

## The ACMHA Santa Fe Summit on Behavioral Health

<b>Impacting Healthcare Reform</b>		<b>08</b>
	<b>Leadership in Moving the Mental Health and Substance Use Agenda</b>	<b>Santa Fe March 13 – 15, 2008</b>

**State Health Care Reform – Key Objectives and Insurance Strategies  
February 2008**

# State Health Care Reform

## Framework

States are taking the lead in creating additional access to health care coverage which is often achieved through the use of federal mechanisms (i.e., Medicaid eligibility expansions, S-CHIP, premium subsidies); insurance market reform strategies (e.g. community rating, guaranteed issued and renewability); and various state mandates (e.g., individual and employer coverage requirements). A persistent tension that is common across health reform efforts lies in balancing the number of individuals to be insured with the costs of health insurance plans. While there might be sufficient resources in a system to provide access to more individuals, certain tradeoffs may occur related to the scope of benefits. To cast a wider coverage net, states may develop “bare bones” insurance packages that contain very few benefits outside of traditional primary care or inpatient hospitalization or offer limited coverage for a spectrum of services, such as dental and mental health. Making health insurance affordable for individuals and employers, especially where mandates exist, also puts strain on policymakers to either narrow benefits while expanding access or provide more comprehensive coverage for fewer individuals.

## Organization

The following tables are intended to describe states’ key health reform objectives as well as provide an overview of state approaches to increase access to health insurance coverage. We identified six key reform objectives which are:

- |  |   |
|--|---|
| 1) Expanding Medicaid and S-CHIP Coverage  | 2) Mandating Individuals to Obtain Coverage |
| 3) Mandating Employers to Provide Coverage | 4) Encouraging Healthy Behaviors            |
| 5) Paying for Prevention                   | 6) Reforming the Insurance Market           |

Health reform objectives are reflected in legislation recently passed or proposed in states and encompass several strategies a state may use to increase access, decrease costs and improve quality. The six reform objectives are defined in the following pages along with brief descriptions of state efforts to achieve objectives. The *MH/SU Discussion* column describes the extent to which the six reform objectives generally create new mental health and substance use coverage opportunities.

In addition, specific *Public Insurance Strategies* and *Private Insurance Strategies* are defined in order to provide an understanding of the specific approaches that can be used by states to increase access to health care coverage. Unlike the key health reform objectives that generally describe states’ intentions for reform, the tables related to public and private insurance strategies offer details on the specific mechanisms states use to create coverage. Similarly, the *MH/SU Discussion* column describes the extent to which the insurance strategies create new mental health and substance use coverage opportunities.

### Public Insurance Strategies

- |   |                                |
|---|--------------------------------|
| 1) Medicaid State Plan Coverage Expansion | 2) Deficit Reduction Act (DRA) |
| 3) Section 1115 Waivers                   | 4) Premium Assistance          |
| 5) HIFA                                   |                                |

### Private Insurance Strategies

- |                          |   |
|--------------------------|---|
| 1) Reinsurance           | 2) High Risk Pools  |
| 3) Limited Benefit Plans | 4) Group Purchasing [Purchasing Pools/Insurance Exchange] |
| 5) Dependent Coverage    | 6) Community Rating                                       |

## Limitations on Use

This information is provided to supplement participants’ understanding of state health reform efforts and is not intended to be a full analysis and examination of every strategic approach. Ideally this information will lead participants to further explore and understand various coverage strategies as well as engage in additional dialogue, planning and action around appropriate coverage of mental health and substance use treatment services.

