employers have an incentive to encourage their workers to take up the insurance being offered, or sign up with a spouse’s insurance. The fees charged for uninsured workers help to fund the coverage expansion in the state. Because of the commitment required by employers, states requiring employer participation are generally aiming to reach universal access to coverage and are often paired with an individual requirement to build support from both employers and their workers.

In **Massachusetts**, employers with more than 10 employees must offer insurance or pay a portion of their employees’ health insurance premiums and must also offer its employees the ability to buy health insurance using Section 125 tax-free deductions of premiums.

Employers in **Vermont** are required to pay \$365 annually for each full-time employee if the employer does not offer insurance, only offers insurance to some workers, or some employees remain uninsured. This will be required of all employers with nine or more employees in 2007 and increasing to employers with five or more employees starting in 2010.

The Employee Retiree Income Security Act (ERISA) is a law establishing federal guidelines for self-insured benefit plans, which are characteristic of large employers. ERISA does not allow state laws to interfere with the federal

provisions laid out in the law. Whether a state law interferes with the federal guidelines is determined by the federal court system. Therefore, concerns that ERISA preempts state requirements regarding employer participation in health coverage expansions raises questions for state initiatives to achieve universal coverage. However, the courts' opinion on using employer requirements remains unclear. As the states proposing such requirements begin to implement them, the issue will be closely watched to determine whether the courts declare that such state laws preempt ERISA. A ruling that employer requirements preempt ERISA could have a major impact on several state reform proposals.

Individual Requirements

Some state reform proposals mandate that residents obtain health insurance coverage. This mandate is used as a mechanism to encourage all residents to participate in the health insurance system, increasing the pool of individuals and spreading risk across a larger group. Through state income tax filings, individuals who can afford coverage and are found not to have insurance will be fined. The fine is expected to be substantial enough to encourage the individual to buy health insurance.

States pursuing individual mandates as a tool to achieve universal coverage pair the requirement with other mechanisms, such as premium subsidies and required employer participation, to make health insurance more affordable. As a result, the requirement to have health insurance does not place an undue financial hardship on individuals.

Massachusetts is implementing a plan to insure every resident of the state. The plan includes an individual mandate requiring all residents to have health insurance by July 1, 2007. Through state income tax filings, residents of the state will be fined if they are found not to have insurance.

Maine's Governor John Baldacci has proposed a plan to further the Dirigo Health Reform efforts. The governor has proposed to make the Dirigo Health Plan a self-insured plan that will be more affordable for small businesses and uninsured individuals. As affordability of coverage is addressed, the reforms will include an individual mandate to require all individuals to have health coverage.

Tax Incentives

Section 125 of the Internal Revenue Service (IRS) tax code permits tax-free deductions of health insurance premiums from workers' paychecks. This federal tax incentive saves money for the employee because the money used for the premium is not taxed. It also saves money for the employer because the money used for the employee's premium is not included in the employer's taxable revenue. Many health reform initiatives are requiring or encouraging employers to set up the option for tax-free health insurance premium deductions for their workers.

States requiring employers to set up Section 125 plans typically assess a fine on employers that do not set up the option. The tax advantage does not entail employer contributions and imposes minimal administrative burdens to the employer. The level of involvement for employers remains small, regardless of whether the employer offers insurance. If paired with a connector model, an employer not offering insurance to its workers could set up a Section 125 plan and allow the workers to pay for premiums tax-free for health insurance offered through the connector instead of the employer.

The CoverTN program in **Tennessee** offers affordable and portable health insurance to employers with 25 or fewer full-time employees that offer the plan to all employees and agree to pay a third of the employee's premium. Participating employers are required to set up Section 125 plans for the employees to have the pretax deduction of insurance premiums.

As part of **Missouri's** Medicaid redesign, Governor Matt Blunt is using the opportunity to reform the health care system and has plans to expand access to affordable and portable coverage. The proposal requires the purchase of insurance premiums with tax-free dollars through the use of Section 125 plans set up by employers.

The Connector Model

A goal of many state reform initiatives is to increase the affordability and the number of insurance products offered through the individual and small group markets, which are often prohibitively expensive. A “connector” or “exchange” model offers health coverage through a quasi-governmental authority or agency that may also negotiate with health insurers to offer a minimum standard of benefits within a certain premium range. A connector may pool individuals together, which spreads the risk of the individuals across a larger group, and as a result, the coverage is more affordable. Another potential approach places most benefit and rate setting authority with the state insurance commission, leaving the connector to solely provide insurance options for employers and individuals.

Most proposed connectors consolidate the small group and individual markets into the pool to make it more sustainable by adding more people and spreading the risk. A number of states have proposed initiating connector models and intend to offer subsidies for low-income individuals to purchase health insurance through the connector. This option gives individuals more choices in their health insurance options. The insurance is also portable, allowing individuals not to be dependent on their employer for the coverage, but rather they can take the insurance with them to another job.

The **Massachusetts** Commonwealth Health Insurance Connector Authority, which offers small businesses and individuals the opportunity to buy affordable health insurance through a large purchasing pool, started selling plans on May 1, 2007. The Connector's board members worked with insurers to create a benefit package and negotiated to reach an agreement on affordable premiums.

In **Minnesota**, the governor's plan creates the Minnesota Health Insurance Exchange, a connector model, to make coverage more affordable and portable. Employers will be able to use the Exchange to give their employees access to health care coverage, and the individual market will be folded into the Exchange. The Exchange will monitor the products being offered and ensure they meet basic requirements. It will also collect premiums and make the premium payments to the plans, reducing the administrative burden for both individuals and employers.

In **Michigan**, uninsured individuals will have access to private sector insurance plans offered by a newly created “Exchange,” which will administer the plan. The Exchange will establish a minimum benefit package with flexibility to be able to offer a range of services at various premium levels.

State-Defined Benefit Packages

Offering a state-defined package of benefits through private insurers can provide affordable and basic health coverage to uninsured individuals. In this model, states negotiate benefit packages and premiums with insurers, generally providing access to primary care health services, such as routine physicals and preventive care, as well as emergent and hospital care.

The standard benefit packages offered in this model usually incorporate existing state benefits—and negotiations with private insurers vary significantly from state to state, depending on the insurance market. However, the benefits are likely to include low cost-sharing preventive care, urgent inpatient care, laboratory services, and prescriptions at reasonable rates. There are likely to be higher fees for using the emergency room in non-emergent cases to encourage individuals to use emergency services appropriately.

By negotiating with private insurers, the state is not responsible for providing the insurance, yet individuals receive basic coverage at a reasonable rate through private insurance. In addition, the insurers have flexibility to vary the services and cost-sharing offered to provide various options of benefit packages, as long as the basic services are covered.

In **Vermont**, individuals without access to an employer-sponsored insurance plan will be offered the Catamount Health plan, which is provided by private insurers and must offer a standard set of benefits defined by the state. Premiums range from \$60 per month for individuals with household income of less than 200 percent of poverty to \$135 per month for individuals with household income between 275 and 300 percent of poverty.

Connecticut Governor M. Jodi Rell has introduced the Charter Oak Health Plan, which will create a private-public partnership offering a state-defined benefit package through private insurers. The plan will be available to adults who do not have insurance through their workplace. Issue of a Charter Oak policy is guaranteed, and there are premium subsidies available on a sliding scale for lower income individuals. The proposed plan includes reduced fees for preventive care and the assignment to a primary care physician. The target monthly cost for an unsubsidized member is \$250, plus copayments and deductibles. It will be offered by insurers willing to participate in the plan, and the state will help connect people with the participating insurers.

