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Policy Research, Inc.

**Analytic Support for
Washington Citizens'
Work Group on Health
Care: Evaluation of
Health Care Reform
Proposals**

Final Report

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CONTENTS

Chapter	Page
EXECUTIVE SUMMARY	xv
I INTRODUCTION.....	1
II PROPOSAL 1: REDUCED REGULATION OF HEALTH INSURANCE	5
A. KEY ASSUMPTIONS AND FINDINGS	5
B. CHANGES IN PREMIUMS.....	8
C. CHANGES IN COVERAGE	10
1. Small Group Enrollment.....	10
2. Individual Enrollment.....	11
D. SOURCES OF FUNDS.....	16
E. FINANCIAL IMPACT ON INDIVIDUALS.....	18
F. FINANCIAL IMPACT ON EMPLOYERS.....	19
III PROPOSAL 2: THE HEALTH INSURANCE CONNECTOR.....	21
A. KEY ASSUMPTIONS AND FINDINGS	22

Chapter	Page
III	<i>(continued)</i>
B.	CHANGES IN PREMIUMS..... 24
C.	CHANGES IN COVERAGE 25
1.	Enrollment by Age 27
2.	Enrollment by Family Income..... 27
3.	Enrollment by Health Status..... 28
4.	Change in Insured Status of Residents Eligible for Medicaid, SCHIP, or Basic Health..... 29
D.	SOURCES OF FUNDS..... 30
E.	FINANCIAL IMPACT ON INDIVIDUALS..... 30
F.	FINANCIAL IMPACT ON EMPLOYERS..... 33
IV	PROPOSAL 3: THE HEALTH PARTNERSHIP 35
A.	KEY ASSUMPTIONS AND FINDINGS 36
B.	CHANGES IN PREMIUMS..... 38
C.	CHANGES IN COVERAGE 38
1.	Enrollment by Age 40
2.	Enrollment by Family Income..... 41
3.	Enrollment by Health Status..... 42
D.	SOURCES OF FUNDS..... 42
E.	FINANCIAL IMPACT ON INDIVIDUALS..... 44
F.	FINANCIAL IMPACT ON EMPLOYERS..... 47

Chapter	Page
V	PROPOSAL 4: SINGLE-PAYER PLAN 51
	A. KEY ASSUMPTIONS AND FINDINGS 51
	B. CHANGES IN PREMIUMS..... 54
	C. CHANGE IN COVERAGE..... 54
	D. SOURCES OF FUNDS..... 56
	E. FINANCIAL IMPACT ON INDIVIDUALS..... 58
	F. FINANCIAL IMPACT ON EMPLOYERS..... 60
VI	PROPOSAL 5: THE GUARANTEED HEALTH BENEFIT PROGRAM 63
	A. KEY ASSUMPTIONS AND FINDINGS 63
	B. CHANGES IN PREMIUMS..... 65
	C. CHANGES IN COVERAGE 66
	1. Enrollment by Age 67
	2. Enrollment by Family Income..... 67
	3. Enrollment by Health Status..... 8
	D. SOURCES OF FUNDS..... 69
	E. FINANCIAL IMPACT ON INDIVIDUALS..... 70
	F. FINANCIAL IMPACT ON EMPLOYERS..... 72

Chapter	Page
VII	COMPARATIVE RESULTS..... 75
A.	CHANGES IN COVERAGE AND TOTAL COST, AND IMPACTS ON HOSPITAL CHARITY CARE 75
B.	SCOPE OF COVERAGE AND CONSUMER CHOICE..... 78
C.	ESTIMATES OF ECONOMIC IMPACT..... 80
D.	IMPROVING COST EFFECTIVENESS AND QUALITY 82
1.	Improved Health Outcomes..... 82
2.	Evidence-Based Care 84
3.	Preventive Services..... 85
4.	Chronic Disease Management 85
5.	Medical Homes 86
6.	Financial Incentives..... 87
APPENDIX A:	SUMMARY OF WASHINGTON STATE HEALTH CARE REFORM PROPOSALS..... A-1
APPENDIX B:	DETAILED ESTIMATES OF PROJECT CHANGES IN COVERAGE AND EXPENDITURES: ALL PROPOSALS, FY 2010 B-1
APPENDIX C:	ISSUE BRIEFS: IMPROVING THE COST EFFECTIVENESS AND QUALITY OF HEALTHCARE IN WASHINGTON STATE C-1
APPENDIX D:	METHODS..... D-1

T A B L E S

Table	Page
II.1 ESTIMATED PERCENT CHANGE IN PREMIUMS FOR INDIVIDUAL PRODUCTS AVAILABLE TO INDIVIDUALS AGED 19 TO 34: PROPOSAL 1, FY 2010.....	9
II.2 ESTIMATED SOURCES AND DISTRIBUTION OF COVERAGE OF PERSONS UNDER AGE 65: CURRENT CASE AND PROPOSAL 1, FY 2010	10
II.3 ESTIMATED PERCENT OF ADULTS ENROLLED IN INDIVIDUAL COVERAGE BY AGE OF ENROLLEE AND TYPE OF COVERAGE PROPOSAL 1, FY 2010	13
II.4 ESTIMATED SOURCES OF COVERAGE BY AGE OF ENROLLEE: PROPOSAL 1, FY 2010.....	14
II.5 ESTIMATED SOURCES AND DISTRIBUTION OF COVERAGE BY FAMILY INCOME FOR ALL PERSONS AND ADULTS AGED 19-34: PROPOSAL 1, FY 2010....	15
II.6 ESTIMATED PERCENT OF ALL PERSONS AND ADULTS AGED 19-34 WITH GOOD, FAIR, OR POOR HEALTH STATUS BY SOURCE OF COVERAGE: CURRENT CASE AND UNDER PROPOSAL 1, FY 2010	16
II.7 ESTIMATED TOTAL EXPENDITURES BY SOURCE OF FUNDS: PROPOSAL 1, FY 2010.....	17
II.8 ESTIMATED CHANGE IN AVERAGE INDIVIDUAL EXPENDITURES: PROPOSAL 1, FY 2010.....	18
II.9 ESTIMATED CHANGE IN TOTAL EXPENDITURES FOR THE MEDIAN INDIVIDUAL: PROPOSAL 1, FY 2010.....	19

Table	Page
II.10 ESTIMATED EMPLOYER CONTRIBUTIONS TO HEALTH COVERAGE: PROPOSAL 1, FY 2010.....	20
III.1 ESTIMATED MINIMUM CONNECTOR PREMIUMS AND BASIC HEALTH PREMIUMS FOR SINGLE COVERAGE BY AGE OF ENROLLEE: PROPOSAL 2, FY2010.....	25
III.2 ESTIMATED NUMBER OF PERSONS UNDER AGE 65 BY COVERAGE STATUS: PROPOSAL 2, FY 2010	25
III.3 ESTIMATED DISTRIBUTION OF UNINSURED: PROPOSAL 2, FY2010	26
III.4 ESTIMATED SOURCES AND DISTRIBUTION OF COVERAGE BY AGE OF ENROLLEE: PROPOSAL 2, FY2010	27
III.5 ESTIMATED SOURCES AND DISTRIBUTION OF COVERAGE BY FAMILY INCOME: PROPOSAL 2, FY 2010.....	28
III.6 ESTIMATED NUMBER AND PERCENT OF PERSONS REPORTING GOOD, FAIR, OR POOR HEALTH BY SOURCE OF COVERAGE: PROPOSAL 2, FY 2010	29
III.7 ESTIMATED MEDICAID, SCHIP, AND BASIC HEALTH ELIGIBLE PERSONS AND ENROLLEES: PROPOSAL 2, FY2010	29
III.8 ESTIMATED TOTAL EXPENDITURES BY SOURCE OF FUNDS: PROPOSAL 2, FY2010.....	31
III.9 ESTIMATED CHANGE IN AVERAGE INDIVIDUAL EXPENDITURES: PROPOSAL 2, FY 2010.....	31
III.10 ESTIMATED CHANGE IN TOTAL EXPENDITURES FOR THE MEDIAN INDIVIDUAL: PROPOSAL 2, FY 2010.....	32
III.11 CURRENT EMPLOYER CONTRIBUTIONS TO COVERAGE AS A PERCENT OF PAYROLL AND ESTIMATED CHANGE: PROPOSAL 2, FY 2010.....	33
IV.1 ESTIMATED NUMBER OF PERSONS UNDER AGE 65 BY COVERAGE STATUS: PROPOSAL 3, FY 2010.....	39
IV.2 ESTIMATED NUMBER OF PERSONS ENROLLED IN MEDICAID OR SCHIP BY NEW OR CURRENT ENROLLMENT, AND COMPARED WITH THE HEALTH PARTNERSHIP: PROPOSAL 3, FY 2010	40

Table	Page
IV.3 ENROLLMENT IN THE HEALTH PARTNERSHIP BY AGE AND PLAN TYPE, FY 2010.....	41
IV.4 ESTIMATED NUMBER OF ENROLLEES BY FAMILY INCOME BY SOURCE OF COVERAGE AND FAMILY INCOME, FY 2010.....	41
IV.5 ESTIMATED NUMBER AND PERCENT OF PERSONS REPORTING GOOD, FAIR, OR POOR HEALTH BY SOURCE OF COVERAGE: PROPOSAL 3, FY 2010	42
IV.6 ESTIMATED TOTAL EXPENDITURES BY SOURCE OF FUNDS: PROPOSAL 3, FY 2010.....	43
IV.7 ESTIMATED FINANCING FOR PROPOSAL 3, FY 2010.....	45
IV.8 ESTIMATED CHANGE IN AVERAGE INDIVIDUAL EXPENDITURES: PROPOSAL 3, FY 2010.....	46
IV.9 ESTIMATED CHANGE IN TOTAL EXPENDITURES FOR THE MEDIAN INDIVIDUAL: PROPOSAL 3, FY 2010.....	47
IV.10 ESTIMATED CHANGE IN EMPLOYER EXPENDITURES FOR PREMIUM CONTRIBUTIONS AS A PERCENT OF TOTAL PAYROLL: PROPOSAL 3, FY 2010	48
V.1 ESTIMATED NUMBER OF PERSONS UNDER AGE 65 ENROLLED IN STATE PROGRAMS FOR LOW-INCOME RESIDENTS BY ENROLLEE AGE: PROPOSAL 4, FY 2010.....	55
V.2 ESTIMATED TOTAL EXPENDITURES BY SOURCE OF FUNDS: PROPOSAL 4, FY 2010.....	57
V.3 ESTIMATED FINANCING FOR PROPOSAL 4, FY 2010.....	59
V.4 ESTIMATED CHANGE IN AVERAGE INDIVIDUAL EXPENDITURES: PROPOSAL 4, FY 2010.....	59
V.5 ESTIMATED CHANGE IN TOTAL EXPENDITURES FOR THE MEDIAN INDIVIDUAL: PROPOSAL 4, FY 2010.....	61
V.6 ESTIMATED CHANGE IN EMPLOYER EXPENDITURES FOR PREMIUM CONTRIBUTIONS AS A PERCENT OF TOTAL PAYROLL: PROPOSAL 4, FY 2010	61
VI.1 ESTIMATED PERCENT OF PERSONS WITH MEDICAL EXPENSES ABOVE \$10,000 AND PREMIUM REDUCTIONS BY AGE: PROPOSAL 5, FY 2010	65