### Key Health Care Reform Objectives<sup>1</sup>

Type:	States	Selected Highlights	MH/SU Discussion
<p><b>Expanding Coverage</b> – Extending coverage to uninsured individuals by expanding eligibility requirements for public programs (i.e., Medicaid and S-CHIP), creating Medicaid buy-in opportunities and private insurance premium subsidies. (Also <u>see</u> Public and Private Insurance Strategies).</p>	<p>Various</p>	<p><b>Illinois</b> Covered contains provisions for premium subsidies to individuals with incomes between 100-400 percent FPL to help them purchase insurance as well as a new program to expand health care coverage to families up to 400% FPL.</p> <p><b>Massachusetts'</b> MassHealth (Medicaid program) enabled coverage expansions to children up to 300 percent of the federal poverty level.</p> <p><b>Oregon</b> Governor Kulongoski (D) sought to expand Medicaid and SCHIP eligibility for children with family incomes up to 200 percent of the federal poverty level; provide premium subsidies to children in families with incomes between 200 percent of the federal poverty level and 300 percent of the federal poverty level; and allow children in families with higher incomes to buy-in to the program at full cost.</p>	<p><b>Are new MH/SU coverage opportunities created under this strategy?</b>  <i>It depends. Based on the coverage mechanism used, a Medicaid expansion could lead to more individuals being eligible for MH/SU treatment. However, some federal provisions permit states to offer reduced Medicaid benefits to expansion populations.</i></p> <p><i>Expanding insurance in the private market would only facilitate MH/SU coverage to the extent the benefits are covered in commercial insurance products.</i></p>
<p><b>Mandating Individuals to Obtain Coverage (Individual Mandate)</b>-A legal requirement that every individual obtain health insurance coverage as a means of ensuring universal coverage.</p>	<p>CA, CO, ME, MA, NM, PA</p>	<p>On April 12, 2006, <b>Massachusetts</b> enacted legislation, Chapter 58 of the Acts of 2006, which included a mandate requiring that all residents have health insurance by December 31, 2007.</p> <p>On October 25, 2007, Governor Bill Richardson (D) announced his "Health Solutions <b>New Mexico</b> Plan" which he will propose in the 2008 legislative session. The plan includes a mandate that individuals must show proof of health care coverage by January 1, 2010. Proof of coverage can be shown through commercial insurance, public program enrollment, or proof of the ability to self-fund health problems that may arise (individuals below 300% of the FPL are exempt).</p> <p>In mid-February 2008, the state legislature will vote on Governor Edward Rendell's (D) "Cover all <b>Pennsylvanians</b>" proposal. The plan includes a mandate requiring all adults with incomes above 300% of the FPL to obtain insurance coverage. It also requires full time college and graduate students to obtain a minimum level of health insurance.</p>	<p><b>Are new MH/SU coverage opportunities created under this strategy?</b>  <i>Not necessarily. As part of proposed legislation, states may specify what must be in the minimum benefit package to meet the test of having coverage and MH/SU could be excluded. However, if the MH/SU is included as a supplemental benefit and individuals are required to share in the cost of their coverage, it is possible that individuals may forego more costly behavioral health coverage.</i></p>

<sup>1</sup> Adapted from materials developed by the Kaiser Commission on Medicaid and the Uninsured. For additional information please see <http://kff.org/uninsured/index.cfm>.

### Key Health Care Reform Objectives<sup>1</sup>

Type:	States	Selected Highlights	MH/SU Discussion
<p><b>Mandating Employers to Provide Coverage (Employer Mandate) or Mandating Employers to Provide Section 125 (Cafeteria) Plans</b> -A legal requirement that employers provide health care coverage or contribute to the cost of their employees' health care coverage. Many states make an exception for employers with a small number of employees.</p>	<p>CA, CO, ME, MA, MN, NM, VT</p>	<p>On January 28, 2008 the state Senate Health Committee rejected the legislation put forth by <b>California</b> Governor Schwarzenegger (R). The plan would have required employers with to provide coverage or contribute a certain percent of payroll to the cost of their employees' coverage.</p> <p>On April 12, 2006, <b>Massachusetts</b> enacted legislation, Chapter 58 of the Acts of 2006, which requires employers with 11 or more employees provide health insurance coverage or pay a "fair share" contribution of up to \$295 annually per employee.</p> <p>On January 11, 2007, <b>Minnesota</b> Governor Tim Pawlenty (R) announced a new health care reform plan that requires employers with more than 10 employees to establish a Section 125 plan to allow employees to purchase health insurance with pre-tax basis income.</p>	<p><b>Are new MH/SU coverage opportunities created under this strategy?</b>  <i>It depends. If states mandate MH/SU coverage, then more individuals could have access to MH/SU treatment. However, to ensure that plans are affordable for employers, reduced behavioral health benefits or high deductibles could be instituted, either making the benefit impracticable or too costly for individuals.</i></p> <p><i>The extent of MH/SU coverage also depends on whether the required percentage of payroll is large enough to purchase a benefit package that includes MH/SU services. Under ERISA, states cannot mandate specific benefit packages, but they probably can collect a tax on employers and then give a credit against the tax for the amount employers spend on health care. The requirement for Section 125 Plan would make coverage more affordable, thereby encouraging some people to purchase new coverage and others to purchase more comprehensive coverage, both of which could include MH/SU services.</i></p>
<p><b>Encouraging Healthy Behaviors</b> -Plans that encourage citizens to take responsibility for their personal health and for their health care coverage.</p>	<p>KS, ME, WI</p>	<p>On November 1, 2007, the <b>Kansas</b> Health Policy Authority made health reform recommendations to the Governor and Legislature which will be considered in the 2008 Legislative Session. The recommendations included promoting personal responsibility by encouraging healthy behaviors, promoting health literacy, collecting and publicizing health care cost and quality information, and asking all Kansas to contribute to the cost of health care.</p> <p>In February 2007, Governor Chris Gregoire (D) proposed legislation, the "Healthy <b>Washington</b> Initiative," which includes measures to promote prevention.</p> <p>The 2007 <b>Wisconsin</b> Act provides universal health care coverage for all children regardless of income and also provides incentives for healthy behavior.</p>	<p><b>Are new MH/SU coverage opportunities created under this strategy?</b>  <i>Potentially. Individuals may be encouraged to consider behavioral health as essential to their overall health, but that recognition may not translate into appropriate or affordable coverage for needed services.</i></p>