IMPROVING THE HEALTH CARE SYSTEM

Although the majority of attention paid to state-led health care reform initiatives has been centered on coverage efforts, most proposals include major components targeted at improving the quality of the health care system as well as the overall health of the population. Quality improvement and measurement seek to ensure that efficient and safe care is being provided—and that data regarding physician and hospital quality is available to the public so individuals can make more informed health decisions based on provider performance or therapeutic efficacy. Health information technology also plays a large role in many states' efforts to improve the quality of care delivered.

Additionally, ensuring that public health measures are incorporated into health reform plans allows for more efficient and effective care. Adding preventive measures and treating preventable chronic diseases reduces the costs of treating chronic diseases that are not discovered until the disease has progressed and the costs are expensive. The rationale for addressing simultaneous goals of coverage and care improvement is to ensure full value in the system and contain costs within the coverage expansions. If coverage expansions do not provide individuals with access to high quality and efficient care, the value of coverage is diminished and the cost of expansions could become unsustainable.

Quality Improvement and Measurement

Using coverage expansion and Medicaid redesign as vehicles, many states have incorporated quality improvement and measurement into their reform plans to improve efficiency and patient care. States are using quality standard measures to evaluate the standards of care providers are delivering. These measurements are reviewed by the state and released to the public to allow individuals to view their providers' outcomes and make decisions based on the quality of care being provided.

States are also using pay-for-performance measures to increase quality of care, which provides incentives to providers to offer care according to established quality standards in exchange for a higher reimbursement rate. Several states are also taking steps toward interoperability with electronic data systems by developing a system for electronic data exchange, including electronic health records. Health information technology advancements help to eliminate duplicative care, reduce medical errors, and increase efficiency with the exchange of real time medical data.

Minnesota has created QCare (Quality Care and Rewarding Excellence)—a quality standard that will be used to reward top performing providers. QCare was developed by a coalition of public and private sector partners involved in the purchase and delivery of health care services. QCare will initially set standards for quality of care in four areas where many of Minnesota’s health care dollars are spent: diabetes, hospital stays, preventive care for adults and children, and cardiac care. The Minnesota Department of Health estimates that if QCare standards are met, more than \$153 million in health care costs will be saved annually.

North Carolina’s Medicaid Community Care is a managed care program that emphasizes quality improvement by adopting standards determined by an advisory group, including asthma and diabetes care. The governor is proposing to expand the Community Care program to include private insurers and the state employee health plan that will measure quality improvement across five diseases by examining claims data and chart audits.

To improve the quality of health care in **Pennsylvania**, Prescription for Pennsylvania will focus on improving patient safety by eliminating hospital-acquired infections and targeting avoidable medical errors. Pennsylvania will also promote the use of a successful, nationally proven model that manages treatment for chronic conditions such as heart and lung disease, diabetes, and asthma. The plan also updates hospital regulations to require state-of-the-art patient safety and electronic health records.

Washington Governor Chris Gregoire has focused on building a high-performing health care system. Her legislation, signed in May 2007, takes a comprehensive approach to quality. It creates the Washington Quality Forum to address disparities in care based on the location care is received; expands chronic care management in all state health programs; and directs state health agencies to change state contracts and reimbursement to pay-for-performance and promote prevention. The plan also implements health records banks to enhance health information technology systems statewide and pilots an “informed patient decision” model to give patients more information about treatment options. Washington has implemented a statewide Technology Assessment Program that uses scientific evidence and clinical expertise to guide coverage decisions about new and emerging technologies.

Prevention and Wellness Benefits

In order to address the needed improvement of the health care system through more efficient and effective care, many states are incorporating prevention and wellness benefits into their reform plans. Several reform proposals require that the basic state-defined benefit package include certain preventive benefits to promote healthier living. These benefits typically include routine physicals, screenings for preventable chronic diseases, such as diabetes and heart disease, along with early screenings for such illnesses as breast and cervical cancers. Many states are allowing no or low-cost preventive care visits before the plan’s deductible is met to encourage individuals to seek preventive care.

Health promotion benefits are also being included in many state reform plans, state employee health insurance plans, Medicaid redesigns, and small group and individual markets. It is common for states to incorporate weight loss and smoking cessation programs into their initiatives because preventing obesity and lung cancer, along with several other smoking-related illnesses, can significantly contain costs for the state. Many state reform plans are using these wellness benefits as incentives for lower cost insurance or requirements for participation in state-defined plans. As states are attempting to expand coverage and improve the quality of care in the health system, they are also looking to individuals to increase their responsibility for their own health.

The **Rhode Island** Office of the Health Insurance Commissioner created a “wellness health benefit plan” that insurers are required to offer to employers with fewer than 50 workers and individuals purchasing health plans. The insurers are required to offer a plan that is aimed at improving the health of its members by focusing on five wellness initiatives, including selecting a primary care physician and completing a health assessment. It also requires

participation in a wellness program and tiered physician networks. The plan is expected to lower costs based on prevention incentives offered to enrollees.

In **California**, the governor's proposal encourages health lifestyles and behaviors. Rewards will be available in the Medi-Cal, Healthy Families, and CalPERS (the public employees program) for practicing healthy behaviors. In addition, the governor's plan supports quality measurement and uniform interoperability standards and the adoption of health information technology.

Nebraska has established a steering committee and an advisory committee to improve the health of the state's employees. The program made a health appraisal survey available to state employees and is addressing the need for improved physical activity, nutrition, and smoking cessation. The program has also requested proposals from organizations to offer tobacco cessation classes under contract for state employees.

CONCLUSION

The continually rising cost of health care and growing number of uninsured individuals in the United States has increased momentum for state reform to contain costs and increase coverage for the uninsured. To improve the health care system and contain costs, governors are proposing and implementing ambitious health reform initiatives. Governors are approaching health reform broadly and are seeking to increase access to coverage, as well as improve cost-containment efforts through quality improvement and incorporating prevention and wellness benefits into their health reform plans. Through the many innovative strategies to improve health outcomes, governors are aiming high to reform the health care system in their states.

Appendix: Snapshot of State Health Reform Initiatives

IMPLEMENTED STATE HEALTH REFORMS

Arkansas

Arkansas created the ARHealthNet plan for small businesses to offer their employees access to health care coverage. In order to participate in the program, employers with two to 500 employees cannot have offered group health insurance for the past 12 months and must guarantee 100 percent employee participation, unless an employee has other medical coverage. All employees of qualifying small businesses are eligible for coverage, regardless of health status. Subsidized premiums are available for workers with incomes below 200 percent of poverty. There is a \$100 deductible (not applicable to office visits and prescriptions), 15 percent coinsurance on most covered services, and a \$1,000 annual out-of-pocket limit. The program is funded by the state's tobacco settlement funds, Medicaid dollars, and employer contributions.

Illinois

The All Kids program offers affordable health insurance to all children in the state. Because the program is an extension of the existing Medicaid and SCHIP combination program, the All Kids program offers the Medicaid benefit package. The program offers subsidized premiums on a sliding scale with the maximum premium at \$300 per month per child. Cost-sharing amounts are also based on a sliding scale, with the exception of preventive care, for which there are no copayments. In order to qualify, individuals must have been without health insurance for 12 months.