Table	Page
VI.2 ESTIMATED NUMBER OF PERSONS UNDER AGE 65 BY COVERAGE STATUS: PROPOSAL 5, FY 2010	66
VI.3 ESTIMATED SOURCES AND DISTRIBUTION OF COVERAGE BY AGE OF ENROLLEE: PROPOSAL 5, FY2010.....	68
VI.4 ESTIMATED SOURCES AND DISTRIBUTION OF COVERAGE BY FAMILY INCOME: PROPOSAL 5, FY 2010.....	68
VI.5 ESTIMATED NUMBER PERCENT OF PERSONS REPORTING GOOD, FAIR, OR POOR HEALTH BY SOURCE OF COVERAGE: PROPOSAL 5, FY 2010	69
VI.6 ESTIMATED TOTAL EXPENDITURES BY SOURCE OF FUNDS: PROPOSAL 5, FY2010.....	70
IV.7 ESTIMATED FINANCING FOR PROPOSAL 5, FY 2010.....	71
VI.8 ESTIMATED CHANGE IN AVERAGE INDIVIDUAL EXPENDITURES: PROPOSAL 5, FY 2010.....	72
VI.9 ESTIMATED CHANGE IN TOTAL EXPENDITURES FOR THE MEDIAN INDIVIDUAL: PROPOSAL 5, FY 2010.....	73
VI.10 ESTIMATED CHANGE IN EMPLOYER EXPENDITURES FOR PREMIUM CONTRIBUTIONS AS A PERCENT OF PAYROLL: PROPOSAL 5, FY 2010.....	73
VII.1 PERCENT UNINSURED AND TOTAL EXPENDITURE, AND PERCENT CHANGE: PROPOSALS 1-5, FY 2010.....	76
VII.2 ESTIMATED CHANGE IN AGGREGATE ECONOMIC OUTPUT: PROPOSALS 1 THROUGH 5, FY 2010 (MILLIONS).....	81

FIGURES

Figure		Page
II.1	ESTIMATED PERCENT OF PEOPLE UNDER AGE 65 WHO ARE CURRENTLY UNINSURED BY SOURCE OF COVERAGE: PROPOSAL 1, FY 2010.....	12
II.2	ESTIMATED PERCENT OF PERSONS AGED 19 TO 34 BY SOURCE OF COVERAGE PROPOSAL 1, FY 2010	12
IV.1	ESTIMATED NUMBER OF CURRENT AND NEW MEDICAID ENROLLMENT THROUGH THE HEALTH PARTNERSHIP, BY AGE, FY 2010 (000s)	40
IV.2	ESTIMATED HEALTH PARTNERSHIP ENROLLEE PAYMENTS AS PREMIUMS, PAYROLL TAXES, AND OUT-OF-POCKET COSTS: PROPOSAL 3, FY 2010.....	46
V.1	ESTIMATED PERCENT OF PEOPLE UNDER AGE 65 BY SOURCE OF COVERAGE UNDER PROPOSAL 4, FY 2010.....	54
V.2	ESTIMATED PERCENT OF SINGLE PAYER ENROLLEES AND ENROLLEES IN MEDICAID BY SELF-REPORTED HEALTH STATUS: PROPOSAL 4, FY 2010	56
VI.1	ESTIMATED RESPONSES OF CURRENTLY UNINSURED WORKERS TO OFFERS OF GROUP COVERAGE: PROPOSAL 5, FY 2010.....	67

EXECUTIVE SUMMARY

In 2008, the Washington State Legislature passed Engrossed Substitute SB 6333 (2008), which called for economic analysis of several health reform bills and the formation of a Citizens' Work Group on Health Care Reform. Pursuant to enactment of this bill, the Legislature contracted with Mathematica Policy Research to conduct an evaluation of five health care reform proposals, as follow:

- Proposal 1 would modify insurance regulations in Washington State for products sold to small groups and young adults. Specifically, it would (1) authorize health plans that do not include mandated benefits; and (2) allow carriers to pool the health risk of young adults separately from other enrollees, in effect widening the rate bands for coverage sold to older adults.
- Proposal 2 would include many components of the 2006 Massachusetts reforms. It would merge the small group, association, and individual markets; all residents would be required to obtain coverage, but would be exempted from this requirement if coverage was deemed unaffordable (by assumption, greater or equal to 5 percent of gross family income). By giving small group enrollees unrestricted choice among available plans, Proposal 2 would foster full portability of coverage in the merged market. Basic Health would be folded into the Connector, and all individuals with income below 200 percent FPL would be eligible for subsidized premiums in the Connector. No specific source of financing is proposed.
- Proposal 3 would cover all Washingtonians with a comprehensive standardized benefit package through a PEBB-like program with an independent administrator. Enrollees would choose among participating carriers, networks, or the fee-for-service option, and would pay premiums equal to the difference between the low or lowest-cost plan in their geographic area and the plan that they choose. Participation in the low or lowest cost plan would be fully paid by an assessment on payroll paid by employers, employees, and self-employed individuals. Eligibility for Medicaid and SCHIP would be expanded.

- Proposal 4 would establish a “single-payer” system that would replace all nonfederal sources of coverage. The single payer plan would automatically enroll all residents. It would absorb Medicaid while reducing eligibility for the program automatically enroll all eligible residents, and provide wrap-around benefits to qualify for federal match. No specific source of financing is proposed.
- Proposal 5 would create a guaranteed health benefit program that would cover preventive services and other qualified health expenditures in excess of \$10,000 for all Washingtonians. Carriers that write individual coverage would be required to accept all eligible applicants, and could not exclude coverage for preexisting conditions. The program would be financed by a graduated payroll tax on employers and self-employed workers (increasing as total payroll is larger) and a flat payroll tax on employees.

This report provides estimates of the changes in coverage and health care expenditures that would result from implementation of Proposals 1 through 5. Selected key findings related to the impacts of each proposal are summarized in Table 1 and also described below. Note that each of the proposals would, of course, affect individuals—not only their employers, as reported in Table ES.1. However, the impacts on individuals are complex and vary widely, depending on the current coverage status of the individual and the coverage options that are newly available to them. Because an attempt to summarize these impacts on individuals succinctly is likely to be misleading, they are not included in Table ES.1.

PROPOSAL 1: REDUCED REGULATION

- The number of uninsured would decline 11 percent—from 9.6 percent of the population under age 65 currently, to 8.5 percent. The number of people with individual coverage would increase about 20 percent, to 6 percent of the population under age 65.
- Assuming that small employers that now offer coverage would not switch to reduced-benefit plans, initial enrollment in these plans would be very low. Initially, these plans would cover fewer than 3,000 workers and dependents. Requiring employers to offer a Section 125 plan would not substantially increase initial enrollment.

Table ES.1. Selected Key Results: Proposals 1 through 5, FY 2010

	Current Case	Proposal 1: Reduced Regulation	Proposal 2: Connector	Proposal 3: Health Partnership	Proposal 4: Single payer	Proposal 5: Guaranteed Health Benefit
Number of persons uninsured (000s)	542.8	482.6	152.0	--	--	201.8 ^a
Percent uninsured	9.9%	8.5%	2.7%	0.0%	0.0%	3.6% ^a
Percent change in number of uninsured	na	-11.1%	-72.0%	-100.0%	-100.0%	-62.8% ^a
Total health care expenditures (billions)	\$24.9	\$25.0	\$24.6	\$24.1	\$25.9	\$25.5
Percent change in total health care expenditures	na	0.1%	-1.3%	-3.6%	3.8%	2.3%
Net change in State expenditures (billions)	na	nc	\$0.4	\$11.9	\$15.8	\$6.60
Small employer contributions for health care with proposal financing (percent of total payroll)						
All employees	5.4%	5.4%	2.7% ^b	6.3%	8.4% ^c	3.4%
Currently covered employees	12.6%	nc	5.6% ^b	6.4%	8.4% ^c	4.3%
Large or self-insured employer contributions for health care with proposal financing (percent of total payroll)						
All employees	8.4%	nc	8.6% ^b	6.1%	8.1% ^c	3.4%
Currently covered employees	11.4%	nc	11.1% ^b	6.1%	8.1% ^c	3.5%
Net new economic activity (billions)	na	nc	\$0.5	\$3.9	\$2.1	-\$0.3

Source: Mathematica Policy Research.

Notes: "na" indicates category that is not applicable; "nc" indicates no change.

^a Uninsured except for Guaranteed Health Benefit Plan coverage.

^b No source of financing was specified for this proposal, and none was estimated. The change in employer payments as a percent of payroll needed to finance this proposal would be negligible, if financed on the same basis as Proposals 3, 4, and 5.

^c No source of financing was specified for this proposal. Estimates assume payroll tax financing similar to Proposal 3.

- Overall, very few young adults would enroll in reduced-benefit plans—reflecting low demand for insurance among young adults who would not need the excluded services. Proposal 1 would target just 29 percent of young adults aged 19 to 34—those who are uninsured or have individual coverage. Of these, most would remain uninsured (22 percent of all young adults) or enroll in a standard individual plan or WSHIP (5 percent). Just two percent would enroll in a reduced-benefit plan.¹
- Low-income young adults would account for a larger proportion of enrollees in individual reduced-benefit plans compared with enrollees in standard individual coverage. Among all adults who would enroll in individual reduced-benefit plans, 61 percent have incomes below 200 percent of the federal poverty level (FPL). However, among all young adults under 200 percent FPL who are currently uninsured—the primary target population for Proposal 1—94 percent would remain uninsured.
- Most people under Proposal 1 would not change coverage and their expenditures do not change. However, individuals who enroll in either a reduced-benefit plan generally would experience lower health care expenditures—including out-of-pocket expenses and premium payments. Conversely, uninsured individuals (aged 25 to 34) who enroll in a standard individual plan generally have greater expenditures, reflecting their willingness to buy coverage when it is affordable despite relatively low health care expenditures when uninsured.
- Few small employers newly offer coverage under Proposal 1, and those that do are willing to contribute relatively little for the approximately 2,700 workers who gain coverage. Small employers that offer a reduced-benefit plan pay 2.7 percent of payroll, compared with an estimated 12.6 percent among small employers that currently offer standard coverage. The low premiums paid for reduced-benefit plans reflect employers’ selection of high cost sharing (as well as reduced benefits), consistent with currently-nonoffering employers’ relatively low demand for coverage.

PROPOSAL 2: THE HEALTH INSURANCE CONNECTOR

- The number of people with individual coverage would approximately double, and those with small group coverage would increase about 20 percent. However, many older workers would drop coverage. As a result, workers aged 45 to 64 would account for nearly two-thirds (61 percent) of uninsured workers.

¹ The Washington State Health Insurance Pool (WSHIP) is Washington’s health plan for high-risk individuals denied coverage in the commercial market.

