

## **Health Care Expansion and Reform in Pennsylvania: What Is Driving It, What Are the Proposals, and What Can Be Learned from Other State Initiatives?**

This document presents a summary of “Health Care Expansion and Reform in Pennsylvania: What Is Driving It, What Are the Proposals, and What Can Be Learned from Other State Initiatives?” a seminar sponsored by The Pew Fund for Health and Human Services. Held on April 17, 2007, the seminar was part of The Pew Charitable Trusts’ information series called *Programs Adjusting to a Changing Environment* (PACE), created to improve nonprofits’ ability to succeed by providing them with critical information, tools and resources.

Faced with rising numbers of uninsured (now estimated at close to 47 million nationally), and a lack of direct action at the federal level, several states have initiated efforts to expand health care coverage for their residents. Earlier this year, Governor Rendell proposed Prescription for Pennsylvania, designed to expand coverage for the commonwealth’s uninsured adults, reduce health care costs and improve quality. The proposal has multiple components, and its full implementation will involve a number of legislative and regulatory changes. This session was designed to help Pew Fund agencies understand key aspects of the plan and its potential implications for their organizations and clients, and to learn how other states have gone about addressing the needs of the uninsured. The session included two presentations. Ann S. Torregrossa, senior policy manager at the Governor’s Office of Health Care Reform, described the proposed Pennsylvania plan. Sonya Schwartz, program manager at the National Academy for State Health Policy, an organization that analyzes state policies and practices on a range of health insurance coverage issues, then provided an overview of what other states are doing and how it compares to Pennsylvania’s approach. Each presentation was followed by a question-and-answer period.

### **Prescription for Pennsylvania**

Ann Torregrossa explained that, in 2004, the Pennsylvania Department of Insurance did a study of households across the state to find out who was insured and who was not. They found that nine percent of the state’s population, or 900,000 people—including 767,000 adults and 133,000 children—lacked health insurance. Armed with those numbers, the state applied for and received a federal grant to create a plan for covering the uninsured, and put together an advisory council of approximately 100 people—including such diverse groups as health economists, heads of nonprofit organizations and legislators—to help develop the initiative. These were among Torregrossa’s major points in her introduction to the proposed plan, called Prescription for Pennsylvania:

- **The state must take action, because the cost of inaction is far too great.** Between 2000 and 2006, family health insurance premiums rose nearly 76 percent, compared to an overall inflation rate of 17 percent. During the same period, median wages increased only a little more than 13 percent. The result is that growing numbers of people—including both employers and workers—cannot afford to pay for health insurance.

- **Inefficiencies in the current system add up to an estimated \$7.6 billion a year.** This figure includes more than \$6.2 billion for health care services that could have been avoided, especially additional hospital days that resulted from hospital-acquired infections and other medical errors, and hospitalizations that could have been avoided with better community-based care for patients with chronic diseases such as diabetes and asthma. Pennsylvanians pay another \$1.4 billion to help cover the costs of treating people who are uninsured and underinsured.
- **Prescription for Pennsylvania uses an integrated approach to begin to address these conditions.** The goal of the plan is to make basic health insurance more affordable through a range of strategies that are designed to work together to improve access and quality and constrain costs. (A detailed description of the plan can be found at <http://www.gohcr.state.pa.us/prescription-for-pennsylvania/Prescription-for-Pennsylvania.pdf>.)

### **Cover All Pennsylvanians (CAP)**

The central program in Prescription for Pennsylvania is Cover All Pennsylvanians (CAP), which would offer affordable basic health coverage, through the private insurance market, to small businesses and the uninsured. Torregrossa noted that CAP builds on the model of Cover All Kids, which targets the 133,000 uninsured children in Pennsylvania and recently began offering coverage, for a small monthly premium, to children in families with incomes of up to 300 percent of the federal poverty level (FPL). Just over 70 percent of uninsured adults in Pennsylvania are at or below 300 percent of FPL, so covering all of them would have a significant effect.

