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State Financing for Health Coverage Initiatives

Observations and Options

June 2009

By Courtney Burke and Kimberley Fox

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The Nelson A. Rockefeller Institute of Government is the public policy research arm of the State University of New York. The Institute focuses on the role of state and local government in the American federal system. The New York State Health Policy Research Center, a program of the Rockefeller Institute, provides relevant, nonpartisan research and analysis of state health policy issues for New York State and national policymakers. With funding support from the New York State Health Foundation and other foundations, HPRC uses its in-house staff of health policy experts, as well as national experts, to build on the Rockefeller Institute's strength in analyzing the role of state and local governments in financing, administering, and regulating state health care systems.

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Regardless of whether health reforms are enacted at the federal level, states will continue to play a significant role in financing health insurance coverage initiatives in the coming years. Financing health coverage initiatives will be challenging for states. Current federal stimulus money is helping states deal with an increase in Medicaid enrollment, but much of this money is temporary, and some economists predict that state budget gaps in fiscal year (FY) 2012 are likely to rival those facing states before the adoption of the stimulus legislation.[1]

States rely on a patchwork of sources to finance health coverage.[2] This paper categorizes states' financing strategies into three levels. The first level is the most widely used and substantial funding source — Medicaid, including both Medicaid eligibility expansions and Medicaid waivers. The second category includes those financing strategies outside of Medicaid that are also important, widely used, and relatively substantial in some states. The third group of financing strategies is not as widely used, less substantial, or nonrecurring.

Which strategy or strategies a state uses may depend on the comprehensiveness of their coverage initiative. For instance, some expansions may be done simply by increasing Medicaid income eligibility levels; others may be done by covering new services or populations through Medicaid waivers. These two strategies are critical for all states because they allow states to share costs with

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the federal government. States also may use other financing strategies such as provider taxes or tobacco taxes.

For states that are attempting universal coverage, each relies on a variety of financing strategies, but in each instance Medicaid has been important to these expansions and new sources of funding were required. The experiences of two states that are attempting universal coverage — Massachusetts and Vermont — suggest that a state as large as New York cannot realistically achieve universal coverage without relying more heavily on federal Medicaid revenue, lowering the growth rate of health costs, redirecting existing funds, generating new revenues, and using multiple revenue streams such as provider taxes, insurer taxes, sin taxes, and possibly employer contributions.[3]

The paper does not offer particular recommendations for policymakers, but identifies numerous options that could produce several billion dollars in new revenues and savings from current expenditures. Such options include enacting new taxes dedicated to health coverage, building on current revenue streams, implementing administrative efficiencies, and better managing high-cost medical cases. The study concludes that most potential revenue streams may not be robust enough on their own to finance universal coverage. However, if the state were to incrementally increase revenues, significantly reduce the rate of health care cost growth, and draw upon multiple sources, it may be able to finance universal coverage in a sustainable way. The paper also concludes that the process that New York uses to determine sources for financing coverage initiatives will also be important to success.

I. Federal Financing Through Medicaid and SCHIP

Medicaid plays a central role in financing state health insurance coverage initiatives. It constitutes one of the largest parts of state budgets and generates billions of dollars in federal matching funds for states. This section briefly reviews the ways in which states draw upon this central source of financing for coverage initiatives.

A. Regular Medicaid/SCHIP Match

Financing for Medicaid is split between federal and state (and sometimes local) governments. The amount that states contribute varies. At least 12 states paid the maximum state share of Medicaid (50 percent) in FY 2008, but those with lower average per capita incomes paid less.[4] The federal contributions to Medicaid's sister program, the State Children's Health Insurance Program (SCHIP),[5] for children with slightly higher incomes than those who qualify for Medicaid, are even higher.[6]

One way states leverage additional federal dollars for health insurance coverage initiatives is by increasing eligibility levels for regular Medicaid and SCHIP or by covering more optional Medicaid and SCHIP services. For instance, about half of states

Adding services and increasing income eligibility levels under Medicaid and SCHIP allows states to leverage significant federal dollars for coverage initiatives and has been a major financing strategy for many states for years.

have raised income eligibility levels for Medicaid from the federally required minimum of 133 percent of poverty for children ages 0-5 to over 200 percent of the federal poverty level (FPL).[7] Under separate SCHIP programs, at least 16 states have eligibility levels above 200 percent FPL.[8] States have also added optional services to the Medicaid program such as personal care or dental care.

Adding services and increasing income eligibility levels under Medicaid and SCHIP allows states to leverage significant federal dollars for coverage initiatives and has been a major financing strategy for many states for years. Even though Medicaid and SCHIP serve as critical funding sources for every state, they are income-based programs and so far they have not been used as the sole means for achieving universal coverage.[9]

B. Medicaid Waivers

States also may secure federal funding through Medicaid by negotiating a waiver. A waiver, which must be approved by the federal government and requires that changes under the waiver are budget neutral, essentially allows states more flexibility in administering their Medicaid program. States use three types of Medicaid waivers: 1115 waivers, which are used for researching and demonstrating new ways of delivering care; 1915(b) waivers, which allow states to limit individuals' choice of providers or implement managed care; and 1915(c) waivers that allow states to provide long-term care services to persons in the home or community.

To provide coverage to new populations, states have most often used the 1115 Medicaid research and demonstration waiver because it provides them administrative and budgeting flexibility. For example, Vermont's 1115 "Global Commitment" waiver uses savings from administrative efficiencies achieved through combining several previous waivers, having the state operate as a managed care organization, and supporting employer sponsored premium assistance to expand coverage for families otherwise ineligible for Medicaid. In its efforts to achieve universal coverage, Massachusetts was able to negotiate flexibility around the waiver's "budget neutrality" cap.[10] Other states also have been able to modify how Medicaid dollars are matched by the federal government in ways that shift a greater burden of cost sharing from the states to the federal government.[11] Flexibility through Medicaid waivers has been important for states to generate extra revenues for more comprehensive coverage initiatives, as well as for increasing coverage incrementally for a subset of the population.

II. Core Sources of State Funds for Health Coverage Expansions

In order to finance the state share of Medicaid, states generate matching funds from a handful of key sources. This section reviews three of the primary sources other than Medicaid that are

used by states. These sources are sizeable, used by a majority of states, and are reliable and continuous sources of funding. The financing sources also may be earmarked for health coverage initiatives other than Medicaid.

A. Broad-Based Taxes

Broad-based taxes are widespread and contribute to states' general fund revenues, which are then used as a state's Medicaid match. Broad-based taxes can include everything from personal income taxes, corporate income taxes, or sales taxes. Many broad-based taxes go into states' general fund revenues and can then be used to fund the state's share of Medicaid expenses. Broad-based taxes can yield greater revenues than other financing mechanisms through only slight increases in the tax rate.

There are disadvantages to using broad-based taxes as a revenue source for health coverage initiatives. Some taxes may be regressive, creating unequal burdens on low-income populations. In addition not all broad-based taxes are robust during economic downturns, they may not keep pace with the growth in health care costs, and there may be negative impacts from the tax on business competitiveness and wages.

Broad-based taxes can yield greater revenues than other financing mechanisms through only slight increases in the tax rate.

B. Health Care Industry Specific Taxes and Assessments

Provider taxes may include taxes on hospitals, specific types of providers, or medical services. Approximately 43 states have some kind of provider tax, and 30 states taxed more than one category of providers.[12] Provider taxes have been used to leverage federal Medicaid matching funds, although recent changes to federal regulations have limited the use of these payments in certain instances.[13]

Assessments on health insurers tend to be based on a percent of the claims paid by the insurer or third-party administrator or on a percent of gross revenues. New York uses a "covered lives assessment," which essentially is a tax on individual and family health insurance policies issued in the state. Part of the revenue from the assessment is used to fund graduate medical education (GME).[14] Maine funds its Dirigo-subsidized insurance product through an assessment on insurers that is determined annually based on demonstrated cost savings resulting from reforms, up to a maximum cap of 4 percent. Many states place assessments on health insurers, then use revenues from the assessment to subsidize insurance for persons in the state's high-risk pool.[15]

One of the advantages of revenue generated from health industry taxes is that it tends to reflect the health care growth rate and keep pace with actual cost, as opposed to general revenue growth, which generally does not keep pace with the growth of health costs. This makes revenues from taxes on health care providers more robust and sustainable over time and a more predictable revenue source for health coverage initiatives.

The downside of taxing the health industry is that it may cause providers to pass the cost of the tax on to purchasers, which then makes insurance less affordable, resulting in more uninsured. Taxing insurers may have a similar impact. Another drawback of this revenue source is that some groups may be exempt from certain taxes, thus limiting revenues and creating an unlevel playing field for in-state insurers.

