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Wellmark. BlueCross BlueShield of Iowa

Statement to Joint Appropriations Subcommittee on Health & Human Services

February 7, 2007

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Wellmark Blue Cross Blue Shield of Iowa

Wellmark Blue Cross Blue Shield of Iowa supports efforts to create a mechanism to enable a broad-based group to discuss options for improving Iowa's health insurance market and providing greater access to affordable coverage. Such efforts are consistent with our corporate vision of continuously improving the health of our members and the communities we serve. Implementation of a health reform commission is under consideration in several states at the present time, including South Dakota where Wellmark also operates.

The Wellmark public policy agenda is guided by four inter-related objectives:

- To strengthen the state-regulated health insurance market that has produced in Iowa one of the highest levels of health coverage in the nation
- To improve the Iowa health care delivery system that is threatened by inadequate public program payments, increased public health demands, quality concerns and health care worker shortages.
- To address the drivers of health care costs, the greatest barrier to accessing coverage, because close to 85 cents of every dollar of Wellmark premium goes directly to Iowa hospitals, physicians and other health care providers for services received by our members.
- To reduce the number of uninsured through strategies targeted at the specific and diverse needs of the various segments of Iowa's uninsured population

The time is right for an Iowa health reform discussion. It has been more than 15 years since a similar effort focused on the problems of cost, quality and access was undertaken. Much has changed during the past 15 years—reform of the individual and small group insurance markets in

the state; the information technology explosion; increased consumer demands for new and costly medical treatments; shrinking government reimbursement for providers; new public health risks; and erosion of the employer-based health insurance system. Yet the underlying challenges of 15 years ago remain the same today------health care costs rising faster than general inflation, medical errors continuing at unacceptable levels and access to affordable health care increasingly out of reach.

Any broad-based discussion of Iowa's health insurance market should focus on crafting solutions that meet the unique needs of the Iowa environment and avoid disruption of those aspects of the system that has allowed close to 90% of Iowans to be covered and at premium rates for private health insurance which according to Families USA are well below the national average. The first goal of any reform efforts should be to "do no harm" to those persons and businesses with coverage today. Proposals that result in driving up the cost of coverage for the currently insured may have the unintended consequence of shifting the uninsured population, not reducing it overall.

A second goal should be to acquire a clear and thorough understanding of Iowa's uninsured population so that solutions are crafted to meet their specific needs. Because the cost of coverage is a significant barrier, addressing the underlying drivers of health care costs should be included in the work of the commission. Mandated benefits are one of these costs, therefore, a review of current and proposed mandates would be a helpful addition to the charge of the commission.

Third, as the work of the interim commission is being defined, it would be unfortunate if the opportunity to make incremental reforms yet this session is missed. Bi-partisan consensus appears to be developing around a series of steps that could be implemented while the work of the commission proceeds. For example, proposals offered by the Federation of Iowa Insurers would provide additional flexibility for associations to separately pool their risks. These proposals would also encourage the use of wellness credits and other premium flexibility in the small group market which if adopted could result in lower costs for some small groups yet this year. Enactment of these incremental reforms this session should be pursued.

Unlike the other health insurers active in the state, Wellmark Blue Cross Blue Shield is focused exclusively in Iowa and South Dakota and covers more than 1.6 million in Iowa alone. This large database of information enables us to provide policymakers with extensive information on where health care is delivered in Iowa and variations that exist within the state from community to community. In addition to this information which is publicly available on our website under "The Wellmark Report", we can provide actuarial expertise on how Iowa insurance market performs today and analysis of proposed changes under consideration by the commission.

Wellmark Blue Cross Blue Shield of Iowa is part of a network of more than 30 independent Blue Cross Blue Shield plans that insure over 94 million people nationwide, nearly one in three of all Americans. Through our affiliation with the Blue Cross Blue Shield Association, we have access to comparative information on other states' insurance markets. For example, we know that the Massachusetts individual and small group insurance markets were structured very differently than those in Iowa. Policy decisions adopted by that state in prior years resulted in the individual market becoming so high priced as to be non-viable, necessitating major insurance market reform as part of the comprehensive legislation in 2006. Iowa's needs may involve different solutions.

Other information from BCBSA includes the just-released report *Expanding Access to Coverage -- Overview of State Initiatives: 2003-2006*, copy of which is attached for your consideration. BCBSA has also been an active member of the multi-stakeholder coalition, Health Care Coverage for the Uninsured (HCCU) which released its proposal last month.

HCCU, a group of 16 major national organizations including physician and hospital associations, insurers, business interests and consumer advocates, reached consensus on a two-part approach to address the uninsured problem at the federal level. Phase 1 calls for the immediate expansion of coverage for children through reauthorization and expansion of SCHIP, targeted tax credits for families and grants to states for innovation. Phase 2 focuses on uninsured adults and calls for expansion of Medicaid eligibility, tax credits and other measures. HCCU's recommendations include a balance of private and public initiatives and are the culmination of meetings over the past two years among organizations with often diverse views.

While work proceeds at the national level, Wellmark is committed to working constructively with Iowa policymakers to address the unique needs for Iowa's uninsured population.

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

News Release

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Expanding Coverage Options, Partnering With Private Sector And Promoting Healthcare Quality Top States' Legislative Agendas

Blue Cross and Blue Shield Association "State of the States" report provides update on top legislative healthcare and insurance issues from around the country

WASHINGTON – State lawmakers aggressively worked on a broad variety of approaches to expand access to affordable, quality healthcare, according to the Blue Cross and Blue Shield Association's (BCBSA's) annual *State Legislative Health Care and Insurance Issues* report, released today. The report found that in 2006 state lawmakers turned to the private sector to assist in expanding coverage through a range of initiatives, including employer and individual mandates; public-private insurance partnerships; and initiatives to improve quality.

Susan Laudicina, BCBSA director of state services research, provided an overview of the report that included an update on how state legislators addressed key health issues during 2006 and the trends to look for in 2007.

The report compiles state legislative information and trends from a BCBSA survey of each of the independent Blue companies around the country. In addition, the report includes reference tables and graphs that summarize state legislation in major issue areas on a state-by-state basis.

(more)

2006 Trends in State Healthcare Legislation

After surviving significant budget deficits from FY 2001-2005, states continue to face fiscal pressures. Lawmakers turned to the private sector to help expand access to affordable care. They pursued this goal in 2006 through legislative reforms that: (1) mandated private employers and individuals to assume responsibility for covering the uninsured; (2) built public-private partnerships to promote coverage and contain costs; and (3) promoted quality healthcare.

