

AcademyHealth
State Health Research and Policy Interest Group
June 27, 2009
Meeting Summary

AcademyHealth's State Health Research and Policy Interest Group was formed in 2005 to provide a forum for researchers, policymakers, and practitioners to share state-level research that emphasizes the unique challenges of working within a state policy and political environment. The group's fourth annual meeting was held on June 27, 2009 in conjunction with AcademyHealth's Annual Research Meeting in Chicago. The meeting was sponsored, in part, by The Commonwealth Fund, the Robert Wood Johnson Foundation, the Rutgers Center for State Health Policy, and the Nelson A. Rockefeller Institute of Government.

Through a call for proposals process, the group selected speakers to highlight innovative approaches to address state policy research and evaluation needs, effective strategies for expanding and sustaining coverage, and ways that states can get better value from their health care systems. The first panel discussed innovative state approaches to improve outcomes and manage costs. The second panel focused on new state strategies to expand and sustain coverage, while the third panel of speakers discussed early results from the State Health Access Reform Evaluation (SHARE) program. (See agenda in meeting folder.) A poster session of relevant topics was also available to Interest Group attendees. (See list and abstracts of posters in meeting folder.)

Session One: Innovative State Approaches to Improve Outcomes and Manage Costs

Developing Quantitative Methods to Identify Actionable Causes of Excess Emergency Department Utilization in a Managed Care Medicaid Program

The first presentation in this panel, by **William McQuade**, D.Sc., M.P.H., Senior Health Policy Analyst at ACS, State Health Services, Inc., focused on developing quantitative methods to identify actionable causes of excess emergency department (ED) utilization in a Rhode Island managed care Medicaid program. Dr. McQuade explained that most of the research on excess ED utilization focuses on the uninsured and populations without access to a usual source of care (USC) but that ED utilization in Medicaid populations is substantially higher than among the uninsured. This is a pattern that persists even among Medicaid populations enrolled in managed care programs, which shows that there are factors other than access to health insurance and a USC which drive excess ED utilization.

The Core program population within Rhode Island's Medicaid managed care program, known as Rite Care, is the population examined in Dr. McQuade's study. This population includes pregnant women up to 350 percent of the federal poverty level (FPL), adults up to 175 percent FPL, and children up to 250 percent FPL. Dr. McQuade provided a series of graphs showing that the study population has significantly higher ED utilization rates than the Medicare population but significantly lower rates than the general Medicaid population; that the annual ED utilization rates for the study population is higher and growing at a faster rate than for the U.S. general population; and that there has been an unsustainable increase each year in the per ED visit cost within the study population. A frequency distribution of ED visits within the study population for calendar year 2007 showed that 10 percent of Rite Care members fell into the repeat category and that this category of the population accounted for 65 percent of ED visits. Through this data analysis, Dr. McQuade learned that this 10 percent was the group on which to focus for potential intervention.

Further data analysis revealed that having access to a usual source of care (USC) in general was not a significant factor for having excess ED utilization, but that the site of primary care did make a statistically significant difference; those using a federally qualified health center (FQHC) or hospital-based clinic as a USC had significantly higher ED utilization rates than those using a private physician office. Dr. McQuade explained that this finding means that access to insurance and a primary care provider (PCP) is not a contributing factor for excess ED utilization in and of itself, but rather that it appears that components of the primary care setting affect the rate of ED utilization. Dr. McQuade identified causes of excess ED utilization to be patient characteristics related to disease burden, utilization of services, continuity of enrollment, and system characteristics such as the site of primary care. Dr. McQuade summarized initiatives that health plans could implement that focus on the primary care setting – these are components to make the primary care settings or medical homes function more efficiently and effectively for their patients. Those initiatives include having better after-hours coverage; using care management for those with chronic conditions and for those repeat ED users; focusing on more provider and patient education; and doing additional outreach to hospital-based clinics and FQHCs.