## Key Health Care Reform Objectives<sup>1</sup>

Type:	States	Selected Highlights	MH/SU Discussion
<p><b>Paying for Prevention</b>-State initiatives that value prevention efforts enough to cover their cost as a means to encourage people to take advantage of them.</p>	<p>IL, KA, MN</p>	<p>In October 2007, <b>Illinois</b> became the first state to provide free mammograms, breast exams, pelvis exams, and Pap tests to uninsured women.</p> <p>On November 1, 2007, the <b>Kansas</b> Health Policy Authority made health reform recommendations to the Governor and Legislature which will be considered in the 2008 Legislative Session. The recommendations included promoting paying for prevention by Increase Medicaid provider reimbursement, implementing statewide community health records, enacting a statewide smoking ban, collecting information on health/fitness of Kansas school children, and creating a wellness grant program for small businesses.</p> <p>On January 11, 2007, <b>Minnesota</b> Governor Tim Pawlenty (R) announced a new health care reform plan that gives enrollees care discounts for meeting prevention goals.</p>	<p><b>Are new MH/SU coverage opportunities created under this strategy?</b></p> <p><i>Potentially. Payment for preventive activities that promote and pay for preventive physical and mental health services could also encourage individuals to understand the value of early treatment. However, such recognition may not translate into appropriate or affordable coverage for needed services. On the other hand, this objective could serve as a catalyst for states to develop practical solutions around integrated physical and behavioral health care by reclassifying some behavioral health services as primary care prevention.</i></p>
<p><b>Reforming the Insurance Market</b> - Restructuring insurance regulations in order to make insurance more accessible such as guaranteed issue, guaranteed renewability, community rating. (<i>Also see</i> Private Insurance Strategies).</p>	<p>CA, CO, NM</p>	<p>Governor Schwarzenegger's <b>California</b> proposal contained requirements for guaranteed issue and guaranteed renewability of coverage purchased in the individual insurance market (already required under federal law in the small-group market).</p> <p><b>Colorado's</b> plan would require health plans to provide coverage to anyone who is not eligible for Cover Colorado, regardless of pre-existing conditions.</p> <p>The Health Solutions <b>New Mexico</b> Plan would require commercial health care insurers to spend at least 85 percent of premiums directly on health care as well as requiring guaranteed issue without exclusion of pre-existing medical conditions.</p>	<p><b>Are new MH/SU coverage opportunities created under this strategy?</b></p> <p><i>To some extent. Some people formerly denied coverage (perhaps because of treatment for MH/SU) would now be eligible for coverage, and, if guaranteed-issue is combined with community-rating requirements, coverage would be more affordable for these people who are, by reasons of their medical history, higher risk. To date 46 states have enacted some type of mental health parity law aimed at ensuring equal coverage of mental health benefits, mandating minimum mental health benefits, or ensuring that mental health services are offered as an optional (and often more costly) benefit.</i></p> <p><i>Alternatively, insurance market reforms could result in fewer coverage mandates as an incentive to promote insurer participation.</i></p>