Mandating Employer and Individual Responsibility

Three states pursued broad coverage expansions for their residents by enacting employer and/or individual insurance mandates: Massachusetts, Vermont and Maryland. These initiatives have sparked debate across-the-country. Although a variety of similar bills were introduced in 25 other states during 2006, none were enacted.

Building Public-Private Partnerships

During 2006, 11 states created or expanded innovative programs to make private insurance coverage affordable for low-income workers, some of whom may also be Medicaid-eligible. Seven of these states (AR, KY, OK, RI, UT, VT, WA) will leverage public funds to help subsidize the premium cost of private employer-sponsored health plans for Medicaid eligibles as well as other low-income workers. In Arizona, Massachusetts and Tennessee, eligibility for premium subsidies is restricted to non-Medicaid eligibles.

Promoting Quality Healthcare

A growing number of lawmakers are recognizing the potential of health information technology (IT) to improve patient safety, quality of care and increase efficiencies. Many states have formed or are forming collaborative partnerships with key stakeholders, including providers, payers and state agencies to develop state roadmaps for advancing health IT. Twelve states approved proposals to promote the adoption of integrated, statewide health IT systems. Transparency also emerged as an important issue during the 2006 sessions. State officials increasingly recognized that educating consumers about healthcare services holds promise for improving quality and promoting cost consciousness.

Based on the legislative debates of 2006, the report also predicted that the following initiatives are likely in 2007:

(more)

- State lawmakers will explore how best to expand coverage to their citizens and may consider whether provisions of the Massachusetts universal coverage law (e.g., individual responsibility, employer assessment) can work in their states, given their unique political, economic and business environments. In particular, officials will debate whether adequate funding sources exist for broad coverage expansions.

- States will continue to examine incremental measures to promote affordable and high quality healthcare services (e.g., "mandate-lite" policies; employer premium subsidies; and Medicaid reforms that incorporate best practices).

- The quality and cost transparency debate over the approach that will most benefit healthcare consumers will continue in 2007 legislative sessions.

- Advances in health IT networks will be a top priority as states look to increase quality of care while reining in costs. Developments in health IT are likely to take into account concerns for patient privacy and health data security.

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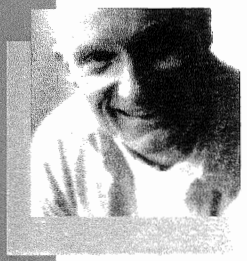
BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Expanding Access to Coverage

Overview of State Initiatives: 2003 - 2006



Office of Policy and Representation

Major State Initiatives to Expand Access to Coverage (2003-2006)

State lawmakers have pursued a variety of innovative strategies to expand access to health coverage since 2003. As described in the attached matrix, these trends fall into the following categories:

Employer/Individual Mandates

- Employer requirements for contributions in Massachusetts and Vermont aim to insure 95 percent or more of state residents
- Large employer "play or pay" mandate enacted in Maryland (preempted on ERISA grounds in U.S. District Court on 7/19/06); similar bills introduced in 25 states during 2006, but none have passed
- Unprecedented activity at local level calling for employers to cover workforce (i.e., New York City, San Francisco and Suffolk County in New York)
- Individual requirement to purchase "affordable" health products in Massachusetts

Medicaid/SCHIP Expansions

- Several states won federal approval to design flexible benefit packages tailored to specific, low-income populations and to encourage healthy lifestyles
- Many states expanded coverage to children and low-income parents

Small Group/Individual Subsidy Programs

- Public-private partnerships to offer employer premium subsidies are proliferating
- Tax credits to help employers purchase coverage enacted in some states

Insurance Market and Other Reforms

- Four additional states created high risk pools, bringing the total to 34
- Mandate waiver laws allowing sale of "mandate-lite" products remain popular
- Nearly all states authorized tax deductions for contributions to HSAs

Major State Initiatives to Expand Access to Coverage (2003-2006)

State	Employer/Individual Mandate	Medicaid/SCHIP Expansions and Other Innovations	Small Group/ Individual Subsidy Programs	Insurance Market Reforms	Other Initiatives
AL					
AK					
AZ			**Health insurance tax credit program** (2006) • *Eligibility* – uninsured small firms (2-25) and low-income individuals (<250% of FPL) • *Subsidy* – lesser of 50% of premium or $1,000 single coverage/ $3,000 family coverage	**Mandate waiver law** allows sale of "mandate-lite" products to uninsured small firms (2006)	**HSA contributions** deductible for state income tax purposes Voters approved a ballot initiative to raise the state tax on cigarettes to help fund public health programs (2006)
AR		Federal waiver permits subsidies for basic benefit product under the Safety Net Benefit Program (2006)	**"Safety Net Benefit" subsidy program** (2006) • *Eligibility* – uninsured low-income workers (under 200% of FPL) in firms with 2-500 employees • *Subsidy* – employer fees and employee premiums are under development		**HSA contributions** deductible for state income tax purposes
CA	• Employer "play or pay" mandate enacted 2003; SB 2 would have required firms with >50 employees to provide coverage or pay an assessment equal to 80% of premium **This law was rescinded by voters in November 2004 in a special ballot initiative.** • "Play or Pay" mandate bill (S 1414) for large employers vetoed by Governor on 9/13/06 • Single-payer bill (S 840) vetoed on 9/22/06 • San Francisco enacted an employer "play or	State health officials authorized to allocate new federal Medicaid waiver funds for pilot projects to expand coverage to low-income uninsured (2006)			Voters rejected a ballot initiative to raise tobacco taxes to fund expansion of the state CHIP program (2006)

Major State Initiatives to Expand Access to Coverage (2003-2006)