Strategies and Policies to Advance Medical Homes for Medicaid/SCHIP Participants

The second presenter, **Neva Kaye**, Senior Program Director at the National Academy for State Health Policy, spoke about her research to identify how Medicaid and CHIP programs are increasing participants' access to high-performing medical homes. Through information obtained from a survey, internet research, and directly from the states, Ms. Kaye gathered high-level information about Medicaid and CHIP initiatives. Ms. Kaye explained that, since 2006, many states have engaged in an effort to advance medical homes in Medicaid and CHIP but that these medical home efforts vary widely. Most of these Medicaid medical home efforts have legislative or executive branch support and start with sub-populations, some have plans to go statewide, and all of them are targeting their work with the primary care physicians (PCPs) regardless of the type of delivery

system they use for their Medicaid population: fee-for-service, primary care case management (PCCM), or through managed care organizations.

She analyzed 10 states and identified five key strategies in which the states have all engaged. The first strategy is forming partnerships with key stakeholders (e.g., community health centers, provider associations, other state agencies, etc.) with whom they collaborate on program design, implementation, and operation. Another commonality is that all are defining ‘medical home’ and a putting in place a system for identifying practices that meet that definition. Identification ranges from state-developed processes to national standards developed by NCQA, for example. A third common strategy is implementing reimbursement changes to reward practices operating as high performing medical homes. The fourth activity that Ms. Kaye discussed was that of the states developing and experimenting with new models of delivery, along with providing ongoing support to practices serving as medical homes for Medicaid beneficiaries. She noted that some of this focus has also involved providing greater patient support by establishing patient incentives, increasing patient knowledge and engagement, and working to create a system of personal health records. A final and crucial activity among all the states is measuring the results of their medical homes initiatives. Only a handful of them have gone so far as to identify potential measures but all recognize that they will need to demonstrate positive results in their own initiatives. In Washington State, for example, they closely measure PCP ability through adherence to clinical practice guidelines and track patient experience through parent and patient surveys. Multi-payer pilots, such as those in Pennsylvania, Rhode Island and Vermont, are tracking clinical outcomes, costs, NCQA scores, and patient and provider satisfaction.

Ms. Kaye summarized her talk by conveying that Medicaid and CHIP programs have a long-standing interest—now heightened because of pressures to contain costs, improve quality of care and incorporate HIT advances—in increasing participants’ access to a medical home model of care.

How a Systems Dynamic Model of Childhood Obesity Can Inform State Policymaking

The final presentation from this panel, by **Karen Minyard**, Ph.D., Executive Director of the Georgia Health Policy Center at Georgia State University, centered on her work to develop and use a systems dynamics model of childhood obesity to improve state policy-making. Dr. Minyard explained that a policy-level foundation of this work is the Legislative Health Policy Certificate program, which is sponsored by the Georgia Health Policy Center and designed to prepare legislators and their staff to address challenging health issues for the state. One topic from last year’s session was interventions to reduce childhood obesity with the hope that this would engender more rigorous discussions of policy alternatives. Dr. Minyard’s main research objective was to apply systems thinking methods to broaden health policy discussions regarding causes of, and solutions to, childhood obesity. The model—created by a collaborative modeling team of legislators and staff, nutritionists, epidemiologists, physical activity experts, and economists—used the epidemiological data and structure from a similar tool that was previously developed by the Centers for Disease Control and Prevention (CDC). The modeling team removed

the piece of the CDC model relating to children, incorporated state-specific information and assumptions where available, and inserted policy interventions.

Dr. Minyard described the six policy areas that she and her team modeled: 1) increasing the proportion of school-aged children who walk to school; 2) improving school food options; 3) increasing time spent on school physical education (PE) and the quality of PE activities; 4) improving nutrition and physical activity education in preschool programs; 5) improving nutrition and physical activity education in after school programs, and 6) reimbursing Medical Nutrition Therapy for obese children insured by Medicaid. The model included data for children ages 0-18 years.