## Public Insurance Strategies<sup>2</sup>

Type:	States	Selected Highlights	MH/SU Discussion
<p><b>Medicaid State Plan Coverage Expansions –</b> Federal Medicaid regulations permit states to amend State Plans to increase the number of categorically eligible individuals.</p>	<p>Various</p>	<p>In 2007 <b>Maryland</b> amended its Medicaid State Plan to allow the State to provide Medicaid benefits to children through 300% of the Federal poverty level.</p> <p><b>Ohio</b> recently expanded Medicaid coverage for pregnant women up to 200% FPL and foster children through age 21.</p> <p>However in January 2008 CMS, for varying reasons, denied requests by <b>Ohio</b> and <b>Oklahoma</b> to cover more uninsured adults, as well as children earning up to 300% of poverty.</p>	<p><b>Are new MH/SU coverage opportunities created under this strategy?</b></p> <p><i>Potentially. Creating coverage opportunities under Medicaid enables previously non-eligible individuals to access covered MH/SU benefits. However, recent CMS actions have made it difficult for states to obtain approval of expanded eligibility for individuals with incomes greater than 250% of the federal poverty level.</i></p>
<p><b>Deficit Reduction Act</b> - In February 2006, President George W. Bush signed the Deficit Reduction Act (DRA) of 2005, one of the most significant changes to the Medicaid program in its 40 year history. The DRA is projected to reduce federal Medicaid spending by \$11.5 billion over five years and \$43.2 billion over 10 years. The DRA provides states with new flexibility to make certain changes, which would have previously required waiver authority, through the more streamlined state plan amendment process. The DRA does not, however, provide states with a new vehicle for expanding coverage with the exception of giving states the option to allow parents of certain children with disabilities to “buy-in” to Medicaid for their children if they have a family income at or below 300 percent FPL. In fact, the flexibility provided under the DRA is limited to groups covered prior to 2006.</p>	<p>ID, KS, KY, WV</p>	<p>In 2006 <b>Idaho</b> undertook a Medicaid reform initiative under authority of the DRA. This allowed the state to split the Medicaid and SCHIP populations into three major benefit plans. Upon enrollment or annual re-enrollment into Medicaid or SCHIP, enrollees are placed into the Plan that best fits their health needs.</p> <p>In 2006, <b>Kentucky</b> received approval from CMS on plans to implement DRA flexibility. The new plan, KyHealth Choices, offers four different benefit packages tailored to specific populations, increases cost sharing, and expands access to community-based long-term care.</p> <p>In 2006, <b>Kansas</b> received approval from CMS to establish a benchmark benefit for its Working Healthy Ticket to Work Medicaid Buy-In program under DRA authority. Working Healthy provides working individuals with disabilities who have incomes below 300 percent FPL the State Plan Medicaid coverage, in addition to the following benefits: Personal assistance services, which can be self-directed or agency directed, including a "Cash and Counseling" model; Assessment to determine personal assistance and related service needs; Independent living counseling; and Assistive services.</p>	<p><b>Are new MH/SU coverage opportunities created under this strategy?</b></p> <p><i>Potentially. Iowa's use of DRA provisions to establish a legitimate payment mechanism for habilitation services provides one solution for meeting the habilitative needs of individuals with mental health conditions. In addition, DRA contains a mechanism to demonstrate the benefit of alternatives to psychiatric residential treatment facilities; a means for developing benchmark plans for some Medicaid populations; Money Follows the Person opportunities for developing nursing facility institutional alternatives for individuals with mental illness; and self-directed personal assistance services.</i></p>

<sup>2</sup> Adapted from The Robert Wood Johnson Foundation's State Coverage Initiative national program. For additional information please go to <http://www.statecoverage.net/>.

**Public Insurance Strategies<sup>2</sup>**

Type:	States	Selected Highlights	MH/SU Discussion
<p><b>1115 Waivers</b> - Section 1115 of the Social Security Act grants the Secretary of the U.S. Department of Health and Human Services broad authority to waive certain federal requirements for the purpose of conducting pilot, experimental, or demonstration projects that are likely to promote the objectives of the Medicaid program. States have used this federal waiver authority to change their program in ways that would not otherwise be allowable under federal requirements. Many states have used waivers to expand Medicaid eligibility to new groups of people. In addition to eligibility changes, waivers have been used to change other federal requirements such as rules related to the delivery system or benefit package design.</p> <p>Centers for Medicare and Medicaid Services policy requires that Medicaid waivers must be budget neutral. This means that CMS will not approve waivers that would result in a higher level of federal spending than would have occurred without the waiver. SCHIP waivers meet allotment neutrality requirements.</p>	<p>AR, CA, DE, DC, FL, HI, IA, MD, MA, MN, MS, MO, MT, NV, NJ, NM, NY, OR, RI, TN, UT, VT, WI</p>	<p>Approved in July of 2005, the <b>IowaCare</b> program expands a limited set of Medicaid benefits to all adults (19 - 64), including parents of Medicaid or SCHIP eligible children, using a limited provider network. The program is a capped, non-entitlement and converts uncompensated care funds into insurance coverage for adults.</p> <p>In 2004, <b>Mississippi</b> received a waiver to provide Medicaid benefits to a select group of the formerly covered Poverty Level Aged &amp; Disabled (PLAD) population after services had been discontinued.</p> <p>In January 2004, CMS approved a Medicaid Section 1115 waiver that would allow <b>Montana</b> to provide a limited Medicaid benefit package of optional services for Medicaid eligible parents aged 21 - 64 who are not pregnant or disabled.</p> <p>In September of 2005, CMS approved <b>Vermont's</b> new Section 1115 waiver, the Global Commitment to Health. Vermont will manage its Medicaid program within a five-year, \$4.7 billion budget and the state will be financially at risk to keep expenditures below this target. Vermont has chosen to accept a capped federal contribution, with a 9 percent inflationary trend adjustment, in exchange for increased program flexibility, the authority to alter pieces of the benefit package, increase participant cost sharing, and flexibility to implement new cost-control strategies.</p>	<p><b>Are new MH/SU coverage opportunities created under this strategy?</b>  <i>Potentially. Although recently enacted state coverage strategies using 1115 waivers do not generally describe mental health or substance use treatment coverage (except <b>Mississippi's</b> expanded coverage for dual eligibles receiving anti-psychotic medication), under an 1115 waiver states can chose to federalize state-funded behavioral health services for an expansion population.</i></p>
<p><b>Premium Assistance</b> - Premium assistance is a health insurance purchasing strategy in which a state uses Medicaid or SCHIP funds to pay for a portion of the premium costs of employer-sponsored insurance (ESI) for eligible populations. Many states have expressed interest in pursuing premium assistance because they want to take advantage of the contributions that employers make toward the cost of employee health insurance coverage. Some states also place value on using the private sector to provide coverage, rather than expanding public programs.</p>	<p>CA, GA, IL, IA, MA, MO, NJ, OR, PA, RI, TX, UT, VA, WI</p>	<p><b>Illinois</b> operates a premium assistance program - All Kids/FamilyCare Rebate - under its HIFA waiver, which allows eligible children between 134 and 200 percent FPL, and parents or caregiver relatives between 134 and 185 percent FPL to enroll in employer-sponsored or private insurance and receive a monthly rebate from the State.</p> <p><b>Rhode Island</b> operates a premium assistance program, RItShare, available to those who qualify for Medicaid coverage. RItShare helps families get health insurance coverage through their (or spouse's) employer. If a family qualifies, RItShare will pay for all or part of the</p>	<p><b>Are new MH/SU coverage opportunities created under this strategy?</b>  <i>Potentially. To the extent private insurance plans offer an appropriate behavioral health benefit, individuals have a mechanism to access treatment services. However, to ensure that plans are affordable for employers, reduced behavioral health benefits or high deductibles could be instituted, either making the benefit impracticable or too costly for individuals. (Also see Employer Mandate under Key Reform Objectives).</i></p>