Kansas

The Small Employer Health Insurance credit offers small businesses a tax credit for offering and contributing to health savings accounts for their employees. The Small Employer Health Insurance credit is available to businesses with fewer than 50 employees that have not contributed to their employees' health insurance over the past two years. The enhanced credit for newly contributing employers is \$70 per member per month in the first year, phasing down to \$35 per member per month in the third year, and ending after the third year.

Maine

Dirigo Health Reform is a comprehensive package of initiatives aimed at achieving universal access to coverage within five years of implementation. It includes efforts aimed at cost-containment and improving health care quality. The Dirigo Choice plan, which began providing coverage January 1, 2005, is a health care plan in which the state contracts with a private insurer to offer coverage to small businesses, self-employed and uninsured individuals.

The plan requires participating employers to cover at least 60 percent of the employee's cost plus a maximum \$300 fee for the Dirigo program. Enrollees with incomes below 300 percent of poverty pay subsidized premiums and cost-sharing on a sliding scale. Also under Dirigo Health, MaineCare (Medicaid) expanded eligibility for parents with incomes up to 200 percent of poverty.

Dirigo Health created the Maine Quality Forum to improve the quality of health care in the state, as well as inform consumers on available quality health care data. The Forum serves as a clearinghouse for information on health care and quality for providers and consumers.

Montana

Under the Insure Montana initiative, tax credits and subsidies are available for both employees and employers of small businesses to make health coverage more affordable. A tax credit is available for small businesses with fewer

than 10 employees who currently offer and contribute toward their employees' health insurance costs. On average, participating small businesses receive a credit of up to \$100 per month per employee.

In addition, subsidies are available to workers in small businesses with fewer than 10 employees not providing health insurance. Coverage is available through the state's purchasing pool, for which employers pay 50 percent of the employee's premium. Some of that premium is returned through an employer incentive payment from the state. Employees receive premium assistance from the state, in addition to the amount that the employer contributes, to ensure the premiums are affordable.

New Mexico

New Mexico developed the State Coverage Insurance program (NMSCI) in 2005, an employer-sponsored program that provides health insurance through a public-private partnership with federal, state and private dollars. Uninsured adults 19 to 65 years of age with family incomes up to 200 percent of poverty can participate. The program offers employers and the self-employed a state-designed health insurance plan. Employers are expected to contribute \$75 per employee per month, and employees pay premiums up to \$35 per month and copayments based on a sliding scale. There is an annual benefit package limit of \$100,000, and out-of-pocket spending is limited to 5 percent of family income. During the 2007 legislative session, Governor Richardson successfully expanded Medicaid coverage for approximately 18,000 more adults up to 100 percent of poverty through the NMSCI program. This expansion will be available during the summer of 2007.

In addition, New Mexico has taken additional incremental steps to expand access to health insurance for uninsured individuals, including requiring insurers to offer health insurance plans for part-time employees when their employers choose to offer coverage. The state has also created premium assistance programs for children and pregnant women who do not qualify for Medicaid but cannot afford or do not have access to health insurance. New Mexico has expanded eligibility for pregnant women to those with incomes up to 235 percent of poverty.

New York

The Healthy NY program, which offers affordable health insurance options to small employers, has been in operation since 2000. The Healthy NY program offers state-defined benefit packages to businesses with 50 or fewer employees. The costs of the health plans are subsidized by the state to ensure affordability. Employers must have a 50 percent participation rate in the program and must contribute at least 50 percent of the employee's premium. The Healthy NY plans are offered by any of the HMOs in the state.

Oklahoma

The Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC) program was created to assist small businesses in offering their employees health insurance. Participating employers with 250 or fewer employees must contribute 25 percent of the employee's premium and must offer a qualified O-EPIC plan. The state funds 60 percent of the insurance costs, and the employee pays the remaining 15 percent. Participating employees have incomes below 250 percent of poverty. Qualifying O-EPIC plans are required to cover state-defined basic benefits and have maximum out-of-pocket spending limits.

Pennsylvania

The Cover All Kids program is available to all children in the state. For children in families with incomes below 200 percent of poverty, there is no cost for the program. For those families with incomes below 300 percent of poverty, there are sliding scale premium subsidies available ranging from \$36 per month per child to \$57 per month per child. Families with incomes that exceed 300 percent of poverty and cannot find or afford private health insurance for their children can buy into the Cover All Kids program.

If parents have access to employer-sponsored coverage for their children but cannot afford it, the state will offer premium assistance, rather than enrolling the child in the Pennsylvania's SCHIP program. To discourage parents from canceling private coverage to take advantage of the state subsidy, families cannot have had coverage for the last six months, unless the child is two years of age or less.

Utah

Utah's Premium Partnership for Health Insurance (UPP) program is designed to help residents pay for employer-based health insurance that would otherwise be too costly. UPP is available to employees with low-incomes who are eligible for their employer's plan but do not currently have health insurance. Eligible individuals can receive up to \$150 for their monthly premium and up to \$100 per month for each child. Enrolled children also have options for dental coverage. Utah law requires employers to pay half of their employees' premiums.

West Virginia

Governor Joe Manchin, III has expanded access to affordable health care through an expansion of the SCHIP program. The state expanded eligibility from 200 percent to 220 percent of poverty in the program and has plans to expand the program incrementally up to 300 percent of poverty. In addition, the state created four pilot programs around the state that offer primary and preventive care. The programs offer prepaid premiums of less than \$100 per person per month for primary and preventive care, including doctor visits, laboratory work, and radiology.

STATE HEALTH REFORMS BEING IMPLEMENTED

Indiana

Governor Mitch Daniels has signed into law a series of health reforms to improve access and quality of care in the state. Indiana has created a health insurance plan for adults and pregnant women with incomes below 200 percent of poverty. Under the Healthy Indiana plan, participating individuals will have a Personal Wellness Responsibility (POWER) Account, which acts as an HSA, with \$1,100 to cover the deductible. A private health insurance plan approved by the state is available to individuals after they have met the deductible and includes services, such as preventive care and disease management. The plan also includes \$500 for preventive care, such as physicals, screenings, chronic disease management, and smoking cessation. In addition, the plan, which passed with overwhelming bipartisan support, includes a 44-cent increase on cigarettes that is estimated to discourage 40,000 fewer youth smokers and 23,400 fewer adult smokers. As a result, an extra \$11 million will go toward childhood immunizations.

In addition, the governor's health care initiative includes increasing eligibility in the SCHIP program to 300 percent of poverty and providing presumptive eligibility for pregnant women. The plan also uses incentives for employers by providing a small business qualified wellness program tax credit (50 percent of creating a qualified plan) and a tax credit for small businesses for the cost of setting up a Section 125 plan (\$50 per employee). The law also gives the Family and Social Services Administration Secretary the authority to develop a program that allows small businesses to purchase group health insurance together.

Kansas

Governor Kathleen Sebelius has created a short-term initiative to address the issue of the uninsured in the state while a more comprehensive approach is being developed. The plan provides low-income uninsured families with incomes below 100 percent of poverty with assistance in purchasing private health insurance. The initiative also includes funding to small businesses to encourage them to group together to buy more affordable coverage.