Dr. Minyard summarized the findings and conclusion with the key point that no single policy had a large impact on future rates of obesity, which is consistent with recent epidemiologic evidence. However, some policy combinations lowered the prevalence of obese children to 10 percent, which would effectively return the prevalence to 1970 rates. Dr. Minyard ended by stating that efforts should go toward supporting both a more rigorous conversation and coherent policy combinations that are implemented intensively and sustained over time.

Lunch/Poster Session

Posters were solicited from state-based and academic researchers to present findings on their work related to state-level research and policy. Ten posters were selected for display. Posters covered a wide range of topics including health care workforce shortages, performance of small group insurance markets, the state of community health centers, the role of public programs in promoting child health, and new approaches to thinking about state health policymaking.

Session Two: New State Strategies to Expand and Sustain Coverage

Preliminary Evaluation of the Maryland Kids First Act's Use of Tax Forms to Find Eligible Enrollees

The first presenter from this panel, **David Idala**, M.A., Senior Research Analyst at The Hilltop Institute at the University of Maryland, Baltimore County, gave a presentation on the preliminary findings of an evaluation of the Maryland Kids First Act. Mr. Idala introduced the Kids First Act as a 2008 law that requires a Medicaid or CHIP outreach initiative based on information from state income tax forms. For tax years 2008 and 2009, a taxpayer is asked to report on the tax return whether each dependent child for whom an exemption is claimed is with or without health care coverage. If a dependent child is uninsured then the comptroller must send a Medicaid/CHIP application and enrollment instructions to the taxpayer. The taxpayer is not penalized for failing to provide this information. Mr. Idala explained that his study evaluated the implementation of the initiative and the impact of the state's outreach campaign.

Mr. Idala's research looked at key decisions made and various aspects of the policy-making process and analyzed what was involved in using data from state income tax forms as a basis for Medicaid/CHIP outreach. In addition, he noted that the research looked at how well implementation of the initiative ended up achieving its goal of identifying and enrolling uninsured, eligible children into either public program. All of the evaluation findings relate to the 2008 Maryland tax form redesign. The study data came from Maryland Medicaid/CHIP application and enrollment data merged with income tax data. Primary outcomes measures include percent of targeted children that apply, are found eligible, and ultimately enroll in Medicaid/CHIP.

Mr. Idala presented some of the design and implementation challenges as running the gamut, from concerns about wording of the question on the tax form, to legal issues relating to informed consent, to the inability to track cost-effectiveness or number of people whose enrollment resulted from this outreach method. Mr. Idala pointed out that other states, many of which are considering similar tax form-based initiatives, will be able to make use of the study findings when determining how to approach the development and implementation of these types of initiatives. Some of Mr. Idala's recommendations for making this sort of initiative more successful include involving the major stakeholders in the development phase; determining from the outset whether data can be shared across state agencies; consulting health literacy experts and seeking public input on the wording of notices and letters; designing a mechanism to track Medicaid/CHIP applications and inquiries that result from the mailing; and expanding self-employment criteria on the tax form. Not all of these recommendations require legislation but Mr. Idala suggested that it is helpful to aim for legislation because this can then require the modification of state tax forms to support the effort, mandate the comptroller to send out information packets containing applications for Medicaid/CHIP, and more easily permit the use of outreach money to support the initiative.

As Mr. Idala explained, under the federal Children's Health Insurance Reauthorization Act of 2009 (CHIPRA), states are allowed to use tax return data to auto-enroll uninsured children into public programs. With this in mind, he pointed out that an important policy question will be to what extent states are willing to deviate substantially from current guidelines in order to simplify eligibility determination, or auto-enroll individuals. Mr. Idala summarized the next steps for his work in Maryland to include conducting interviews with operational staff at the Department of Health and Mental Hygiene, analyzing the 2009 tax form question and instructions, and examining the 2008 application and enrollment outcomes in the target population.