**Public Insurance Strategies<sup>2</sup>**

Type:	States	Selected Highlights	MH/SU Discussion
		<p>employee's share of the health insurance premium and for co-payments in the employer's health insurance plan.</p> <p>In November 2006, <b>Utah</b> announced a revised premium assistance program, the Utah Premium Partnership for Health Insurance (UPP) which draws federal matching funds under the Primary Care Network waiver and the State's SCHIP Program. Qualified low-income workers and their families can receive up to \$150 per adult and \$100 per child on a monthly basis to help defray the cost of employer-sponsored insurance premiums if these premiums represent more than 5 percent of their annual income.</p>	
<p><b>HIFA</b> - In August 2001, a major new Section 1115 waiver initiative was launched, the Health Insurance Flexibility and Accountability (HIFA) initiative. The goal of HIFA is to encourage new comprehensive state approaches that will increase the number of individuals with health insurance coverage within current level Medicaid and SCHIP resources. In order to be considered a HIFA demonstration, a proposal must include a coverage expansion; include a public-private coordination component; set a goal and include a methodology for monitoring changes in the rate of uninsurance; promise to meet maintenance of effort (if a state-funded program is being federalized); and meet a test of budget neutrality (for Medicaid funds) or allotment neutrality (for SCHIP funds).</p> <p>Under a HIFA waiver, a state may not reduce services to mandatory Medicaid eligibles or provide coverage to individuals with incomes above 200 percent FPL (with certain exceptions).</p>	<p>AZ, CA, CO, ID, IL, ME, MI, NV, NM, OK, OR</p>	<p>In 2002, <b>Maine</b> received approval from CMS for a HIFA waiver to expand health insurance coverage to childless adults with incomes at or below 125 percent FPL.</p> <p>In 2002, <b>New Mexico</b> received a HIFA waiver to expand coverage to low-income uninsured working adults.</p> <p>In 2005, CMS approved the <b>Oklahoma</b> Premium Assistance Plan under HIFA to cover an additional 50,000 residents with incomes at or below 185 percent FPL in the Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC). O-EPIC premium assistance has two different strategies for covering low-wage workers. The Employer Sponsored Insurance program helps low-wage workers in small firms purchase qualified insurance offered by their employer. The Individual Plan will help qualified individuals get health insurance coverage even if they are not able to get coverage through their employer.</p>	<p><b>Are new MH/SU coverage opportunities created under this strategy?</b></p> <p><i>Not really. None of the enacted HIFA waivers mention mental health or substance use treatment coverage in their strategies. Furthermore, CMS has signaled that no new HIFA waivers will be approved.</i></p>