CAP includes these key features:

- **It would offer a limited benefits health care package.** It would include inpatient hospital acute care, health assessments, routine diagnostic tests, prescription and over-the-counter drugs, and behavioral health coverage, to be provided through managed care plans doing business in Pennsylvania. Blue Cross Blue Shield would be required to submit proposals, and the state believes that other insurers would also apply.
- **The program would focus on small employers, and self-employed and other uninsured individuals are also eligible to participate.** Close to three quarters of uninsured adults in Pennsylvania are employed, many of them by small businesses. Thus, CAP would target small businesses with from two to fifty employees. To be eligible, these businesses must be low-wage employers—the average wage of all employees must be less than the average wage in Pennsylvania, which currently is \$39,000—and must enroll at least 75 percent of employees who work 20 or more hours per week.
- **CAP is not intended to replace coverage that employers are currently providing.** Before they are eligible for CAP, small low-wage employers must have not provided other insurance for six months; individuals with household incomes greater than 200 percent of FPL must have been uninsured for six months; and individuals with household

incomes below 200 percent of FPL must have been uninsured for three months. These proposed requirements are intended to discourage employers and individuals from dropping their current coverage in order to apply for CAP.

- **CAP would replace adultBasic.** Supported by the state's Tobacco Settlement Fund, adultBasic provides health insurance to approximately 48,000 Pennsylvanians who meet low-income requirements. Residents of Pennsylvania who are enrolled in adultBasic would be transferred to CAP, and those on the adultBasic waiting list will be given the opportunity to immediately enroll in CAP. AdultBasic is funded entirely through state dollars, and the shift to CAP would allow the state to get federal matching funds for those dollars. It would also allow them to cover more people, and to cover prescription drugs.

### **How Will the State Pay for CAP?**

Torregrossa explained that the revenue for CAP would come from a range of sources:

- **Public sources include state and federal money.** These include existing state money from the Tobacco Settlement Fund and Community Health Reinvestment Fund, as well as federal Medicaid funds.
- **The state has projected premiums for small employers and their employees, and for individuals and the self-employed.** While the Commonwealth would subsidize a portion of the premium for health insurance through CAP, employers and enrollees would share in the cost. Employers would pay approximately \$130 per employee per month, while employees' projected premiums are \$10 to \$70 a month, depending on family income. Projected premiums for individuals and the self-employed would also be based on income: \$10 a month (for those at zero to 100 percent of FPL), \$40 a month (for 101 to 200 percent of FPL), and \$60 a month (for 201 to 300 percent of FPL). Individuals and the self-employed with incomes greater than 300 percent of FPL could apply to CAP and would pay monthly premiums at the full Commonwealth projected price of \$280 a month.
- **There would also be an assessment on employers.** The state's proposed Fair Share Assessment (FSA) levies a uniform tax on employers, with credits equaling the tax for those who offer health insurance. During the first three years of the plan, all employers would be assessed a three percent FSA on the wages of all employees, with this percentage rising slightly in following years. Employers would get a credit, equal to the full assessment, if they offer qualifying health insurance to all of their eligible employees. Because some small employers may not be able to afford coverage right away, the plan includes a quarterly credit of \$15,000 against the cost of the assessment for employers who do not offer qualifying health insurance for the first five years of CAP, although the amount of the credit will decrease each year. The Fair Share Tax Assessment is a potentially controversial aspect of CAP. While Torregrossa said that it provides a uniform tax and uniform tax credits and, thus, meets the requirements of the state constitution, she also said that the proposal has split the business community.

