Efforts to Increase Access to Health Insurance: An Overview of State Activities

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State Coverage Initiatives (SCI)

- An Initiative of the Robert Wood Johnson Foundation
- Direct technical assistance to states
  - State specific help, research on state policy makers' questions
  - Convening state officials
  - Web site: http://statecoverage.net
  - Publications
- Grant funding

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Drivers of State Health Reform Efforts

- Increasing uninsured
  - Declines in employer sponsored insurance
  - Increase in public coverage offsets what would be larger increase in uninsured
- Health insurance is increasingly unaffordable to working families
- Some states beginning to emerge from fiscal crisis
- Lack of national consensus

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Coverage Strategies Focus on Common Problems

Problem

- Nationally, 99% of large firms offer, but only 42% of small firms
- 8 out of 10 uninsured from working families
- Poor are twice as likely to be uninsured

Strategy

- Public-private partnerships, many focus on small business
- Medicaid and SCHIP options attractive because of federal matching funds

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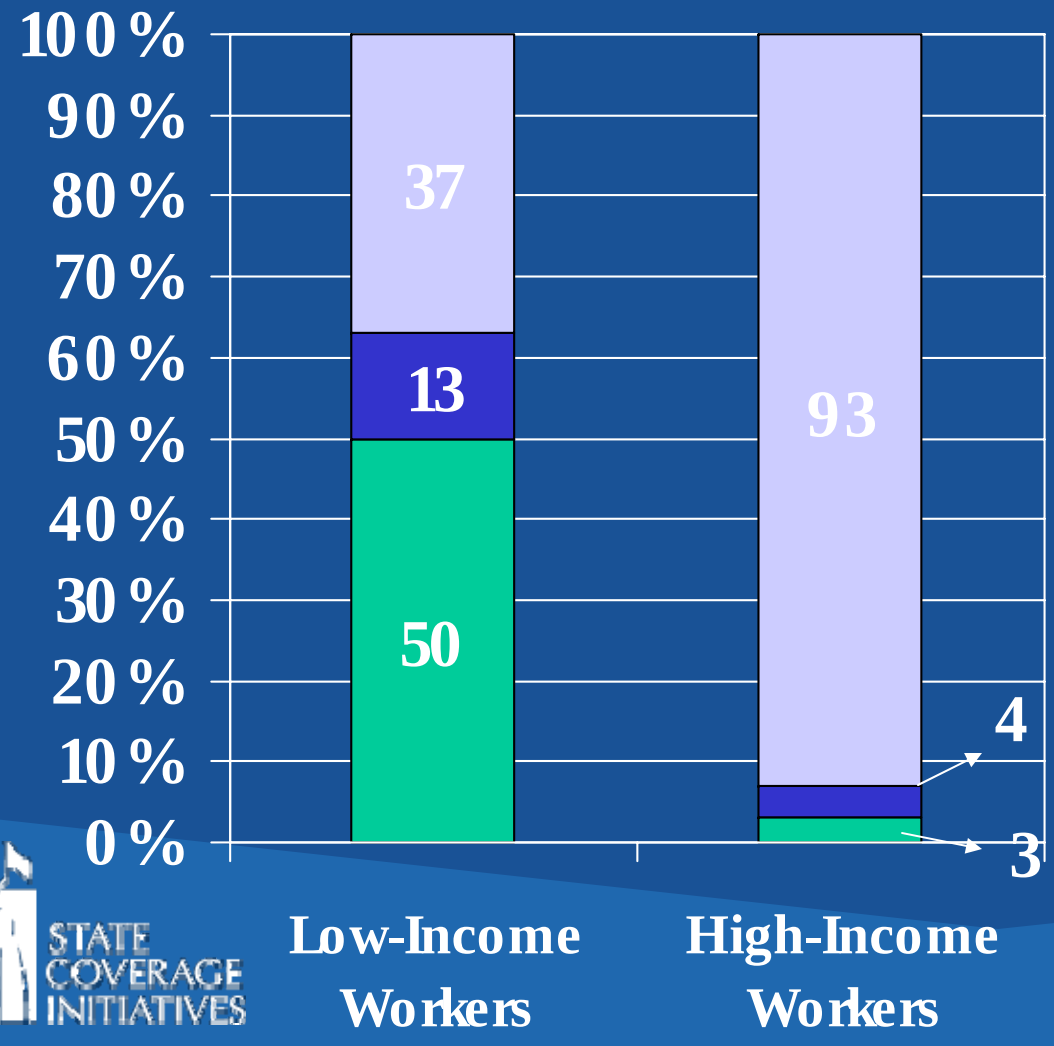
For low-income working uninsured, problem is both “offer” and “take-up”