C. Sin Taxes

Another widespread source for state health coverage initiatives is targeted taxes on products that are considered unhealthy or "sinful" such as cigarettes, alcohol, or soft drinks. The Tax Foundation indicates that nearly all states tax at least one of these items, although there are large disparities in the tax amounts.[16] In addition, it is not clear if and how much of the revenues generated from these taxes go toward coverage initiatives. The National Conference of State Legislatures (NCSL) reports that "health, welfare and human services programs are the recipients of earmarked state taxes in 34 states. The largest source of dedicated revenue for this program area is from tobacco taxes (23 states), followed by alcoholic beverage taxes (13 states)."[17] Even though a fair amount of sin taxes are earmarked, it is unclear how many are specifically targeted at coverage initiatives. Further research found at least two examples of states where sin taxes were earmarked for coverage — Indiana and New Mexico. Indiana proposed a tax on non-nutritive beverages, with money going to fund a long-term care continuum administered by Medicaid. New Mexico proposed a tax on soft drinks and would have used the revenue to create the Soft Drink Medicaid Fund.[18]

Some previous attempts by states to generate revenue from sin taxes have been met with resistance. For example, in 2008, Maine passed legislation to tax beverages such as soft drinks, wine, and malt liquor to help fund the state subsidized DirigoChoice insurance plan. Shortly after the legislation passed, those opposed to the tax collected enough signatures to initiate a referendum on the ballot to repeal the tax. In November 2008, the referendum passed and the tax was rescinded. In 2008, Governor David Paterson of New York proposed a tax on sugared beverages such as nondiet soda but later withdrew this proposal in part because of widespread public opposition.[19] In addition to the difficulty of passing sin taxes, another drawback is that they may decrease over time because the tax may deter consumption. And, as with many other taxes, they do not keep pace with the cost of health care growth.

III. Less Sustainable, Less Widespread, and Nonrecurring Funding Sources

Beyond Medicaid and the primary sources of general fund Medicaid matching revenues, there are other health coverage financing options for states. Most of these sources of financing, however, are not widespread. They also may be nonrecurring or

less sustainable than some of the financing strategies outlined in the first two sections of this paper. This may make them more appropriate as one part of a multi-pronged solution for financing universal coverage or as the sole source for an incremental initiative, such as one that provides subsidies for privately purchased insurance or incrementally expands Medicaid eligibility levels.

A. Employer Contributions

The provision of health insurance by employers is voluntary in all states except Hawaii, so states are limited in how much they can encourage employers to offer health insurance.[20] Two states that have recently successfully leveraged employer contributions for financing health coverage are Vermont and Massachusetts.[21] Employers above a specific size in these states that do not provide health insurance must pay a yearly fee of $365 and $295 dollars per employee, respectively. That money is placed in a common pool and used to support subsidies for low-income uninsured residents to purchase insurance. Other states, such as California, also have examined ways to leverage employer contributions. The state proposed a 1.0 to 6.5 percent health care contribution fee for employers that did not provide health coverage. Had the measure passed, the fee would have been dependent on the size of the employer.[22]

Employer contributions have been a relatively important source for financing comprehensive coverage initiatives in Vermont and Massachusetts. They are important not because of their size but because they are a new source of financing and they help create a sense of shared responsibility for financing.

One of the drawbacks of using employer contributions for coverage initiatives is that very few states have used employer contributions. In fact, the legality of this method of financing as used in Massachusetts and Vermont has not been in existence very long and may face legal challenges. Employer contributions also may place an additional financial burden on certain businesses.

B. Utilizing Savings

Another way for states to finance coverage initiatives is to use savings in their health care programs for coverage initiatives. If they do so within their Medicaid program, it may require securing a waiver. Utilizing savings to expand coverage under a Medicaid waiver may be a preferable financing option for some states because it does not require any new funding; however, it is difficult to do and may require initial investments to create the efficiencies.

One example of a state that attempted to use savings to finance coverage initiatives without seeking a Medicaid waiver is Maine, through a mechanism known as the savings offset payment (SOP). The state proposed an assessment on insurance carriers and third-party administrators of up to 4 percent of the total value of all annual health claims. The assessment was contingent on the agency demonstrating that health systems savings derived from the Dirigo law reforms were equal to or greater than the

amount of the assessment, so that this new cost to the insurance industry would not result in a corresponding markup of insured payers' premiums.[23] Health plans were expected to recoup the cost by reducing payments to providers commensurate with the cost savings.

Maine experienced some difficulty with administering and implementing the SOP.[24] The strategy depended on enrolling a substantial number of uninsured people. When enrollment fell short of expectations, fewer savings resulted from reductions in charity care. Additionally, while the courts have upheld the state's right to count savings attributable to all Dirigo Health initiatives for the SOP, controversies and litigation over this funding mechanism have continued. Savings were not always realized in a short enough timeframe, resulting in cash-flow problems. The difficulties faced by Maine in implementing the SOP have not deterred other states from trying this financing approach. Minnesota, for instance, passed legislation in 2007 to reduce health costs and use savings for various health care initiatives.[25]

States that invested the tobacco settlement money to create trust funds have been able to use them as a funding source for health programs.

C. Tobacco Settlement Funds

During the 2001 fiscal downturn, many states relied on tobacco lawsuit settlement funds for coverage initiatives (or simply to maintain coverage levels). The tobacco settlement funds came at a time when many states were experiencing revenue shortfalls. The timing of the funds was helpful in preventing cuts in health coverage.

Some states, such as Oklahoma and New Mexico, invested the tobacco settlement money in trust funds.[26] Other states securitized the funds to fill budget gaps that might have otherwise resulted in cuts in coverage for public health insurance program enrollees. New York, for instance, securitized nearly $4 billion of tobacco settlement funds to plug two years of budget gaps, helping to avoid cuts in coverage programs.[27] Some of the money was placed in what is known as the Health Care Restructuring Act (HCRA) fund. This fund has several other revenue sources and part of it is used to provide coverage through programs such as Family Health Plus (FHP) and Healthy New York.[28]

Unfortunately, for states that securitized tobacco settlement funds, they lost the opportunity to invest this money in an interest bearing trust as a longer-term means to fund coverage initiatives. States that invested the tobacco settlement money to create trust funds have been able to use them as a funding source for health programs.

D. Conversion Funds

In many states, nonprofit insurers that have converted to for-profit status are required to use a percent of their conversion proceeds to pay back the tax benefit they previously received in ways that meet their charitable mission.[29] Typically, conversion funds are used to establish charitable foundations, which, in turn,

may fund state coverage initiatives or research that informs coverage initiatives. Foundations that were formed from conversion funds have been helpful in supporting the planning and research associated with state coverage initiatives. In New York, for example, the New York State Health Foundation, which was established from conversion proceeds, has funded extensive research on issues that have helped inform decisions regarding health insurance coverage options.

Conversions can be controversial because certain groups believe health insurance should be a charitable venture as opposed to a profitable one. This can make conversions difficult to implement. Conversions also may be subject to statutory limitations regarding the use of the funds and may not directly fund coverage expansions.

E. Lottery/Gambling Funds

Typically, funding from state lotteries or casinos is not robust enough to finance large-scale coverage initiatives. The funding also is not directly tied to health care and may be difficult to shift from other sources, such as education, which traditionally receives funds from sources like state lotteries. However, part of the universal coverage plan that Governor Schwarzenegger proposed in 2007 was to be funded by lottery funds. The governor's plan estimated $2 billion in revenues if the state leased the state lottery program to a private firm.[30]

Other states, such as Pennsylvania, use a lottery fund to help pay for prescription drug programs that benefit seniors.[31] In 2008, Massachusetts Governor Deval Patrick proposed using revenues from casinos as a possible source for health initiatives, although whether and how much funding might be used for coverage initiatives was not clearly indicated.[32] Other states, such as New Jersey, have used casino revenue for incremental or targeted coverage initiatives like providing prescription drug assistance programs, but, in general, this financing method does not seem to be widely used.[33]

IV. A Closer Look at the Financing Strategies for a Select Number of States

A. Financing Incremental Coverage Strategies

For political, financial, or other reasons, it may only be possible for some states to increase coverage incrementally especially if state revenues are lower, as they currently are in many states. This section provides brief examples of three states' financing strategies for incremental coverage initiatives, (i.e., those that cover a small or targeted portion of the population). Incremental coverage expansions can be done relatively easily by states by increasing Medicaid eligibility levels in Medicaid or SCHIP. Indeed, two of the three incremental coverage initiatives reviewed in this section used Medicaid eligibility expansions. But not all incremental

strategies rely on Medicaid expansions. The other incremental strategy reviewed in this section shows how a state used a tobacco tax increase to generate funds to subsidize purchase of employer-based insurance.

i. Oklahoma[34]

An example of a state that increased coverage incrementally is Oklahoma. It began a program in 2002 that provides premium subsidies for health insurance coverage sponsored by small businesses. The program, Employer/Employee Partnership for Insurance Coverage (O-EPIC), requires that employers pay 25 percent of the premium, employees pay 15 percent (or less), and the state-financed O-EPIC pays the remainder.[35] The state caps how much an employee must contribute in total. The program is financed through a revolving fund that earns interest on money from a state tobacco tax. In 2004, residents voted to increase funding for the program by raising the state's cigarette tax to 55 cents per pack. The program has been sustainable so far because tax revenues for the fund were collected before the program was fully up and running. Early implementation of the financing allowed the program to build a reserve. However, demand for the program has been growing and the fund is diminishing as more people enroll. As a result, program enrollment may have to be capped at 16,000, leaving nearly 40,000 people on a waiting list.[36]

ii. Indiana

Funding for the HIP program came from $50 million in disproportionate share hospital (DSH) payments and through a 44 cent per pack tax on cigarettes.