## A Focus on Affordability

While CAP is the key program in Prescription for Pennsylvania, this proposed reform initiative is comprehensive and includes 21 components under three interrelated categories: affordability, access and quality. Torregrossa noted that, in addition to CAP, affordability components include insurance reforms to protect people from spikes in their health care premium costs; providing information on cost and quality so consumers can make informed decisions; planning in order to avoid expensive, duplicative facilities; and reducing the number of uninsured young and healthy adults. These were among her major points about the components intended to help contain the costs of health care and insurance:

- **One key to making health care more affordable is to change the way that insurers use “ratings” to determine the costs of premiums.** Insurers used to have a “community rating” system, which meant that risks were shared by everyone covered by the insurance, and this tended to keep premium rates relatively stable. However, these insurers have increasingly been determining the cost of premiums by using demographic ratings—including such factors as age, gender, medical conditions and size of the group. The result has been “skyrocketing rates,” Torregrossa said. Pennsylvania, the only state in the country that has not limited these demographic ratings, now wants to put constraints on how they are used and limit them to three items: age, family size and geographic region. In addition, the group with the highest premium would not pay more than twice as much as the group with the lowest premium.
- **A second important measure would require health insurers to use their income from premiums primarily to pay for medical costs.** Health insurers currently vary in the percentage of premiums that is used to pay medical costs versus the percentage used for administrative expenses, profits and reserves. As several other states have done, Pennsylvania would establish a requirement for the minimum percentage of premiums that has to be used to pay medical claims. This percentage, called a “minimum loss ratio,” would be 85 percent.
- **Consumers will be able to make informed decisions if they have better information about cost and quality.** Pennsylvania’s health care market should be as “transparent” as possible, so consumers will know where they can obtain the best quality health care at the best price. Each month, for example, retail drug stores would be required to submit their charges for the 150 most commonly prescribed drugs so Pennsylvanians can find the best price for their prescriptions. Ambulatory surgery facilities and imaging centers would be required to submit on an annual basis information regarding the payments they received for the 50 most frequently performed procedures so, again, the information is accessible to everyone and can help in making decisions. Having this information public and easily accessible may also promote competitive pricing and, thus, help to contain costs.
- **Capital expenditures on new facilities and equipment should increase quality and access to care, not duplicate existing services.** Currently, for example, anyone can build an ambulatory care center and add expensive new imaging equipment, whether or not

there is a need for it in the region. Pennsylvania has no way of controlling duplicative and expensive health care capital expenditures—there is no system for planning about what is needed and what is not. Thus, Prescription for Pennsylvania would develop a process to ensure that large capital investments meet local health care needs and can be afforded by the health care payers in that region.

- **Too many people living or going to school in Pennsylvania who could afford health insurance do not have it, and the cost of their uncompensated care is passed on to those who are insured.** The commonwealth, thus, wants to require colleges in the state to provide health insurance coverage or require students to have coverage. The ultimate goal is to phase in a mandate of health insurance for all Pennsylvanians with incomes of more than 300 percent of FPL.

### **Improving Access to Health Care**

Not all Pennsylvanians have access to primary care providers and services and, thus, do not get preventive care or see a doctor when they first need treatment. One consequence, Torregrossa said, is that the state has among the highest levels of emergency room use in the country—over five million visits a year, half of which could be taken care of more cost effectively if more people had access to primary health care. The “accessibility” components of Prescription for Pennsylvania are intended to address this situation. Torregrossa described these aspects of the plan’s approach to increasing access to health care:

- **One goal is to ensure that all licensed health care providers—including nurses, advanced nurse practitioners, midwives and physician assistants—can practice to the fullest extent of their education and training.** Physicians should not be the only source of contact with patients, but Pennsylvania currently has laws and regulations that limit what these other health care providers are allowed to do. As one example, Torregrossa noted, Pennsylvania is the only state that does not allow nurse-midwives to prescribe medications. Prescription for Pennsylvania would eliminate barriers at the state level and also require insurers to use and appropriately compensate these currently underutilized health care providers.
- **The plan would increase access to primary care.** It includes two main approaches for doing this. One is to make primary health care more available in areas that are now underserved by providing start-up resources for health centers and nurse-managed care centers in these areas. A second approach is to provide financial incentives for primary care providers to offer health care during evenings and weekends so people can avoid having to go to emergency rooms for treatment they could receive more cost effectively in a medical office.
- **There is also a focus on workforce development for the health care sector.** There are both immediate and long-term needs for more health care providers. Some regions of Pennsylvania, particularly rural areas, already have significant shortages of health care workers and, thus, have urgent needs. As Pennsylvanians age and health care workers retire, the problem will grow more acute unless the state invests in workforce

development for this sector, along with providing incentives to attract and retain health care providers in underserved parts of the state.

