Definitions and Discussion

Cover All Kids/Major Expansions

Following **Illinois'** lead, **Cover All Kids** proposals, which typically build on Medicaid and SCHIP and include sliding scale premiums, are being pursued in many states this year. Supporters, including **Oregon** Gov. Ted Kulongoski, believe that expanding coverage to all children can lay the groundwork for comprehensive **health care for all** reform. He said, "If you drive the plan into the middle class, it's not just viewed as a public assistance program. You build a base of support for the program to provide health care for all of us."

Adult Expansions

Direct Medicaid expansions for parents and childless adults are increasingly important components of both incremental and comprehensive reforms. States are also increasing eligibility for free or subsidized insurance programs, such as a proposal in **New Mexico** to raise income eligibility from 200% of the poverty line to 300% for the **State Coverage Initiative** which combines public and private dollars to offer a basic level of services to eligible residents.

Public/Private Program

Starting with the roll-out of **Maine's DirigoChoice** insurance program in 2005, states have increasingly looked to public/private arrangements to increase health insurance options for low-income residents and small businesses. As in Maine's case, the state determines eligibility and benefits design and offers subsidies for the purchase of insurance from qualifying health plans.

Pay or Play/Employer Mandate

Employers have precipitously dropped health care benefits in recent years. In response, more states are requiring employers to provide coverage or pay a fee to help fund expansion efforts. **Massachusetts** and **Vermont** included pay or play provisions in their reforms enacted in 2006 and will soon require employers to provide coverage or pay a small fee: $295 per year for each uncovered employee in Massachusetts and $1 a day per uncovered employee in Vermont. **San Francisco's** plan to cover the uninsured includes a more robust "pay or play" provision, requiring employers to spend a certain amount on health benefits or pay a fee that could be as much as $180 per month per employee.

Individual Mandate

More states are looking to pair employer mandates with mandates on individuals to obtain health insurance. **Massachusetts** became the first state to require individuals to obtain a minimum set of benefits, effective July 1, 2007. However, the affordability of the mandated coverage is a major issue, with actual costs for an individual to be an estimated $380 per month with a $2,000 deductible, far exceeding initial estimates.

Reform Commission

Several states are using commissions to develop comprehensive reforms. A **New Mexico** commission will compare the estimated costs and effectiveness of three different proposals to achieve universal access in the state, from a single-payer system to a public/private model that builds on employer-based coverage.

Single-Payer

A single-payer health care financing system would ensure all residents have access to health care. A single entity, or government run organization, would collect all health care fees and pay out all health care costs. Traditional **Medicare** is a form of a single-payer system for US citizens age 65 and older.

Insurance Market Reforms

Examples of insurance market reforms include: **guaranteed issue** in the individual and small group markets so that no one can be denied coverage based on their health status or perceived risk; **community rating**, which establishes a single premium rate, or range, for an insured population often regardless of health status and gender; and, **merging the individual and small group markets**.

Cost Controls and Quality Improvement

States increasingly recognize that containing health care costs and improving quality of care are vital to sustainable **health care for all** reforms. In fact, improving quality by reducing medical errors, for instance, saves costs. Maine established the **Maine Quality Forum** to serve as a quality watchdog and promote best medical practices. Cost and quality efforts include: expanding coverage to the uninsured to reduce the bad debt and charity care cost shift; increasing medical loss-ratios to limit insurance company profits and administrative expenses; regulating hospital construction and acquisition of costly equipment through Certificate of Need; reducing hospital-based infections; and, promoting best medical practices.