Massachusetts

Massachusetts is implementing a proposal to insure every resident of the state. The plan includes an individual mandate requiring all residents to have health insurance by July 1, 2007. Employers with more than 10 employees must offer insurance or pay a portion of their employees' health insurance premiums and must also offer their employees the ability to buy health insurance using Section 125 tax-free deductions of premiums.

The plan created the Massachusetts Commonwealth Health Insurance Connector Authority, which offers small businesses and individuals the opportunity to buy affordable health insurance through a large purchasing pool. In addition, the state has created the Commonwealth Care Health Insurance Program, which offers sliding-scale subsidies for individuals with incomes up to 300 percent of poverty to buy health insurance. Massachusetts also increased the eligibility levels for the SCHIP program to 300 percent of poverty.

The Massachusetts plan will use funding from the existing uncompensated care pool, Medicaid funds, general state revenues, and employer contributions. Massachusetts has \$385 million in federal Medicaid DSH funds that needed to be used for uncompensated care. The DSH money was used to create the plans offered through Commonwealth Care program.

Minnesota

Governor Tim Pawlenty has created plans to improve health care quality and control cost through a system that pays for better performance and outcomes. The plan includes the creation of QCare (Quality Care and Rewarding Excellence)—a quality standard that will be used to reward top performing providers. QCare was developed by a coalition of public and private sector partners involved in the purchase and delivery of health care services. The Minnesota Department of Health estimates that if QCare standards are met, more than \$153 million in health care costs will be saved annually.

QCare will initially set standards for quality of care in four areas where many of Minnesota's health care dollars are spent: diabetes, hospital stays, preventive care for adults and children, and cardiac care. In each of the designated health care areas, quality will be measured, reported, and rewarded when a recognized standard for care has been identified, measured, and targeted for improvement. All measures will be publicly reported. Payments to providers and benefit packages will then be aligned to quality measures, providing an incentive to increase quality and performance. The State of Minnesota will apply QCare to all state-purchased health care.

Puerto Rico

Governor Aníbal Acevedo Vilá's health care initiatives include restructuring the Commonwealth's Substance Abuse and Mental Health Administration, in order to improve the quality and access to these services for the population, in particular Medicaid recipients. In addition, the Commonwealth is investing \$90 million on improving the State's Medical Center to provide quality care in state-of-the-art facilities.

Rhode Island

The Rhode Island Office of the Health Insurance Commissioner created a "wellness health benefit plan" that insurers are required to offer to employers with fewer than 50 workers purchasing health plans. The insurers will be required to offer a plan that is aimed at improving the health of its members by focusing on five wellness initiatives, including selecting a primary care physician and completing a health assessment. In addition, enrollees must pledge to maintain a healthy weight or participate in a weight management program, remain smoke-free or participate in a smoking cessation program, and participate in disease and case management programs, if necessary. It also requires participation in a wellness program and tiered physician networks.

The plan is expected to lower costs based on prevention incentives offered to enrollees. There are Basic and Advantage plans with different cost-sharing tiers, but the premiums for each plan will be the same. The average premium cannot exceed 10 percent of average wages in the state, and in 2007, will be \$309 or \$322 per month per individual, depending on the insurer. The wellness health benefit plan will be available in October 2007.

Tennessee

Governor Phil Bredesen has created a program with several components to address the issue of the uninsured in the state. The three insurance aspects of the CoverTennessee program offer comprehensive coverage to different populations.

First, the CoverKids program is the new SCHIP program in the state. It offers comprehensive health insurance modeled after the state employee health plan and is offered to all uninsured children. Children below 250 percent of poverty pay no premiums and small copayments, and those above 250 percent can buy into the program. The program emphasizes prevention and wellness with a focus on well-child visits and immunizations. More than 1,600 children are enrolled in the CoverKids program.

Second, the CoverTN program, the centerpiece of the governor's health care plan, offers affordable and portable health insurance to small businesses and their employees. CoverTN is available to employers with 25 or fewer full-time employees that offer the plan to all employees and agree to pay a third of the employee's premium. Employers may set up Section 125 plans for the employees to have the pretax deduction of insurance premiums. The coverage offered through CoverTN is defined by the state and administered by private insurers. The employee pays a third of the premium and the state subsidizes the remaining third of the premium. The plan offers basic benefits and has no deductible and small copayments. More than 12,000 businesses have pre-qualified, and more than 3,500 individuals are enrolled.

Third, the AccessTN program is a high-risk pool for adults with serious illnesses who can afford coverage but have been turned down by insurance companies. The benefits in the AccessTN plan are modeled after the state employee health plan. The premiums are capped at 1.5 to 2 times the standard market rates and subsidies are available for low-income individuals. More than 1,600 individuals are enrolled in the program.

CoverRx is a statewide pharmacy assistance program designed to assist those who have no pharmacy coverage, but have a critical need for medication. CoverRx is not health insurance. It provides up to five prescriptions per month (insulin and diabetic supplies will not count against the monthly limit). More than 22,000 individuals are enrolled in the program.

Utah

Governor Jon Huntsman has created an initiative to make health insurance more affordable by lifting the cap placed on SCHIP enrollment due to budgetary constraints. In addition, the state is creating the Utah Health Insurance Exchange, which will offer affordable and portable health insurance to residents of the state. Paired with the Exchange, the governor's plan utilizes Section 125 plans. The design allows businesses to be able to offer insurance to their workers through the Exchange and to pay for the premiums tax-free.

Vermont

Governor Jim Douglas created a program that extends affordable insurance coverage while reducing health care costs through several quality improvement initiatives. Individuals without access to an employer-sponsored insurance plan will be offered a Catamount Health plan, which is provided by private insurers and must offer a standard set of benefits defined by the state. Premiums will range from \$60 per month for individuals with household income below

200 percent of poverty to \$135 per month for individuals with household incomes between 275 and 300 percent of poverty.

In addition, employers are required to pay \$365 annually for each full-time employee if the employer does not offer insurance, only offers insurance to some workers, or some employees remain uninsured. This requirement is applicable to all employers with nine or more employees in 2007 and increasing to employers with five or more employees starting in 2010.

Low-income, uninsured Vermonters with access to an employer-sponsored insurance plan will be offered premium assistance. Vermonters eligible for the state's Medicaid program with access to approved employer-sponsored insurance also will be offered premium assistance to participate in employer-sponsored insurance.

A chronic care management system will be created to manage the chronic conditions of individuals enrolled in Medicaid and the State Children's Health Insurance Program, Dr. Dynasaur. The law also proposes steps to control costs and cost shifts within the health care system by promoting healthy behaviors through a grant program to fund community health and wellness programs. In addition, the state will adopt rules to permit health insurance companies to offer premium discounts or other incentives—known as a Healthy Choices Discount—to people who participate in health promotion or disease prevention programs such as smoking cessation.

Washington

Governor Chris Gregoire has created a health care reform plan to improve access and quality in health care in the state. The children's initiative includes the goal of extending access to health insurance coverage to all children by 2010, creating performance measures to ensure the delivery of high quality care, and setting wellness goals for children.