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SOURCE: Kaiser Commission Medicaid and Uninsured, Key Facts, December 2003

Common Reactions to Recent State Reforms

- New idea, still in a honeymoon period
  - Sense of possibility/Don't want to be left behind
- Maybe this works for that State, but we are different
- New ideas tested (maybe parts of a larger strategy) spark other ideas and creative approaches
- Fear of over-reaching – sustainability of initiatives
- Importance of on-going coalition of support

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Different Strategies to Coverage

1. Comprehensive approaches
2. Covering children
3. Making new insurance options more affordable for low-income working uninsured
4. Medicaid Strategies

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Comprehensive Efforts

Massachusetts Health Care Reform

- Individual mandate for those that can afford
- Employer (>10) Fair Share Assessment - $295/FTE
- Employer (>10) Free Rider Surcharge
- All employers must offer Section 125 (cafeteria) plans
- Commonwealth Health Insurance Connector
- Market reforms – merging small group market and individual market
- Commonwealth Care Health Insurance (begins 3/07)
  - Sliding scale subsidies < 300% FPL
  - Medicaid expansion
- Health Safety Net Fund

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Massachusetts Connector

- Providing small businesses, sole-proprietors, and individuals w/out access to ESI more choices
- Increasing adoption of pre-tax premium payment options by small business (Section 125 plans)
- Allowing portability for consumer
- Connector is the exclusive administrator of Commonwealth Care premium assistance
- Commonwealth Care plans offered exclusively through Medicaid MCOs for first 3 years (subsidized product)

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Source: Lischko, A. *Massachusetts Healthcare Reform*. Slides presented at SCI's Summer Workshop for State Officials, Chicago, IL. August 2006.

Commonwealth Care

- Premium assistance up to 300% FPL ($60K/family 4)
  - Zero premiums for individuals under 100% FPL
  - Premiums increase on sliding scale with income
  - No deductibles permitted for low-income
- Key Assumptions:
  - Anticipate 200,000 to be eligible
  - $300 pmpm for individuals
  - Average state subsidy will be between 80-85% of monthly premiums

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Source: Lischko, A. *Massachusetts Healthcare Reform*. Slides presented at SCI's Summer Workshop for State Officials, Chicago, IL. August 2006.

Massachusetts Individual Mandate

- Individual mandate for all those who can afford - key implementation question is defining "affordability"
- Statewide enrollment in Commonwealth Care begins March 2007
- Beginning July 1, 2007 all Massachusetts residents will be required to have health insurance
- Enforcement
  - Indicate insurance policy number on state tax return
  - Loss of personal tax exemption for tax year 2007
  - Fine for each month w/out insurance = 50% of affordable insurance product for tax year 2008

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Source: Lischko, A. *Massachusetts Healthcare Reform*. Slides presented at SCI's Summer Workshop for State Officials, Chicago, IL. August 2006.

Massachusetts Employer Mandates

- Fair Share Assessment for employers (>10 workers), $295/FTE
- Free Rider Surcharge for employers (>10 workers) with uninsured workers with uncompensated care
- All employers must offer a section 125 (cafeteria) plan
  - Not a requirement for employer to pay for insurance
  - Allows employees to buy insurance with pre-tax dollars

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Source: Lischko, A. *Massachusetts Healthcare Reform*. Slides presented at SCI's Summer Workshop for State Officials, Chicago, IL. August 2006.