State	Employer/Individual Mandate	Medicaid/SCHIP Expansions and Other Innovations	Small Group/ Individual Subsidy Programs	Insurance Market Reforms	Other Initiatives
	pay" bill requiring employers with 20-99 workers to either provide coverage or pay $1.06/hour for employees who work at least 12 hours/week; requires firms with 100+ workers to provide coverage or contribute $1.60/hour into city uninsured fund; assessments capped at about $275/month per worker (2006)				
CO		Federal waiver expanded SCHIP eligibility from 185% to 200% of FPL (2005)	**Premium subsidy program** Legislative Committee directed to design a demonstration project that subsidizes private coverage for uninsured workers (2006)	• **Small group rating law** permits limited health status rating (2003) • **Mandate waiver law** allows sale of "mandate-lite" products to uninsured small firms (2003)	**HSA contributions** deductible for state income tax purposes
CT					• **HSA contributions** deductible for state income tax purposes • **Removed barriers to HSAs** by allowing qualified plans to apply deductibles for home health care visits (2004)
DE					**HSA contributions** deductible for state income tax purposes
DC		Expanded SCHIP eligibility from 200% to 300% of FPL (2006)	**"Healthy DC" subsidy program** (2006) • *Eligibility* - uninsured low-income individuals (200%-300% of FPL) *Subsidy* – would raise Blue Plan's tax on its indemnity business from 1% to 1.7% to fund subsidies		**HSA contributions** deductible for DC's income tax purposes
FL		Federal waiver allows Medicaid recipients to		**Mandate waiver law** allows sale of "mandate-lite"	

Major State Initiatives to Expand Access to Coverage (2003-2006)

State	Employer/Individual Mandate	Medicaid/SCHIP Expansions and Other Innovations	Small Group/ Individual Subsidy Programs	Insurance Market Reforms	Other Initiatives
		choose among competing MCOs that are paid on a capitated, risk-adjusted basis; benefits will vary for different populations; includes option for recipients to enroll in employer-sponsored coverage (2005)		products to uninsured low-income residents (2004)	
GA				**Mandate waiver law** allows sale of "mandate-lite" products to small firms (2005)	• Commission will make recommendations on creating/funding a high-risk pool (2005) • **HSA contributions** deductible for state income tax purposes
HI	[**Note**: Hawaii implemented an employer mandate law in 1974, under an ERISA waiver from Congress]	Federal waiver permits SCHIP expansion from 200% to 300% of FPL and Medicaid coverage to certain adults up to 100% of FPL. Also permits state to provide more limited benefits to expansion population (2006)	Governor vetoed bill (H 3116) to create **subsidy program** for certain uninsured children (2006)		**HSA contributions** deductible for state income tax purposes
ID		• Federal approval for flexible Medicaid benefits: three new Medicaid benefit packages tailored for healthy children and adults, the disabled, and dual eligibles (2006) • Federal waiver permits subsidies to purchase employer-based coverage (2004)	**"Small Business Health Insurance" subsidy program** (2004) • *Eligibility* – uninsured low-income workers (< 185% of FPL) in small firms (2-25) and their families (Enrollment limited to 1,000 adults) • *Subsidy* – state pays $100/month per person (up to $500/family/ month) directly to participating health plans, based on available state funding; employers not required to participate **Tax Credit** State allows employers to claim a		**HSA contributions** deductible for state income tax purposes

Major State Initiatives to Expand Access to Coverage (2003-2006)

State	Employer/Individual Mandate	Medicaid/SCHIP Expansions and Other Innovations	Small Group/ Individual Subsidy Programs	Insurance Market Reforms	Other Initiatives
			tax credit of $1,000/year for any new employee whose hourly earnings average $15.50 or more and who are eligible to receive employer-provided health insurance (2004)		
IL		Federal approval for state ALL KIDS initiative to cover all uninsured children under 19 who are not eligible for Medicaid or SCHIP (2005-2006)			**HSA contributions** deductible for state income tax purposes
IN					**HSA contributions** deductible for state income tax purposes
IA		Federal waiver permits limited benefit packages to all adults up to 200% of FPL using a limited provider network (2006)		Phasing out guaranteed issue in individual market by shifting future applicants into high-risk pool (2003)	**HSA contributions** deductible for state income tax purposes
KS			**Tax credit** is available for small employers to help purchase coverage for their uninsured workers or make contributions to health savings accounts; tax credit is $70 per month per eligible employee in year 1, reducing to $50 in year 2 and $35 in year 3 (2005)		• **HSA contributions** deductible for state income tax purposes • **Removed barriers to HSAs** by allowing qualified plans to apply deductibles for treatment mental health and substance abuse (2004)
KY		• Federal approval for flexible Medicaid benefit packages tailored for general Medicaid population, children, elderly needing nursing care (2006) • Also allows adults eligible for employer-based coverage to enroll in that coverage (2006)	**Premium subsidy program** (2006) • *Eligibility* – uninsured low-income workers (< 300% of FPL) in small firms (2-25) as well as currently insured small employers who cover at least one employee with a high-cost health condition • *Subsidy* - employers contribute at least 50% of premium cost and receive vouchers of $40 PMPM if previously uninsured and $60 PMPM if they cover at least one	**Mandate waiver law** allows sale of "mandate-lite" products to small firms (2005)	**HSA contributions** deductible for state income tax purposes

Major State Initiatives to Expand Access to Coverage (2003-2006)

State	Employer/Individual Mandate	Medicaid/SCHIP Expansions and Other Innovations	Small Group/ Individual Subsidy Programs	Insurance Market Reforms	Other Initiatives
			employee with a high-cost health condition		
LA		State and federal officials are negotiating how best to redesign health care delivery and financing system; a plan will be drawn up that includes Medicaid waivers	**"Safety Net" premium subsidy program** (2003) • *Eligibility* – employers who have not provided coverage in the past year; employers who currently provide coverage also eligible, but only for low-income workers (< 200% of FPL); not implemented yet • *Subsidy* - employers contribute at least 50% of premium cost	**Mandate waiver law** allows sale of "mandate-lite" products to small firms and individuals (2004)	**HSA contributions** deductible for state income tax purposes
ME		Medicaid expanded to cover childless adults < 125% of FPL and parents < 200% of FPL (2003)	**"Dirigo Health" premium subsidy program** (2003) • *Eligibility* - uninsured small firms (1-50) and low-income individuals (<300% of FPL) • *Subsidy* – employers contribute at least 60%; carriers assessed to help fund subsidies for state-designed Dirigo Choice product; enrollees receive sliding-scale discounts on premiums and cost-sharing based on their income and family size		
MA	**Employer "play or pay" mandate and individual mandate law** (2006) • *Employer mandate* affects employers with more than 10 workers; must offer coverage and make a "fair and reasonable" contribution or pay assessment of up to $295/year per worker • Under new regulations, employers must insure 1/4 of their workforce or offer to pay at least 1/3	• Federal waiver permits subsidies for low-income residents as part of 2006 reform law • Expanded SCHIP eligibility from 200% to 300% of FPL • Expanded eligibility for existing Insurance Partnership Premium Subsidy Program	**"Commonwealth Care" premium subsidy program** (2006) • *Eligibility* – uninsured low-income individuals (< 300% of FPL) and low-income employees • *Subsidy* – 100% subsidy for individuals earning <100% of FPL, with sliding scale based on income for those from 100%-300% of FPL; subsidy funded through employer assessments, Uncompensated Care Pool funds, general revenues **Insurance Partnership Premium Subsidy Program (2006)** • *Eligibility for pre-existing program* expanded from 200% of FPL to	New reform law merges and pools the small group and individual markets (2006)	**HSA contributions** deductible for state income tax purposes