The "Healthy Washington Initiative" adopts many of the recommendations from the Blue Ribbon Commission on Health Care Costs and Access. Legislation, signed in May 2007, creates the Washington Quality Forum to address disparities in care based on the location care is received; expands chronic care management in all state health programs; and directs state health agencies to change state contracts and reimbursement to pay-for-performance and promote prevention. The plan also implements health records banks to enhance health information technology systems statewide and pilots an "informed patient decision" model to give patients more information about treatment options. Washington has implemented a statewide Technology Assessment Program that uses scientific evidence and clinical expertise to guide coverage decisions about new and emerging technologies. The initiative also improves the state's existing high risk pool and will evaluate methods for reinsurance in order to make health insurance more affordable.

The Health Care Authority is responsible for implementing a connector, called the Health Insurance Partnership, to make insurance more affordable and portable for small businesses. The Partnership will offer low-income workers subsidized premiums to be able to purchase an affordable plan beginning in September 2008.

Wyoming

Governor Dave Freudenthal is expanding access to affordable coverage by increasing funding for the State Health Insurance Pool, the high-risk pool. The additional funding allows for two eligibility categories within the pool. Individuals with incomes below 250 percent of poverty will pay a lower premium than those with higher incomes.

PROPOSED STATE HEALTH REFORMS

Arizona

Governor Janet Napolitano is planning to expand access to children's health insurance. The plan expands eligibility for the Arizona SCHIP program, KidsCare, for children up to 300 percent of poverty. The program will also increase its outreach efforts to enroll more eligible children.

Governor Napolitano is also moving forward with the implementation of a web-based health information exchange system that will allow Medicaid providers to have real time patient data, which will result in fewer medical errors, reduced repeat procedures, better coordination of care, and increased use of preventive services. The electronic data will include patient demographics and eligibility information, patient problem lists, medications, lab orders/results, radiological results and images, inpatient discharge summaries, and clinic notes. This system will contain costs within the Medicaid system.

California

Governor Arnold Schwarzenegger has proposed a comprehensive, universal health care plan that addresses health coverage, quality of care delivered, and wellness and prevention. The plan includes an individual mandate to require all residents of the state to have health insurance. Enforcement of the individual mandate will be monitored through state income tax filings.

The governor's plan includes a 4 percent payroll assessment for employers with 10 or more employees that do not offer insurance to their employees. In addition, employers must establish Section 125 plans to give their employees the option of pretax deductions of their health insurance premiums.

All children under 300 percent of poverty, regardless of residency status, will have access to either Medi-Cal or the Healthy Families program. Adults with incomes below 100 percent of poverty will be eligible for Medi-Cal coverage.

The plan proposes using a connector to provide affordable private health insurance to uninsured individuals and small businesses. Adults with incomes between 100 and 250 percent of poverty will have their premiums subsidized to be able to buy insurance through the connector. Working insured individuals with incomes between 100 and 250 percent of poverty are eligible for premium subsidies to assist with the purchase of insurance through the connector if the employer contributes to the employee's premium.

The initiative also requires providers to pay an assessment to ensure the money stays within the system and supports the coverage expansions. Physicians will be required to pay 2 percent of revenue, while hospitals will contribute 4 percent of revenue.

The governor's proposal also encourages health lifestyles and behaviors. Rewards will be available in the Medi-Cal, Healthy Families, and CalPERS programs for practicing healthy behaviors. In addition, the governor's plan supports quality measurement and uniform interoperability standards and the adoption of health information technology.

Connecticut

Governor M. Jodi Rell has introduced a health care plan to provide access to care for all residents of Connecticut. The Charter Oak Health Plan will create a private-public partnership offering a state-defined benefit package through private insurers. The proposed plan will be available to adults who do not have insurance through their workplace. There will be guaranteed issue for the health plan, and premium subsidies will be made available on a sliding scale

for lower income individuals. The proposed plan includes reduced fees for preventive care and the assignment to a primary care physician. The target monthly cost for an unsubsidized member is \$250, plus copayments and deductibles. The plan will be offered by insurers willing to participate in the plan, and the state will help connect people with the participating insurers. Governor Rell's proposal also includes premium assistance for Medicaid patients who already have coverage through an employer. This assistance would wrap around benefits to provide services that are not offered by the employer plan.

In addition, the governor's HUSKY Health 2007 initiative targets children who are eligible but not enrolled in the HUSKY program. It waives the premium for the first two months following birth of an eligible child, eliminating any possible reason for not enrolling a newborn. The new initiative also focuses on health coverage for school-aged children. The governor is proposing to require health insurance status notification at the beginning of every school year and providing referrals to the HUSKY Plan for uninsured children.

Delaware

In her FY2008 budget proposal, Governor Ruth Ann Minner has proposed to expand the Delaware Healthy Children Program to cover certain parents of enrolled children with incomes up to 120% FPL. The proposed budget also includes preliminary funding to provide coverage for the uninsured and funding to establish electronic data sharing among providers through the Delaware Health Information Network (DHIN). Governor Minner is also supporting legislation to create transparency in health care cost and quality data.

In addition, Governor Minner continues to champion her already successful disease and population-specific programs. These initiatives, designed to cover gaps in access and outcomes in the current health care system, include payment for cancer treatment for the uninsured, state employee wellness programs and incentives, funding for programs to improve prenatal care and reduce infant mortality, and support for programs to improve racial and ethnic health disparities.

Florida

Governor Charlie Crist has proposed to reverse some administrative and policy barriers that limited enrollment periods, tightened eligibility standards, increased documentation requirements, and created a complex administrative process that contributed to declining enrollment in the Kidcare program. The governor is supporting improvements in the structure and administration of the Kidcare program to provide health care benefits to more children.

The state is proposing to consolidate the fragmented Kidcare program under the Agency for Health Care Administration to create a more efficient and effective program, which, in combination with a better outreach and eligibility determination process, will result in more insured children. Other features of the proposed system include a simplified and uniform eligibility determination process, uniform benefits and standards between Medicaid and SCHIP, presumptive eligibility, no caps on private full pay participants, and a seamless transition between Medicaid and SCHIP funding.

Illinois

Governor Rod Blagojevich created the Illinois Covered program to offer access to affordable, quality health care to all the state's residents. The plan includes the Illinois Covered Choices program, which is available to individuals without access to group coverage, regardless of health status. The program will also offer coverage to businesses with 25 or fewer employees who agree to contribute 70 percent of the employee's premium. The program proposes to offer access to private insurance options with a standard benefit package.

The Illinois Covered Rebate program will provide individuals assistance in purchasing coverage through Illinois Covered Choice or buying employer-sponsored insurance. The rebate program will offer premium assistance to families with incomes up to 400 percent of poverty.

The Illinois Covered Assist program offers affordable coverage to childless adults below 100 percent of poverty through a state-provided program. If those individuals have access to employer-based insurance, the state will pay the premium.

The plan also proposes to expand eligibility in the FamilyCare program up to 400 percent of poverty to provide low-income working, uninsured parents with health insurance.

The proposal will create the Roadmap to Health, which will work to improve the health care system by promoting wellness, managing chronic conditions, improving patient safety, promoting electronic health records, improving access to information on quality of care and reducing administrative costs.

Louisiana

Louisiana created the Louisiana Health Care Redesign Collaborative following the devastation to New Orleans and other parts of Louisiana caused by Hurricane Katrina. The idea is to redesign and rebuild the health care system in a way that is driven by quality and incorporates evidence-based and accepted standards of care.

The proposed redesigned health system is based on a medical home model in which individuals are assigned a primary care provider who facilitates their care. The model emphasizes community-based and preventive care, and the need for specialty and other more complex health needs are managed by the medical home.