In 2007, Indiana enacted the Healthy Indiana Plan (HIP), which is a Medicaid waiver that gives the state the flexibility to use federal funds to expand public insurance eligibility to low-income uninsured parents and childless adults who are not eligible for Medicaid.[37] The HIP plan required a federal waiver that allowed the state to use federal funds to cover childless adults and to implement a health savings account feature. Funding for the program came from $50 million in disproportionate share hospital (DSH) payments and through a 44 cent per pack tax on cigarettes. The money is allocated to a special fund that maintains reserves.[38] Currently, there are no plans to expand the program.[39]

iii Colorado

In 2008, a state commission charged with examining health reform options for Colorado, including improving insurance coverage, developed a series of recommendations that included incremental ways to achieve universal coverage. The state implemented one of these recommendations, expanding SCHIP eligibility from 205 percent of the FPL to 225 percent in March 2009.[40] To help finance program expansion, hospitals in the state have agreed to pay a per-patient fee, which currently is estimated to provide insurance coverage for an additional 200,000 residents.[41]

B. Financing Comprehensive Coverage Initiatives

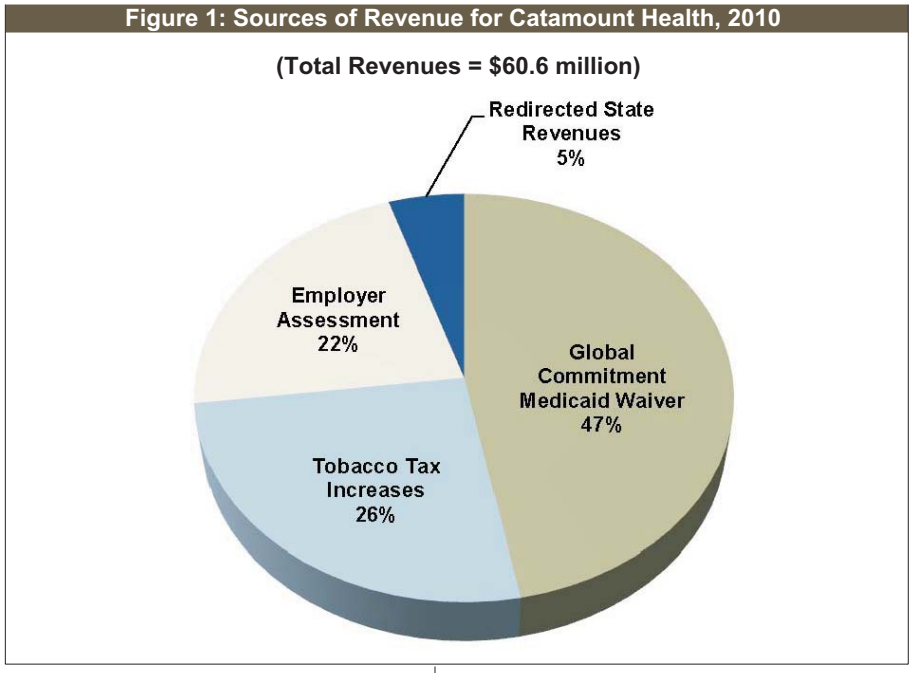
A small number of states have attempted to achieve universal health coverage. The financing strategies of two of those states — Massachusetts and Vermont — are reviewed in this section. In both states, a variety of sources of financing were required but Medicaid waivers and Medicaid eligibility expansions were central to both states' initiatives. In addition, both states had to draw upon new sources of financing, including employer contributions.

i. Vermont[42]

In 2006, Vermont implemented a series of reforms to increase access to affordable health care. One part of the reforms created a subsidized insurance plan called the Catamount Plan. The reform also established an employer premium assistance program.

In 2010, the Catamount Plan is projected to cost $60.6 million. Financing the program involves multiple funding sources (see Figure 1). The state established the Catamount Health Fund (converted from its existing Health Care Trust Fund) as the source of funding for the state's share for the Catamount Health and Employer-Sponsored Insurance (ESI) premium assistance programs.[43] The biggest source of funding for these reforms came from the federal government through the state's Medicaid 1115 Global Commitment to Health waiver.

Figure 1: Sources of Revenue for Catamount Health, 2010



Source: Analysis by Ken Thorpe and the Joint Fiscal Office (JFO) for the Vermont Legislature.

Some of the financing was augmented by a previous waiver the state had received in 2005, which provided the state with financial and programmatic flexibility to provide more effective services, expand coverage, and foster innovation by focusing on health outcomes. The waiver consolidated funding for most of the state's Medicaid programs that previously had been under separate waivers. It also converted the state's Medicaid agency to a public managed care organization, thereby allowing it to invest in services not otherwise covered by Medicaid, as well as pursue innovative reimbursement models.

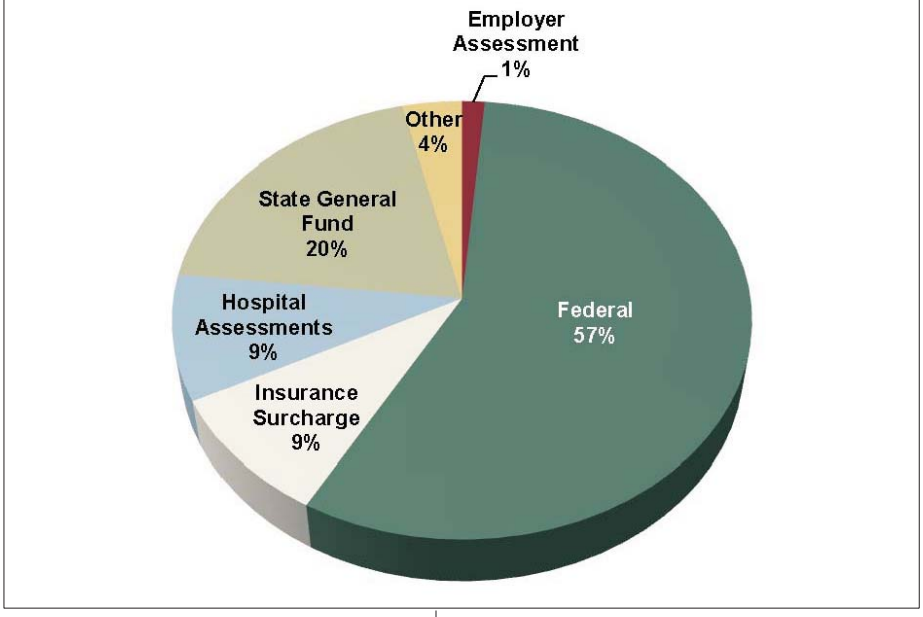
Other revenue includes a portion (17.5 percent) of the state's 80 cent increase in the cigarette tax, an employer health care premium contribution, Catamount premium assistance amounts paid by individuals to the state, and other revenues established by the General Assembly.[44]

An employer contribution is made by employers that do not offer health insurance or whose employees are ineligible or do not enroll in health insurance and have no other coverage. The employer payment provision requires qualifying employers to pay an assessment of $365 per full time employee, indexed annually to Catamount premium growth.[45] Actual revenues produced by the phased-in assessments on employers have been lower than expected, but enrollment and savings achieved from higher income groups (above 150 percent FPL) enrolled in the program have exceeded estimates.[46]

ii. Massachusetts[47]

Massachusetts' comprehensive health reform effort, which has received significant publicity for its early success in achieving near universal coverage, is financed by several sources — most notably, federal dollars (see Figure 2). Without the redirection of existing federal dollars that the state was under threat of losing, reforms may not have been possible. In FY 2008, more than half of the state's estimated $1.7 billion annual budget for health reform was funded by the federal government ($981 million), much of which was redirected funds. Federal funds were redirected from two sources: disproportionate share dollars that had helped support the Massachusetts Uncompensated Care Pool (UCP), and supplemental managed care organization (MCO) and hospital payments provided to two safety net institutions in the state. [48]

Figure 2: Revenue Sources for Massachusetts Health Reform, FY 2008



Source: Raymond, A., The 2006 Massachusetts Health Care Reform Law: Progress and Challenges After One Year of Implementation: Boston, MA, May 2007. Based on 2008 budget recommendations as filed on 2/28/07.

These funds were redirected in part due to pressure from the federal government.[49] When the state's 1115 waiver was up for renewal in 2005, the Centers for Medicare and Medicaid Services (CMS) predicated that renewal on the fact that all MCO payments be based on actuarially sound rates. State leaders persuaded CMS to allow the state to keep the federal dollars associated with these payments ($385 million in 2005) by committing to use the money to expand health insurance for previously uninsured low-income individuals.[50] CMS also agreed to provide federal matching funds for a number of previously state-only funded programs called such as home care services, universal immunization, and mental health programs.[51]

Under a waiver renewal approved in December 2008, the state negotiated greater flexibility around the budget neutrality cap.

Under a waiver renewal approved in December 2008, Massachusetts negotiated greater flexibility around the budget neutrality cap.