How States Are Financing Health Coverage Initiatives

Courtney Burke, M.S., Director of the Health Policy Research Center at the Rockefeller Institute of Government, presented information about how states are financing their insurance coverage expansions. Ms. Burke noted that in some states the target population for expansions is all of the uninsured, while in other states it is a specific group of individuals, such as small business employees. For the research study, Ms. Burke did a literature review and interviewed state officials. She found that the major financing

categories are the following: Medicaid funds through increased eligibility and services or a waiver that thereby confers administrative or budgeting flexibility; primary state sources such as broad-based taxes, health industry taxes, sin taxes, or redirected funds; and a final category which includes less widespread or less sustainable sources like employer contributions, tobacco settlement, or gambling revenue.

Ms. Burke explained that there are examples among the states of both incremental and comprehensive financing of state health insurance coverage initiatives. In the category of incremental financing, she cited Oklahoma, Indiana and Colorado. Oklahoma created a revolving fund from a tobacco tax and premium contributions from employers, individuals and the state. In Indiana, the Healthy Indiana Plan was financed using \$50 million in Disproportionate Share Hospital (DSH) funds and a cigarette tax. Colorado managed to expand CHIP (and thereby a federal match) through a hospital per patient fee. In the area of comprehensive financing, Ms. Burke mentioned Vermont and Massachusetts. Vermont had a Global Commitment waiver, a cigarette tax increase, and an employer contribution. Massachusetts made use of \$1.7 billion of redirected federal funds, redirected DSH money and supplemental hospital and managed care payments, a new match for services, change in the budget neutrality cap, cost offsets that included an individual penalty for non-compliance with the mandate and employer contributions, and a \$1 per pack increase in the tobacco tax. She pointed out that leveraging of federal funds is the most common form of financing among the states and that it is generally the most sustainable approach.

In introducing some background on New York, Ms. Burke told about the governor's interest in universal coverage and the state's CHIP expansion to 400 percent FPL. To attain universal coverage, Ms. Burke listed the financing options for New York as the following: Medicaid/CHIP/Family Health Plus eligibility and services expansions; a Medicaid waiver; redirecting funds (DSH payments, for example); applying administrative savings; broad-based taxes; sin taxes; employer contributions; and other funding sources, such as HRSA grant money. Some of Ms. Burke's concluding remarks about obtaining financing for health insurance expansions among the states included that federal Medicaid match plays a central role; maximizing waiver negotiations is important; finding new funding sources is necessary; focusing on cost control is essential; and that shared responsibility (in the form of an employer contribution or an individual mandate, for example) is a key factor in success.

Session Three: Early Results from the State Health Access Reform Evaluation (SHARE) Program

Overview of SHARE and "What We Are Learning"

Serving as the moderator of the final panel, **Lynn Blewett**, Ph.D, principal investigator at the State Health Access Data Assistance Center (SHADAC), gave a brief presentation on the preliminary results from the State Health Access Reform Evaluation program (SHARE). A national program of the Robert Wood Johnson Foundation, the SHARE program aims to support and coordinate state health reform evaluations, disseminate the

findings from these evaluations (especially to state health policy makers), and to create a community for research and practice with the end goal of fostering evidence based reform. Fifteen grantees were awarded a total of 5.4 million dollars, with 7 multi-state studies and 8 single-state studies examining a broad range of topics (insurance market initiatives, CHIP reform, and Medicaid reform among other topics.)

Dr. Blewett summarized preliminary findings from the SHARE grantees, discussing important results from grantees doing outreach and enrollment, access expansions, and insurance market reform. Preliminary results discussed include the effectiveness of community-based organizations to increase enrollment, comprehensive reforms that are coupled with premium assistance are the most effective due to their ability to address affordability concerns, and that legal concerns stemming from HIPAA kept many small employers from utilizing Section 125 plans. Dr. Blewett concluded by noting the importance of close state partnerships for effective state research, pointing out that maintaining a cooperative relationship with the state will ensure unimpeded access to vital state data resources.