Major State Initiatives to Expand Access to Coverage (2003-2006)

State	Employer/Individual Mandate	Medicaid/SCHIP Expansions and Other Innovations	Small Group/ Individual Subsidy Programs	Insurance Market Reforms	Other Initiatives
	of premium to avoid $295 fee • *Individual mandate* requires all uninsured individuals to purchase "affordable" coverage or face tax penalties		300% of FPL • *Subsidy* – Employers must contribute 50% of premium		
MD	• **Employer "play or pay" mandate** for employers with more than 10,000 workers; for-profit firms must spend 8% of payroll on health benefits or pay $250,000 penalty to support Medicaid (2006) • This mandate (Fair Share Health Care Act) preempted on ERISA grounds in U.S. District Court on 7/19/06			**Mandate waiver law** allows sale of "mandate-lite" products to small firms (2004)	• **High-risk pool** created with a premium cap of 110-200%; funds losses with assessments on providers and carriers (2003) • **HSA contributions** deductible for state income tax purposes
MI				**Small group rating law** permits Blue Plan to use age and industry factors; HMOs and commercial carriers to use age industry and group size; and allows limited health status rating for all carriers (2003)	**HSA contributions** deductible for state income tax purposes
MN				**Mandate waiver law** allows sale of "mandate-lite" products to small firms (2005)	**HSA contributions** deductible for state income tax purposes
MS					**HSA contributions** deductible for state income tax purposes
MO					**HSA contributions** deductible for state income tax purposes
MT		Federal approval to expand CHIP that will	**Small Business Insurance Pool**	**Mandate waiver law** allows sale of "mandate-lite"	**HSA contributions** deductible for state income

Major State Initiatives to Expand Access to Coverage (2003-2006)

State	Employer/Individual Mandate	Medicaid/SCHIP Expansions and Other Innovations	Small Group/ Individual Subsidy Programs	Insurance Market Reforms	Other Initiatives
		raise state's enrollment cap from 10,900 to 13,900 children	• *Eligibility:* uninsured workers (earning < $75,000) in very small firms (2-9 workers) • *Subsidies* – Employers pay 25% of premium; employees receive premium assistance ranging from 20%-90% depending on family income **Tax Credits** • *Eligibility:* Very small firms (2-9) with workers earning < $75,000 that currently provide health insurance • *Subsidies* – new tax credits of $100 per employee per month Funded in part by tobacco tax revenues (2005)	products to small firms (2003)	tax purposes
NE					**HSA contributions** deductible for state income tax purposes
NV					
NH				• **Small group rating law repealed** use of health status and area as rating factors; carriers may use only age, size and industry (2005) • **Small Employer Health Reinsurance Pool** assesses all carriers on a covered lives basis; carriers can decide whether to cede risk to the pool (2005)	
NJ					• Annual assessment on HMOs raised from 1% to 2% of net written premiums to generate funds to support hospital charity care (2006) • **Removed barriers to HSAs** by allowing qualified plans to apply deductibles for

Major State Initiatives to Expand Access to Coverage (2003-2006)

State	Employer/Individual Mandate	Medicaid/SCHIP Expansions and Other Innovations	Small Group/ Individual Subsidy Programs	Insurance Market Reforms	Other Initiatives
					treatment for lead poisoning (2005)
NM		Waiver implemented to expand coverage to childless adults and parents of Medicaid/SCHIP children up to 200% of FPL through a new State Coverage Initiative Program (2005)	**NM State Coverage Initiative Program** (2005) • *Eligibility* – low-income workers (<200% of FPL) in small firms (2-50) and self-employed individuals (<200% of FPL) • *Subsidies* – Employers pay $75 per month; employees pay up to $35 per month on a sliding scale basis		• Small firms who have not offered coverage may buy into the state employee health benefit plan (2005) • **HSA contributions** deductible for state income tax purposes
NY	Both the N.Y. City Council and Suffolk County, N.Y. passed employer "play or pay" mandate laws in 2005; the Suffolk County measure is being contested in court		**"Healthy NY" premium subsidy program** • *Current Eligibility* - uninsured low-income workers (any size employer) and self-employed individuals (incomes <$26,000); and low-income workers (at least 30% of whom must earn <$30,000) in small firms (2-50) • New rules allow offering of HSAs under Healthy NY (2006) • *Subsidy* - employers contribute at least 50% of premium cost; subsidy funded through uncompensated care pool funds, assessments on Blue Plans/insurers/providers, tobacco settlement and other sources; program operates with a stop-loss mechanism to reimburse HMOs		**HSA contributions** deductible for state income tax purposes
NC			Under a new health insurance tax credit, small employers (1-50) can receive $250/ year per low-income worker (<$40,000 wages) if they pay 50% of worker's premium cost (2006)	**Small group rating law** amended by increasing from 20% to 25% the adjusted community rate variance for premiums (2006)	• **HSA contributions** deductible for state income tax purposes • **High-risk pool** bill passed House July 2006
ND					• **HSA contributions**

Major State Initiatives to Expand Access to Coverage (2003-2006)