Massachusetts: Insurance Market Reforms

Existing Market	Reformed Market
Dysfunctional individual market	Individual/small market merger
Limited take-up of HSAs	More products with HSAs
"Any willing provider"	Value-driven networks
Bad value for younger adults	19-26 year-old market
No consequence for lifestyle choices	Tobacco usage is a rating factor
Hard cut-offs for dependent status	More flexible up to 25 years-old
Growing list of mandatory benefits	Two year moratorium
Optional, smaller risk pools	Mandatory, larger risk pools

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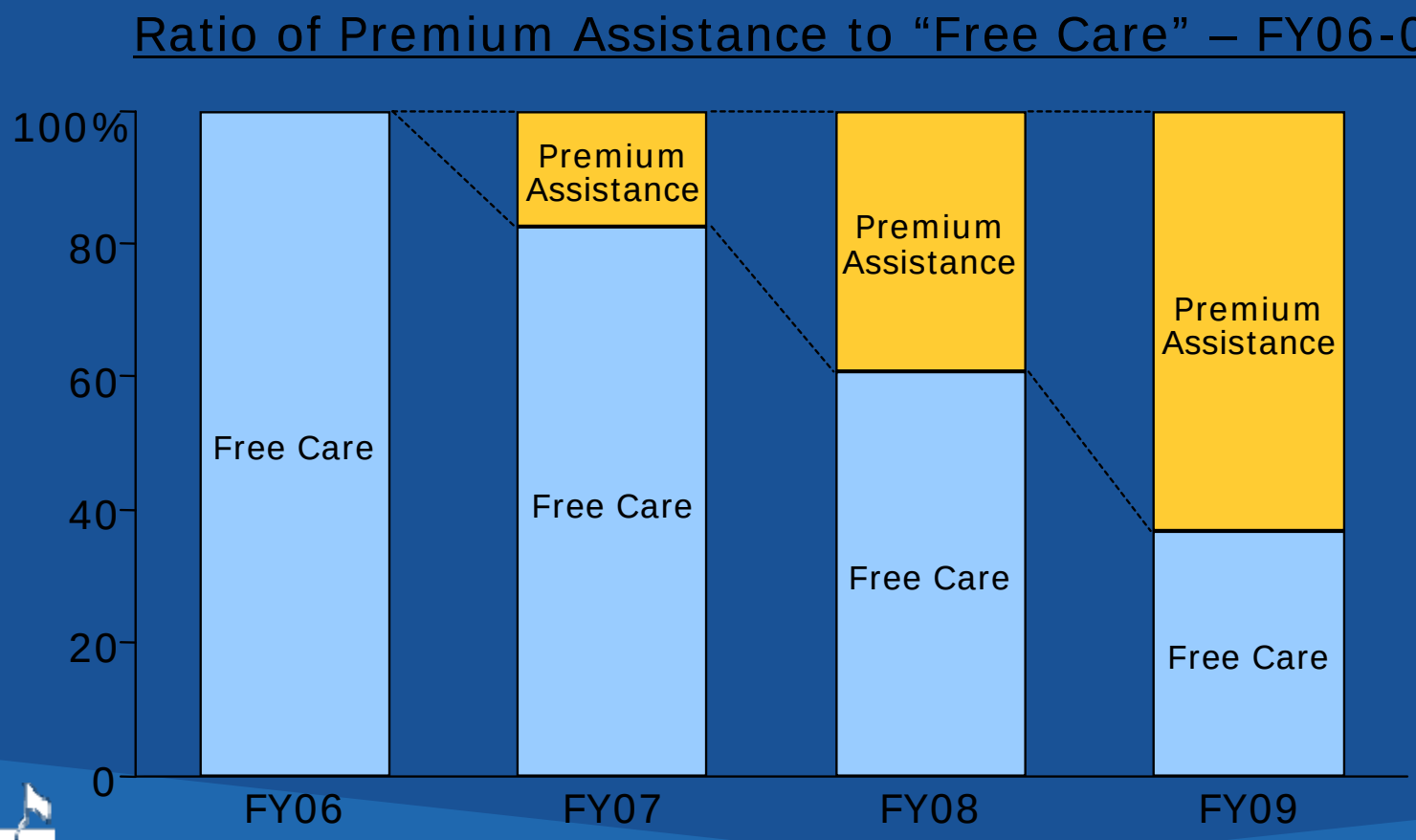
Redeploying existing funding makes the program financially sustainable