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- Netting out gains and losses in coverage, the number of uninsured persons would decline 72 percent. Approximately 152,000 people would remain uninsured, compared with 542,800 who are uninsured currently. Of those who would remain uninsured, 30 percent are low-income individuals or families exempted from the individual mandate.
 - Many low-income residents would obtain coverage. Residents with income below the federal poverty level would constitute just 3 percent of the uninsured. Two-thirds of the uninsured would have incomes above 300 percent FPL.
 - The percentage of uninsured eligible for Medicaid, SCHIP, or Basic Health would decline from 74 percent currently to 12 percent under Proposal 2.
 - The financial impacts on Washington residents vary widely due to the significant gains and losses of coverage that occur under Proposal 2. Because some older individuals and small group workers would drop coverage, average expenditures (premiums plus out-of-pocket costs) would be lower among workers who obtain group coverage through the Connector—primarily due to younger workers taking coverage. Residents who currently buy individual coverage would benefit the most: average spending on premiums plus out-of-pocket costs for those who gain small group coverage in the Connector would drop 70 percent, largely reflecting new employer contributions. Among those who continue to purchase individual coverage (but through the Connector), average expenditures would drop by 15 percent. At least half of group- and individual- insured residents would pay less under Proposal 2 than they do currently.
 - Measured as a percent of total (Medicare) payroll, small employers that currently offer coverage would see their contributions drop from 13 percent of covered workers' wages to 6 percent under Proposal 2—reflecting the changed composition of their covered workforce. Overall, small employers' contributions to coverage would decline from 5 percent of payroll to 3 percent.

PROPOSAL 3: THE HEALTH PARTNERSHIP

- Reflecting the intention of Proposal 3 that all residents would enroll in either the Health Partnership, Medicaid, or SCHIP, Proposal 3 would cover everyone under age 65 who is now uninsured, as well as all residents who are currently insured.
- Most residents would enroll in the Health Partnership. However, 40 percent would either remain in Medicaid or SCHIP, or would become newly enrolled in these programs.

- New Medicaid enrollees would include many more adults than currently, and at higher incomes. Nevertheless, nearly half of Medicaid enrollees (48 percent) would be children.
- Just 18 percent of Health Partnership enrollees would have income below 200 percent FPL; these enrollees would pay no deductible for covered health services.
- Assessments in the range of 1-2 percent for employees and approximately 6 percent for employers and self-employed workers would provide the minimum revenue needed to finance the Health Partnership as well as additional state spending for Medicaid and SCHIP.
- While some residents would pay more in the Health Partnership, others would pay less. In general, the extent to which individuals pay more is related to their higher incomes and, therefore, higher payroll tax liability under Proposal 3. Conversely, the extent to which residents pay less is largely attributable to the high premiums they currently pay. Average expenditures would increase \$443 (36 percent) for residents who currently have group coverage when they enroll in the Health Partnership, and decrease \$1,069 (41 percent) for residents who currently have individual coverage. Among residents who are now uninsured and would become newly enrolled in Medicaid/SCHIP, average expenditures would fall more than 70 percent.
- Employers would no longer contribute directly to coverage but would pay payroll taxes instead. We estimate that employers would need to pay 7.5 percent of Social Security wages (about 6 percent of total wages) to finance Proposal 3, while employed workers would pay 1.7 percent. However, this amount is less than employers now pay in the aggregate, and much less than employers currently pay for the workers they cover.

PROPOSAL 4: SINGLE PAYER

- Approximately 5.5 million Washington residents would be enrolled in the single payer plan, including all residents who are currently enrolled in employer coverage, state programs, or individual health insurance plans.
- All uninsured Washington residents under age 65 would gain coverage—approximately 542,800 adults and children. Including people who are homeless in Washington State and probably undercounted in population estimates, this estimate might increase by as many as 24,000 additional people (about 4 percent).
- Of the 5.5 million residents enrolled in the single payer plan, approximately 1.4 million (25 percent) would be Medicaid/SCHIP enrollees.

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- Total spending for health care services would increase approximately 4 percent. Overall, state spending (including the single payer plan and state expenditures for Medicaid) would increase more than 375 percent.
 - State spending for Medicaid would increase 47 percent, but just 25 percent compared with combined State spending for Medicaid, SCHIP, and Basic Health in the current case. To the extent that homeless residents are not currently enrolled in Medicaid, state spending for Medicaid might increase as much as 52 percent.
 - No specific revenue source for this expenditure is proposed. However, with a payroll tax structured like that for Proposal 3, we estimate that employers and self-employed workers would need to pay 9.9 percent of Social Security wages and employees would need to pay 2.2 percent of Social Security wages to finance Proposal 4.
 - Assuming payroll tax financing as described above, workers with group coverage (who would constitute 70 percent of enrollees in the single payer plan) would see very little change in expenditures. Under Proposal 4, their average expenditures would increase just 3.4 percent; at the median, covered worker would pay an additional \$158 per year, reflecting their relatively high wages and therefore, higher tax liability. Residents with individual coverage and residents who are uninsured would pay much less than they do currently.
 - Again assuming payroll tax financing as described above, employers as a whole would pay slightly less for health insurance than in the current case. However, for employees that are currently covered, both large and small employers would pay substantially less: 8.1 to 8.4 percent of their covered workers' wages, compared with 11.4 to 12.6 percent currently. Small employers as a whole (including many small employers that do not offer coverage or cover all of their workers) would pay more under Proposal 4, because they would contribute to coverage for all of their workers.

PROPOSAL 5: GUARANTEED HEALTH BENEFIT PLAN (GHBP)

- Proposal 5 would reduce premiums for group and individual coverage significantly. Consequently, the number of people without basic coverage would fall by 63 percent, as some small employers newly offer coverage and many people respond to lower premiums by taking individual coverage. More than half of uninsured workers who had previously rejected an employer offer of coverage would enroll in group coverage at the new, lower premiums.
- Approximately 8,500 individuals newly eligible for Basic Health would enroll in that program.

- Young adults account for a disproportionate percentage of residents who would remain uninsured except for GHBP coverage. While young adults represent just 25 percent of the population under 65, they would account for 85 percent those without basic coverage. More than two-thirds of residents who would remain without basic coverage have incomes less than 100 percent FPL.
- Health care expenditures would rise by 2 percent, driven by the availability of benefits through the GHBP and the take-up of coverage by the currently uninsured. Out-of-pocket spending would fall by 26 percent.
- Most workers and other residents who currently have coverage would see lower expenditures for health care under the GHBP. Workers and dependents with group coverage (two-thirds of the population under 65 and nearly 90 percent of those with GHBP coverage) would see their average expenditures drop \$137.
- Employers that currently offer coverage would pay much less for health care. Small employers would see contributions for their covered workers drop from 12.6 percent of these workers' wages to 4.3 percent. Large insured and self-insured employers would see their spending for health care drop from 11.4 percent of covered workers' wages to 3.5 percent. Employers that do not offer coverage or that do not cover most of their workers would begin to pay 3.4 percent of the wages of their uninsured workers.

COMPARATIVE RESULTS

Changes in coverage and impacts on hospital charity care

The proposals vary significantly in their impacts on the number of people who would gain coverage—or conversely, who would either remain or become uninsured. Proposal 1 would have relatively little impact on the number of uninsured. Proposals 2 and 5 would reduce the net number of uninsured by much more than half, while Proposals 3 and 4 would cover all residents under age 65. Because Proposal 4 would cover all residents under age 65, and also increase Medicaid reimbursement to commercial rates, it would probably have the greatest impact on hospital charity care—effectively eliminating hospital charity care for residents under age 65.

Scope of Coverage and Consumer Choice

Most of the proposals would provide access to comprehensive coverage, either at least equivalent to current coverage (Proposals 2 and 5) or equivalent to coverage that is currently available in PEBB (Proposals 3 and 4). Proposal 1 is the exception: it would allow insurers to offer “bare bones” plans that would be exempt from a number of mandated benefits.

The proposals would affect consumer choice in different ways. While Proposal 1 would allow the sale of reduced benefit plans that are not currently available in the market, employer offer and take up of these plans would, at least initially, be quite low. For workers and individuals who enroll in reduced-benefit plans, consumer choice among both providers

and treatment options might be reduced. Proposals 2 and 3 would offer enrollees the greatest choice among plans, available to enrollees in the Connector and the Health Partnership, respectively. Proposal 5 might broaden choice among plans by making all plans more affordable.

Proposal 4 would maximize consumer choice among providers: it would allow enrollees to seek care from any licensed provider, and it would pay providers the same rates for all enrollees—including those enrolled in Medicaid. However, unless the single payer system focused on developing regional and state-wide systems of integrated care management, consumers could lose the option to obtain that service.

Estimates of Economic Impact

The primary source of economic impacts associated with the proposals would relate to any change in federal spending in Washington State, either federal spending for programs (Medicaid or SCHIP) or federal tax expenditures related to changes in employee contributions to group coverage. Each of the proposals would have very different impacts on net federal spending, and therefore, on immediate economic activity (measured as the production of paid goods and services, or economic output) in Washington:

- Proposal 1 would neither affect any federal program nor induce significant new offer of employer based coverage. As a result, it would have no impact on federal spending in the state, and consequently, no impact on overall economic activity.
- Proposal 2 would result in reduced total expenditures on health care as young workers and dependents would gain coverage through the Connector, and older workers and dependents would drop coverage in response to list-rated coverage. Households' aggregate federal tax liability would drop by \$370 million, due to greater use of Section 125 plans to shelter premiums, stimulating an estimated \$536 million in new economic activity.
- Proposal 3 would have the greatest impact on economic activity. By significantly expanding Medicaid enrollment, it would increase federal spending by more than \$2 billion, stimulating \$4.6 billion in new economic activity. Net of increased federal tax payments among households whose taxable income would increase, Proposal 3 would increase economic activity in Washington by an estimated \$3.9 billion.
- Proposal 4 also would generate increased federal spending—due both to the expansion of Medicaid eligibility to many more low-income adults and also to an increase in provider reimbursement rates to current commercial rates. However, compared with Proposal 3, fewer residents would be enrolled in Medicaid, and federal spending would be about one-third less. On net, Proposal 4 would stimulate an estimated \$2.1 billion of new economic activity.

- Proposal 5 would affect economic activity in the state due only to a change in households' aggregate federal tax liability. Federal tax payments would increase by an estimated \$200 million, reducing economic activity by about \$292 million.

IMPROVING COST EFFECTIVENESS AND QUALITY

We reviewed six topics of particular interest to the Legislature, in order to provide additional background for comparing the proposals. While Proposal 3 appears to pay the greatest attention to several of these issues, most of the proposals could be modified in various ways to encourage attention to them.

Improved Health Outcomes

Insurance should make it easier for people to obtain health services that are known to produce better outcomes—presuming that it covers services that are known to be effective. These would include a specific preventive and screening services, drug benefits, and disease management programs that have been proven effective. Insurance that covers only basic acute care needs or that leaves individuals or families with large out-of-pocket costs can keep people with greater health care needs or low incomes from obtaining effective care.