**Private Insurance Strategies<sup>3</sup>**

Type:	States	Selected Highlights	MH/SU Discussion
<p><b>State Funded Reinsurance</b> - States have shown interest in reinsurance as a strategy to stabilize health insurance markets and to maintain or increase health insurance coverage. A reinsurance program can be used to reduce premiums by shifting some of the expenses for high-cost enrollees to the state). In essence, the state subsidizes insurers by taking on some of risk for high-cost cases. This permits insurers to lower premiums by approximately the amount of the subsidy. In addition, reinsurance may lower premiums by reducing the incentive for carriers to hold excess reserves. Reinsurance can be linked to other strategies to make coverage more affordable, such as purchasing pools and new small business insurance products.. Reinsurance can smooth price volatility in existing markets by spreading risk, and keep carriers in the small group or individual market, thereby promoting a competitive market.</p>	<p>AZ, CT, ID, MA, NH, NM, NY</p>	<p>The state of <b>Idaho</b> operates reinsurance pools for both the small group and the nongroup (individual) markets. In the small group market, the insurer is responsible for the first \$13,000 worth of claims as well as 10 percent of the next \$12,000 in the basic plan, \$87,000 in the standard plan, and \$130,000 in the catastrophic plan. Above those amounts, the pool pays claims up to maximums of \$25,000 for the basic plan, \$100,000 for the standard plan and \$200,000 for the catastrophic plan. Carriers determine whether they want to reinsure individuals, dependents, or small groups but all carriers participating in the health insurance market are assessed to cover loses incurred by the pool so, in essence, all carriers participate. In the nongroup (individual) market, the state operates the Individual High-Risk Reinsurance Pool that reinsures five guaranteed issue products and sets premiums for the guaranteed issue products. The primary insurer is responsible for the first \$5,000 in claims and 10 percent of the next \$25,000. All claims exceeding \$25,000 are covered by the reinsurance pool, up to the lifetime maximums of the guaranteed issue products.</p> <p>In 2005, <b>New Hampshire</b> passed legislation (SC 125) establishing the New Hampshire Reinsurance Pool by January 1, 2006. The legislation requires all health insurance carriers become members of the reinsurance pool. The reinsurance pool board has developed a standard benefit package for small employers, and it is that package on which reinsurance premiums are based. Any insurer may purchase reinsurance from the pool, with a \$5,000 deductible per covered life. The choice to reinsure is determined by individual carriers, but if pool expenses exceed premiums, all member carriers will be assessed proportionally on the number of lives they cover.</p> <p>Healthy New York is a reinsurance program available to certain small employers in <b>New York</b> who have not previously had coverage and have a preponderance of</p>	<p><b>Are new MH/SU coverage opportunities created under this strategy?</b>  <i>Only generally. Reinsurance helps to increasing benefits broadly by making them more affordable across the reinsurance pool.</i></p>

<sup>3</sup> Adapted from The Robert Wood Johnson Foundation's State Coverage Initiative national program. For additional information please go to <http://www.statecoverage.net/>.