Evaluation of Small Group Employer Participation in New Mexico's State Coverage Insurance Program

Anna Sommers, Ph.D, senior research analyst at the Hilltop Institute at the University of Maryland, Baltimore County, gave a presentation on the Hilltop Institute's evaluation of small group employer participation in New Mexico's State Coverage Insurance (SCI) program. Dr. Sommers began by giving a brief overview of the New Mexico SCI program. As she explained, SCI is financed through a public-private partnership, where CHIP funds comprise the majority of funding (71%), with state funds and employer and individual premiums making up the remainder. The New Mexico Human Services Department, which runs the program, contracts with three managed care organizations (MCOs) to provide a comprehensive benefit package, and insurance brokers, certified by the state and paid commissions by the MCOs, market SCI to employers and individuals alongside their commercial offerings. Employers with fewer than 50 employees and individuals between ages 19 and 64 under 200 percent FPL may enroll in SCI. Employers pay a monthly premium of \$75 for their employees, but this premium is fully subsidized by the state for employees under 100 percent FPL. Individuals pay premiums on a sliding scale based on income. The premium subsidy, which was enacted in August 2007, resulted in significant increases in non-group enrollment in the program.

Dr. Sommers went on to detail the Hilltop Institute study, explaining that the study's purpose was to identify factors that lead small employers to participate in SCI. The policy focus of the study was to identify opportunities to expand employer participation in SCI. Dr. Sommers explains that two groups are the logical focus of this effort: employers who inquire about SCI but choose not to participate and non-participating employers with workers who are directly enrolled in SCI.

Dr. Sommers and her colleagues conducted a telephone survey of all inquiring employers and compared these to those employers that moved to participate in SCI during the same

time frame. Compared to participating employers, inquiring employers tend to have fewer employees, are less likely to be located in frontier areas of the state, have fewer low-wage employees, and employ more contract workers, who cannot be covered by SCI. In addition to these comparisons, Dr. Sommers and her colleagues also read the inquiring and participating employers a series of statements covering several aspects of the application and enrollment process and asked if the employers considered any of these aspects burdensome. These statements covered both administrative and cost issues. Though two-thirds of both groups answered that at least one of the administrative issues was a concern, both employer groups equally considered the administrative issues burdensome, except that participating employers were almost twice as likely to say that the amount of time required to process applications was a concern. With regards to cost concerns, roughly a third of inquiring employers expressed concern with being able to pay the premiums during the first month while nearly half cited the long-term cost of the program as a major concern.

Both inquiring and participating employers were also asked “what a business like yours should have to spend on health care coverage.” Despite the significant portion of inquiring employers that expressed concern regarding the cost of SCI, nearly two-thirds of both employer groups indicated they would be willing to pay 75 dollars or more per employee for health care coverage. This amount, which exceeds the average per worker cost of SCI, suggests that inquiring employers overestimate the cost of SCI to their business.

Turning to non-participating employers with workers directly enrolled in SCI, Dr. Sommers explained that the policy objective with this group was to examine why so many individuals are enrolled in SCI without group sponsorship and determine how many of these individuals could enroll through a group. To answer these questions, a telephone survey was administered to a random sample of individuals directly enrolled in SCI. These individuals were screened based on employment status, and for those individuals who were not self-employed, additional questions were asked about employer characteristics. The survey found that 60 percent of all workers with no group sponsor have an employer with fewer than 50 employees, which are eligible to participate in SCI. Nearly all the workers surveyed had strong ties to their employer (they were a permanent year round employee, work 20 or more hours per week, or worked for 6 months or more), but much fewer of those reporting these strong ties also worked for an employer with fewer than 50 employees (55 percent). This suggests that to move large numbers of individuals from non-group to group enrollment in SCI, some engagement of larger firms will be necessary. Lastly, Dr. Sommers noted that half of those surveyed work for a business with no offer of private coverage, and even fewer (38 percent) of firms with fewer than 50 employees offer coverage, a group that is eligible for group coverage through SCI.