The new waiver established a three-year aggregate cap, compared to the annual cap of the previous waiver. The cap increased by $4.3 billion overall and by $1 billion for the Safety Net Care Pool (SNCP) over the prior three-year period. The higher caps were achieved by redefining what was included in the "without waiver" spending base to include increases in provider payments and certain members of Commonwealth Care and MassHealth who could have been categorically eligible for Medicaid without the waiver. Spending for these groups also is no longer counted against the waiver's SNCP cap.[52]

While the majority of financing for Massachusetts' coverage program comes from federal Medicaid funds, the remaining amount comes from a variety of sources, including cost offsets from consumer premiums and cost-sharing contributions, employer contributions for new employees covered as a result of the individual mandate, and tax penalties on both individuals (as a result of the individual mandate, which was a penalty of $219 in 2007 and $912 in 2008) and businesses (through a "Fair Share" contribution of $295 per uninsured FTE per year). The Fair Share contribution represents the cost of free care used by employees of noncontributing employers. The program also includes a $125 million contribution from the general fund for the first three years, $25 million of which was allocated for start-up of the new Connector Authority in the first three years.[53]

Enrollment in Mass Health in the first year exceeded the total number of estimated uninsured, and the actual budget was $625 million. To adjust for these increases, the state raised the tobacco tax by $1 per pack, which was expected to raise $174 million in new funding. In addition, the state passed a supplemental appropriations bill in July 2008 to provide $89 million in additional funding from one-time assessments and fees levied on health plans and providers. Cost-sharing for Commonwealth Care enrollees with incomes above 150 percent FPL had been increased as a result of second year increases in plan premiums. The increased assessment on health plans and providers was seen as a way to distribute the burden of unexpected higher program costs equally among providers and employers.[54]

The financial sustainability of the program over time continues to be a question. After the mid-year supplemental appropriation, Commonwealth Care enrollment slowed, thus relieving some of the cost pressures on the program. In the short-term, the increased availability of federal dollars under the state's new waiver has allowed the state to avoid any major cutbacks to Commonwealth Care and has even expanded the program to $869 million under the governor's proposed FY 2009 budget.

V. The Case of New York

In 2006 and 2007 New York was among a handful of states considering ways to achieve universal coverage. This section reviews the status of New York's efforts, its current financing

sources, challenges, and potential options for financing. It does not advocate for any particular source of financing, but reviews possible options and, in some cases, estimates potential revenues. It concludes that regardless of which funding sources are used, multiple sources are likely to be necessary for any large-scale coverage initiative. It also concludes that the processes that are used to determine financing will be important, as will the need for more administrative efficiencies and cost growth reductions.

A. Background Regarding Current Coverage Initiatives

In 2007, New York State's commissioner of health and the insurance superintendent were charged with collecting information to help the state develop a plan to achieve universal coverage. The "Partnership for Coverage," a group of health care experts appointed by the governor and legislature and overseen by the commissioner and superintendent, are helping these efforts. The partnership was tasked with holding public hearings around the state to develop options for achieving universal coverage. The partnership released its initial findings from the public hearings in a 2008 report, which outlined four possible ways to achieve universal coverage.[55] The state then contracted with the Urban Institute, a nonpartisan think tank, to model the four coverage plans. As this paper was being written, the modeling of the four proposals had yet to be released.

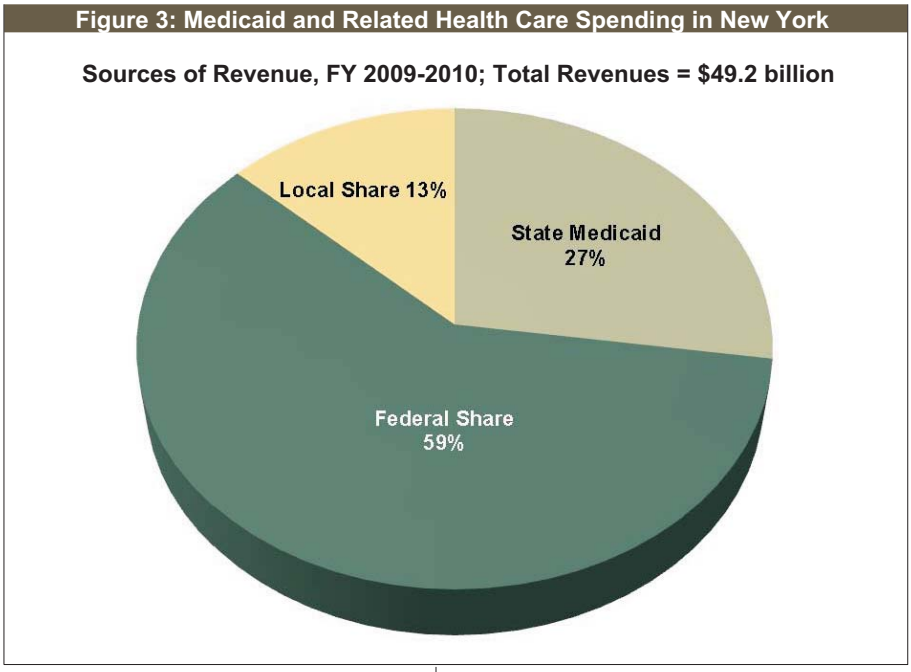
B. Current Financing

Since the Partnership for Coverage was first convened, revenues in New York have plunged relative to projections, while expenditures have continued to rise at a rate well above inflation. The budget that was finalized in early April closed an estimated budget gap of over $16 billion dollars that had been projected for the fiscal year that began on April 1, 2009.[56] The budget includes funding for major existing public and private coverage initiatives such as the state's part of the Medicaid match, Child Health Plus, Family Health Plus, Healthy New York, and the Indigent Care Pool.[57]

Total health care spending by New York State in 2009-2010 will be approximately $49.2 billion. Federal contributions will be approximately $29.2 billion. State-funded Medicaid spending is expected to total $13.4 billion. Of the state share, approximately $8.3 billion is general fund money and the remaining amount (a little over $5 billion) is from the HCRA and other sources. Unlike many states, New York splits the cost of Medicaid with its counties. Of the Medicaid that is funded by state and local governments, counties contribute approximately 29 percent and the state contributes approximately 71 percent. Local share funding for Medicaid is therefore likely to be around $6.6 billion.[58]

Financing for most coverage initiatives outside of Medicaid comes from what is known as the Health Care Reform Act (HCRA) fund, which was first implemented in 1996. HCRA, which totals about $5 billion, is financed from various sources. The 2009-2010

Figure 3: Medicaid and Related Health Care Spending in New York



Source: New York Division of the Budget. Note: State and local share amounts are affected by the temporary increase in the FMAP allocation under the American Recovery and Reinvestment Act.

budget shows that the largest amount comes from surcharges and an assessment on hospital revenues ($2.24 billion), a "covered lives" assessment on purchasers of insurance products ($1.17 million), cigarette tax revenues ($884 million), conversion proceeds ($95 million), a 1 percent hospital assessment ($306 million), taxes on for-profit HMOs ($131 million), and all other ($273 million).[59]

C. Challenges in New York

New York will face many challenges in financing universal coverage: the economy is weak; revenues from sources such as conversion funds cannot be realized quickly, as there typically is a lag between legislative approval and the ability of the insurer to go to market; and savings from investments in information technology, primary, or outpatient care also take time to accrue. And as Maine's experience demonstrates, avoided costs and/or savings can be difficult to quantify or capture; new sources of revenue, such as a soda tax, previously have been met with resistance.

Helping to alleviate New York State's revenue shortfall is several billion dollars in additional federal funding through a temporary FMAP increase under the stimulus legislation. The federal government may help New York by providing a federal match for public insurance program enrollees in Child Health Plus with incomes between 250 percent and 400 percent FPL, and the state is hoping to eventually use savings from an 1115 managed care waiver to cover new populations.

Even if the state can generate new revenues for more coverage initiatives, sustaining revenues adequate to pay for growing costs may be even more challenging. Massachusetts already has analysts predicting that the state will not be able to sustain its universal coverage initiative in five to ten years without significant cost controls and the state has a commission to reform reimbursement as part of an effort to control cost growth.[60]

D. Options for New York

Discussions about the best financing sources for universal coverage initiatives in New York will depend partly on the estimated cost of the four coverage proposals currently being modeled by the Urban Institute. There are reasonable arguments for and against every potential financing option. For example, if additional federal aid is obtainable, it may require the state to give up

some flexibility in designing programs funded with such aid. Raising taxes (or fees or "assessments") may have undesirable impacts on employers and individual purchasers of health insurance. Finding savings in the state's existing health care expenditures may mean reduced services for some recipients and fewer jobs in some sectors of the health care industry.

In examining ways to finance a large-scale coverage initiative in New York, several observations and potential options emerge.

i. Federal Financing and Medicaid Waiver Negotiations

The experiences of Massachusetts, Vermont, and other states suggest that New York cannot realistically achieve universal coverage without significant new revenues and that federal funding can be a major source of support. New York, like other states, already relies heavily on federal Medicaid matching funds. New York State will spend an estimated $20 billion of its own-source revenue (not counting federal funds) on Medicaid and other health programs this year. In addition to covering basic health services, the Medicaid program pays for an array of services and populations such as special education, services for persons with mental retardation or developmental disabilities, children in foster care, and alcohol and substance abuse services.[61]

The experiences of Massachusetts, Vermont, and other states suggest that New York cannot realistically achieve universal coverage without significant new revenues and that federal funding can be a major source of support.

If New York chooses to maximize federal matching dollars further it could seek to qualify other populations or programs, such as Family Health Plus or FHP buy-in for a federal match.[62] And to the extent that the federal stimulus funds are not already committed, they potentially could go toward planning or start-up costs for further coverage expansions, as was done in Maine in 2003 when additional federal dollars were made available to states. However, such funds would not be available on an ongoing basis.