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Source: Lischko, A. *Massachusetts Healthcare Reform*. Slides presented at SCI's Summer Workshop for State Officials, Chicago, IL. August 2006.

Massachusetts – transferability of reforms

- Different segments of the uninsured require different solutions
- Insurance connector
- Market Changes
  - Impact of merging individual and small group market
  - Raising age of dependents – up to 25
- Employer requirements – such as requirement to set up pre-tax plans (section 125)
- Benefit designs
- Individual mandate – key interest for many states, but difficult for most states to address affordability without significant funding

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Vermont Reforms

- Catamount Health – new affordable comprehensive product for uninsured
  - Sliding scale premiums up < 300% FPL
  - Funding from $365/FTE employer assessment, cigarette tax and individual premiums (possibly federal matching funds)
- Premium Assistance for uninsured <300% FPL who have access to employer sponsored insurance
- Cost containment that focuses on chronic disease prevention

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Vermont – Potential Lessons

- Cost containment efforts that focus on chronic disease prevention
- Catamount Health
  - Enrollment experience
  - Funding sources

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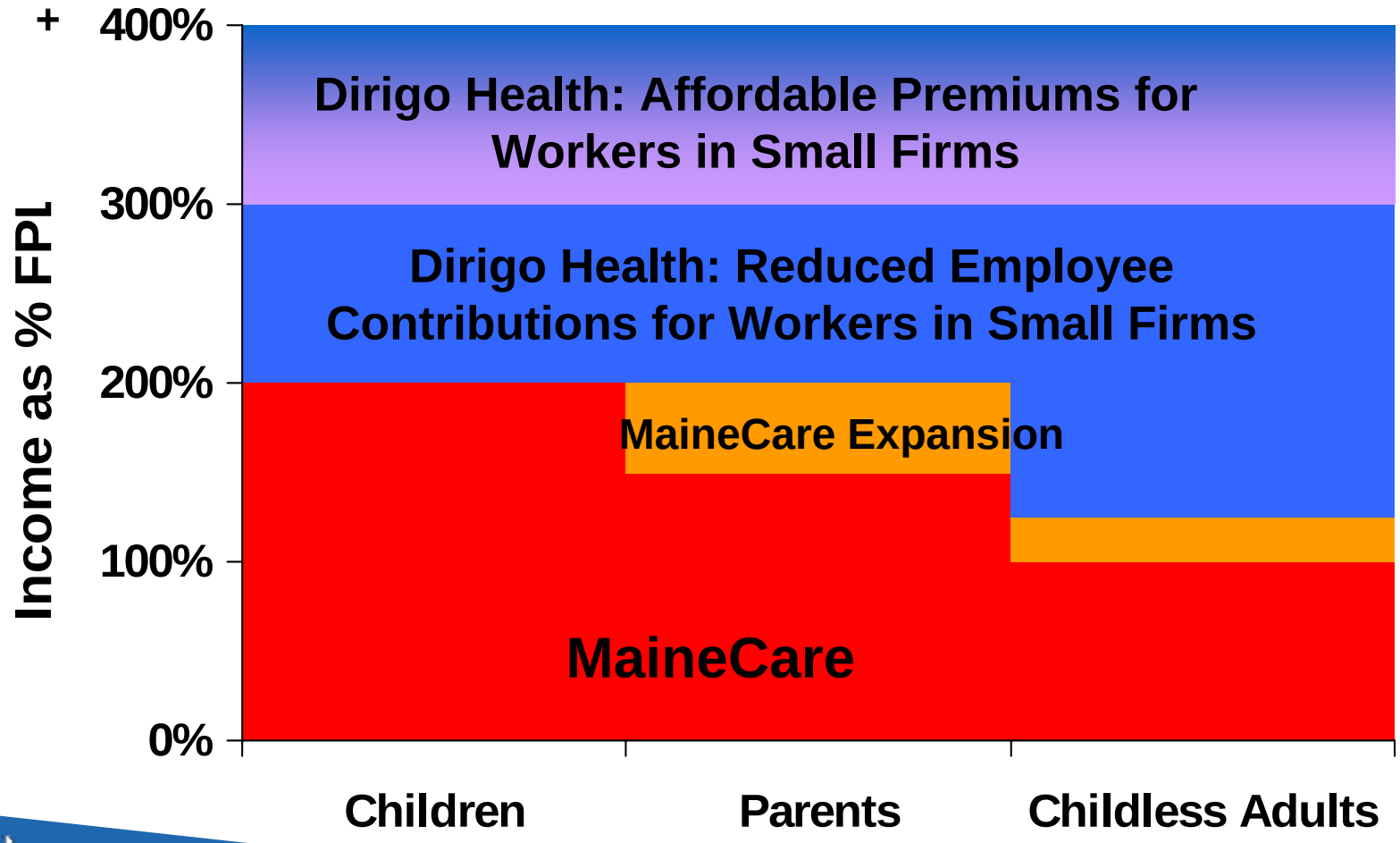
Maine's Dirigo and MaineCare Eligibility