Dr. Sommers concluded by summarizing the implications of the study for states and federal health reform. She notes that there is a significant trade off between accessing federal matching funds through Medicaid/CHIP and recruiting employers in sufficient numbers to support an innovative public insurance option. Federal funds come with a

burdensome application process and the eligibility standards for employees lack transparency making it difficult for businesses to estimate costs. Additionally, reaching the smallest firms may require different strategies, such as intensive educational campaigns or other sets of incentives. For some small firms, it may be more cost efficient to have employees enroll directly with SCI and avoid the administrative costs of firm enrollment.

With regard to federal reform, Dr. Sommers noted that delinking federal funds to states from Medicaid and CHIP would allow for more transparent eligibility standards. Such transparency could be better fostered by making eligibility based on workers' income, which an employer can measure, rather than family income. Lastly, Dr. Sommers notes that the establishment of a "pay-or-play" federal employer mandate could improve state engagement with larger employers.

State Policies Expanding Dependent Coverage to Young Adults in Private Health Insurance Plans

Joel Cantor, Sc.D, director and professor at the Center for Health Policy at Rutgers University, presented on state regulatory changes expanding dependent coverage to young adults. Dr. Cantor starts by noting that young adults aged 19-29 make up a significant portion of the total uninsured population (30%). However, there are significant differences within this group between full time students and non-full time students, with a much greater share of full time students (49%) being covered as a dependent on an employer plan. Dr. Cantor goes on to note that despite the fact that young adults are, on average, healthier than other age groups, they still suffer negative health consequences because of uninsurance. In addition, their absence from risk pools raises costs for other groups.

Of the 25 states that have pursued dependent coverage expansions, the average increased age for coverage was 3.5 years for students and 5.7 years for non-students. The laws expanding dependent coverage also have a number of other provisions including requirements that the individual be unmarried, not have dependents of their own, live within the state (except for full time students), and be financially dependent or live with parents. States take different paths with regards to premium rules for individuals insured under expanded dependent coverage, with some states forbidding a separate rating category and incorporating the cost into the family premium, while others establish separate rating criteria. Dr. Cantor went on to list some of the factors that can potentially limit the impact of dependent coverage expansions, highlighting the importance of ERISA preemption for self-insured employers, potential burdens of expanding dependent coverage on insurers or employers, risk selection, and various unanticipated consequences (movement of young adults from non-group market and associated increases in risk).

Dr. Cantor next summarized the complex model employed by the study to evaluate the effects of dependent coverage expansions. Using this model, Dr. Cantor explained that states that expanded dependent coverage eligibility resulted in increases in young adults

moving to be covered as dependents under employer sponsored plans. However, the model showed no changes in uninsurance. The model did show that there was a negative effect on employer sponsored insurance in an employee's own name; this negative impact almost exactly offset the increases in employer sponsored dependent coverage. While Dr. Cantor cautioned that, due to certain limits of the model, crowd out could not be measured, he stated that the results certainly suggest that young adults are dropping employer coverage in their own name and moving to be covered as dependents.

Dr. Cantor concluded by explaining the limitations of the study. The study only has 23 state-years experience to draw from, with many of those years being the first year after implementation of a dependent coverage expansion in a state. Additionally a number of eligibility criteria went unmeasured (many of these criteria are not measured in the Current Population Survey, which was used as a data source). Some of these criteria include parental coverage status, the parental state of residence, and the financial dependence of young adults on parents.