The state also could seek flexibility in how the waiver cap and other expenses are negotiated. Massachusetts was able to leverage approximately $1 billion in additional federal dollars over the prior waiver by negotiating a three-year aggregate cap, modifying what was counted as "off-waiver" projected expenses, and excluding expenditures for people otherwise eligible for Medicaid from counting toward the cap. By counting certain expenditures as "off-waiver," such expenditures were not subject to the usual Medicaid budget neutrality requirements.

From the federal government's perspective, the cap on aggregate spending was a key element of the Massachusetts plan. Policymakers in New York may wish to consider whether agreeing to some upper limit on Medicaid expenditures could be worth negotiating as part of a potential waiver proposal that would also include an ongoing, significant increase in federal assistance. Such a step would, in turn, require identifying ways to limit future growth in costs.

As previously outlined in this paper, Vermont's waiver gave the state unprecedented control to consolidate funding for most of the state's Medicaid programs, as well as to act as a public

managed care organization, thereby allowing it to invest in services not otherwise covered by Medicaid and pursue innovative reimbursement models. New York could explore whether similar flexibility might be provided by the federal government during its own waiver negotiations.

ii. Using Savings and Redirecting Funds Under a Medicaid Waiver

New York also can use the flexibility of the Medicaid waiver process to generate and use savings for coverage initiatives. Currently, New York's 1115 Medicaid waiver, the Federal-State Health Reform Partnership (F-SHRP), which was most recently negotiated with the federal government in 2006 and expires in 2011, is investing up to $1.5 billion in reform initiatives. The state is required to generate $3 billion in gross Medicaid savings ($1.5 billion federal) over the five-year demonstration period.[63] New York could generate more savings under this waiver by continuing to better manage chronic diseases for persons enrolled in Medicaid, showing gains in population health improvement, or shifting consumers to lower-cost providers, as is being done in Minnesota and Vermont.[64]

The state should continue to seek ways to lower costs by focusing on high-cost patients. As reported in a United Hospital Fund publication, "the 4.5 million beneficiaries who did not use long-term care services in FFY [federal fiscal year] 2004 collectively accounted for $16 billion in Medicaid spending. The top 1 percent (numbering about 45,000) accounted for 20 percent of spending ($3 billion), at a per capita average of $71,000."[65] Pilot programs in seven New York health care organizations, aimed at reshaping patient care and reducing costs, produced some striking results. For example, patients in a pilot program at Bellevue Hospital Center recorded a 67 percent reduction in emergency department visits and 45 percent fewer inpatient admissions. If the state could successfully curb even 10 percent of expenditures for these high-cost patients through such strategies as avoiding hospitalizations, the savings could be $300 million or more annually. (Such steps would likely improve patient care dramatically, as well.) Under current federal reimbursement rules, such savings would be split between Washington, DC, and the state, with New York City and the 57 counties. State officials could consider seeking federal approval of new waiver rules that would allow the state and its localities to reap a higher proportion of such projected savings, given that Washington would benefit as well.

New York State also has the potential to realize more savings through the waiver process by streamlining administration of the Medicaid program. As it stands now, "more than a dozen state entities, 57 counties and the City of New York, and private contractors all play roles in the administration of Medicaid."[66] Efforts are underway to reorganize Medicaid administration, but savings from such actions could be clearly documented so money could be directed toward coverage initiatives.

The Citizens Budget Commission (CBC) estimated in 1995 that nearly $3.1 billion could be saved from streamlined administration of Medicaid and social services programs.[67] CBC noted, for example, that a more centralized process could improve recovery of payments from the estates of long-term care recipients. Such recoveries have become more frequent in recent years, but are still relatively uncommon. The Rockefeller Institute's Health Policy Research Center reported recently that counties across the state vary significantly in the proportion of Medicaid long-term care applications they deny because of asset transfers.[68] Such variations may suggest the potential for significant programmatic savings if Medicaid were administered consistently throughout New York. While the CBC report covered major programs outside Medicaid, and some of its recommendations have been implemented over the past decade, centralizing certain administrative duties under Medicaid would likely produce savings. The state will spend more than $1.1 billion on Medicaid administration this fiscal year, according to the 2009-10 Executive Budget. Such costs are split almost evenly between the state's General Fund and federal aid. Achieving administrative efficiencies of 15 percent, for example, would save the state more than $75 million and produce similar savings for the federal government that New York officials might seek to convert, at least in part, to additional savings for the state.

In addition to examining ways to use funds created through efficiencies, the state also could use the waiver process to redirect portions of other spending, such as graduate medical education or disproportionate hospital share payments, and receive a new federal match for coverage initiatives. More effective management of such a large portion of the budget could free up substantial resources for expansion of health coverage. One example of a redirection of funds included moving $141.3 million in graduate medical education funding to provide more resources for indigent care.[69]

In FY 2009 New York will receive over $1.6 billion in federal disproportionate share hospital allotments.[70] This figure is 14 percent of all DSH funds nationally.[71] In 2006, the Urban Institute estimated that $3.5 billion in government funding was transferred to uninsured care providers in New York. Some of these payments helped offset Medicaid underpayments while most of the remaining amount helped pay for uncompensated care.[72] Instead of retroactively reimbursing for uncompensated (and presumably less well managed care), the state could use some of these dollars to cover more uninsured.

Challenges for New York include successfully addressing the politics of shifting dollars from one area to another, effectively quantifying these savings, and realizing them in a timely manner.

Challenges for New York include successfully addressing the politics of shifting dollars from one area to another, effectively quantifying these savings, and realizing them in a timely manner. In seeking additional federal matching dollars, the state should evaluate whether it has the fiscal capacity to finance the state share of Medicaid. It also might keep in mind that not all federal administrations will be supportive of such expansions or

negotiations, and that waivers will be subject to renegotiation and therefore potential changes.

iii. Broad-Based Taxes

This paper does not examine in-depth the possibility of increasing the state's broad-based taxes — those on personal income, sales and use of goods and services, and corporate income — to pay for expanded health coverage. Such broad tax increases, when enacted, are generally intended to provide revenue for a range of public services, including existing health programs and public education. State leaders are well aware of such revenue options and make choices, as part of each year's budget deliberations, whether to change the structure of broad-based taxes.

As part of the current debate in Washington over health care reform, some observers have suggested including in taxable income the cost of employer-paid contributions for health insurance and long-term care insurance. Such contributions are currently excluded from federal taxable income and, because New York's income-tax structure follows the federal system for most purposes of defining taxable income, from New York tax as well. The state-level exclusion reduces New York taxpayer liability by an estimated $3.7 billion this year, according to the New York State Department of Taxation and Finance.[73] Outright elimination of the existing federal exclusion would be highly controversial and is speculative at this point. However, if Congress revises federal law in this area, New York policymakers may wish to consider conforming to any such change as one means of generating new revenue for health-insurance coverage.

Governor Paterson and the legislature agreed to create a new broad-based tax this year in the form of a payroll tax on employers within the 12-county Metropolitan Commuter Transportation District that will be used to expand services for the Metropolitan Transportation Authority. This payroll tax of 34 cents on every $100 of payroll is expected to generate $1.53 billion annually.[74] Supporters of the payroll tax for downstate transportation argued that it would support services that provide broad benefits to the region. Advocates of more widespread health-insurance coverage might make similar arguments. Opponents of the new tax criticize it as potentially harmful to the regional economy, where overall tax burdens are already relatively high. Recommendations for funding streams for coverage initiatives in California included a small payroll tax as one of several sources of revenue. It was thought that a payroll tax would be a more stable funding source if there were fluctuations in other revenue sources.[75, 76]

iv. Provider Taxes

Taxes on the health care industry are another substantial source of revenue for funding coverage initiatives. In New York, taxes on insurers include a covered lives assessment or charge for each individual policyholder. The 2009-10 enacted budget reflects $920 million in assessments placed upon state insurers, as well as

the extension of the covered lives assessment to insurers headquartered out-of-state ($5 million).[77]

A review of provider taxes by the National Conference of State Legislatures (NCSL) indicates that New York taxes a number of different types of providers and that in some instances, the taxes are higher than other states.[78] Specific revenues from providers for fiscal years 2008-09 and 2009-10 in New York are shown in Table 1.

Hospitals assessments, which are the largest source of funding for HCRA, will increase in the coming year, as will taxes on insurers.[79] Like some other states, New York has previously turned to taxes on health providers and health insurers to provide new revenue. In April 2009, Colorado instituted a hospital provider fee to increase Medicaid eligibility levels for parents and single adults, children and pregnant women, and others.[80] In Massachusetts, the state enacted mid-year one-time assessment increases on hospitals and insurers to help with a funding shortfall resulting from higher than expected enrollment in the program.[81] In New York, .05 percent average increase could produce as much as $225 million in new revenues.