### **Emphasizing Quality**

The third major area of Prescription for Pennsylvania is quality, which includes a range of components aimed at improving health care through such approaches as eliminating hospital-acquired infections, providing better management of chronic medical conditions, and helping people to lead healthier lives. All of these initiatives should, in turn, also help control the costs of medical care. Torregrossa emphasized these points:

- **Last year, hospital-acquired infections led to nearly 2,500 deaths in Pennsylvania and to more than \$3.5 billion in hospital charges.** Most of these infections are avoidable, and the state plan would require hospitals to implement quality management systems that could significantly reduce the infections, as well as other costly and dangerous medical errors.
- **Payment systems would be changed to encourage the effective prevention and treatment of such chronic diseases as heart disease, diabetes and asthma.** Pennsylvania has some of the worst hospitalization rates in the nation for chronic diseases because people with those diseases do not receive appropriate outpatient care. The state plan promotes the use of a nationally recognized chronic care model and aligns payments to support the use of this model.
- **The plan includes initiatives to promote healthy lifestyles for children, as well as for adults.** The emphasis on healthy lifestyles would begin with wellness education in Pennsylvania public schools, starting in kindergarten, so children will understand the importance of nutrition, exercise and health. The plan would also expand access to school breakfast and to nutritious foods throughout the school day. Other proposals include making all Pennsylvania workplaces, restaurants and bars smoke-free and implementing consumer incentives that reward healthy behavior, such as exercising, stopping smoking and losing weight.

### **How Does the Pennsylvania Plan Compare to Other Recent State Health Reforms?**

Among the steps the Commonwealth took in developing Prescription for Pennsylvania was to examine other states' plans for reforming health care coverage. After Torregrossa's presentation, Sonya Schwartz, of the National Academy for State Health Policy, provided an overview of three state initiatives that have already been implemented. These were among the points she made in her introduction:

- **At the federal level, there has been little movement to cover the uninsured.** In addition to this inaction, the Deficit Reduction Act of 2005 reduced funding for Medicaid and made dramatic changes in coverage, although it is still unclear what the effects will be at the state level.

- **There are a few more positive indications coming from Congress.** The State Children's Health Insurance Program (SCHIP), which covers low-income children, is likely to be reauthorized at a budget level higher than the administration has proposed. Congress has also introduced some bills that would send more health care money to the states. While those bills are not necessarily moving forward this year, they are an indication of a possible direction.
- **States are taking up the challenge of covering the uninsured.** Maine, Massachusetts and Vermont were the first three states, in that order, to pass plans and implement reforms. Their plans include these common components: new coverage options, individual responsibility, employer responsibility, private market reforms and provider practice reforms.

### **Finding the Money**

Schwartz noted that one of the most challenging aspects of expanding coverage is finding the resources to do it. Unlike the federal government, states cannot go into deficit. Thus, they are taking the following approaches to supporting their plans:

- **The states are using a mix of funding sources.** These include individuals, employers, and federal and state Medicaid and SCHIP funding.
- **Like Pennsylvania, the other three states, have individuals and families paying premiums and cost-sharing.** In Maine, employers also pay premiums, while in the other two states, employers pay both premiums and assessments.
- **Medicaid has limits as a funding source.** Medicaid is an entitlement, with strict regulations about whom it can and cannot cover. While some states have applied for waivers to cover additional populations, these waivers have to be budget neutral. This means that if a state wants to expand coverage for new populations under a waiver, it may have to cut benefits for existing populations, or if possible, use existing Medicaid uncompensated care funds toward coverage.