Achieving Universal Coverage Through Comprehensive Reform

Ronald Deprez, Ph.D, Executive Director of the University of New England Center for Health Policy, gave a presentation that analyzed the comprehensive health reforms passed in Vermont, placing emphasis on examining health care affordability, health services accessibility, and sustainability of the reforms. Dr. Deprez first briefly summarized Vermont's 2006 Health Care Affordability Act, noting the major goals (increase access, improve quality, contain costs), distinguishing features, and key programs (Catamount Health Insurance Program, Employer Sponsored Health Insurance Premium Assistance (ESIA) Program, Blueprint for Health) of the reform.

Dr. Deprez went on to discuss the research design of the reform analysis. During the first year of the study, Dr. Deprez and his colleagues conducted a process evaluation carrying out key informant interviews to clarify the historical context, policies and practices involved with the implementation of the reform and also to gain insight around what lessons could be learned to help other states. An outcomes evaluation was also conducted which utilized a number of data sources including the Vermont Household Health Insurance Survey, the Current Population Survey, and the Medical Expenditure Panel Survey.

Dr. Deprez then moved on to introduce the initial findings from the process and outcome evaluations. The study was designed to answer a number of key questions in the process evaluation, the first of which was, "how has implementation compared to what was expected?" Dr. Deprez explained that outreach efforts have been successful in identifying eligible populations and enrollment into the reform's major programs (namely Catamount and ESIA) have increased steadily since their inception. The process evaluation also revealed a number of barriers to enrollment in the reform's various programs including the cost of premiums, the 12-month waiting period (and individual must have no insurance for 12 months prior to being eligible), and the multi-step enrollment process. Dr. Deprez continued by summarizing lessons learned from the

implementation of the reform. As he noted, implementation of the reforms are an ongoing process involving frequent changes to both legislation and newly created programs. Stakeholder collaboration between private and public sectors is crucial to the successes of the reform, as is continued federal assistance to ensure long term sustainability. Ensuring the eligibility and enrollment process is more streamlined will further enhance the reform's reach. Lastly, Dr. Depez notes that health system level improvements, such as the Blueprint for Health, are a vital long term strategy for Vermont's reform.

Dr. Depez then moved on to summarize the findings of the outcome evaluation. The outcome evaluation examined enrollment as an indicator of affordability looking at four programs: Catamount Health with premium assistance, Catamount Health without premium assistance, ESIA, and Vermont Health Access Program (VHAP) ESIA (employer sponsored insurance for those otherwise eligible for VHAP). The evaluation found that of the 8,758 individuals that have enrolled in Catamount Health, nearly half have family incomes between 150 percent and 200 percent FPL. Of all Catamount enrollees, 13.1 percent have family incomes above 300 percent FPL and receive no premium subsidy. Although Catamount has been remarkably successful at attracting younger age groups (especially individuals ages 18-24), the majority of take-up has been in individuals ages 35 and over. Lastly, Dr. Depez noted that enrollment in Catamount Health has been accompanied by increased enrollment in traditional Medicaid and VHAP.

Dr. Depez and his colleagues also conducted an impact analysis of the reform that analyzed trends in insurance coverage for Vermonters between 2005 and 2008 and compared them to both the New England region and national trends. The impact analysis also sought to determine whether increases in public coverage were due to increased eligibility or increased take-up on the part of those previously eligible, as well as analyzing the evidence of possible crowd out of private insurance. The impact analysis found that health insurance in Vermont increased 2.2 percent for all age groups and 2.4 percent for individuals ages 0-64, both of which were statistically significant increases. These figures represent increase in both public and private coverage and were significantly higher than increases in insurance coverage in the rest of New England (excluding Vermont and Massachusetts).

Dr. Depez finished by briefly summarizing the study's analysis of the Vermont reform's sustainability. Noting that there have been significant decreases in the Catamount fund balance and that the decrease in revenues continues to outpace the decrease in expenditures, Dr. Depez explains that, as of now, the reforms do not appear to be sustainable in the long run. Finally, Dr. Depez outlined planned activities for the second year of the study.