The Collaborative has proposed the creation of the Louisiana Health Care Quality Forum (LHCQF) to ensure quality improvement and performance measurement are incorporated across the health care system. Health care providers will be expected to report on quality performance measures to participate in the medical home network.

In addition, the Louisiana Healthcare Redesign Collaborative has proposed to increase the use of health information exchange by developing an interoperable health exchange system that incorporates electronic health records to facilitate communication between providers and patients.

Maine

Governor John Baldacci has proposed a plan to further the Dirigo Health Reform efforts. The governor has proposed to make the Dirigo Health Plan a self-insured plan that will be more affordable for small businesses and uninsured individuals. As affordability of coverage is addressed, the reforms will include employer requirements to encourage employers to contribute toward their employees' health insurance. The plan also proposes an individual mandate to require all individuals to have health coverage.

Market reforms in the proposal include a plan for reinsurance, new insurance rate regulations, and requirements for insurers to offer discounts to non-smokers and wellness programs in the workplace. The controversial savings offset payment, which has been challenged in court, will be revised to become an assessment on hospital claims paid by all payers in Maine and based on the amount of uncompensated care that was avoided by DirigoChoice enrollment in the preceding year. There will also be new cost-containment measures for MaineCare and efforts will be made to improve case management services in the program.

Michigan

Governor Jennifer Granholm has proposed the Michigan First Healthcare Plan, which will provide universal access to affordable health insurance for Michigan citizens. The plan will extend affordable health care to Michigan citizens by creating an affordable private market health insurance product for individuals and businesses; subsidizing care for those who can least afford it; creating incentives for businesses to offer coverage to their employees; and reducing the overall cost of health care delivery by expanding technology and promoting healthy lifestyles. Uninsured individuals will have access to private sector insurance plans offered by a newly created “Exchange,” which will administer the plan. The Exchange will establish a minimum benefit package with flexibility to be able to offer a range of services at various premium levels.

To implement the plan, the state will apply for a Medicaid waiver to provide the state with the flexibility necessary to provide premium assistance for private health insurance products for uninsured individuals who do not currently have access to affordable health care coverage.

Minnesota

Governor Tim Pawlenty has proposed “Healthy Connections,” a health reform plan to increase access to affordable insurance and enhance the quality and value of care. The plan proposes to modernize the MinnesotaCare (MNCare) program by reducing the premiums for children by a third, expanding eligibility to 300 percent of poverty for children, and increasing subsidies in private coverage rather than the state-provided MNCare program for children above 200 percent of poverty. For this option, a standard benefit package, called MNCare II, will be developed by the state and offered in the private market to ensure basic services are covered and coverage is affordable. The governor’s plan requires insurers with more than 3 percent of individual market to offer the MNCare II. Insurers can modify the benefit in order to make it attractive to parents of children who may be enrolled.

The governor’s plan creates the Minnesota Health Insurance Exchange, a connector model, to make coverage more affordable and portable. Employers will be able to use the Exchange to give their employees access to health care coverage, and the individual market will be folded into the Exchange. The Exchange will monitor the products being offered and ensure they meet basic requirements. It will also collect premiums and make the premium payments to the plans, reducing the administrative burden for both individuals and employers.

Employers with more than 10 employees will be responsible for establishing a Section 125 plan to ensure their employees can make tax-free deductions of their insurance premiums from their paychecks.

To build on Minnesota’s current quality of care programs, the governor proposes to continue to invest in interoperable health systems and to provide transparency of quality and cost data in order for consumers to make informed decisions about their health care.

Missouri

Because Missouri’s Medicaid program is sun-setting in 2008, Governor Matt Blunt is in a unique position to reform the Medicaid program and address the issue of the uninsured simultaneously. The proposed redesigned Medicaid program, called MO HealthNet, focuses on prevention and wellness. MO HealthNet participants will be assigned to a health care home and will undergo a health care assessment to determine any chronic conditions that require management. In addition, the new Medicaid program stresses the importance of electronic health information technology. A health care home coordinator is responsible for monitoring the patients’ conditions and sharing information electronically with the participant.

The governor's plan to expand coverage to the uninsured also stresses the importance of prevention, wellness, and consumer engagement. The proposal requires the purchase of insurance premiums with tax-free dollars through the use of Section 125 plans set up by employers. The plan also allows for portability of health insurance to allow workers to stay insured when changing jobs. The proposal aims to increase enrollment in the state's high-risk pool by easing enrollment requirements for the program.

Nebraska

Due to increasing costs of the state employee health insurance and increased expenditures for medications treating hypertension, diabetes, high cholesterol and depression, Governor Dave Heineman has established steering and advisory committees to address the wellness of its state employees. The program made a health appraisal survey available to state employees and is addressing the need for improved physical activity, nutrition, and smoking cessation. The program has requested proposals from organizations to offer tobacco cessation classes under contract for state employees. The state is also providing literature outlining the variety of services offered by the Tobacco Free Nebraska program to all state employees. In addition, a website is being developed to provide health supports and a source for sound medical information for employees.

New Hampshire

Governor John Lynch has proposed that all providers have e-prescribing capabilities by 2008. Through the New Hampshire Citizens Health Initiative, the plan calls for all primary care providers to have access to e-prescribing technology by October 2007 and all providers have the capability by October 2008. The state is considering pay-for-performance measures, including using e-prescribing as one measure.

In addition, the state has established a committee to develop a wellness program for state employees and retirees. The committee will create measurements of evaluating the effectiveness of the wellness programs and ways to encourage employees to live healthier lives.

New York

In his fiscal year 2007-2008 budget proposal, Governor Eliot Spitzer proposed to expand the Child Health Plus program to families with incomes up to 400 percent of poverty and streamline the enrollment process for the program. The budget proposal is the first step in reforming the health care system in the state.

North Carolina

Through a proposed Medicaid waiver, Governor Michael Easley is planning to expand eligibility from 200 percent to 300 percent of poverty for the state's Health Choice for Children program. The state is also proposing to expand Medicaid eligibility for foster children from 18 to 21 years of age.

In addition, North Carolina's Medicaid Community Care is a managed care program that emphasizes quality improvement by adopting quality standards determined by an advisory group, including asthma and diabetes care. The governor is proposing to expand the Community Care program to include private insurers and the state employee health plan that will measure quality improvement across five diseases by examining claims data and chart audits.

Ohio

Governor Ted Strickland is proposing various health care proposals to expand coverage and improve the health of Ohioans. The proposals include increasing Medicaid eligibility for parents from 90 percent to 100 percent of poverty and increasing SCHIP eligibility from children from families with incomes from 200 percent to 300 percent of poverty. The plan also includes the Premium Participation Program, which offers a buy-in to the Medicaid program for those children whose family incomes do not qualify them for SCHIP. The state will offer assistance with the

premium for lower income families. In addition, adults ages 19 to 22 who do not have access to health insurance will have the opportunity to buy in to the program.

The governor's plan also includes an exchange for access to affordable health insurance plans for individuals and small businesses that do not have or offer health coverage. Subsidies will be available to help pay for the coverage purchased through the exchange for those with incomes below 150 percent of poverty.

The proposal is also emphasizing prevention and wellness benefits by creating the Healthy Ohio initiative, which would increase efficiency among Ohio's prevention programs, use evidence-based medicine in programs, and incorporate pay-for-performance measures to hold providers accountable for the services they provide.