Table 1. Overview of Revenues from Provider Taxes and Assessments in NYS

Provider Assessments - Base Collections:	2008-09 ($ millions)	2009-10 ($ millions)	Change ($ millions)
HCRA Surcharges on Hospitals/Clinics*	$2,054	$2,143	$89
HCRA Covered Lives Assessment (CLA)*	$925	$920	-$5
HCRA 1% Hospital Assessment*	$294	$306	$11
Nursing Home 6% Assessment*	$548	$548	$0
Sub Total Base Collections	**$3,821**	**$3,917**	**$95**
Enacted Deficit Reduction Plan (DRP) / Budget Proposals:			
DRP: Increase HCRA Covered Lives Assessment	$120	$120	$0
DRP: Shift HCRA Healthy NY / HMO Direct Pay to 332 Ins. Assessment	$178	$222	$44
Expand HCRA Covered Lives Assessment to Out of State Insurers	$0	$5	$5
Increase HCRA Surcharges to 9.63%	$0	$99	$99
Re-establish Hospital Assessment @ 0.35%	$0	$124	$124
Re-establish Home Care Assessment @ 0.35%	$0	$14	$14
Sub Total Enacted DRP / Budget Collections	**$298**	**$584**	**$287**
Total Collections	**$4,119**	**$4,501**	**$382**

** Source: New York State Division of the Budget. *2008-09 amount reflects actual collections per Office of the State Comptroller.*

Taxes on the health care industry are a robust source of revenue because they keep pace with cost growth in health care. But the question for New York policymakers is how much higher the state can raise these taxes. If the tax increases raise the cost of care too much, the revenue gains may be negatively offset by the number of persons who can no longer afford coverage. Various studies have shown that increases in the cost of health insurance may drive increases in the number of uninsured. Careful examination of the link between provider taxes and the cost of health insurance would help to inform decisions on this issue.

v. Sin Taxes

New York could revisit the possibility of instituting a soda tax or sin taxes, such as those on tobacco and alcohol products. Although the recent resistance to the state's proposed tax on nondiet soda and the defeat of a similar measure in Maine are not positive harbingers that such a tax would be successful in the future, there are at least a dozen other states that have targeted sales taxes on items such as soda, candy, or sweetened beverages.[82] New York might examine more closely how these states define the products

Tobacco taxes have been a substantial source of revenue for New York.

being taxed, tax rates, whether there was public opposition, and the ability of such sources to generate revenue for coverage.

Tobacco taxes have been a substantial source of revenue for New York. The state raised the tobacco tax in 2008 to $2.75 per pack, the highest in the nation.[83] In New York City and certain other jurisdictions, locally imposed levies add substantially to the tax. The state tobacco tax generated $973 million in 2008.[84] An additional 1 percent increase in the tobacco tax, for example, could generate approximately $9.7 million in new revenue. However, it is not clear how much higher the state can raise these taxes before taxable consumption drops to the point where the revenue generated is less than what it would be with no tax increase.[85]

One study that examined the effect of taxes on consumption and revenues concluded taxes typically raise revenues.[86] The study also found that the proportionate reduction in demand for alcohol after introduction of a tax was smaller than the proportionate size of the tax revenue increase, because consumers respond slowly to price hikes.

New York's taxes on spirits, wine, and beer were $6.44, $.19, and $.11 per gallon, respectively, as of January 1, 2009.[87] Compared to New York, taxes on spirits were at least twice as high in states like Oregon, Washington, and Virginia.[88] (On the other hand, states such as California, Connecticut, and Maryland impose some alcoholic-beverage taxes that are lower than those in New York.) If New York raised alcohol taxes by, for example 5 percent, it could generate approximately $10.3 million in new revenues.[89]

The enacted 2009-10 state budget increases alcoholic beverage taxes on wine and beer, generating an estimated $14 million in new revenue.[90] At least a dozen states have considered stand-alone alcohol tax increases.[91] Proposals in New York's executive budget, but not in the enacted budget — including a proposal to allow the sale of wine in grocery stores that was rejected by the legislature — would have generated a further revenue increase of more than $100 million. However, such taxes would have likely gone to general revenues rather than earmarked for state coverage initiatives.

In addition, had the governor's proposed 18 percent "soda tax" passed it would have generated an additional $404 million in revenue. If the public were willing to support a tax in the future if it was earmarked for universal coverage, the governor or legislature could consider reintroducing the tax.

The state also might consider generating revenue for health coverage by collecting taxes on cigarettes sold on Native American reservations to non-Native Americans. Projections about the amount of revenue that could be generated from this source range from $70 million to $400 million in revenues.[92]

vi. Employer Contributions

In Massachusetts and Vermont, employer contributions in the form of fees have been small but have been important to the concept of sharing responsibility for financing. New approaches that

promote employer-based health care, such as Section 125 plans or health savings accounts, or an individual mandate to obtain coverage could also be considered as a means for bolstering employer coverage and avoiding the need for public health coverage or additional public financing.

The individual mandate in Massachusetts was significant in assuring that individuals accessed employer-sponsored coverage. In fact, the business community estimated that as much as $750 million in employer contributions was generated for their share of the premiums once individuals signed up for employer-sponsored insurance.[93] Such a strategy is unlikely to be robust enough to offset the total costs for financing universal coverage but it could help alleviate the need for new government revenues.

VI. Conclusion

Most of the potential revenue streams discussed in this paper, if implemented on their own may not be robust enough to finance universal coverage, suggesting that states will either have to move incrementally with coverage initiatives, significantly reduce the rate of health care cost growth, or draw upon multiple sources in attempting to finance universal coverage. However, the report identifies several potential revenue sources that could make financing for universal coverage in New York possible. The state also could take advantage of a timely opportunity to secure federal funds for coverage initiatives through the Health Resources Services Administration.

Even if New York is able to secure funds, the experience of Massachusetts suggests that New York should implement strategies that lower costs. Massachusetts is experiencing difficulty sustaining financing for its universal coverage program and has established a commission that is examining ways to control cost growth.[94] The commission is expected to recommend changes to the way doctors and hospitals are reimbursed. New York is already engaged in reimbursement reforms, and continuing these reforms could potentially lower future costs and the need for revenue.

Beyond the question of what revenue sources to draw upon, the process that New York uses to determine sources for financing coverage initiatives will also be important. A shared approach to financing that involves contributions from several different groups, and a process that is iterative and allows for public input, may be viewed as more equitable. An approach of shared responsibility for financing was important to initial success in Massachusetts and could be important for other states as they seek ways to finance coverage initiatives.[95]

Endnotes

1 Donald Boyd, What Will Happen to State Budgets When the Money Runs Out?, Rockefeller Institute of Government, February 2009.

2 Because the focus of this paper is state options for financing coverage initiatives, it does not cover in-depth all financing mechanisms such as changing the tax treatment of employer-based insurance or broad-based increases in federal taxes.

3 "Sin" taxes refer to taxes targeted at products such as cigarettes, alcohol, or soft drinks, which are often considered unhealthy.

4 For a state-by-state breakdown of what percent each state and the federal government pay for Medicaid, see http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4, accessed 3/13/09. States that paid the maximum state share of 50 percent include: CA, CO, CT, DE, IL, MD, MA, NH, NJ, NY, VA, WY.

5 SCHIP is a public health insurance program available to persons with slightly higher incomes than those who qualify for Medicaid.

6 States pay anywhere from 17 to 35 percent of the SCHIP cost. From the Georgetown University Center on Children and Families, http://ccf.georgetown.edu/index/full-brief, accessed 3/13/09.

7 http://www.statehealthfacts.kff.org/comparemaptable.jsp?typ=2&ind=203&cat=4&sub=53&sortc=1&o=a, accessed 5/18/09.

8 Ibid.

9 New York State's legislature has proposed a universal coverage plan for a "Medicaid buy-in," which would achieve universal coverage by allowing all individuals the option to purchase Medicaid coverage using a sliding scale, income-based premium system.

10 Massachusetts's new waiver established a three-year aggregate cap, compared to the annual cap of the previous waiver. The cap increased by $4.3 billion overall and by $1 billion for the Safety Net Care Pool (SNCP) over the prior three-year period. Waivers require "budget neutrality" meaning that no more can be spent on Medicaid than would be spent in the absence of the waiver (essentially a cap on funding). Because of the budget neutrality requirements, states assume the risk for costs that exceed the negotiated federal budget cap.

11 In the past, states used what are known as upper payment limits (UPL), intergovernmental transfers (IGT), and disproportionate share hospital (DSH) payments to draw down extra federal Medicaid matching dollars, but the money was not always spent on direct services. It was estimated that at least $10 billion in Medicaid UPL expenditures were made in 2000. The federal government issued regulations limiting state UPL matching practices in 2003 and further clarified rules regarding state matching funds in the Deficit Reduction Act (DRA) of 2005. For more information see Teresa Coughlin et al., in "States' Use of Medicaid UPL and DSH Financing Mechanisms in 2001," Urban Institute, January 2003. Provisions to clarify state matching allowances outlined in the DRA are reviewed in a paper from the National Academy for State Health Policy, Sonya Swartz et al., "Moving Beyond the Tug of War: Medicaid State Fiscal Integrity," August 2006.

12 Elliot Wicks, "Can a Sales Tax on Medical Services Help Fund State Coverage Expansions?" AcademyHealth State Coverage Initiatives, Robert Wood Johnson Foundation, July 2008, at http://www.statecoverage.org/node/161.

13 *Health Care Provider, Industry Taxes and Fees,* National Conference of State Legislatures (NCSL), updated March 3, 2009, at http://www.ncsl.org, accessed 3/12/09.

14 For information on the amount of the covered lives assessment for GME by region, see http://www.health.state.ny.us/nysdoh/hcra/gmecl.htm, accessed 4/6/09.

15 Colorado's High-Risk Pool, Colorado Health Institute, http://www.coloradohealthinstitute.org/documents/PolicyBriefs/High-RiskPool.pdf, accessed 3/24/09.

16 http://www.taxfoundation.org/taxdata/show/245.html, accessed 5/14/09.