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Maine's Experience

- 8,700 individuals enrolled (November 2005)
- $43.7 million in savings
  - $33.7 million - hospital voluntary measures
  - $2.7 million - avoided bad debt and charity care
  - $7.3 million – provider fee initiative
- Assessing full Savings Offset Payment ($44 million) to continue Dirigo Health, including $7 million for MaineCare Expansion
  - lifts waiting list for individuals and sole proprietors

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Maine - Potential Lessons

- Financing – challenge of using savings to finance expansion
- Challenge of building and maintaining a consensus

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Expansions for Children

Illinois AllKids

- Previous recent expansions
  - Coverage for Children expanded from 185% to 200% FPL
  - Phased in coverage for parents from 49% to 133% FPL (waiver allows 185%)
  - KidCare rebate – premium assistance program
- AllKids expansion (July 2006)
  - All uninsured children eligible
  - $45 million estimated cost to be financed through savings from shift to a primary care case management model (PCCM)
- Other States also proposing: NM, OR, WA, WI

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Make Insurance More Affordable

Efforts to Make Insurance More Affordable

- Building purchasing power
- Limited benefits
- Consumer directed health care
- Medicaid Strategies

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Building Purchasing Power

West Virginia Small Business Plan: Uses State Purchasing Power to Lower Premium

- Initiative addresses the “volume” needed to get purchasing power for small employers
- Allows carriers to access State Employees' reimbursement rates → reduce premiums by 20-25%
- Eligibility: Firms w/2-50 employees
- Minimum employer contribution of 50%; 75% of eligible employees must participate

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Purchasing Pools

- Mixed results: improves plan choice in small firms and has increased coverage, but enrollment has generally been low
- Have not generated significant administrative savings or price discounts to date
- Adverse selection problems
- States continue to express interest in this option

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Arizona HealthCare Group: Contracting Power

- Open to small business and sole proprietors who have been without health insurance for 6 months
- State subsidy ended July 2005, program now funded by premiums
- Managed by AHCCCS, coverage provided by private health plans (mostly Medicaid MCOs)
- Recent enrollment growth may provide lessons for other states
  - Current enrollment over 20,000 up from about 10,000 in ‘04 (92% enrollment groups <3)
  - Need data to understand what is driving growth and overall program impact

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Healthy New York lowers premiums for small businesses and uninsured workers

- 20% of people account for 80% of health spending
- State subsidizes costs for high cost enrollees with the goal of lowering premiums for all
- State requires all HMOs to offer product
- Some benefits excluded (MH/SA)
- Small firms w/ low-wage workers, low income self-employed, uninsured workers w/o access to employer sponsored insurance may enroll