State	Employer/Individual Mandate	Medicaid/SCHIP Expansions and Other Innovations	Small Group/ Individual Subsidy Programs	Insurance Market Reforms	Other Initiatives
					deductible for state income tax purposes • Removed barriers to HSAs by allowing qualified plans to apply deductibles for first five visits of substance abuse treatment (2005)
OH				**Small group rating law** amended by increasing from 35% to 40% the amount that premium rates may vary(2006)	**HSA contributions** deductible for state income tax purposes
OK		Federal waiver permits subsidies for certain Medicaid/ SCHIP eligibles who work for small firms to purchase employer-based coverage (2005)	**Premium subsidy program** (2006) • *Eligibility* - Low-income workers (< 185% of FPL) in small firms (2-50) • *Subsidy* - employers pay 25% of premium, workers pay 15%; state contributes tobacco tax revenues		**HSA contributions** deductible for state income tax purposes
OR					**HSA contributions** deductible for state income tax purposes
PA		Lawmakers enacted the Cover All Kids program which expands CHIP to provide coverage for children with family incomes up to 300% of FPL; state officials will seek a federal waiver to implement this initiative (2006)			• **HSA contributions** deductible for state income tax purposes (2006) • **Removed barriers to HSAs** by allowing qualified plans to apply deductibles for medical foods and other mandates (2005)
RI			**Premium subsidy program** (2006) • *Eligibility* - low-wage small firms (average wages < 25th percentile) and high-risk individuals • *Subsidy* - employers contribute at least 50% toward a state-designed benefit plan		• Insurance Commissioner directed to design a high-risk pool for approval by legislature (2006) • **HSA contributions** deductible for state income tax purposes • **Removed barriers to HSAs**

Major State Initiatives to Expand Access to Coverage (2003-2006)

State	Employer/Individual Mandate	Medicaid/SCHIP Expansions and Other Innovations	Small Group/ Individual Subsidy Programs	Insurance Market Reforms	Other Initiatives
			• Carriers to offer a discounted premium (<90% of *actuarially*-determined rate approved by DOI)		by allowing qualified plans to apply deductibles for early childhood intervention and other mandates (2005)
SC		Governor's initiative will transform Medicaid by permitting a variety of Medicaid benefit packages, including health savings accounts (2006)			**HSA contributions** deductible for state income tax purposes
SD				Repealed individual market guaranteed issue law (2003)	**High-risk pool** created with 150% premium cap; funds losses with a $3 annual assessment on subscribers (2003)
TN		Created a new SCHIP program called CoverKids for children up to age 18 and pregnant women in families with incomes up to 250% of FPL (2006)	**"Cover Tennessee" premium subsidy program** (2006) • *Eligibility* - uninsured low-income workers (< 250% of FPL) in small firms (2-50) • *Subsidy* – employers, employees and state each pay one-third of premium for state-approved basic benefit plan	**Mandate waiver law** allows sale of "mandate-lite" products to small firms (2004)	**High-risk pool** created with 150-200% premium cap; funds losses 50% from general revenues and 50% from an assessment on carriers (2006)
TX				**Mandate waiver law** allows sale of "mandate-lite" products to small firms (2003)	
UT		• Federal waiver expanded Medicaid coverage to uninsured low-income residents (<150% of FPL), who receive a modified benefit package • Waiver permits subsidies to purchase employer-based coverage (2003)	**"Utah Premium Partnership" subsidy program** (2006) • *Eligibility*- uninsured low-income legal residents (e.g., family of three with monthly income up to $2,767 • *Subsidy* – monthly state subsidies will range from up to $150 per adult and up to $100 per child; cap of 1,000 on enrollment due to budgetary constraints		**HSA contributions** deductible for state income tax purposes
VT	**Employer "play or pay" mandate** requires	Federal waiver allows VT to:	**"Catamount Health" premium subsidy program** (2006)		**HSA contributions** deductible for state income

Major State Initiatives to Expand Access to Coverage (2003-2006)

State	Employer/Individual Mandate	Medicaid/SCHIP Expansions and Other Innovations	Small Group/ Individual Subsidy Programs	Insurance Market Reforms	Other Initiatives
	employers with more than 8 employees to provide health insurance coverage to their workers or pay an assessment of $365/ year per "uncovered employee" (i.e. not offered coverage or elects not to accept coverage and is uninsured) (2006)	• Alter benefit packages, increase cost-sharing, and implement new cost-control strategies • Manage Medicaid program within a global budget and retain savings to expand coverage to uninsured (2005)	• *Eligibility* - Uninsured Vermont residents under 300% of FPL without access to employer-sponsored insurance as good as Catamount Health (residents with incomes >300% of FPL can buy in at full cost) • *Subsidy* – available for state-designed individual product that carriers could be required to offer; subsidy funded through employer assessments and tobacco taxes		tax purposes
VA		• State directed to apply for a federal waiver to reform Medicaid (2006) • Federal waiver permits premium assistance program for children under 200% of FPL (2005)		• Permits creation of voluntary **purchasing cooperatives** for small firms (2006) • **Mandate waiver law** allows sale of "mandate-lite" products to small firms (2005)	**HSA contributions** deductible for state income tax purposes
WA		State directed to apply for a federal waiver to cover parents of children enrolled in Medicaid or SCHIP (2006)	**"Small Employer Partnership" premium subsidy program** (2006) • *Eligibility* – low-wage workers (<200% of FPL) in small firms (2-50) • *Subsidy* - employers contribute at least 40% towards coverage that is actuarially equivalent to state's Basic Health Plan for low-income residents; legislature provided only limited funding for this effort • Sliding scale premium subsidy using same schedule developed for the subsidized Basic Health Plan	• **Mandate waiver law** allows sale of "mandate-lite" products to small firms (2005)	
WV		• SCHIP eligibility expanded from 200% to 220% of FPL (2006) • Federal approval for flexible Medicaid benefits;		**Mandate waiver law** allows sale of "mandate-lite" products to uninsured individuals, including part-time and seasonal	• Insurers can offer uninsured small firms (2-50) lower-cost products that require providers to accept state employee plan payment

Major State Initiatives to Expand Access to Coverage (2003-2006)

State	Employer/Individual Mandate	Medicaid/SCHIP Expansions and Other Innovations	Small Group/ Individual Subsidy Programs	Insurance Market Reforms	Other Initiatives
		enhanced benefits provided if adults agree to adopt healthy behaviors (2006)		employees (2006)	levels (2004) • **High-risk pool** created that funds losses with provider assessment (2005) • **HSA contributions** deductible for state income tax purposes
WI				Permits creation of private, competing voluntary **purchasing cooperatives** for small employers (2005)	New law improved stability of medical high-risk pool by providing a state premium tax credit to insurers equivalent to their assessments to finance pool losses (2006)
WY		SCHIP eligibility expanded to include parents of eligible children with incomes up to 133% of FPL (2006)		Lowered cost of **reinsurance** small group carriers must buy from public reinsurance pool and created a premium tax credit for carriers of 100% for reinsurance assessments (2006)	

Public-Private Partnerships to Expand Access: State Subsidy Programs (2003-2006)

State governments are increasingly partnering with the private sector to expand access to employer-based health insurance. Since 2003, almost half (19) of the states have enacted laws to create or expand employer premium subsidy programs. These initiatives are designed to assist uninsured low-income workers to purchase an employer health benefit plan and to encourage small employers to offer or retain coverage.