Because the potential for making significant improvements in population health is greater if coverage is widespread and continuous, the proposals that would generate the greatest increase in the number of persons who are stably insured—with relatively comprehensive benefits and affordable cost sharing—would probably have the greatest impact on health outcomes. Both Proposals 3 and 4 would ensure that every resident is enrolled in comprehensive coverage, and both would expand Medicaid coverage. Presuming a reasonably adequate supply of services—especially for those enrolled in Medicaid—either proposal could generate a significant improvement in health outcomes. On net, because Proposal 4 would increase reimbursement to Medicaid providers to commercial levels, it might provide the most vulnerable residents somewhat better access to care and, therefore, offer better prospects for improving health outcomes.

Evidence-Based Care

Efforts to encourage evidence-based practice have produced different results in different settings and localities, and among different populations. To be successful, these efforts entail new approaches to provider and consumer education as well as investment in developing new information and reporting systems.

Strategies that would provide the most comprehensive coverage for the largest number of people through a common administrative system—Proposals 3 and 4—probably have the greatest chance of improving the delivery of evidence-based services by establishing criteria for plan participation and provider reimbursement, respectively.

Under Proposal 5, the Guaranteed Health Benefit Plan might also focus on the delivery of evidence-based care, specifically for preventive services and high-cost diagnoses. Assuming the GHBP (like Medicare) would contract with carriers as intermediaries, it might negotiate with these carriers to adopt consistent policies and incentives to encourage

evidence-based care below the GHBP threshold. While the Connector (Proposal 2) also could pursue the measures to encourage evidence-based care, it would cover less than one-quarter of the population under age 65 under a common administrative system capable of instituting and enforcing consistent incentives for evidence-based practice.

Preventive Services

Clinical preventive services can substantially improve health outcomes. Expanding health coverage could increase use of appropriate preventive care, if preventive services are covered with little or no cost sharing.

Except for Proposal 1, each of the proposals would provide comprehensive coverage of preventive services. However, even though Proposal 1 would authorize carriers to sell to young adults policies that omit coverage of many preventive services, it is unlikely that carriers would sell products that exclude coverage for preventive benefits.

Chronic Disease Management

Disease management (DM) programs identify patients with costly chronic conditions (such as diabetes or asthma) and encourage them to follow good self-care behaviors. Some programs focus providers and patients on adherence to specific evidence-based care guidelines. DM programs have multiplied quickly and the potential for improvements in both quality and cost-effectiveness is large, there is no consensus that chronic disease management generally improves health outcomes or reduces costs.

Several of the proposals could be modified to explicitly address chronic disease management in at least the same terms as Proposal 3 which would provide enrollees with information about chronic disease management programs. However, the proposals that would serve most residents through a common administrative system—Proposals 3 and 4—probably would have the greatest chance of encouraging widespread and consistent use of chronic disease management.

While Proposal 5 might have little impact on chronic disease management, it could be uniquely vulnerable to ineffective chronic disease management. It would pay for the highest cost care, but would have no necessary impact on the interval of care between preventive services and catastrophic care. However, if the GHBP contracted with carriers as intermediaries, it might also negotiate with them to improve chronic care management—reducing GHBP's financial exposure while also improving health outcomes.

Medical Homes

A medical home is a source of comprehensive primary care. It focuses on helping patients to manage their health care better. While Proposal 3 would provide assistance to enrollees to select a medical home, none of the proposals otherwise address the development of medical homes. As with incentives to promote evidence-based care and use of chronic disease management, the proposals that would serve most residents through a common administrative system—Proposals 3 and 4—might have the greatest chance of fostering the development of medical homes. In either proposal, the administrative agency

(for the Health Partnership or the single payer system, respectively) could develop consistent funding and incentives for all participating health plans and/or providers. Because Proposal 3 would probably encourage contracting with provider networks and/or multi-specialty group practices by plans that participate in the Health Partnership, it might offer the greater potential for the development of medical homes.

Financial Incentives

Carefully-designed financial incentives can promote the effective use of health services and discourage the use of marginally effective or inappropriate services. Because Proposals 2, 3, and 4 all would establish an administrative entity that would (or could) negotiate with health plans or providers for a comprehensive set of services, these proposals could consider options for developing consistent financial incentives for both providers and consumers potentially to greater effect than Proposals 1 or 5. Again, because proposals 3 and 4 would serve the largest number of residents under a single administrative structure, they might have the greater prospects for establishing consistent financial incentives and adequately compensating providers for reporting performance.

CHAPTER I

INTRODUCTION

In 2008, the Washington State Legislature passed Engrossed Substitute SB 6333 (2008), which called for economic analysis of several health reform bills and the formation of a Citizens' Work Group on Health Care Reform. Pursuant to enactment of this bill, the Legislature contracted with Mathematica Policy Research to conduct an evaluation of five health care reform proposals, as follow:

- Proposal 1 would modify insurance regulations in Washington State for products sold to small groups and young adults. Specifically, it would (1) authorize health plans that do not include mandated benefits; and (2) allow carriers to pool the health risk of young adults separately from other enrollees, in effect widening the rate bands for coverage sold to older adults.
- Proposal 2 would include many components of the 2006 Massachusetts reform. It would merge the small group, association, and individual markets. By giving small group enrollees unrestricted choice among available plans, it would foster full portability of coverage in the merged market.
- Proposal 3 would cover all Washingtonians with a comprehensive standardized benefit package through a PEBB-like program with an independent administrator. Enrollees would choose among participating carriers, networks, or the fee-for-service option, and would pay premiums equal to the difference between a low or lowest-cost option and the option that they choose. Participation in the low or lowest cost option would be fully paid by an assessment on payroll paid by employers, employees, and self-employed individuals. Eligibility for Medicaid and SCHIP would be expanded.
- Proposal 4 would establish a “single-payer” system that would replace all nonfederal sources of coverage. The single payer plan would automatically enroll all residents. It would absorb Medicaid while reducing eligibility for the program automatically enroll all eligible residents, and provide wrap-around benefits to qualify for federal match. No specific source of financing is proposed.

- Proposal 5 would create a guaranteed health benefit program that would cover preventive services and other qualified health expenditures in excess of \$10,000 for all Washingtonians. Carriers that write individual coverage would be required to accept all eligible applicants, and could not exclude coverage for preexisting conditions. The program would be financed by an assessment payroll, paid by employers, employees, and self-employed individuals.

This report provides estimates of the changes in coverage and health care expenditures that would result from implementation of each proposal. The report is organized as follows. Chapters II through VI provide coverage and expenditure results, respectively for each proposal. Each chapter provides a summary of the proposal, key assumptions and results, a discussion of the changes in premiums (when required) that drive changes in coverage, an analysis of changes in coverage, and an analysis of changes in expenditures. Where a source of financing is proposed—for example imposition of a payroll tax, estimates of the level of tax required are presented. While Proposal 4—the single payer plan—does not specify a source of financing, for the purpose of comparison we assume payroll financing, in order to provide estimates that are comparable to the financing estimates for the other proposals.

Each chapter concludes with a discussion of impacts on individuals and employers. With respect to individuals, we present changes in average and median payments for health care (including premiums, out-of-pocket cost, and any new tax payments to support coverage) relative to the current case, contingent on the individual's current coverage status. With respect to employers, we compare estimates of contributions to health insurance and any new tax payments to support coverage relative to total payroll. Estimates are presented separately for small employers, and large or self-insured employers—relative to both total payroll and the wages of workers that they currently cover. Estimates also are presented for the State and other public employers participating in PEBB.

Finally, Chapter VI summarizes key results across the four proposals—including changes in coverage and potential impacts on hospital charity care, and estimates of economic impacts for each proposal. This chapter also provides discussion of each proposal with respect to the potential for improving cost effectiveness and quality. This discussion focuses on areas of specific concern to the Legislature, namely:

- Improved health outcomes
- Prevention and early intervention
- Chronic care management
- The delivery of evidence-based services
- Incentives to use effective and necessary services, and disincentives for marginally effective inappropriate services, and
- The development and use of medical homes.

The report also includes a number of appendices as references for the reader or as additional information that might be helpful but is not essential to understanding the report. Appendix A includes a summary and comparison of key elements of the proposals in matrix format. Appendix B includes detailed coverage results for each proposal compared with no policy change (the current case) and additional tables comparing sources of coverage and funds in detail for each of the proposals. Appendix C includes a series of short “issue briefs” related to each of the specific cost effectiveness and quality concerns addressed in Chapter VII. Finally, Appendix D provides an explanation of the methods and data sources underlying our estimates.

CHAPTER II

PROPOSAL 1: REDUCED REGULATION OF HEALTH INSURANCE

Proposal 1 would combine the provisions of SB 5789 (2007) and PSSB 6030 (2007). Taken together, they allow carriers to sell reduced-benefit plans to small groups and young adults in the individual market and change how individual health insurance products are rated.

Specifically, under Proposal 1, carriers could:

- Sell to small employers reduced-benefit (ERB) plans, exempt from a wide range of conditions, services, and providers that are currently mandated benefits in Washington State.²
- Sell individual reduced-benefit (IRB) plans to young adults (19-34 years old). IRB plans would be exempt from various state mandates regarding coverage of certain services and providers, as well as prescription drugs.
- Establish a separate (single) rate class for young adults for all individual products. Premiums for enrollees 35-64 would remain subject to a 3.75:1 rate band on age.

A. KEY ASSUMPTIONS AND FINDINGS

To model Proposal 1, it was necessary to make a number of assumptions about how small firms and individuals would behave when confronting a change in their premiums and new options for coverage. These assumptions produce estimates of initial enrollment in reduced-benefit plans that may be lower than would occur over time, as health care costs continue to increase. As now, employers and individuals would be forced to consider lower-premium products—including greater cost sharing and reduced-benefit plans.

² A complete list of the exclusions that would apply to small group and individual coverage is included in Appendix A.

The key assumptions underlying the simulation estimates for Proposal 1 are as follow:

- For small firms that currently offer health benefits, adopting an ERB plan would entail restructuring their compensation package. Therefore, employers that currently offer coverage do not consider an ERB plan. (Note that in a dynamic analysis, this assumption might change as premiums rise. However, employers might prefer increased cost sharing to manage premium increases over excluding coverage for categories of care that workers may need.)
- Current individual rate bands are not substantially restrictive. Therefore, separating adults aged 19 to 34 into a single rate band does not affect rates for adults aged 35 to 64.³
- When offered, ERB plans are subject to the same rating rules and industry standards that otherwise apply in the small-group market.⁴
- Carriers do not sell products that exclude coverage for as many services as Proposal 1 would allow. Specifically, carriers continue to cover many preventive benefits as well as generic prescription drugs.⁵ Products marketed to small firms comply with federal requirements.⁶
- Young adults with employer-sponsored insurance (ESI) do not consider moving into the individual market to take an IRB plan.
- Carriers price ERB and IRB plans to obtain the same average loss ratios as in the current small group and individual markets, respectively.
- Carriers reduce premiums for IRB plans an additional 2 percentage points in anticipation of favorable risk selection. Anticipating no significant change in risk

³ Note that this is an assumption based on analysis of cost variation within a representative large group for a single plan design. In Washington, rate bands are applied across carriers' health products, restricting the extent to which carriers are able to develop products that would segment the market and reduce risk pooling. If the current rate band is in fact restrictive, removing young adults from the rate band could cause insurers to develop additional products that would increase risk segmentation among products, increase premiums for current products, or both.