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Healthy New York Reinsurance Subsidy

- Estimated savings of 50% for individuals
- Over 110,000 enrolled (1/06)
  - Most enrollment is non-group
- State Reinsurance Fund spent $13.3 million in 2003 and $34.5 million in 2004

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Healthy New York - Potential Lessons

- "Product" vs "Program"
- Perceived efficiency and value of program
- Getting participation requires long-term partnership to build trust that coverage will continue to be there
- Challenge – mostly individuals vs. small groups
- Market oversight key feature to assure State Reinsurance contributions result in lower premiums

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Limited Benefit Products

Value of Limited Benefit Plans is Matter of Debate

- At least 13 states have passed limited benefit legislation, 2 states passed new laws in 2005
- Responds to criticism that too many mandates are increasing costs; however, savings from eliminating mandated benefits not sufficient to increase take-up rates
- New coverage for currently uninsured or crowd-out those who have comprehensive health insurance?
- Opponents: Illusory cost-savings - increased uncompensated care for providers
- Continued use of safety-net by beneficiaries
- Report by Commonwealth Fund cites increased health / financial risks for consumers who have less benefits or substantial increases in deductibles

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Medicaid Strategies

Medicaid Coverage for Low-income Workers

- New insurance products for small firms with low-wage workers
- Employers, individual and Medicaid pay premium
  - New Mexico – open to uninsured adults <200% FPL, individuals may pay employer contribution
  - Oklahoma covers workers and spouses <185% FPL who work for small firms; program begins with voucher; safety-net option will be provided for workers with employers unwilling to participate
  - Arkansas recently received waiver to offer limited benefit product to small firms, Medicaid funding will be available for low-wage workers (<200% FPL)

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Goal of New Mexico's State Coverage Insurance (SCI) Program

Goal #1

- Address New Mexico's high rate of uninsured and low rate of employer sponsored health care

Goal #2

- Create a public/private partnership

Goal #3

- Offer affordable health care coverage to low-income working adults through an employer-based system

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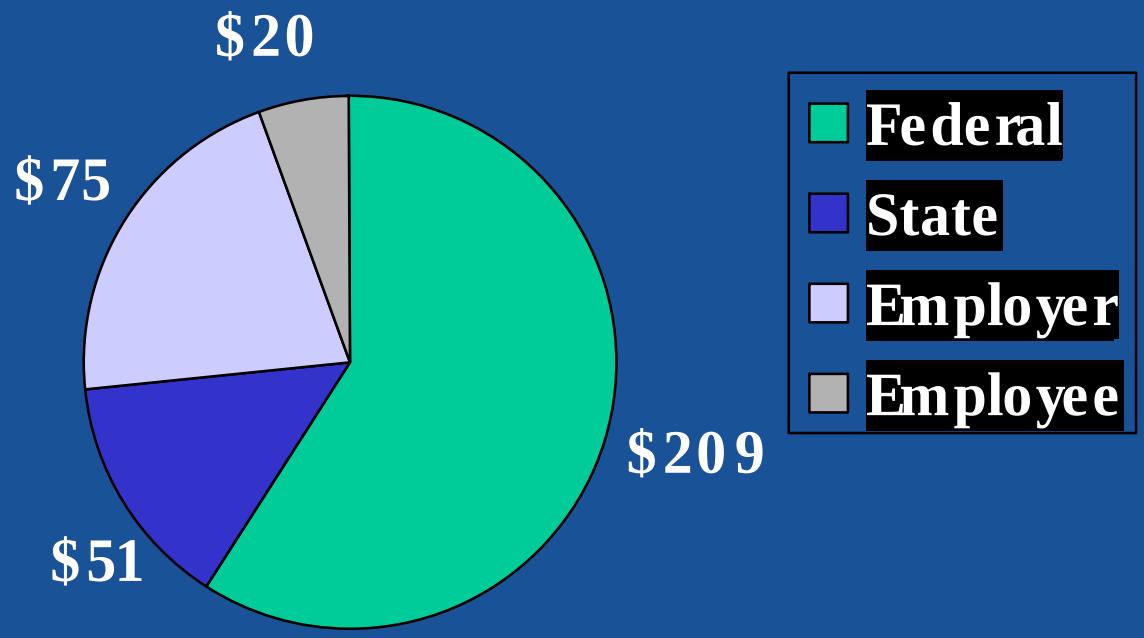
New Mexico's State Coverage Insurance, Contributions to Premium