Many state officials believe that a properly designed premium subsidy program is a win for all the players involved because:

- consumers get the same quality private coverage as their co-workers and avoid the stigma of enrolling in Medicaid;
- consumers have improved access as more providers accept commercial insurance;
- states leverage employer contributions and avoid adding to Medicaid/SCHIP rolls;
- employers benefit from improved worker productivity and job stability; and
- private insurers can expand their small group business.

As described in the attached chart, employer premium assistance programs fall into the following categories:

Subsidies for Low-Income Workers to Buy State-Approved Private Products – Mandatory Employer Participation

- Massachusetts and Vermont

Subsidies for Low-Income Workers to Buy State-Approved Private Products – Voluntary Employer Participation

- Arkansas, Idaho, Kentucky, Maine, Montana, New Mexico, Oklahoma, Rhode Island, Tennessee, Utah, Washington

Tax Credits to Subsidize Cost of Buying Any Licensed Private Insurance Product

- Arizona, Kansas and Montana

Public-Private Partnerships to Expand Access: State Subsidy Programs (2003-2006)

State	General Information	Subsidy	Covered Benefits	Funding/Administration	Enrollment/Impact
AZ	**Approach:** Tax Credit **Eligibility:** Low-income individuals (<250% of poverty) and small employers (2-25) who have not had health insurance in the past 6 months **Employer participation:** voluntary **Enacted:** 2006	Equal to the lesser of 50% of premium or $1,000 for single coverage/ $3,000 family coverage	Any licensed insurance product	**Funding:** State general revenues. Funding capped at $5 million per year **Administration:** AZ Department of Revenue (DOR) **Tax credit payment:** DOR issues certificates of eligibility; insurers then deduct the amount of tax credit from the premium charged and take that amount as a credit against their state premium taxes	Effective 1-1-07
AR	**Approach:** HIFA waiver *Arkansas Safety Net Benefit Program* will subsidize coverage for eligible workers **Eligibility:** Uninsured low-income workers (under 200% FPL) in firms with 2-500 employees that have not provided health insurance coverage to employees in the past year **Employer participation:** Voluntary, but employees must enroll unless they provide evidence of coverage Employers only eligible to join during regular open enrollment periods and must commit to 12 months' continuous participation **Enacted:** 2006	• A "safety net" benefit package will be subsidized for eligible workers • The state anticipates subsidizing 75%-80% of premium costs, but exact amounts, including employee premiums and employer fees, are under development	State-designed limited benefit package	**Funding:** Medicaid and SCHIP funds and contributions from employers and employees **Administration:** The state will assume the full risk for the program and contract with a single TPA to provide the benefit package and administer the program (on an ASO basis) for the first two years. The goal is to transition to an insured product after that time, with a state-licensed insurer providing coverage on a full risk basis (if determined to be a viable option) **Subsidy payment:** Not yet specified	Coverage will begin in early 2007. This pilot phase may enroll up to 15,000 participants. A second phase may take enrollment to as high as 80,000 total participants, based on available funding.
CO	Legislative Committee will design a demonstration project that subsidizes private coverage for uninsured workers (2006)				Not yet implemented
FL	**Approach:** §1115 waiver **Eligibility:** Existing Medicaid eligibles **Employer participation:** No	Risk-adjusted premiums will be calculated for each Medicaid eligible individual, who can use such premiums to subsidize their share of employer-	Any licensed insurance product	**Funding:** Medicaid funds, employer and individual contributions **Administration:** State will contract with outside vendor to operate the Medicaid opt-out program	Implemented July 2006 in two counties; may be expanded statewide in future

Major State Initiatives to Expand Access to Coverage (2003-2006)

State	General Information	Subsidy	Covered Benefits	Funding/Administration	Enrollment/Impact
	direct employer role; Medicaid-eligible workers can choose to be covered by employer-based plans **Enacted:** 2005	sponsored coverage, or, for self-employed individuals, to purchase individual coverage		**Subsidy payment:** For workers, payments will go directly to employers; for self-employed, payments will go directly to insurers	
ID	**Approach:** HIFA waiver *Access to Health Insurance* program subsidizes employer-provided coverage for eligible workers **Eligibility:** Uninsured low-income workers (<185% FPL) of small employers (2-25) Enrollment capped at 1,000 workers **Employer participation:** Voluntary **Enacted:** 2004	**Premium subsidy:** Employer pays at least 50% of premium. State pays $100/month per person for qualified employees and dependents (maximum of $500/month/family); employees responsible for remaining premium and all cost-sharing	Any licensed insurance product	**Funding:** Medicaid funds, employer and individual contributions **Administration:** State Department of Health and Welfare, Adult & Children's Health Insurance Unit All carriers selling small group health insurance in Idaho are eligible to participate in the program **Subsidy payment:** State pays subsidy directly to participating health plans	As of 6-15-05, enrollment cap of 1,000 reached; 125 small employers participating
KS	**Approach:** 3-year tax credit program **Eligibility:** Small businesses (2-50) that have not contributed to any health insurance premium or health savings account on behalf of an employee within the past two years **Employer participation:** Voluntary **Enacted:** 2005	Provides tax credit of $70 per month per eligible employee in year 1, reducing to $50 in year two and $35 in year three	Any licensed insurance product	**Funding:** State general revenue funds **Administration:** Kansas Department of Revenue **Subsidy payment:** Employers receive funds in form of a refundable tax credit once a year (after filing their taxes)	State DOI estimates about 400 small businesses had signed up by August 2006
KY	**Approach:** Federal approval under Deficit Reduction Act flexibility *Insurance, Coverage, Affordability and Relief to Small Employers (ICARE) program* **Eligibility:** Small employers (2-25) with low-income workers (< 300% of FPL) who: 1) have not provided coverage in the past year; or 2) have provided	4-year pilot program will subsidize private coverage for small employers; employers contribute at least 50% of premium cost The state will provide vouchers to eligible small employers for: • $40 PMPM to previously uninsured small employers who offer coverage • $60 PMPM to currently	• Coverage for uninsured small employers to be offered through participating insurers, who must offer at least 3 state-approved plans: a consumer-driven plan, a basic benefit plan, and an enriched plan	**Funding:** State general revenue funds, Medicaid funds; the program has a budget of $20 million for the first 2 years **Administration:** State Office of Insurance (authority to select a TPA to administer program) *Note: **All insurers** in the small group market required to participate in ICARE* **Subsidy payment:** State will make payments directly to employers	Applications accepted beginning 11-1-06; enrollment may be limited based on available funding Note: Medicaid eligibles required to use employer-based coverage, if it is more cost-effective