17 Arturo Pérez, *Earmarking State Taxes*, FY 2005, National Conference of State Legislatures (NCSL), September 2008, p. 3.

18 Indiana House Bill No. 1164, Introduced Version, January 20, 2004, and Fiscal Impact Report of New Mexico Senate Bill 374 (dated 2/6/04).

19 The soda tax was opposed 60 to 37 percent according to a Quinnipiac poll released on December 24, 2008: http://www.quinnipiac.edu/x1318.xml?ReleaseID=1245, accessed 3/13/09.

20 Hawaii's employer mandate, enacted in September 1974, is unique in that it was grandfathered in and exempted from the federal Employer Retirement Income Security Act (ERISA) that Congress passed in the same year. ERISA is a pension reform law whose preemption clause had been broadly interpreted by the courts until the mid-1990s as prohibiting any state legislation that had any impact on or referred to private sector employee plan benefits, structure, or administration.

21 Few states have required employer cost-sharing because of limits established by ERISA. This legislation limits the ability of states to require certain employers to provide general cost-sharing. The degree to which ERISA limits employer cost-sharing is not entirely clear and is being tested by states through the legislative and judicial process. Maryland also passed legislation requiring certain employers to provide health coverage for employees. This legislation was found to violate ERISA. To date, the Massachusetts employer payment requirement for employers not offering health insurance has not been successfully challenged.

22 *State of the States*, State Coverage Initiatives, Robert Wood Johnson Foundation, January 2008.

23 Savings in Maine were expected to be achieved through a reduction in bad debt and charity care as a result of more people becoming insured, as well as other cost containment measures in the law (e.g., reductions in hospital trend lines resulting from voluntary hospital margin benchmarks, expanded certificates of need, etc.).

24 Elizabeth Kilbreth and Kimberley Fox, *The Dirigo Health Reform Act: A Case Study of Small Group Market Reform in Maine*, Rockefeller Institute of Government, September 2008.

25 *State of the States*, State Coverage Initiatives, Robert Wood Johnson Foundation, February 2009. It is not clear if the savings achieved in Minnesota go directly toward coverage initiatives; rather, many of the initiatives restructure health care more generally. According to a conversation with Julie Sonier on April 6, 2009, director of the Health Economics Program at the Minnesota Department of Health, savings estimates will be available in June 2010.

26 The Oklahoma Tobacco Settlement Trust Fund "constitutionally protects the majority of the settlement funds in an endowment from which only the interest and dividend earnings may be spent on programs to improve the health of Oklahomans." For more information, see http://www.ok.gov/tset/index.html, accessed 3/12/09. New Mexico's tobacco settlement funds are "governed by a law passed in 2000 by the Legislature and signed by Governor Gary E. Johnson (R) that placed 50 percent of the state's tobacco settlement payments in a permanent trust fund, and allowed the other half to be placed into a tobacco settlement program fund to be spent on a variety of health-related programs appropriated through the state's annual budget process." http://www.tobaccofreekids.org/reports/settlements/state.php?StateID=NM, accessed 5/20/09.

27 John Holahan et al., *State Responses to Budget Crisis in 2004: An Overview of Ten State*s, Urban Institute, January 2004. The New York case study was written by Teresa Coughlin.

28 Family Health Plus is a public health insurance program for adults ages 19 to 64 who have income or resources too high to qualify for Medicaid. Family Health Plus is available to single adults, couples without children, and parents who are residents of New York State and are United States citizens or fall under one of many immigration categories. For more information see http://www.health.state.ny.us/nysdoh/fhplus/. The Healthy NY program is designed to assist small business owners in providing their employees and their employees' families with the health insurance they need and deserve. In addition, uninsured sole proprietors and workers whose employers do not provide health insurance may also purchase comprehensive coverage directly through the Healthy NY program. For more information see http://www.ins.state.ny.us/website2/hny/english/hny.htm.

29 Amy Tiedemann, et al., *Sustaining the Charitable Mission of Horizon Blue Cross Blue Shield after Conversion to a For-Profit Corporation: Issues and Best Practices: Discussion Paper*, Rutgers Center for State Health Policy, February 2003.

30 Jordan Rau, "Governor looks to Lotto as healthcare fix," *The Los Angeles Times*, October 10, 2007.

31 Sharon Ward and Judith Lave, Medicaid Spending in Pennsylvania, Pennsylvania Medicaid Policy Center, http://www.pamedicaid.pitt.edu/documents/pabudgetfs_format-pak_5_.pdf, accessed 3/31/09.

32 Donovan Slack, "Menino tries his luck at procasino lobbying," *The Boston Globe*, February 20, 2008, at http://www.boston.com/news/local/massachusetts/articles/2008/02/20/menino_tries_his_luck_at_proc

asino_lobbying/, accessed 3/12/09. Governor Patrick's proposal was rejected by the state's House of Representatives in 2008. See Glen Johnson, "Cahill: Build slot parlors instead of casinos," Associated Press, March 3, 2009, at http://www.southcoasttoday.com/apps/pbcs.dll/article?AID=/20090303/NEWS/90303007, accessed 3/12/09.

33 GAO–HEHS-00-162, "State Pharmacy Programs: Assistance Designed to Target Coverage and Stretch Budgets – (Table 5)" U.S. Government Accountability Office (GAO), September 2000.

34 For a more detailed description of the Oklahoma program see Alice Burton, Isabel Friedenzohn, and Enrique Martinez-Vidal, *State Strategies to Expand Health Insurance Coverage: Trends and Lessons for Policymakers*, by Commonwealth Fund, January 2007.

35 Kaiser Commission on Medicaid and the Uninsured.

36 Information obtained from a conversation with Oklahoma state officials Matt Lucas and Nico Gomez on 12/19/08.

37 *State of the States*, State Coverage Initiatives, Robert Wood Johnson Foundation, February 2009.

38 Information obtained from a conversation with Seema Vera, consultant, by phone on 12/4/08 and by e-mail on 3/5/09.

39 Efforts to implement a hospital tax to expand the program were defeated.

40 Information obtained from a conversation with Joan Henneberry, executive director for the Colorado Department of Health Care Policy and Financing, 12/15/08.

41 http://www.kaisernetwork.org/, accessed 1/8/09.

42 Information on Vermont is based on a literature review and interviews with stakeholders conducted by the Muskie School of Public Service, University of Southern Maine under a grant from the RWJF SHARE initiative.

43 Act 71 of 2007 revised the original use of this fund as established in Acts 191 and the State Appropriations Bill of 2006, to limit it to Catamount Health, ESI Premium Assistance, Immunization Initiatives, and the Blueprint for Health and deleted previous uses allowed for non-group market health insurance market assistance and transfers to the Medicaid fund, *Overview of Vermont's Health Care Reform*, State of Vermont Agency of Administration, October 2008.

44 A $.60 per pack increase began on July 1, 2006 and an additional $.20 per pack increase became effective July 1, 2008.

45 Assessments on small employers were phased in from employers of eight or more FTEs in 2007/2008 to employers with four or more in 2010.

46 Consultants for the state have proposed other funding sources, including a 1 percent increase in the sales tax and expansion of the tax to other items. Elimination of the capital gains exemption also was proposed, but the governor was committed to no new taxes. Another proposed funding source for the program, a cigarette tax, was viewed by stakeholders as uncontroversial and became part of the political compromise that helped complete funding to finance the program.

47 Information on Massachusetts is based on a literature review and interviews with stakeholders conducted by the Muskie School of Public Service, University of Southern Maine, under a grant from the RWJF SHARE initiative.

48 The Massachusetts uncompensated care pool (UCP), created in the 1980s, is funded by assessments on hospitals and insurers ($160 million each) and matching state and federal DSH dollars. Prior to health reform, individuals ineligible for MassHealth were eligible to receive full free care up to 200 percent FPL and partial care up to 400 percent FPL through the free care pool. Hospitals and community health centers submit bad-debt charity-care expenses to the state and receive a portion back to promote the use of primary care.

49 In 1997, Massachusetts received an 1115 Medicaid managed care waiver, which sought to expand MassHealth (Massachusetts Medicaid program) coverage. The uncompensated care pool maintained funding at 100 percent even though the number of people served by the pool declined due to MassHealth's expansion. To defray costs incurred in providing uncompensated care to the uninsured or by treating disproportionate numbers of Medicaid patients at lower reimbursement rates, the state's two largest

safety-net hospital systems created their own Medicaid MCOs under the waiver, and the state paid them annual "MCO supplemental payments" above and beyond capitation payments for Medicaid beneficiaries enrolled in MCOs. These two systems also received special "hospital supplemental payments" beyond DSH payments in the UCP. The waiver authorized use of intergovernmental transfers (IGTs) from these providers in lieu of state general fund appropriations in order for the state to finance the non-federal share of the MCO supplemental payments. According to the U.S. Government Accountability Office (GAO), by 2006, Massachusetts was distributing through all its various supplemental payments $1.6 billion a year in federal and state Medicaid funds. In 2005, the MCO supplemental payments amounted to $770 million, of which $385 million were federal matching funds.

50 Stephanie Anthony, R. Seifert, and J. Sullivan, *The MassHealth Waiver 2009-2011…and Beyond*, Massachusetts Medicaid Policy Institute and Massachusetts Health Policy Forum, February 2009. With this money, the state created a Safety Net Care Pool (SNCP), which combined funding from the former MCO supplemental payments ($770 million in state and federal payments) with funding from the state's disproportionate share hospital program ($574.5 million) that had been used to fund the Health Safety Net (HSN) Trust Fund (formerly the Uncompensated Care Pool).