**Private Insurance Strategies<sup>3</sup>**

Type:	States	Selected Highlights	MH/SU Discussion
		low-wage workers. The state pays 90% of claims between \$5,000 and \$75,000.	
<p><b>High Risk Pools</b> - A high-risk pool is, typically, a state-created, entity or program that offers health insurance coverage to individuals who have been denied coverage because of a pre-existing health condition or other characteristic that makes insurers unwilling to insure them or willing to do so only at a rate far above the standard rate. The high-risk pool rates are usually somewhere between 125% to 200% of the standard rates but still insufficient to cover claims, so that the state subsidizes the rates. Many state high-risk pools also now serve as the "fallback" option under the guaranteed portability requirement of HIPAA for those individuals moving from qualified group coverage to individual coverage. High-risk pools are characterized by strict eligibility requirements which vary from state to state. Generally, the number of people covered is small.</p>	<p>AL, AK, AR, CA, CO, CT, FL, ID, IL, IN, IA, KS, KY, LA, MD, MN, MS, MO, MT, NE, NH, NM, ND, OK, OR, SC, SD, TN, TX, UT, WA, WV, WI, WY</p>	<p>The <b>Alabama</b> Health Plan became operational in 1998 and as of June 2006, there were just over 3,000 people enrolled. The program is financed by member premiums and assessments to the insurance industry based on premium volume in the state. The program has a premium cap that is 200 percent of market rate for comparable coverage.</p> <p><b>Florida's</b> high-risk pool, the Florida Comprehensive Health Association has been closed to new enrollment since 1991. There are approximately 500 individuals who remain enrolled in the program which was originally established in 1983. The premium cap varies (between 200 percent and 250 percent) and is determined by risk. The program is financed through premiums and assessments on insurers.</p> <p>The <b>Nebraska</b> Comprehensive Health Insurance Pool became operational in 1986. The premium cap for the program is set at 135 percent of average standard health insurance rates. Premium charges for children are set at 50 percent of the standard rate. At the end of May 2006, just over 5,400 persons were enrolled in the pool.</p> <p>The <b>South Carolina</b> Health Insurance Pool became operational in 1990 and is financed by premiums and assessments on insurers. The premium cap is set at 200 percent for comparable coverage on the market. At the end of the 2005, just over 2,200 persons were enrolled in the program.</p>	<p><b>Are new MH/SU coverage opportunities created under this strategy?</b>  <i>Potentially. To the extent the high risk plan offers an appropriate behavioral health benefit, individuals have a mechanism to access treatment services. Ideally, high risk pools would account for the needs of individuals with mental health and substance use disorders and contain a useful set of services and interventions. But the number of people enrolled in high-risk pools is likely to remain small.</i></p>
<p><b>Limited Benefit Plans</b> - Limited-benefit or "bare bone" plans reduce premiums by decreasing the number of covered services in comprehensive health benefits plans. Depending on the state, these types of plans can be referred to as bare bones, mandate-light, mandate-free, limited benefit,</p>	<p>AR, CO, FL, GA, KY, MD, MN, MT, NJ, ND, TX, UT, WA</p>	<p>In 2003, the <b>Colorado</b> legislature passed HB 1164, which requires carriers in the small group market to offer one of three basic health benefit plans: Basic Health Benefit Plan without specified mandates; Basic High Deductible Health Benefit Plan; or Basic High Deductible Plan without specified mandates.</p> <p>In 2005, <b>Georgia</b> enacted the Georgia Consumer Choice Benefits Health Insurance Plan Act which allows health</p>	<p><b>Are new MH/SU coverage opportunities created under this strategy?</b>  <i>No. Limited benefit plans typically do not contain coverage for mental health and substance use conditions.</i></p>

**Private Insurance Strategies<sup>3</sup>**

Type:	States	Selected Highlights	MH/SU Discussion
<p>minimum benefit, flexible benefit, etc. For more than three decades, states have mandated that private carriers cover certain benefits or the services of specific types of providers, including chiropractors, nurse practitioners, clinical psychologists, psychiatric social workers, and acupuncturists. While mandated benefits vary from state to state, the most common are mammography and diabetes supplies.</p>		<p>plans to offer products without all of the state mandated benefit requirements. The act allows small businesses the opportunity to choose which type of health care coverage best suits their individual needs and level of affordability.</p> <p>Beginning in 2004, <b>Texas</b> required all small employer insurance carriers to offer at least one plan offering all the mandated benefits by law, and at least one Consumer Choice Plan that may exclude or limit coverage of certain mandated benefits. Some of the benefits which may be excluded or reduced include treatment for acquired brain injury; coverage for AIDS, HIV or related illnesses; chemical dependency treatment, or telemedicine/telehealth services. In addition, carriers may also charge higher deductible and coinsurance requirements than are allowed under traditional plans.</p>	
<p><b>Group Purchasing/Purchasing Pools/Insurance Exchanges</b> - Group purchasing arrangements (GPA) are public or private efforts to allow more than one small or large employer and/or individuals to pool together to collectively purchase health insurance. They seek to achieve lower cost premiums by bringing smaller groups together to achieve the buying power of large groups. Some GPAs are established through state legislation or regulation, while others are formed by associations of employers and/or individuals. There are a number of forms of GPAs, including association health plans (AHP), employer alliances or health insurance purchasing coalitions (HIPC), and multiple employer welfare arrangements (MEWA). Because most states either have a MEWA or have access to one from another state, MEWAs are not included in</p>	<p>AR, KS, MT, NM, NY, OH, TX, WI</p>	<p>On January 1, 2005, the first health insurance purchasing group in <b>Arkansas</b> was initiated. Administratively housed within and sponsored by the North Little Rock Chamber of Commerce, businesses with fewer than 100 employees and not currently offering health insurance to band together may negotiate coverage with health insurance carriers.</p> <p><b>Ohio</b> has one of the largest small employer group purchasing cooperatives owned and operated by the Council of Smaller Enterprises (COSE). Started in 1973, this private purchasing cooperative now covers more than 225,000 lives in the greater Cleveland area and retains considerable market share within the small group market.</p> <p>In 2003, <b>Wisconsin</b> Governor Jim Doyle (D) signed legislation into law that creates five regional health care purchasing alliances to bring farmers and small businesses into one pool per region. These cooperatives allow groups to directly negotiate with health plans. By encouraging the establishment of cooperatives, the hope is that not only will more uninsured individuals access health insurance, but also that competition will increase among carriers and create more options for coverage.</p>	<p><b>Are new MH/SU coverage opportunities created under this strategy?</b>  <i>Potentially. To the extent pooled purchasing creates opportunities for cost savings for mental health and substance use conditions, individuals could be afforded new coverage opportunities. However, most GPAs of the past were not able to realize substantial premium reductions. With few exceptions, they never became large enough to realize economies of scale or to have clout in negotiating with insurers.</i></p>