Major State Initiatives to Expand Access to Coverage (2003-2006)

State	General Information	Subsidy	Covered Benefits	Funding/Administration	Enrollment/Impact
	insurance but have at least one employee with a high-cost health condition **Employer participation:** Voluntary **Enacted:** 2006	insured small employers with at least one employee with a high-cost condition	• Insurers must conduct health risk assessments and offer a wellness program, case management services, and disease management services		
LA	**Approach:** *Safety Net Premium Subsidy Program* **Eligibility:** Employers (no size limit) who have not offered coverage in the past year plus those who HAVE offered coverage, but only for employees with incomes <200% of FPL **Employer participation:** Voluntary **Enacted:** 2003	Employers contribute at least 50% of premium cost; the state subsidizes the rest	State-designed minimum benefit package	**Funding:** Employer and employee contributions and state general revenue funds **Administration:** The Louisiana Health Plan (the state's high risk pool) Coverage offered through private insurers **Subsidy payment:** Not yet determined	Not yet implemented; awaiting issuance of final rules
ME	**Approach:** HIFA waiver *DirigoHealth* subsidizes private insurance coverage for uninsured small employers and self-employed individuals, who are pooled into one plan **Eligibility:** Uninsured small firms (1-50) and individuals with incomes below 300% of FPL **Employer participation:** Voluntary, but they must achieve 75% employee participation **Enacted:** 2003	• Employers contribute at least 60% for FTEs and 50% for part-timers; Blue Plan and other carriers assessed to help fund subsidies • Enrollees receive premium assistance and cost-sharing based on income and family size; assistance can be as high as 100%	State-designed comprehensive Dirigo Choice product; currently being offered only through Blue plan	**Funding:** Employer and enrollee contributions, Medicaid funds, and assessments on insurers based on paid claims[1] **Administration:** The DirigoHealth Agency (DHA) administers the subsidy program. **Subsidy payment:** Carriers bill employers, employees and self-employed individuals on a monthly basis; each pays their share of the premium, and DHA makes monthly subsidy payments via debit cards to employees/ self-employed individuals	• DirigoHealth agency cites enrollment of 10,700 including 2,300 small businesses • DirigoHealth board assessed insurers $43.7 M (about 2.4% of paid claims) beginning 1-1-06 based on estimated 2004 "savings" to health care system due to cost controls implemented by Dirigo initiative • Savings of $34.3 M claimed for 2005, but the state is holding off on additional assessments because it expects a new Blue Ribbon Commission to develop

[1] Insurer assessment can total no more than the savings resulting from the existence of the DirigoHealth program. Maine officials believe savings are possible through the recovery and redirection of funds that are spent on bad debt/charity care and cost caps agreed to by hospitals and insurers.

Major State Initiatives to Expand Access to Coverage (2003-2006)

State	General Information	Subsidy	Covered Benefits	Funding/Administration	Enrollment/Impact
					alternative funding
MA	**Approach:** Employer and individual mandate plus §1115 waiver; includes new subsidy program and expansion of existing subsidy program **Eligibility:** • *Commonwealth Care Premium Subsidy Program (new):* Low-income individuals (< 300% of FPL) and low-income employees who have NOT been offered employer coverage during last 6 months and who are NOT eligible for Medicaid or CHIP • *Insurance Partnership Premium Subsidy Program (existing):* Small employers (<50 workers) who provide coverage to their low-income employees and self-employed individuals. Eligibility expanded from 200% FPL to 300% FPL **Employer participation:** Employer "pay or play" requirement for firms with >10 workers; will help fund subsidies **Enacted:** 2006	**New subsidy program** provides 100% subsidy for individuals earning <100% of FPL, with sliding scale based on income for those at 100%-300% **Existing subsidy program** requires employers to contribute 50% of premium costs; it pays employers a subsidy of $50/month per eligible worker and also pays each worker a subsidy of $133/month	**New subsidy program:** State-approved comprehensive product Medicaid Managed care organizations will be the sole providers of subsidized health insurance through July 2009	**New subsidy program:** **Funding:** Employer assessments, Uncompensated Care Pool funds, general revenues, Medicaid funds **Administration:** Public Commonwealth Health Insurance Connector will administer program and certify products offered as being of high value and good quality **Subsidy payment:** Made directly to health plans providing coverage offered through the Connector	Effective 7-1-07
MT	**Approach:** *Insure Montana* premium subsidy program coupled with tax credits **Eligibility:** The premium subsidy is available to uninsured workers earning <$75,000 in very small firms (2-9 workers); the tax credit is available to employers already providing coverage to such employees	**Small business insurance pool.** Eligible small employers purchase coverage from a state purchasing pool and pay 25% of premium; employees receive premium assistance ranging from 20%-90% depending on family income **Tax credits.** State income-tax credit of $100 to $125 per employee per month	State-approved comprehensive products	**Funding:** Funded in part by a $1 per pack tobacco tax *Note: Number of applicants admitted is dependent upon cigarette sales* **Administration:** State DOI **Subsidy payment:** For businesses enrolled in the purchasing pool, premium incentive payments are made to the employer and premium assistance payments are made to employees by direct deposit; these payments are to be combined with the	As of 2-15-06, about 400 businesses (nearly 2,000 people) had enrolled

Major State Initiatives to Expand Access to Coverage (2003-2006)