51 Ibid. The SNCP also funds the Healthy Safety Net, and supplemental payments to be phased out over time to the two providers that previously received supplemental MCO payments.

52 Under the new agreement, Massachusetts renegotiated the budget neutrality cap to $21.2 billion for the three-year extension, an increase of $4.3 billion over the prior year period. The SNCP cap was increased to $4.6 billion for three years, a $1 billion increase over the prior three-year period. This renegotiated cap allows the state to meet all health care obligations for FY 2009 and allows the governor to expand $1 billion for programs in the safety net care pool. This expanded federal contribution is expected to keep the program solvent through 2010.

53 In order to avoid "crowd-out" of employer-based coverage (employers changing their insurance offerings because of the existence of public insurance), the definition of what is a "fair and reasonable" contribution on the part of employers was defined broadly, limiting the number of employers that were likely to be subject to the penalty. The contribution from employers initially required that they have at least 25 percent of full-time employees enrolled in the employer's health plan or the employer must offer to pay at least 33 percent of the employee insurance plan's premium costs. More recent rules changed the language to require that both conditions be met. Employers were also required to set up Section 125 plans to allow employees to purchase health insurance with pre-tax dollars or potentially be subject to a free rider surcharge for uninsured employees using services through the uncompensated care pool. No free rider surcharges have been collected, as all employers have provided Section 125 plans. Actual Fair Share contributions by employers also have been lower than expected. In FY 2008 filings to date, only $5 million was collected relative to $23.9 million estimated in the budget for FY 2008 as a whole. The FY 2009 budget only anticipates $5 million in revenues from this source. As most employers complied with making Section 125 plans available, no revenues have been generated from the free rider surcharge.

54 The financial sustainability of the program over time continues to be a question. After the mid-year supplemental appropriation, Commonwealth Care enrollment slowed, thus relieving some of the cost pressures on the program. In the short-term, the increased availability of federal dollars under the state's new waiver has allowed the state to avoid any major cutbacks to Commonwealth Care and has even expanded the program to $869 million under the governor's proposed FY 2009 budget.

55 A description of the four proposals that are being modeled may be found at http://partnership4coverage.ny.gov/.

56 The size of the budget gap has increased from approximately $14 billion to $16 billion according to the Albany *Times Union*, http://www.timesunion.com/AspStories/story.asp?storyID=783255, accessed 3/25/09.

57 Financing for specific types of services, such as prescription drugs through the Elderly Pharmaceutical Insurance Coverage Program (EPIC) might also be considered part of the coverage initiatives, although this paper focuses on expanding coverage for new populations rather than specific services.

58 The state and local share amounts are affected this fiscal year by the temporary increase in the Federal Medicaid Assistance Percentage allocation under the American Recovery and Reinvestment Act. All budget figures were obtained from the New York State Division of the Budget on 4/23/09.

59 Budget figures obtained from the New York State Division of the Budget on 4/23/09.

60 Kevin Sack, "Massachusetts Faces Costs of Big Health Care Plan," *The New York Times*, March 15, 2009.

61 For an overview of the Medicaid services provided to individuals by a range of state agencies and the cost of the services to Medicaid see Deborah Bachrach et al., *Administration of Medicaid in New York: Key Players and Their Roles*, pp. 6-8, United Hospital Fund, November 2006.

62 The Family Health Plus buy-in program allows employers and Taft-Hartley (union) funds to offer health coverage to employees through an expansion of the state's Family Health Plus (FHP) program. From "Health Care for All New York Fact Sheet," February 2009, at http://hcfany.files.wordpress.com/2008/11/hcfany_fhp_buy_in.pdf, accessed 4/3/09.

63 CMS is counting savings generated in two areas: hospital utilization resulting from eliminating excess acute care capacity and savings generated through Medicaid managed care expansions. Should the state not achieve these savings by the end of the demonstration, it will be required to refund to the federal government the difference between the federal investment in the F-SHRP reforms and the federal savings generated. Source: "New York Federal-State Health Reform Partnership Section 1115 Demonstration Fact Sheet," October 1, 2006, available at http://www.cms.hhs.gov/.

64 Information on Minnesota's 2008 health reforms was taken from Julie Sonier, "Health Care Reform Cost Savings," PowerPoint presentation to the State Coverage Initiatives on July 31, 2008 and from a phone conversation on 4/3/09. Savings are estimated by taking the difference between projecting the cost of health care in the absence of reforms and actual health costs. See http://www.statecoverage.org/files/2008_SCI_Summer_Meeting_Value%20Enhancement-Sonier.ppt.

65 Michael Birnbaum and Deborah Halper, *Rethinking Services Delivery for High-Cost Populations,* United Hospital Fund, March 2009.

66 Bachrach, et al., *Administration of Medicaid in New York.*

67 Final Report of the Budget 2000 Report, Citizens Budget Commission, http://www.cbcny.org/2000.htm#socialwelfare, accessed 5/14/09.

68 This calculation is made using the GDP deflator, which was 58.5 percent from 1996-2008.

69 Enacted budget at http://www.budget.state.ny.us/pubs/press/2009/press_release09_enactedHealthCare.html, accessed 5/14/09.

70 From the Kaiser Commission on Medicaid and the Uninsured. Found at http://www.statehealthfacts.kff.org/comparetable.jsp?ind=185&cat=4, accessed 5/13/09.

71 The total national DSH allotments are estimated to be $11.3 billion.

72 Randall Bovbjerg et al. *Caring for the Uninsured in New York,* Urban Institute, October 20, 2006.

73 *Annual Report on New York State Tax Expenditures*, 2009-10, p. A-2.

74 The payroll tax is 34 cents for every $100 of payroll. See http://www.nytimes.com/2009/05/06/nyregion/06mta.html?_r=2&scp=2&sq=MTA%20bailout&st=cse.

75 Tracy M. Gordon and Kim S. Rueben, *Financing Health Insurance Coverage: California's Revenue Structure and Options*, New America Foundation Health Policy Program, 2008.

76 In Massachusetts, proposals to impose a payroll tax contributed to the business community's support of the more modest employer assessments.

77 New York State Division of the Budget press release, March 29, 2009.

78 *Health Care Provider, Industry Taxes and Fees*, National Conference of State Legislatures (NCSL), at http://www.ncsl.org, accessed 4/2/09.

79 According the enacted budget documents, hospitals will face a 0.35 percent assessment on revenues, which is expected to generate $124.3 million.

80 Expansions for children and pregnant women were raised from 205 to 250 percent FPL; parent levels were raised from 60 to 100 percent FPL; disabled adults and children can buy-in to Medicaid up to 450 percent FPL and childless adults are covered up to 100 percent FPL. Reported by "Stateside," an e-publication of AcademyHealth State Coverage Initiatives, at http://newsmanager.commpartners.com/ahstsd/issues/2009-04-23/4.html, accessed 4/24/09.

81 Information on Massachusetts is based on a literature review and interviews with stakeholders conducted by the Muskie School of Public Service, University of Southern Maine, under a grant from the RWJF SHARE initiative.

82 See http://www.mass.gov/bb/h1/fy10h1/prnt10/exec10/pbudbrief19.htm, accessed 4/1/09. It is not clear how many of these taxes have funded coverage initiatives as opposed to other public health programs.

83 *Health Care Provider, Industry Taxes and Fees*, National Conference of State Legislatures (NCSL), at http://www.ncsl.org, accessed 4/3/09.

84 Tax amount found at http://www.census.gov/govs/statetax/0833nystax.html.

85 The city of New York levies an additional tax on tobacco, bringing the cost per pack to approximately $10.

86 Frank J. Chaloupka, et al., "The Economics of Tobacco Control," *Briefing Notes in Economics*, Issue No. 63, December 2004/January 2005.

87 http://www.taxfoundation.org/files/variousstaterates_2009-20090410.pdf, accessed 5/14/09.

88 The Tax Institute indicates that taxes in Oregon, Washington, and Virginia are $20.76, $19.51, and $19 per gallon, respectively.

89 This figure is calculated by taking 5 percent ($10,263) of total alcoholic beverages sales tax revenues ($205,253 in 2008) at http://www.census.gov/govs/statetax/0833nystax.html, accessed 5/14/09.

90 From the New York State Senate Majority State Budget Summary.

91 National Conference of State Legislatures, http://www.ncsl.org, accessed 4/27/09.

92 Division of the Budget estimates were $70 million, while Senator Nozzolio estimated a $400 million spike in revenue, according to an article by Valerie Bauman found at http://indiancountrynews.net/index.php?option=com_content&task=view&id=4306&Itemid=33, accessed 5/14/09.

93 Information is based literature reviews and interviews with stakeholders conducted by the Muskie School of Public Service, University of Southern Maine under a grant from the RWJF SHARE initiative. It is estimated that the individual mandate resulted in 159,000 more people using employer-based coverage.

94 *Medical News Today* at http://www.medicalnewstoday.com/articles/149490.php, accessed 5/14/09.

95 Some of these suggestions were provided at forum held at the Rockefeller Institute on December 5, 2008. Full audio is available at http://www.rockinst.org/health_care/nys_health_policy.aspx.