Pennsylvania

Governor Edward Rendell proposed "Prescription for Pennsylvania" to increase access to affordable health care coverage for all Pennsylvanians. The proposal calls for the creation of Cover All Pennsylvanians (CAP), a program offering affordable basic health coverage to small businesses and the uninsured through the private insurance market. Businesses with fewer than 50 employees who agree to pay approximately \$130 per month per employee are eligible for the CAP program. The employees will pay premiums on a sliding scale ranging from \$10 to \$70.

Individuals are also eligible to purchase affordable health insurance through CAP. Uninsured adults with incomes below 300 percent of poverty are eligible for premium subsidies. Uninsured adult with income greater than 300 percent of poverty can participate in CAP by paying the full cost of the premium, which will be approximately \$280 per month.

The state will collect an assessment on companies that do not offer insurance to their employees. In the first year of the assessment, employers with fewer than 50 employees would be exempt. The proposal also includes significant reforms to the small group insurance market to make it easier and more affordable to buy insurance through the market.

To improve the quality of health care, the Prescription for Pennsylvania will focus on improving patient safety by eliminating hospital-acquired infections and targeting avoidable medical errors. Pennsylvania will also use disease management programs to manage chronic conditions and pay-for-performance measures to reward quality care. The plan also updates hospital regulations to require state-of-the-art patient safety and electronic health records.

Prescription for Pennsylvania also includes various wellness initiatives and increased access to primary health care through more available providers.

Puerto Rico

Governor Aníbal Acevedo Vilá is considering various health care reforms to improve the care provided in the state. Specifically, Puerto Rico's Department of Health is currently working on the development of Centers for Health Promotion and Prevention. In these centers, individuals will receive assistance, information and workshops to promote healthy lifestyles. The centers will also provide services from various federal and state programs, such as Medicaid and WIC. In addition, the Commonwealth is considering the establishment of a Regulatory Board that can determine the rates to be paid to insurance companies for a state-defined benefit package.

South Carolina

Governor Mark Sanford is proposing health reform activities to encourage greater use of the private marketplace to provide more affordable access to health insurance. The governor is planning to establish a separate, standalone

SCHIP program that has a benefit package modeled after the federal or state employee benefit plan. By establishing a separate program, more funds will be available to expand eligibility to 200 percent of poverty. In addition, the separate SCHIP program will institute monthly premiums in an attempt to engage consumers and encourage personal responsibility. The premiums will discourage those currently in an employer-sponsored plan from dropping their employer coverage to enroll in the SCHIP program.

The governor is also proposing to increase access to affordable insurance by allowing small businesses to pool together to purchase health insurance as a “health group cooperative.” By pooling their employees together, the small businesses will be able to negotiate lower premiums. The proposal also requires a report in 2010 to measure the effectiveness of the health group cooperatives.

Governor Sanford’s reform initiatives also include quality improvement and measurement. The governor is proposing to require all hospitals in the state to collect data on deaths resulting from hospital-acquired infections. The hospitals would be required to submit the information to the state, which would then provide the data to the public. In addition, the state is planning to make e-prescribing more seamless by providing standards for the transmission of electronic prescriptions.

Texas

Governor Rick Perry is proposing a premium assistance program to help those low-income uninsured working adults to have access to affordable health insurance. The state will offer varying levels of premium assistance based on a sliding scale. Participating plans must be certified by the state. The plans include a minimal deductible and copayments, which can be paid for by individuals out of an HSA that is set up by the state.

Wisconsin

Governor Jim Doyle has submitted a Medicaid reform plan to expand coverage to all children in the state. The new program, called BadgerCare Plus, combines several existing programs into one comprehensive program. It also expands coverage to seven new groups, including children with family incomes that exceed 185 percent of poverty, pregnant women with incomes under 300 percent of poverty, parents with incomes up to 200 percent of poverty, and farmers and self-employed parents with incomes below 200 percent of poverty.

With flexibility added by the DRA, Wisconsin has created two benefit plans. The Standard plan covers children, parents, pregnant women below 200 percent of poverty and offers the current Medicaid benefits. Children and pregnant women, along with farmers and other eligible self-employed parents, with incomes above 200 percent of poverty will be enrolled into the Benchmark plan. The Benchmark plan is modeled after the largest and most affordable private insurance plan available in the state and offers the same benefits as the private plan, with the addition of prescription drugs, early developmental services, dental services, mental health and substance abuse services, preventive services, and smoking cessation.

Premiums will be assessed on a sliding scale for certain groups, including children and pregnant women with family incomes over 200 percent of poverty and parents with incomes between 150 and 200 percent of poverty. Copayments will remain the same as in the current Medicaid program for those in the Standard plan, and those in the Benchmark plan will pay copayments for certain services, but beneficiaries will not pay for preventive services. To promote healthier lifestyles mainly through prevention and wellness, the state included incentives for healthier living.

Wyoming

Governor Dave Freudenthal is proposing to increase healthier living by establishing and expanding existing worksite wellness programs. The programs are targeted to reduce five of the leading causes of preventable deaths in the state. The plan promotes physical activity during the work day and healthy food choices.

PLANNING

Alaska

Governor Sarah Palin, through Administrative Order 232, has established the Alaska Health Care Strategies Planning Council, which is charged with preparing and submitting a health care action plan to the governor and legislature by January 1, 2008. This plan must include a description of the current health care system in Alaska; an inventory and analysis of existing health care plans, reports, and initiatives; short-term and long-term statewide strategies to effectively provide access to quality health care for Alaskans, while reducing the costs of that care; and performance measures and accountability mechanisms to assess the success of those strategies.

Colorado

Colorado's Blue Ribbon Commission on Health Reform was created to examine health reform models that focus on expanding affordable coverage to the uninsured and containing costs within the Colorado health care system. The Commission will choose three to five proposals that it determines to be the most viable for the state. It will issue a report with its final recommendations to the Colorado General Assembly by November 30, 2007. Governor Bill Ritter plans to use the Blue Ribbon Commission to create a reform plan that provides basic health insurance to all residents of the states by 2010.

In addition, Colorado is expanding eligibility in the SCHIP program to children with incomes up to 205 percent of poverty and raising Medicaid eligibility to cover children in foster care up to 21 years of age. The state also has initiatives to improve access to and quality of care for children by collecting and analyzing data on provider performance and the development of a health information exchange system in the state.

Iowa

Governor Chet Culver has raised the state cigarette tax by \$1 per pack to fund an expansion of health care coverage to all of Iowa's children.

Kansas

Governor Kathleen Sebelius has tasked the Kansas Health Policy Authority with developing a plan to ensure all state residents have access to health insurance. The plan is to be presented to the governor and the legislature before the 2008 legislative session.

Maryland

Governor Martin O'Malley is establishing the Task Force on Health Care Access and Reimbursement to recommend health care reforms in the state.

Minnesota

Governor Tim Pawlenty signed into law an effort to convene a Health Care Transformation Task Force to develop a statewide plan to improve affordability, quality, access and health status of Minnesotans. Recommendations to reduce the state's health care expenditures by 20 percent will be made by January 2011.

New Jersey

The Commission on Rationalizing Health Care Resources was created to study the status of the health care system in the state. The Commission is to issue a written report of its findings and recommendations no later than June 1, 2007.