$355 estimate per person

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New Mexico: Cost Sharing Provisions Designed To Encourage Access

Sliding Scale Co-Pays

0-100% FPL	101-150% FPL	151-200% FPL
– Most co-pays $0, Inpatient stay - $0 per admission	➢Most co-pays $5, Inpatient stay - $25 per admission	– Most co-pays $7, Inpatient stay - $30 per admission

- RX - $3 per prescription – maximum monthly Rx co-pay $12
- Cost Sharing Maximum – limited to 5% countable household income

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New Mexico: Benefit Design

- $100,000 benefit year maximum on services
- Out-of-pocket limits: 5% of annual countable income
- Specialist covered (except vision screening, eyeglasses & podiatry – except for diabetic patients)
- MH/SA: Limited to 42 days/year combined
- RX: Generic - $3; Brand Formulary - $3; Non-Brand Formulary – not covered
- Exclusions: Acupuncture; Massage Therapy; Chiropractic; Hearing Aids; Case management; skilled nursing facility; pulmonary rehabilitation; inpatient substance abuse (unless for detox); hospice; cancer clinic trials; smoking cessation; TMJ
- Transplants included in $100,000 benefit year maximum

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Oklahoma Employer/Employee Partnership for Insurance Coverage

- HIFA Waiver, tobacco tax financing
- Goal to cover 70,000 uninsured workers
- Open to workers and spouses under 185% FPL who work for small employers and those "seeking" work
- Voucher for small businesses to provide coverage
  - Employer pays 25%; employee pays 15%; state & federal funds 60%
- All products available in small group market meet the eligibility requirements
- Safety-net option for workers with employers unwilling to participate

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Arkansas's New Federal Waiver (1)

- Private sector plan for small businesses with <500 employees (but really targeted to <50)
- 100% of employees must be covered (unless offer proof they have more comprehensive coverage): condition of employment
- Only small employers that have not offered health insurance during the preceding 12 months may qualify
- "Safety Net" benefit plan (encounter cap):
  - six clinician visits
  - seven hospital days
  - two outpatient procedures/ER visits per year
  - two Rx per month
  - No catastrophic coverage

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Arkansas's New Federal Waiver (2)

- Premiums comes from employee/employer; State tobacco settlement funds; and federal match of State funds – will be substantially less than market rates.
- Subsidized for employees <200% FPL but employees with higher incomes can participate – no subsidy.
- Competitive RFP process will choose one or more private sector health insurance companies - Summer 2006
- Potential enrollment: first year capped at 15,000; envisioned up to 80,000 Arkansans

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Potential Lessons

- Rethinking traditional Medicaid "premium assistance" model
  - Rather than buying uninsured into employer-sponsored insurance, creating new products for employers to offer to low wage workers
- Using federal Medicaid funds to support non-traditional Medicaid population – low – wage workers

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Medicaid's Changing Role and Impact of Deficit Reduction Act

- Covering different population, sometimes higher income groups
- Increased cost-sharing
- Changing benefit designs
- Consumer Responsibility
- Role in expanding coverage to uninsured

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Concluding Thoughts – States Leading Reforms

- Progress to be made by states
  - Testing new ideas (politically and practically)
  - Creating momentum for national policy solution
- How do we define success?
  - Right size expectations for what any one state can achieve
  - Role for ambitious goals, but also need a reality check
  - Challenge of incremental reforms is making them seamless
- Fully addressing problem of uninsured likely to need comprehensive national solution

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