⁴ That is, current rate bands for small groups (3.75:1) would apply, as well as minimum contribution and participation rules for small group coverage. Small employers must contribute at least 75 percent of premiums for single coverage and at least 50 percent of premiums for family coverage. At least 75 percent of employees take up their employer's offer for the group to qualify for coverage.

⁵ This assumption reflects carriers' views as reported in: Milliman, Inc., Report to the Office of the Insurance Commissioner: Blue Ribbon Commission on Marketplace Reaction to Potential Changes in Benefit Mandate and Rate Regulations, January 2007. Specifically, all carriers questioned in the Milliman report indicated that they would cover at least generic prescription drugs although allowed to exclude them.

⁶ In particular, the Pregnancy Discrimination Act requires group plans to include maternity benefits for firms with at least 15 employees. Therefore, plans marketed to small firms with 15 to 50 employees are assumed to include maternity benefits.

selection in currently available products, neither individual standard premiums nor ERB premiums are further adjusted.

- When facing a higher premium for individual coverage (as described in Section B), young adults who are currently insured consider continuing with their current plan, taking an IRB plan, or taking a standard policy with greater cost sharing. Those who use excluded services would prefer greater cost sharing over an IRB plan. All others would prefer an IRB plan over greater cost-sharing.
- If the premium for individual coverage decreases or remains the same, currently insured young adults remain in their current policy. Uninsured young adults who can obtain standard coverage at a lower premium first consider standard coverage; only those who would not buy standard coverage at the reduced premium consider an IRB plan.
- Carriers refer as many as 8 percent of individuals to WSHIP when they decide either to change plans or become newly insured. If referred to WSHIP, individuals who currently have coverage enroll in WSHIP with greater cost sharing for the same premium they currently pay. Individuals who are currently uninsured remain uninsured if referred to WSHIP.
- Neither HIP nor WSHIP offer reduced-benefit coverage.
- There is no ramp-up of enrollment in ERB and IRB plans. In the small group and individual markets, these products are marketed on the same basis and are as widely recognized by consumers as all other health insurance products.

Key findings related to the impacts of Proposal 1 are as follow:

- The number of uninsured would decline 11 percent—from 9.6 percent of the population under age 65 currently, to 8.5 percent. The number of people with individual coverage would increase about 20 percent, to 6 percent of the population under age 65.
- Assuming that small employers that now offer coverage would not switch to ERB plans, initial enrollment in these plans would be very low. Initially, these plans would cover fewer than 3,000 workers and dependents. Requiring employers to offer a Section 125 plan would not substantially increase initial enrollment in ERB plans.
- Overall, very few young adults would enroll in reduced-benefit plans, reflecting low demand for insurance among young adults who would not need the excluded services. Proposal 1 would target 29 percent of young adults aged 19 to 34—those who are uninsured or have individual coverage. Of these, most would remain uninsured (22 percent of all young adults) or enroll in a standard individual plan or WSHIP (5 percent). Just two percent would enroll in a reduced-benefit plan.

- Low-income young adults would account for a larger proportion of enrollees in IRBs compared with enrollees in standard individual coverage. Among all adults who would enroll in IRB plans, 61 percent have incomes below 200 percent FPL. However, among all young adults under 200 percent FPL who are currently uninsured—the primary target population for Proposal 1—94 percent would remain uninsured.
- Most people under Proposal 1 would not change coverage and their expenditures would not change. However, individuals who enroll in either an ERB or IRB plan generally experience lower health care expenditures—including out-of-pocket expenses and premium payments. Conversely, uninsured individuals (aged 25 to 34) who enroll in a standard individual plan generally have greater expenditures, reflecting their willingness to buy coverage when it is affordable despite relatively low health care expenditures when uninsured.
- Few small employers newly offer coverage under Proposal 1, and those that do are willing to contribute relatively little for the approximately 2,700 workers who gain coverage. Small employers that offer an ERB plan pay 2.7 percent of payroll, compared with an estimated 12.6 percent among small employers that currently offer standard coverage. The low premiums paid for ERB coverage reflect these employers' selection of high cost sharing (as well as reduced benefits), consistent with their currently non-offering employers' relatively low demand for coverage.

B. CHANGES IN PREMIUMS

Proposal 1 anticipates that premiums for ERB plans would be sufficiently lower than those for standard small group insurance plans to attract employers that do not currently offer coverage. We assume that carriers price ERB products to obtain the same ratio of premium revenue to medical losses as in their standard products, and that carriers anticipate no biased selection into these plans—that is, they view currently insured small groups as representative of the uninsured small groups that would buy an ERB plan. Consequently, ERB premiums would be lower than standard premiums in direct proportion to the change in medical losses paid under an ERB plan. Based on analysis of regional survey data reporting insured medical expenditures, we estimate that ERB premiums would be approximately 15 percent less than standard premiums with the same cost sharing features.

The effect of Proposal 1 on premiums for individual coverage would be more complex. Rating for young adults would change for all products (including IRB plans). Furthermore, it is likely that carriers would anticipate favorable selection into IRB plans. These effects would accumulate as follows:

- *Rating.* Proposal 1 would allow carriers to create one rate for individuals aged 19 to 34 for individual products. We estimate that this provision would increase standard premiums for young adults aged 19 to 24 by 12 percent, and decrease premiums for those aged 25 to 34. Premiums for IRB plans also would be priced with just one rate for 19 to 34 year olds.

- *Reduced benefits.* IRB plan premiums would, on average, be approximately 6 percent lower than premiums for standard plans due to reduced-benefit coverage. This smaller premium difference (compared with that for ERB plans) reflects both fewer proposed exclusions and lower use of excluded services by individuals who are currently insured. In part, the lower use of excluded services reflects the fact that the population with individual coverage is medically underwritten, while small groups are not.
- *Selection bias.* We assume that carriers anticipate favorable selection of healthy people into IRB plans, reducing IRB premiums by an additional 2 percentage points.

Overall, we estimate that IRB premiums would be about 3 percent higher for young adults aged 19 to 24, compared with premiums for a standard plan with the same cost-sharing features (Table II.1). IRB premiums would be 14 percent lower for those aged 25 to 29 and almost 10 percent lower for those aged 30 to 34.⁷

Table II.1. Estimated Percent Change in Premiums for Individual Products Available to Individuals Aged 19 to 34: Proposal 1, FY 2010

Age	Combined Rate Class, All Products	Reduced-benefit Plans		
		Reduced Benefits	Favorable Selection	Summary: Percent Difference in IRB Premiums Relative to Standard Premiums
19 to 24	12.2 %	- 6.0 %	- 2.1 %	3.3 %
25 to 29	- 6.6 %	- 6.0 %	- 2.1 %	- 14.1 %
30 to 34	-1.9 %	- 6.0 %	- 2.1 %	- 9.8 %

Source: Mathematica Policy Research.

Note: Estimated rate changes are cumulative, not additive.

If the current individual rate band is not substantially restrictive, it follows that premiums would not change for adults aged 35 to 64 when younger adults are rated separately. Alternatively, if the current rate band is restrictive, this proposal would affect premiums for individuals aged 35 to 64 as well. In this case, the average rate (within and across products) would increase for individuals aged 35 to 64, and it would probably increase the most for the oldest adults. While we do not model the changes in coverage that might result, we would expect any rate increase to cause some adults to move into plans with higher cost sharing or to drop coverage altogether.

⁷ One major carrier in Washington estimated that a limited benefit design for individuals of any age would reduce premiums for those aged 25 to 34 by 14 percent; an alternative limited benefit design would reduce premiums about 10 percent for adults aged 18 to 29. A second carrier estimated that a limited benefit plan with a maximum of \$50,000 payout would reduce premiums by 15 to 23 percent. See: Milliman, Inc., Report to the Office of the Insurance Commissioner: Blue Ribbon Commission on Marketplace Reaction to Potential Changes in Benefit Mandate and Rate Regulations, January 2007.

Like premiums for IRB plans, premiums for ERB coverage also are lower than for standard coverage. We estimate that ERB plan premiums are generally 15 percent lower due to excluded benefits, calculated across all workers and dependents currently enrolled in small-group coverage.

C. CHANGES IN COVERAGE

Proposal 1 would have little impact on small group coverage, but a somewhat greater impact on increasing individual coverage. Both impacts are presented below, and the characteristics of young adults who would obtain or change individual coverage are described.

1. Small Group Enrollment

In large part because initial enrollment in ERB plans is contingent on employers deciding to offer coverage when they currently do not, enrollment in ERB plans would be very low. Fewer than 3,000 workers and dependents are estimated to enroll in these plans (Table II.2). Enrollment in ERB plans might grow if, over time, these plans also attract employers that currently offer coverage. However, the rate of growth would depend heavily on whether covered workers would prefer a reduced-benefit product to other possible adjustments in compensation—including greater cost sharing for standard benefits.

Table II.2. Estimated Sources and Distribution of Coverage of Persons under Age 65: Current Case and Proposal 1, FY 2010

	Current Case		Proposal 1		Percent change in number of persons
	Number (000s)	Percent	Number (000s)	Percent	
Total	5,663.0	100.0%	5,663.0	100.0%	0.0%
Small groups ^a	670.8	11.8%	673.7	11.9%	0.4%
Reduced-benefit (ERB) plans	na	na	2.8	0.1%	na
Other employer plans ^b	3,224.6	56.9%	3,224.6	56.9%	0.0%
Individual coverage	280.9	5.0%	338.1	6.0%	20.3%
Reduced-benefit (IRB) plans	na	na	24.4	0.4%	na
WSHIP	4.2	0.1%	4.3	0.1%	4.5%
Medicaid, SCHIP, or Basic Health	809.9	14.3%	809.9	14.3%	0.0%
Other state programs ^c	129.9	2.3%	129.9	2.3%	0.0%
Uninsured	542.8	9.6%	482.6	8.5%	-11.1%

Source: Mathematica Policy Research.

Notes: "na" indicates product not available. Details may not add to total due to rounding.

^a Includes small groups insured in market or association plans.

^b Includes insured large groups, self-insured small and large groups, PEBB, FEHBP, military, and COBRA.

^c Includes CHP, GAU, ADATA, Refugees, and AEM.

To develop an estimate that is generally comparable to the enrollment estimates produced for the Health Insurance Partnership Board Studies, we further estimated the enrollment in ERB plans that might occur if employer offer of a Section 125 plan was a precondition to offering an ERB plan. In this simulation, employees would pay their share of premiums with pre-tax dollars, potentially increasing the rate of take up among workers when offered and eligible for coverage. Premiums paid by employers would be the same, whether offering a Section 125 or not.

However, use of Section 125 plans would increase enrollment in ERB plans very little: about 230 additional workers and dependents would enroll—even assuming no significant administrative cost for employers (and therefore the same rate of employer offer). This low impact on enrollment reflects the low incomes (and, therefore, low marginal tax rates) of workers who, when offered employer-sponsored coverage without a Section 125 plan, do not enroll.