New Mexico

The Health Coverage for New Mexicans Committee (HCNMC) is a 23-member task force appointed by Governor Bill Richardson and the legislative leadership. HCNMC's charge is to identify and analyze three health coverage models for New Mexico to achieve universal coverage. The analysis uses the state employee benefit package as basis for comparison. The three models include components such as individual mandates, employer requirements, tax incentives, connectors, and vouchers, as well as a single plan approach. The final recommendations are expected to be released in June 2007.

South Dakota

Governor Mike Rounds and the South Dakota legislature have created a task force to recommend solutions for the problem of the uninsured in the state. The initiative, called Zaniya, which is the Lakota Sioux Indian word for "taking care of the health and well being of your people," is made up of over 50 individuals. The task force will review public program expansions, private marketplace expansions and changes, and improving Indian Health Services both on and off the reservations.

Virginia

In October 2006, Governor Tim Kaine convened a Health Reform Commission that will make recommendations to improve Virginia's health care system by September 2007. The 32-member Health Reform Commission broke into four workgroups to more closely examine the issues outlined in the executive order creating the Commission: (1) Access to Care, (2) Quality, Transparency, and Prevention, (3) Workforce, and (4) Long-Term Care. These workgroups wrapped up their work in June 2007, and the Commission is setting priorities for its final report to the Governor. The Commission is considering expanding Medicaid eligibility for parents and caretakers, expanding SCHIP eligibility to reach additional low-income pregnant women, and increasing funding for the community health care safety net.

In addition, the Commission is exploring options for enhancing affordability and accessibility of health insurance by considering the use of annual maximum cap policies, a public-private partnership to make health insurance more affordable, and a reinsurance program. The Commission is also making recommendations on improving the quality and transparency of care, reducing infant mortality, decreasing tobacco use and obesity rates, improving the health care workforce, and enhancing the delivery of long-term care.

Wyoming

The Wyoming Health Care Commission is currently considering options for expanding coverage to the uninsured. The Commission is considering expanding eligibility in state programs, such as a Medicaid expansion to cover parents of children in the SCHIP program up to 300 percent of poverty. It is also considering a Medicaid expansion to cover all children in the state. Subsidizing premiums for childless working adults with incomes of up to 300 percent of poverty is a possibility, as well.

In addition, the Commission is considering an expansion of the state employee pool to allow those outside of the state government to obtain insurance from the pool. It is also weighing the options of incentivized and mandatory coverage for all residents.

ENDNOTES

- ¹ U.S. Census Bureau, "Table HI01: Health Insurance Coverage Status and Type of Coverage by Selected Characteristics, 2005," Annual Demographic Survey, March Supplement, Current Population Survey, U.S. Census Bureau, last revised April 16, 2007, http://pubdb3.census.gov/macro/032006/health/h01_000.htm.
- ² U.S. Census Bureau, Table HI01.
- ³ U.S. Census Bureau, Table HI01.
- ⁴ U.S. Census Bureau, Table HI01.
- ⁵ Kaiser Family Foundation, "Health Insurance Coverage of Nonelderly 0-64, States (2004-2005), U.S. (2005)," Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2005 and 2006 Current Population Survey (CPS: Annual Social and Economic Supplements), <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Health+Coverage+%26+Uninsured&subcategory=Health+Insurance+Status&topic=Nonelderly+%280%2d64%29>
- ⁶ U.S. Census Bureau, Table HI01.
- ⁷ Karen Davis et al., "Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care," The Commonwealth Fund, http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=482678.
- ⁸ U.S. Census Bureau, Table HI01.
- ⁹ Kaiser Family Foundation/Health Research and Educational Trust, "Section 2: Health Benefits Offer Rates," Survey of Employer-Sponsored Health Benefits, 2006, <http://www.kff.org/insurance/7527/sections/ehbs06-sec2-1.cfm>.
- ¹⁰ Kaiser Family Foundation, "Health Insurance Coverage of Nonelderly 0-64, States (2004-2005), U.S. (2005)."
- ¹¹ U.S. Census Bureau, Table HI01.
- ¹² U.S. Census Bureau, Table HI01.
- ¹³ U.S. Census Bureau, Table HI01.
- ¹⁴ U.S. Census Bureau, Table HI01.
- ¹⁵ Kaiser Family Foundation, "Distribution of the Nonelderly Uninsured by Federal Poverty Level (FPL), States (2004-2005), U.S. (2005)," Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2005 and 2006 Current Population Survey (CPS: Annual Social and Economic Supplements), <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Health+Coverage+%26+Uninsured&subcategory=Nonelderly+Uninsured&topic=Distribution+by+FPL>.
- ¹⁶ Kaiser Family Foundation, "Distribution of the Nonelderly Uninsured by Family Work Status, States (2004-2005), U.S. (2005)," Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2005 and 2006 Current Population Survey (CPS: Annual Social and Economic Supplements), <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Health+Coverage+%26+Uninsured&subcategory=Nonelderly+Uninsured&topic=Distribution+by+Employment+Status>.
- ¹⁷ Kaiser Family Foundation, "Distribution of the Nonelderly Uninsured by Race/Ethnicity, States (2004-2005), U.S. (2005)," Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2005 and 2006 Current Population Survey (CPS: Annual Social and Economic Supplements), <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Health+Coverage+%26+Uninsured&subcategory=Nonelderly+Uninsured&topic=Distribution+by+Race%2fEthnicity>.
- ¹⁸ Kaiser Commission on Medicaid and the Uninsured, "The Uninsured and Their Access to Health Care," 2005, <http://www.kff.org/uninsured/1420-07.cfm>.
- ¹⁹ Kaiser Commission on Medicaid and the Uninsured, "The Uninsured and Their Access to Health Care."
- ²⁰ Karen Davis, et. al, "Mirror, Mirror on the Wall."
- ²¹ Karen Davis, et. al, "Mirror, Mirror on the Wall."
- ²² Aaron Catlin et al., "National Health Spending in 2005: The Slowdown Continues," *Health Affairs*, 26(1):142-153, 2007, <http://content.healthaffairs.org/cgi/content/abstract/26/1/142>.
- ²³ Aaron Catlin et al., "National Health Spending in 2005: The Slowdown Continues."
- ²⁴ Aaron Catlin et al., "National Health Spending in 2005: The Slowdown Continues."

²⁵ Jack Hadley and John Holohan, “The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?” for the Kaiser Commission on Medicaid and the Uninsured, 2004,

<http://www.kff.org/uninsured/7084.cfm>.

²⁶ Jack Hadley and John Holohan, “The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?”

²⁷ Karen Davis, et. al, “Mirror, Mirror on the Wall.”

²⁸ National Association of State Budget Officers and National Governors Association, Fiscal Survey of States, Fall 2006,

<http://www.nasbo.org/publications.php#fsf2006>.

²⁹ Kaiser Family Foundation/Health Research and Educational Trust, “Section 1: Cost of Health Insurance,” Survey of Employer-Sponsored Health Benefits, 2006, <http://www.kff.org/insurance/7527/sections/ehbs06-sec1-1.cfm>.

³⁰ Kaiser Family Foundation, “Insurance Premium Cost-Sharing and Coverage Take-up Snapshot,” Snapshots: Health Care Costs, 2007, <http://www.kff.org/insurance/snapshot/chem020707oth.cfm>.