State	General Information	Subsidy	Covered Benefits	Funding/Administration	Enrollment/Impact
	Employer participation: Voluntary **Enacted:** 2005			employer and employee portions and sent to the insurance company **Tax credit:** Employers can claim the credits on their business tax filings	
NM	**Approach:** HIFA waiver. *State Coverage Insurance Program* creates a new insurance product with incentives for employers and low-income individuals to purchase coverage **Eligibility:** Low-income uninsured workers (<200% FPL) in small firms (2-50) and self-employed individuals (<200% FPL) Individuals and small groups must not have voluntarily dropped insurance coverage for the past 6 months (individual) or 12 months (employers) **Employer participation:** Voluntary **Enacted:** 2002 (not implemented until 2005)	• Employer must contribute $75 PMPM • Employees pay up to $35 per month and their out-of-pocket costs are capped on a sliding scale basis	State-designed basic product	**Funding:** Unspent SCHIP funds, state and federal Medicaid funds **Administration:** State Human Services Department has contracted with three MCO health plans **Subsidy payment:** Participating health plans receive subsidy payments directly from state	As of May 2006, 4,500 individuals were participating in the program
NY	**Approach:** *"Healthy NY" premium subsidy program* **Eligibility:** Uninsured low-income workers (any size employer) and self-employed individuals (incomes <$26,000); and low-income workers (at least 30% must of whom earn <$34,000) in small firms (2-50) **Employer participation:** Voluntary **Enacted:** 2001	• Employers must contribute at least 50% of premiums	State-designed comprehensive product New regulations allow offering of HSAs under Healthy NY (2006)	**Funding:** Uncompensated care pool funds (assessments on insurers/providers, tobacco settlement and other sources); program operates with a stop-loss mechanism to reimburse HMOs **Administration:** State DOI. Coverage offered through participating HMOs **Subsidy payment:** Carriers file annual reconciliation reports April 1 for the prior calendar year to obtain stop-loss reimbursement Premiums are community rated by each plan and health plans are reimbursed for 90% of claims paid in a calendar year for a member between $5,000 and $75,000	As of December 2005, enrollment was 106,944: • 26% - small employers • 18% - sole proprietors • 56% - working individuals enrolling on their own
OK	**Approach:** HIFA waiver	Employers contribute 25% of	Any licensed insurance	**Funding:** Medicaid funds and funds from	As of 7-1- 06, there were

Major State Initiatives to Expand Access to Coverage (2003-2006)

State	General Information	Subsidy	Covered Benefits	Funding/Administration	Enrollment/Impact
	Employer/Employee Partnership for Insurance Coverage – includes premium subsidy program **Eligibility:** Low-income workers (<185% of FPL) in small firms (2-25 currently, but expanding to 2-50 by October 2006) that offer a qualified health plan **Employer participation:** Voluntary **Enacted:** 2005	monthly premiums; employees pay up to 15% percent of premiums (up to 3% of income)	product	increased state tobacco taxes **Administration:** OK Health Care Authority **Subsidy payment:** State pays employers directly after receiving employers' monthly health plan invoices	480 businesses enrolled with a total of 854 covered lives *Note:* Subsidy program so successful that it was expanded in 2006 from 2-25 employees to 2-50
RI	**Approach:** Premium subsidy program **Eligibility:** Low-wage small firms (average wages <25th percentile in firms with <50 workers) and high-risk individuals **Employer participation:** Voluntary **Enacted:** 2006	• Employers contribute at least 50% of premium • Carriers to offer a discounted premium (< 90% of actuarially-determined rate approved by DOI)	State-designed "wellness benefit plan"	**Funding:** None appropriated **Administration:** State DOI; All carriers participating in state Medicaid program or in state employee health plan (including **Blue Plan**) must participate **Subsidy payment:** Structure to be determined by future regulations	Because no funds were appropriated, subsidy program may not be able to take effect in July 2007 as planned
TN	**Approach:** *Cover Tennessee Premium Subsidy Program* **Eligibility:** Uninsured low-income workers (<250% of FPL) in small firms (<50 and self-employed) and small employers with a significant percentage of low-income workers Employers cannot have not offered coverage in past 6 months (or have offered coverage but contributed less than half the costs of coverage) **Employer participation:** Voluntary **Enacted:** 2006	• Employers, employees and state each pay one-third of premium for state-approved basic benefit plan • If employer declines to participate, employees can enroll by paying two-thirds of costs	State-approved basic product	**Funding:** State's portion of the program will come from state money available in TennCare reserves **Administration:** State DOI. State will contract with private insurers to provide coverage and may contract out program administration **Subsidy payment:** The department may either: (1) Establish a method to collect premiums from employers and enrollees and pass them, along with the state's share contributions, to health plans; or (2) Authorize contractors to collect premiums from employers and enrollees	Effective early 2007
UT	**Approach:** *Utah Premium Partnership program*	• State pays up to $150/month per adult and up to $100/month per child	Any licensed insurance product	**Funding:** State general funds **Administration:** State Department of	To be implemented in early 2007

Major State Initiatives to Expand Access to Coverage (2003-2006)

State	General Information	Subsidy	Covered Benefits	Funding/Administration	Enrollment/Impact
	Eligibility: Uninsured low-income legal residents (e.g., family of three with monthly income up to $2,767) **Employer participation:** Voluntary **Enacted:** 2006	• Enrollment is capped at 1,000 residents due to budgetary constraints		Health **Subsidy payment:** Made to individuals	
VT	**Approach:** §1115 waiver *Catamount Health Premium Subsidy Program* **Eligibility:** Uninsured Vermont residents under 300% of FPL without access to employer-sponsored insurance as good as Catamount Health (residents with incomes >300% FPL can buy in at full cost) **Employer participation:** Employer "pay or play" requirement for firms with >8 workers; will help fund subsidies **Enacted:** 2006	State estimates that individuals <200% of FPL will receive over an 80% subsidy and those with incomes 275-300% FPL will receive about a 40% subsidy	Subsidy available for state-designed individual product that carriers could be required to offer	**Funding:** Employer assessments (for employees without coverage), individual premiums, Medicaid funds and tobacco taxes **Administration:** Department of Banking, Insurance, Securities and Health Care Administration State may contract with a private health plan to administer program **Subsidy payment:** Carriers bill individuals and state; state also reinsures 5% of carriers' aggregate claims costs in individual market	Effective 10-1-07
WA	**Approach:** *Small Employer Health Insurance Partnership Premium Program* **Eligibility:** Low-wage workers (<200% FPL) of small employers (<50) **Employer participation:** Voluntary **Enacted:** 2006	• Employers must contribute at least 40% of premium • Sliding scale premium subsidy using same schedule developed for the subsidized Basic Health Plan	Coverage must be actuarially equivalent to state's Basic Health Plan for low-income residents	**Funding:** Legislature provided only limited funding for this effort; and enrollment is capped at levels supported by appropriated funds **Administration:** WA state Health Care Authority **Subsidy payment:** Will go to eligible employees	Effective 7-1-07