2. Individual Enrollment

Because adults aged 19 to 24 would pay higher premiums for standard coverage, many would look for a lower-cost plan—either a standard plan with greater cost sharing or an IRB plan. Premiums for standard coverage for adults aged 25 to 34 would decline, and our estimates assume that they have no specific motivation to look for new coverage.⁸ However, if uninsured, adults aged 25 to 34 now could buy either standard coverage at a lower premium or a newly available IRB plan.

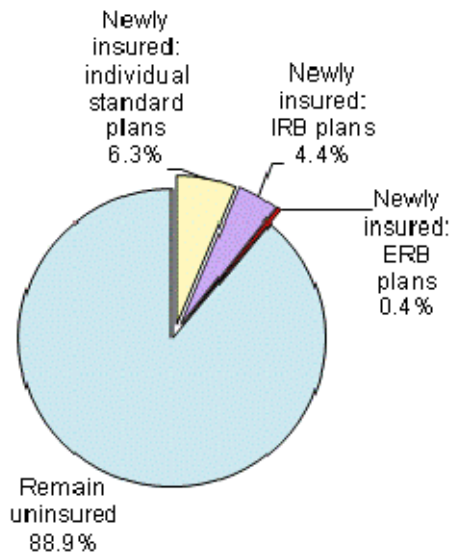
Largely related to lower premiums for adults aged 25 to 34, individual coverage (at any age) would increase about 20 percent (about 58,000 lives) (Table II.2). As individuals are either attracted into the market or seek to change plans in response to a price increase and are underwritten, WSHIP enrollment would increase slightly.

Approximately 89 percent of people who are currently uninsured would remain uninsured (Figure II.1). Of the 11 percent who become insured, less than half would enroll in an IRB or ERB plan.

Proposal 1 also would have relatively little impact on its primary target: young adults aged 19 to 34. Most who are currently uninsured would remain uninsured (22 percent of all young adults under Proposal 1) (Figure II.2). Just two percent would enroll in a reduced-benefit plan—either an IRB or ERB plan.

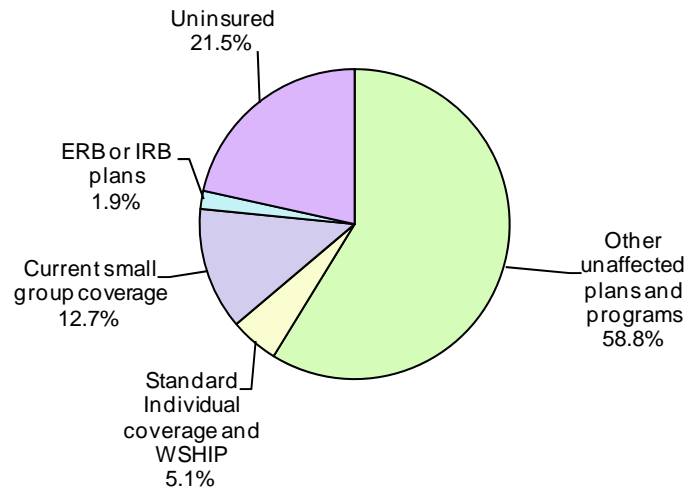
⁸ Similarly, because we assume no change in premiums for adults aged 35 or older associated with the rating change for young adults, older adults have no specific motivation to change coverage or become insured. Reduced-benefit plans would not be available to adults aged 35 or older.

Figure II. 1. Estimated Percent of People under Age 65 Who are Currently Uninsured by Source of Coverage: Proposal 1, FY 2010



Source: Mathematica Policy Research.

Figure II.2. Estimated Percent of Persons Aged 19 to 34 by Source of Coverage Proposal 1, FY 2010



Source: Mathematica Policy Research.

Enrollment by age

In response to the change in how young adults are rated, changes in coverage under Proposal 1 differ by age group. Young adults aged 19 to 24 would see a 12 percent increase in premiums for their current coverage. Nevertheless, nearly half (44 percent) would remain in their current plan (Table II.3). Others would take a plan with greater cost sharing (13 percent of individually insured adults aged 19 to 24) or an IRB plan (5 percent).⁹ However, 38 percent of young adults aged 19 to 24 who would be individually insured under Proposal 1 are currently uninsured and would enroll in an IRB plan.

Adults aged 25 to 34 see a general reduction in their premiums under Proposal 1. As a result, none drop their current coverage, and some become newly insured. Among adults aged 25 to 34 who would buy individual coverage under Proposal 1, 65 percent would be newly insured. Most would enroll in a standard plan (43 percent of individually insured adults aged 25 to 34) and 22 percent would enroll in an IRB plan.

Table II.3. Estimated Percent of Adults Enrolled in Individual Coverage by Age of Enrollee and Type of Coverage Proposal 1, FY 2010

	Percent of Persons				
	All Persons less than Age 65	Less than Age 19	Age 19-24	Age 25-34	Age 35-64
Currently Insured					
Current plan	82.0%	100.0%	44.1%	34.5%	100.0%
Increased cost sharing or WSHIP	0.6%	0.0%	13.2%	0.0%	0.0%
Individual reduced-benefit plan (IRB)	0.2%	0.0%	4.6%	0.0%	0.0%
Currently Uninsured					
New standard plan	10.2%	0.0%	0.0%	43.0%	0.0%
Individual reduced-benefit plan (IRB)	7.0%	0.0%	38.1%	22.4%	0.0%

Source: Mathematica Policy Research.

Although a lower proportion of individually insured adults aged 25 to 34 would enroll in IRB plans, there are more adults in this age group who buy individual coverage. Among all young adults who would enroll in an IRB, 73 percent would be aged 25 to 34 (Table II.4). All of them—and most of the other 27 percent of IRB enrollees, aged 19 to 24—are currently uninsured.

⁹ Recall that we assume that only individuals who did not use excluded services would consider switching to an IRB plan. If these individuals need these services after enrolling in an IRB plan, they would not be covered. Therefore, IRB plans represent the potential for some individuals subsequently to develop health care needs (for example, for mental health care or prescription drugs) that would be uninsured. In turn, this could cause unmet need, delays in care, and medical debt—and they may seek coverage in WSHIP, which we have not modeled.

Table II.4. Estimated Sources of Coverage by Age of Enrollee: Proposal 1, FY 2010

	Persons (000s)	Percent of Persons			
		Less than Age 19	Age 19-24	Age 25-34	Age 35-64
Total	5,663.0	29.3%	8.7%	16.0%	46.0%
Standard plans					
Small group plans ^a	670.8	21.7%	6.4%	20.2%	51.7%
Other employer plans ^b	3,224.6	26.4%	6.1%	14.3%	53.2%
Individual standard plans ^c	313.7	14.3%	2.8%	19.7%	63.2%
Reduced-benefit plans					
Small group plans	2.8	4.8%	31.1%	39.7%	24.4%
Individual plans	24.4	na	26.6%	73.4%	na
WSHIP	4.3	25.4%	6.1%	6.7%	61.7%
Medicaid, SCHIP, or Basic Health	809.9	66.4%	5.6%	10.5%	17.5%
Other state programs ^d	129.9	27.6%	11.7%	14.7%	46.1%
Uninsured	482.6	8.2%	36.6%	25.9%	29.3%

Source: Mathematica Policy Research.

Notes: "na" indicates the product is not available.

^a Includes small groups insured in market or association plans.

^b Includes insured large groups, self-insured small and large groups, PEBB, FEHBP, military, and COBRA.

^c Includes people who retain their current coverage, newly buy standard coverage, or move to higher cost sharing.

^d Includes CHP, GAU, ADATA, Refugees, and AEM.

Enrollment by Family Income

Low-income young adults would account for a large proportion of enrollees in IRBs compared with enrollees in standard individual coverage. Among all adults who would enroll in IRB plans, 61 percent have incomes below 200 percent FPL—in part reflecting the young ages of adults eligible to enroll in these plans (Table II.5). However, among all young adults under 200 percent FPL who are currently uninsured—the primary target population for Proposal 1—94 percent would remain uninsured.

Enrollment by Health Status

Adults who would enroll in IRB plans are approximately as healthy as adults enrolling in standard individual plans. About 25 percent of adults who would enroll in IRB plans report good, fair or poor health status—compared with 23 percent of all enrollees and 22 percent of those aged 19 to 34 in standard individual plans (Table II.6).

Finally, WSHIP enrollees would also show the results of fresh underwriting. The percent of enrollees aged 19 to 34 who report good, fair, or poor health would increase by approximately seven percentage points.

Table II.5. Estimated Sources and Distribution of Coverage by Family Income for All Persons and Adults Aged 19-34: Proposal 1, FY 2010

	Total (000s)	Percent of Individuals		
		0–200% FPL	201–300% FPL	Above 300% FPL
Total, all persons	5,663.0	34.3%	11.4%	54.2%
Standard plans				
Small group plans ^a	670.8	19.5%	19.6%	60.8%
Other employer plans ^b	3,224.6	14.9%	12.0%	73.0%
Individual standard plans ^c	313.7	19.2%	12.2%	68.6%
Reduced-benefit plans				
Small group plans	2.8	75.9%	11.2%	13.0%
Individual plans	24.4	60.6%	5.9%	33.5%
WSHIP	4.3	18.0%	10.3%	71.6%
Medicaid, SCHIP, or Basic Health	809.9	96.3%	3.6%	0.1%
Other state programs ^d	129.9	95.6%	1.9%	2.5%
Uninsured	482.6	72.5%	11.6%	15.9%
Total, adults 19 to 34	1,401.5	48.6%	13.0%	38.5%
Standard plans				
Small group plans ^a	178.5	31.7%	18.9%	49.5%
Other employer plans ^b	659.1	25.3%	16.4%	58.3%
Individual standard plans ^c	70.6	41.6%	15.6%	42.8%
Reduced-benefit plans				
Small group plans	2.0	90.7%	2.1%	7.2%
Individual plans	24.4	60.6%	5.9%	33.5%
WSHIP	0.6	34.7%	36.5%	28.8%
Medicaid, SCHIP, or Basic Health	130.2	100.0%	0.0%	0.0%
Other state programs ^d	34.2	92.7%	7.3%	0.0%
Uninsured	302.0	82.6%	8.4%	9.1%

Source: Mathematica Policy Research.

^a Includes small groups insured in market or association plans.

^b Includes insured large groups, self-insured small and large groups, PEBB, FEHBP, military, and COBRA.

^c Includes people who retain their current coverage, newly buy standard coverage, or move to higher cost sharing.

^d Includes CHP, GAU, ADATA, Refugees, and AEM.