### **The New Subsidized Coverage Options**

The three plans are all, like Pennsylvania's, what Schwartz called "state-organized coverage" or "state-subsidized coverage" that is delivered by private insurers. These are among the features of the plans:

- **The three states all include private insurer coverage for people with up to 300 percent of the federal poverty level.** Maine focuses on workers at small businesses and the self-employed, and offers only one plan (there are only two health insurance companies in the state). Massachusetts has plans offered by four insurance companies, with a full subsidy for people whose incomes are up to 100 percent of FPL and a sliding scale of subsidies for people at 100 to 300 percent. The state also offers non-subsidized coverage for people above that level. The Vermont plan, which is just beginning to be

implemented, includes at least a partial subsidy for people up to 300 percent of FPL, and coverage will likely be offered by two private insurers.

- **There are compelling reasons why 300 percent of the federal poverty level is becoming the new standard for subsidized coverage.** Because health coverage is so expensive, states are subsidizing it for people at higher levels of the income scale. In 2006, across the country, the average cost of coverage for a family of three was \$11,480. The federal poverty level for a family of three was \$16,600, and so 300 percent of FPL was \$49,800. Thus, in Pennsylvania, CAP would cover people with the state's average annual wage, which was \$39,000. The question, Schwartz noted, is "What about people whose incomes are over 300 percent of FPL?" To some extent, cost containment efforts included in the state plans may help to control their premiums with private insurers.
- **The proposed monthly premiums for adults in Pennsylvania are comparable to those of the other states.** In Massachusetts, for example, adults pay \$18 a month if they are at 150 percent of FPL, with a sliding scale of up to \$106 month at 300 percent. In Vermont, the range is from no premiums for those up to 150 percent, with the scale then rising to \$135 at 300 percent. In Pennsylvania, the proposed range is from \$40 for adults at 200 percent or below FPL, up to \$60 at 300 percent.
- **Benefits are also similar.** For example, Massachusetts and Maine include inpatient hospital care, primary and specialist care, mental health and substance abuse, prescription drugs and emergency room visits. Massachusetts also includes vision care and, in some plans, dental care. Massachusetts was initially considering not covering prescription drugs in its basic package for people above 300 percent of FPL but ultimately included it, because access to medications is essential for controlling costs, in large part because it can decrease the need for hospitalizations.
- **The states are using three different approaches to cost sharing.** These include deductibles, premiums, and either co-pays (a flat payment) or co-insurance (a payment that is a percentage of cost). All three states provide preventive care with no cost-sharing, thus making it very accessible. Other co-pays are on a sliding scale based on income. In Massachusetts, for example, they range from \$0 to \$30 for office visits and medications. The states vary somewhat in their required deductibles—Vermont, for example, has a \$250 deductible for individuals and \$500 for families. One important question facing states is what the maximum out-of-pocket cost should be for people—the amount at which they stop being responsible for co-pays.
- **The states include several common features in their initiatives.** These include chronic care management and improved availability of cost and quality information for consumers. The initiatives also include efforts to promote healthy lifestyles, such as Massachusetts' diabetes prevention campaign and Maine's "contract for better health," which all people covered through the plan are required to sign.

## Shared Responsibility

Schwartz noted that in all the state plans, responsibility is broadly shared. Everyone—including government, the private insurance market, health care providers, employers and individuals—has a role in making health care coverage accessible and affordable. These were among her major points:

- **The states have attempted to incorporate employer responsibility into their plans.** In Maine, participation by employers is voluntary; but if they join, they must pay 60 percent of the premium and have at least 75 percent of their employees covered. Massachusetts and Vermont both will have assessments of employers who do not provide minimum coverage for their employees. However, states must be careful about how they define these assessments, because provisions of the federal Employee Retirement Income Security Act of 1974 (ERISA) could otherwise lead to litigation.
- **A key question concerning individual responsibility is whether states should or should not mandate coverage.** As Schwartz pointed out, states mandate that people have automobile insurance if they own a car, so why not mandate health insurance? Mandating coverage would bring younger, healthier people into the pool—one group that does not always have coverage now—and perhaps help bring down rates. While Massachusetts is the only state that currently mandates coverage, both Vermont and Maine are considering it. The plan that was recently proposed in California includes mandated coverage. The Pennsylvania plan does not include an immediate mandate for coverage.
- **A variety of private market reforms are intended to constrain the cost of premiums.** Maine, for example, asks insurers to voluntarily limit their operating margin to 3.5 percent. Massachusetts has merged the individual and group insurance markets, so individuals (defined as groups of one) get the same rates as true groups, thus lowering their rates. Vermont is similarly examining the feasibility of merging the small group and individual markets and is also considering becoming involved in re-insurance. In a re-insurance approach, the state would subsidize claims above a certain amount, such as \$100,000, as a possible way to bring down everyone’s premium rates.
- **A second approach for restraining costs is through provider practice reforms.** The states are using a range of strategies in this area, including strengthening the “certificate of need” process for high-cost expenditures; requiring full disclosure of hospital charges; instituting pay-for-performance for hospitals; and simplifying administrative processes and, thus, costs.

## Lessons and Implications

Schwartz concluded by describing several important lessons learned from these states’ experiences, and by outlining potential implications for nonprofits of the Pennsylvania plan:

- **Several key environmental factors can help lead to success.** First, there should be a strong consensus among key stakeholders—from private insurers to the general public—that reform needs to occur. In addition, there needs to be evidence of inefficient spending

in the health care system. Finally, reform seems more likely to happen when the state has a history of previous initiatives to cover the uninsured, as is the case in Pennsylvania.

- **Additional lessons have also emerged from these other states' expansion efforts.** Perhaps most important is the key role of leadership—it is essential to have a champion in the governor's office. Second, diverse stakeholders have to remain involved and invested. In Massachusetts, for example, the governor's office, the state legislature, and private insurers each had a separate plan, but they were able to compromise because everyone wanted reform. Third, "free" solutions are unlikely to have a significant impact; the state has to invest money, and there also needs to be federal support. Finally, not all decisions need to be made up-front during the planning period; states should consider leaving some decisions to implementation. Maine, for example, waited to decide on whether to have assessments for employers. States should ask themselves how much they have to accomplish through legislation and which parts of their plan they can wait to "hammer out" during implementation.
- **The Pennsylvania plan has a number of possible implications for nonprofit organizations and their clients.** Because organizations' clients who are covered by adultBasic, or on the waiting list for coverage, would be enrolled in CAP, those clients will have improved access to care and also should have better quality care. In addition, nonprofit organizations are also employers, and CAP may affect them in that way as well. If the organization does not now offer coverage, CAP is likely to be less expensive than current options; and if it does now offer coverage, the existence of CAP may mean more transparency in understanding what health insurance plans cover, possibly better rates, and the option of a small-group standard plan. There are also possible assessments and tax credits that nonprofits, like other small employers, will have to pay attention to.

### Question-and-Answer Sessions

Following each presentation, participants had an opportunity to ask questions and raise concerns. These were among the issues they wanted to know more about:

- **Are dependents covered under CAP?** Small employers would only have to pay for the employees, not others in their family. However, applicants for coverage would give information about everyone in their family. Eligible children would then be covered through "Cover All Kids," while others in the family could pay for coverage through CAP.
- **What about people who do not have documentation of citizenship?** Schwartz described the current situation as "confusing." The Deficit Reduction Act of 2005 includes a provision that requires anyone in the Medicaid system to show proof of citizenship and identity, although at least some states are trying to work around this. Illinois, for example, covers all children, regardless of immigration status. However, those children's mothers are not covered, and so they are not getting essential services such as prenatal care. It is difficult to predict now what will happen in Pennsylvania.