**Private Insurance Strategies<sup>3</sup>**

Type:	States	Selected Highlights	MH/SU Discussion
<p>the coverage matrix. In the 1990s, many states encourage the HIPC form of GPA. Almost none survived.</p>			
<p><b>Dependent Coverage</b> - Young adults (19-29 years old) are one the largest and fastest growing groups of the uninsured. In 2004, approximately 13.7 million young adults were uninsured. The majority of the uninsured young adults earn less than 200 percent FPL (69 percent). Unless they are students, dependents typically lose eligibility on their parents' or caregivers' insurance on their 19th birthday and also lose eligibility under Medicaid or the State Children's Health Insurance Program (SCHIP) unless they are students. Once a student graduates high school or college, between 40 and 50 percent will become uninsured during the first year following graduation. In response, states have pursued number of policy options. Some states have changed the definition of dependents and extended it beyond the age of 18 for commercial insurance for students and non-students. Policy holders who elect to maintain coverage for adult dependents will pay additional premium. States control the definition of dependent coverage in the commercial insurance market, the state employees' health insurance pool, and other public programs funded by state dollars.</p>	<p>CO, DE, ID, IL, MD, MA, NH, NJ, NM, RI, SD, TX, UT, WA</p>	<p>Signed by the Governor in 2006, <b>Delaware</b> passed legislation (HB 446) that requires commercial health insurance to continue coverage for unmarried adult children with no dependents under a pre-existing family policy until those children turn 24 years of age, provided that the children either live in Delaware or are full-time students. There is an additional premium charge for the continued coverage if the parents opt to cover their dependents.</p> <p>Enacted legislation in 2007 (House Bill 1057) allows <b>Maryland's</b> young adults (including child dependents of domestic partners) to remain eligible for insurance until the age of 25 if the individual resides with the insured policyholder and is unmarried.</p> <p>In <b>New Mexico</b>, an individual or group health policy may not terminate coverage of an unmarried dependent before the dependent's 25th birthday. This applies regardless of whether the dependent is enrolled in an educational institution. (59A-22-30.1)</p> <p>In 2005, the <b>South Dakota</b> Legislature passed HB 1045. It states that dependents shall have access to insurance up until their 19th birthday. If the young adult is enrolled in an educational institution, they are eligible for insurance until their 24th birthday.</p> <p>Any commercial health plan offering health insurance coverage in the <b>State of Washington</b> must allow the option of covering unmarried dependents up until age 25. Additional premiums may be charged to cover these young adult dependents. If the dependent meets certain disability criteria, parents may continue to cover the dependent irrespective of age for the same premium as dependents under age 20. These requirements also apply to the state employee program.</p>	<p><b>Are new MH/SU coverage opportunities created under this strategy?</b>  <i>Yes. A large number of individuals with MH/SU conditions go without treatment due to their inability to maintain coverage through parents' benefits.</i></p>

**Private Insurance Strategies<sup>3</sup>**

Type:	States	Selected Highlights	MH/SU Discussion
<p><b>Community Rating</b> - A method of establishing the level of premiums for health insurance in which each insurer's premium is based on the average of actual or anticipated services used by <i>all</i> of that insurer's subscribers in a specific geographic area (or the entire state). That is, an insurer must charge everyone, regardless of health condition or other risks factors (usually with the exception of age), the same rate for similar coverage.</p>	<p>CA</p>	<p>California's health reform plan would have included insurance market reforms such as guaranteed issue/renewability and modified community rating (modified for age alone).</p>	<p><b>Are new MH/SU coverage opportunities created under this strategy?</b>  <i>Community rating makes coverage more affordable for higher-risk people and groups, and, of course, someone with a mental health or substance use problem is likely to be categorized as higher-risk. Without community rating, coverage would often be unaffordable for such individuals or the groups within which they would typically buy coverage.</i></p>

## HEALTH MANAGEMENT ASSOCIATES LOCATIONS

### About Health Management Associates

Health Management Associates is a national research and consulting firm specializing in complex health care program and policy issues. Founded in 1985, in Lansing, Michigan, Health Management Associates provides leadership, experience, and technical expertise to local, state, and federal governmental agencies, regional and national foundations, multi-state health system organizations and single site health care providers, as well as employers and other purchasers in the public and private sectors.

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