Table II.6. Estimated Percent of All Persons and Adults Aged 19-34 with Good, Fair, or Poor Health Status by Source of Coverage: Current Case and Under Proposal 1, FY 2010

	Current case	Proposal 1
Total	35.5%	35.5%
Standard plans		
Small group plans ^a	30.5%	30.5%
Other employer plans ^b	28.8%	28.8%
Individual standard plans ^c	22.2%	22.6%
Reduced-benefit plans		
Small group plans	na	24.8%
Individual plans	na	24.9%
WSHIP	68.6%	70.0%
Medicaid, SCHIP, or Basic Health	53.6%	53.6%
Other state programs ^d	84.2%	84.2%
Uninsured	49.0%	52.0%
Adults 19 to 34 - Total	37.3%	37.3%
Standard plans		
Small group plans ^a	30.9%	30.9%
Other employer plans ^b	30.2%	30.2%
Individual standard plans ^c	19.5%	22.2%
Reduced-benefit plans		
Small group plans	na	26.0%
Individual plans	na	24.9%
WSHIP	80.3%	86.9%
Medicaid, SCHIP, or Basic Health	52.5%	52.5%
Other state programs ^d	84.9%	84.9%
Uninsured	45.1%	49.0%

Source: Mathematica Policy Research.

Notes: "na" indicates product not available.

^aIncludes small groups insured in market or association plans.

^bIncludes insured large groups, self-insured small and large groups, PEBB, FEHBP, military, and COB

^c Includes people who retain their current coverage, newly buy standard coverage, or move to higher cost sharing.

^d Includes CHP, GAU, ADATA, Refugees, and AEM.

D. SOURCES OF FUNDS

Reflecting relatively small changes in coverage associated with Proposal 1, there would be relatively little impact on total expenditures for health insurance and health care services. The increase in health care spending overall would be less than 1 percent, as individuals and workers who become newly insured respond by increasing their use of services (Table II.7).

Table II.7. Estimated Total Expenditures by Source of Funds: Proposal 1, FY 2010

	Current Case (millions)	Proposal 1 (millions)	Percent Change
Total	\$24,945.4	\$24,981.3	0.1%
Affected plans and programs:			
Employer-sponsored small group plans ^a	\$2,919.5	\$2,922.7	0.1%
Individual	\$546.0	\$611.4	12.0%
Private plans	\$524.4	\$589.6	12.4%
WSHIP	\$21.7	\$21.7	0.3%
Out of Pocket	\$3,214.9	\$3,182.3	-1.0%
Unaffected plans and programs:			
Federal	\$3,211.2	\$3,211.2	nc
Medicaid	\$1,715.5	\$1,715.5	nc
SCHIP	\$13.8	\$13.8	nc
FEHB and military	\$877.1	\$877.1	nc
Federal tax expenditures for Section 125 plans	\$604.7	\$604.7	nc
State	\$3,988.9	\$3,988.9	nc
Medicaid	\$1,986.8	\$1,986.8	nc
Basic Health	\$342.2	\$342.2	nc
SCHIP	\$7.2	\$7.2	nc
PEBB - State employees	\$1,395.7	\$1,395.7	nc
PEBB - Other	\$256.9	\$256.9	nc
Employer-sponsored insured large group or self-insured plans	\$11,064.9	\$11,064.9	nc

Source: Mathematica Policy Research.

Notes: "nc" indicates no change. State funds for WSHIP are included in that program line and not estimated separately. Medicaid and SCHIP allocations assume FY 2009 federal matching rates. The administrative costs of plan sponsors are not estimated. Estimates include the net cost of private insurance.

^a Includes association plans, other insured small group plans, and projected HIP plans.

With respect to small firms and individuals that Proposal 1 would affect:

- Aggregate employer payments for health insurance would increase, reflecting new offer and take up of ERB coverage. However, in the aggregate this increase is less than 1 percent.
- Payments for individual health insurance would increase 12 percent (from \$546 to \$611 million) as some uninsured adults newly purchase individual coverage in response to the change in rating and the availability of IRB plans.
- As individuals who would newly purchase coverage or change plans are underwritten and referred to WSHIP, individual payments for WSHIP would increase, but by less than one percent.

Finally, aggregate out-of-pocket expenses would decrease slightly. This change is the net result of two opposing effects. Specifically, as some uninsured people gain new coverage, their out of pocket expenditures decline. However, others, who are currently insured, change to policies with higher cost sharing, increasing their out-of-pocket expenditures for care. Because we assume, for the purpose of initial estimates, that employers who currently offer coverage do not switch to ERB plans and that individuals who anticipate using an excluded service always would prefer greater cost sharing to an IRB, there is no increase in out-pocket-spending associated with transitions from standard coverage to a reduced-benefit plan.

E. FINANCIAL IMPACT ON INDIVIDUALS

Most people do not change coverage under Proposal 1, and their expenditures do not change. Because so few change coverage, their experience (as presented below) should be regarded as essentially anecdotal—in actuarial terms, as non-credible.

Approximately 2,000 young adults (aged 19 to 24) with individual coverage respond to increased premiums under Proposal 1 by moving to another plan with greater cost-sharing, either a standard commercial plan or WSHIP. This response produces a very small increase (less than 1 percent) in average health expenditures among all individuals who purchase standard individual plans (Table II.8). A relatively small number of individuals (about 1,400) with standard individual plans in the current case take a reduced-benefit plan (either an IRB plan or a newly offered ERB plan with an employer contribution. Average expenditures among these individuals are much less under Proposal 1.

Table II.8. Estimated Change in Average Individual Expenditures: Proposal 1, FY 2010

Current Coverage	Coverage Under Proposal 1								
	Standard Plan			Reduced-Benefit Plan			Uninsured		
	Number of People (000s)	Change in Average Amount Paid	Percent Change	Number of People (000s)	Change in Average Amount Paid	Percent Change	Number of People (000s)	Change in Average Amount Paid	Percent Change
Standard individual plan ^a	283.7	\$2	0.1%	1.4	-\$1,867	-93.1%	0.0	na	na
Uninsured	34.3	\$1,367	222.2%	25.8	-\$389	-55.0%	482.6	\$0	0.0%

Source: Mathematica Policy Research.

Notes: "na" indicates a category that is not applicable. Dollar amounts include out-of-pocket expenditures plus individual premiums or employee contributions to premiums. Unaffected programs (not shown) include large groups, currently insured small groups, self-insured plans, COBRA, FEBHP, military, Medicaid, SCHIP, Basic Health and PEBB.

^a Includes WSHIP.

About 60,000 individuals who are initially uninsured take up insurance under Proposal 1, either a standard plan (34,300) or in a reduced-benefit plan (25,800)—usually as an individual, but sometimes as a worker newly offered coverage by his employer. Among those who enroll in reduced-benefit coverage, average health expenditures decline by about half (55 percent, or \$389), reflecting lower premiums and often also less cost sharing in the plans these individuals buy. Conversely, among those who enroll in a standard plan, their average health expenditures increase by \$1,367 (recall that these uninsured individuals respond to lower premiums for standard coverage available in the standard market for adults aged 25 to 34).

Within in each classification in Table II.8, there is substantial variation around the average. In Table II.9, we show a different measure of change: the change in individual expenditures at the median. Relative to the median, half of residents would see greater change, and half would see the same or less change. Among those who were in standard individual coverage and take a reduced benefit plan, half pay at least \$1,677 less than before. Among uninsured individuals who take standard coverage, half pay at least \$1,679 more than before; those who take reduced-benefit coverage pay very little more than before (\$75), reflecting a substantial reduction in out-of-pocket expenditures as well as generally low out-of-pocket expenditures when uninsured.

Table II.9. Estimated Change in Total Expenditures for the Median Individual: Proposal 1, FY 2010

Current Coverage	Coverage Under Proposal 1					
	Number of People (000s)	Standard Plan	Number of People (000s)	Reduced-Benefit Plan	Number of People (000s)	Uninsured
Standard individual plan ^a	283.7	\$0	1.4	-\$1,677	0.0	na
Uninsured	34.3	\$1,679	25.8	\$75	482.6	\$0

Source: Mathematica Policy Research.

Notes: “na” indicates a category that is not applicable. Dollar amounts include out-of-pocket expenditures plus individual premiums or employee contributions to premiums. Unaffected programs (not shown) include large groups, currently insured small groups, self-insured plans, COBRA, FEBHP, military, Medicaid, SCHIP, Basic Health and PEBB.

^a Includes WSHIP.

F. FINANCIAL IMPACT ON EMPLOYERS

We assume that only small group employers who do not currently offer coverage would consider offering an ERB plan. Reflecting both the relatively modest reduction in premiums associated with ERB plans relative to standard plans (we estimate 15 percent), very few employers newly offer this coverage. As in the prior section, the estimated number of workers who are newly insured in ERB plans is so small that cost estimates for these workers should be regarded as essentially anecdotal—and certainly not representative of the costs that might result if employers currently offering coverage transitioned into ERB plans.

In Table II.10, employer costs associated with new ERB coverage are presented in aggregate dollar amounts and as a percentage of total (Medicare) payroll. For employees that newly enroll in an ERB plan, their employers contribute an estimated \$2.8 million to premiums, equal to 2.7 percent of their wages. Such low contributions relative to wages reflect not only lower premiums for ERB plans but also relatively high cost sharing in the plans that newly offering employers select.¹⁰ In contrast, small employers in Washington that currently offer coverage contribute, on average, 12.6 percent of wages, estimated over the workers that they cover.

Table II.10. Estimated Employer Contributions to Health Coverage: Proposal 1, FY 2010

Current Case	Current Case Contributions as a Percent of Payroll	Proposal 1	
		Change in Contributions (millions)	Percent of Payroll
Total	8.3%	\$2.8	8.3%
Small groups	5.4%	\$2.8	5.4%
Currently covered employees	12.6%	nc	nc
Employees with new ERB coverage	na	\$2.8	2.7%

Source: Mathematica Policy Research.

Notes: "nc" indicates no change; "na" indicates that the category is not applicable. Other unaffected plans and programs (not shown) include large group plans, self-insured plans, COBRA, FEBHP, military, Medicaid, SCHIP, Basic Health and PEBB.

¹⁰ This result is consistent other research studies that also have found very low demand for coverage among employers that currently do not offer. For example, see: R. Kronick, L.C. Olsen, and T.P. Gilmer, "The Response of Small Businesses to Variation in the Price of Health Insurance: Results From a Randomized Controlled Trial," *Med Care Research and Review Online* First, published on January 28, 2008 as doi:10.1177/1077558707312578 (<http://mcr.sagepub.com/cgi/rapidpdf/1077558707312578v1.pdf>, accessed 3/17/09).

CHAPTER III

PROPOSAL 2: THE HEALTH INSURANCE CONNECTOR

The Health Insurance Connector is described in HB 1569 (2007) and SB 6574 (2008).¹¹ Taken together, these proposals envision a combined small group and individual market. A limited number of benefit packages, each with several cost-sharing options, would be available to individuals and small groups alike. WSHIP and Basic Health would be terminated; current enrollees could enroll in the Connector, where coverage would be guaranteed issue and low-income enrollees would be subsidized. The Connector would not directly affect PEBB, Medicaid, SCHIP, or other State or federal programs.

The Connector would permit carriers to rate adults under age 30 as a single rate class. The current rate band on age would apply to older adults; in effect, the current rate band would be expanded.¹² Because the same rates would apply to both individuals and small-groups enrolled in the Connector, this provision would apply to rating for small-group coverage as well.