- **Why is CAP linked to small businesses with up to 50 employees?** Larger companies are more likely to already be offering health coverage; and, Torregrossa said, the state also did not want to “take on the big insurers at this level.” The biggest need is with small businesses. These are often low-profit businesses with low-wage workers; and, in many cases, these employers have not been able to afford to offer insurance coverage in the past.
- **What will CAP do to integrate chronic disease management and behavioral health care?** Many people with chronic conditions are also depressed, but there is typically a barrier between behavioral health care and chronic disease care. CAP will emphasize a team-based approach—including nurses, doctors and other practitioners—to managing chronic conditions, and the plan is to integrate behavioral health care into this approach.
- **Is the state doing anything to address the shortage of nurses?** There is a serious nursing shortage in the state. In addition, there are a lot of nurses in Pennsylvania who are not practicing because the physical and mental demands of the job lead people to leave the field. Torregrossa said that the state wants to increase the capacity of nursing schools and also has money in the budget for items such as loan forgiveness to cover some of the costs of nursing education. These efforts may help, in part, by attracting new people to the field.
- **Why is the state using this public-private approach to providing health care coverage instead of using a single payer system?** Torregrossa noted that the single payer approach to health care coverage is at one end of the spectrum, while the “individual responsibility” approach is at the other end. She said that Governor Rendell supports the idea of a single payer system, but that would not be passed by the legislature. Thus, the state is focusing on what can be done right now.
- **Would any of the components of Prescription for Pennsylvania going to be piloted?** Some aspects of the proposed plan do not need to be piloted—for example, there are proven best practices for essentially eliminating hospital-acquired infections, and these could be widely implemented right away. However, it may make sense to pilot other aspects of the plan, such as the team-based model of chronic disease management.

### **Additional Resources**

#### **Health Care Expansion and Reform in Pennsylvania: What Is Driving It, What Are the Proposals, and What Can Be Learned from Other State Initiatives?**

The following resources provide additional information.

#### **Alliance for Health Reform**

*<http://www.allhealth.org>*

The Alliance’s 24-page March 2007 guide, “Health Coverage in America: Understanding the Issues and Proposed Solutions,” provides an overview of how Americans get health coverage, why many Americans lack coverage and what can be done to address these issues.

### **Governor's Office of Health Care Reform**

*<http://www.ohcr.state.pa.us>*

The Governor's Office of Health Care Reform (GOHCR) was established by Governor Edward G. Rendell with the goal of improving accessibility, affordability and the quality of health and long-term living services in Pennsylvania. GOHCR spearheaded the development of Rendell's proposal to restructure the commonwealth's health care system. Its Web site houses a variety of materials related to the governor's plans.

### **National Academy for State Health Policy**

*<http://www.nashp.org>*

The National Academy for State Health Policy (NASHP) is a nonpartisan organization that supports improvement in state health care policy and practice. Through its Access for the Uninsured program, NASHP provides information and analysis on state initiatives for expanding health care coverage. NASHP also examines state cost containment, patient safety and health performance issues.

### **National Governors Association**

*<http://www.nga.org>*

The National Governors Association (NGA) serves as the collective voice of the nation's governors and provides governors and their staff members with policy information and technical assistance. With the Kaiser Family Foundation, NGA has launched Elements of State Health Reform, a series of webcasts regarding the design and implementation of health care reform initiatives and coverage expansions.

### **Pennsylvania Health Law Project**

*<http://www.phlp.org>*

The Pennsylvania Health Law Project (PHLP) provides free legal services to Pennsylvanians who are having trouble understanding or gaining access to publicly funded health care coverage or services. PHLP's Health Law PA News, a bimonthly publication, provides policy information and analysis regarding a range of health issues in the state.

### **State Coverage Initiatives**

*<http://www.statecoverage.net>*

State Coverage Initiatives (SCI) is a program of the Robert Wood Johnson Foundation (RWJF) administered by AcademyHealth. SCI's "State of the States" 2007 publication highlights the evolution of state coverage strategies over the past three years, trends in states' initiatives, and lessons learned by policymakers regarding previous coverage initiatives.