Unless self-insured, small firms (with 2 to 50 employees) could offer coverage only through the Connector, if they offer coverage at all. The Connector would require that participating employers offer their workers a Section 125 plan, but it would not require employers to contribute toward coverage. Large groups would be ineligible to participate in the Connector. All individuals—regardless of whether or where they are employed—who do not have an offer of employer-based coverage could purchase individual coverage in the Connector.

Whether enrolled through a small employer or as an individual, everyone insured through the Connector would have the same choice among plans—ensuring portability in the combined market. Small employers that offer coverage would no longer choose a plan for their employees.

¹¹ SB 6574 (2008) refers to this program as the Health Insurance Exchange.

¹² Currently, the highest rate (for 60 to 64 year olds) may not exceed 375 percent of the lowest rate (for 19 to 24 year olds) in either the small group or individual market.

Basic Health would be folded into the Connector. All residents with family income below 200 percent FPL would receive a premium subsidy in the Connector, equivalent to the subsidy currently provided in Basic Health.

As in Massachusetts, the Connector proposal would require most Washington residents age 18 or older to obtain creditable coverage. Residents would be exempt from the mandate if coverage is deemed unaffordable (by assumption, equal to or greater than 5 percent of gross family income).

A. KEY ASSUMPTIONS AND FINDINGS

Modeling the impacts of a Connector in Washington entailed a number of assumptions, as follow:

- Enrollees in the Connector choose among ten health plans, including nine of the current HIP plans and the Basic Health benefit design. The Connector would not offer the three high-deductible HIP plans that are not HSA-qualified.¹³
- Workers can choose any plan in the Connector. To accommodate unrestricted employee choice, small employers that sponsor coverage convert to defined contribution plans. Small employers that currently contribute to coverage continue to pay the same dollar amount per employee, but as a defined contribution to coverage.
- Individual coverage is guaranteed issue. As a result, employee contributions to premiums, when used to buy either group or individual coverage, qualify for Section 125 under HIPAA. WSHIP is terminated.
- Small group employees are list rated. Carriers charge each employee within a group the same age-rated premium as they charge non-group enrollees.¹⁴
- The current limits on rating are not restrictive. Therefore, rating individuals under age 30 as a separate experience pool has no impact on the rates of older individuals.
- Carriers rate Basic Health coverage as they do currently. The Basic Health plan differs from other Connector plans in that it is rated using broader age bands and the range of full premiums is relatively compressed.

¹³ For a description of the twelve HIP plans, see: Chollet, D, J. Ballou, T. Bell, J. Matthisen, A. Lischko, V. Wilson, K. Pollitz, and K. Lucia. *Health Insurance Partnership Board Studies: Enrollment, Cost, and Implementation of a Preliminary Expanded Partnership*, October 2008, as included in the Washington State Health Insurance Partnership Board Preliminary Report (http://www.hca.wa.gov/documents/legreports/E2SHB1569_HIP_Prelim_Report.pdf, accessed 12/13/08).

¹⁴ The alternative (that is, charging rates that average across employees of different ages) would invite adverse selection. If all employees were to pay the same composite rate, older workers would likely choose more comprehensive coverage, driving a selection (or “death”) spiral in those plans.

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- Current minimum participation industry standards apply. At least 75 percent of employees in a small group firm must take up coverage when offered for the group to qualify for coverage. However, group coverage would no longer confer unique benefits on either employers or workers.

In general, list rating in the Connector would induce many currently uninsured individuals—those who are younger, less healthy, and lower-income—to take up coverage. However, list rating would cause a significant a disruption of coverage among older workers: many older workers would drop coverage.

Specific key findings include the following:

- The number of people with individual coverage would approximately double, and those with small group coverage would increase about 20 percent. However, many older workers would drop coverage. As a result, workers aged 45 to 64 would account for nearly two-thirds (61 percent) of uninsured workers.
- Netting out gains and losses in coverage, the number of uninsured persons would decline 72 percent. Approximately 152,000 people would remain uninsured, compared with 542,800 who are uninsured currently. Of those who would remain uninsured, 30 percent are low-income individuals or families exempted from the individual mandate.
- Many low-income residents would obtain coverage. Residents with income below the federal poverty level would constitute just 3 percent of the uninsured. Two-thirds of the uninsured would have incomes above 300 percent FPL.
- The percentage of uninsured eligible for Medicaid, SCHIP, or Basic Health would decline from 74 percent currently to 12 percent under Proposal 2.
- The financial impacts on Washington residents vary widely due to the significant gains and losses of coverage that occur under Proposal 2. Because some older individuals and small group workers would drop coverage, average expenditures (premiums plus out-of-pocket costs) would be lower among workers who obtain group coverage through the Connector—primarily due to younger workers taking coverage. Residents who currently buy individual coverage would benefit the most: average spending on premiums plus out-of-pocket costs for those who gain small group coverage in the Connector would drop 70 percent, largely reflecting new employer contributions. Among those who continue to purchase individual coverage (but through the Connector), average expenditures would drop by 15 percent. At least half of group- and individual- insured residents would pay less under Proposal 2 than they do currently.
- Measured as a percent of total (Medicare) payroll, small employers that currently offer coverage would see their contributions drop from 13 percent of covered workers' wages to 6 percent under Proposal 2—reflecting the changed composition

B. CHANGES IN PREMIUMS

Merging the small group and individual markets and list rating small group workers would both have an effect on the cost of coverage, with premiums for individual coverage and older small group workers increasing relative to the current case, and premiums for some younger small group workers decreasing. These changes increase the incentive for younger workers to take coverage while simultaneously increasing the incentive for older workers and those with individual plans to drop coverage.

On average people who have individual coverage currently are healthier than the small group workers. As a result, they would experience an increase in premiums when rated in a merged market under Proposal 2. At the same time, small group workers benefit from being rated with these healthier individuals and, other things equal, their premiums would fall.

Shifting from composite rating of small groups in the current case to list rating under Proposal 2 would have an additional effect on small group workers.¹⁵ Workers who are relatively young compared with their coworkers in the same firm would experience a decrease in premiums as the worker's own age, rather than the firm's average age, becomes the basis for determining the premium. Similarly, premiums would increase for workers who are older than their firm's average age.

For older workers not eligible for subsidies, the premium increase associated with list rating would be especially significant, more than offsetting the benefit of being rated with the generally healthier people from the individual market. Individuals who would enroll in Basic Health single coverage would experience a 71 percent increase in premium upon turning 55, from \$245.48 per month to \$419.78 (Table III.1). Even a person willing to accept less comprehensive coverage or higher cost-sharing in order to obtain the lowest available Connector premium would see a 36 percent price increase at age 55, from \$245.48 to \$334.18.

As in our estimates for Proposal 1, we assume that the current age band on coverage (3.75 to 1) is not restrictive, and therefore that premiums would not change for older adults when young adults (aged 19 to 30) are rated separately. The primary consequence of Proposal 2 would not be setting premiums for young adults in one rate class (rather than in 5-year classes as is done currently), not in permitting young adults to be rated separately from older adults outside the current rate band on age. The result of rating young adults in one rate class would be slightly higher premiums for the 19–24 age group and lower premiums for the 25–29 age group.¹⁶

¹⁵ Individual coverage is list rated in both the current case and under Proposal 2.

¹⁶ Note that, if the current rate band is restrictive (unlike as we assumed), Proposal 2 would affect premiums for older adults (aged 30 to 64) as well. Most would pay higher premiums, with the oldest individuals seeing the greatest increases. This would induce some individuals to switch to plans with higher cost sharing or to drop coverage altogether.

Table III.1. Estimated Minimum Connector Premiums and Basic Health Premiums for Single Coverage by Age of Enrollee: Proposal 2, FY2010

Age	All Connector Plans, including Basic Health		Basic Health	
	Minimum Single Premium	Increase from Younger Bracket	Single Premium	Increase from Younger Bracket
19-29	\$134.29		\$191.48	
30-34	\$167.12	24.4%	\$191.48	--
35-39	\$188.50	12.8%	\$191.48	--
40-44	\$220.50	17.0%	\$245.48	28.2%
45-49	\$244.27	10.8%	\$245.48	--
50-54	\$245.48	0.5%	\$245.48	--
55-59	\$334.18	36.1%	\$419.78	71.0%
60-64	\$383.86	14.9%	\$419.78	--

Source: Mathematica Policy Research.

Note: The minimum single premium for an age bracket is the lowest available single premium among all plans offered in the Connector, including Basic Health.

C. CHANGES IN COVERAGE

Enrollment in individual coverage would double (increasing 104 percent) under Proposal 2 (Table III.2): an additional 297,600 people would buy individual coverage. Small group enrollment also would increase 20 percent: approximately 133,000 additional workers and dependents would enroll in small group coverage through the Connector. Finally, responding to the individual mandate, some workers who are currently uninsured would accept their current offer of coverage in large groups and self-insured plans.

Table III.2. Estimated Number of People under Age 65 by Coverage Status: Proposal 2, FY 2010

	Current Case		Proposal 2		Percent Change from Current Case
	Number (000s)	Percent	Number (000s)	Percent	
Total	5,663.0	100.0%	5,663.0	100.0%	0.0%
Small groups ^a	670.8	11.8%	803.8	14.2%	19.8%
Other employer plans ^b	3,224.6	56.9%	3,290.8	58.1%	2.10%
Individual coverage ^c	285.1	5.0%	582.6	10.3%	104.4%
Medicaid, SCHIP, or Basic Health	939.8	16.6%	833.8	14.7%	-9.3%
Uninsured	542.8	9.6%	152.0	2.7%	-72.0%

Source: Mathematica Policy Research.

^a Includes small groups insured in market or association plans in the current case.

^b Includes insured large groups, self-insured small and large groups, PEBB, FEHBP, military, and COBRA.

^c Includes WSHIP in the current case.

The number of people who are uninsured would decline 72 percent. Approximately 152,000 people would be uninsured (2.7 percent of the population under age 65), compared with 542,800 currently (9.6 percent). Of those who would be uninsured, 30 percent are low-income individuals or families who would be exempted from the mandate. The other 70 percent (105,800 people) would be subject to the individual mandate but noncompliant. Estimated among individuals subject to the mandate (not exempted), approximately 98 percent of residents would comply with the mandate.¹⁷

The State would terminate Basic Health as a separate program and fold it into the Connector. Because the Basic Health benefit design is offered in the Connector at the current subsidized premium, no one currently enrolled in Basic Health would lose or drop coverage under Proposal 2. Some current Basic Health enrollees would gain small group coverage; others would take individual coverage—either the Basic Health design or another product in the Connector.

Of the 542,200 people without coverage in the current case, just 4 percent (23,400) would remain uninsured under Proposal 2 (upper panel of Table III.3). All others would take individual coverage (61 percent) or small group coverage (24 percent) through the Connector, or they would accept a standing offer of employer coverage in a large group or self-insured plan (11 percent).

Table III.3. Estimated Distribution of People Who are or Become Uninsured: Proposal 2, FY2010

	Number (000s)	Percent
Coverage Status under Proposal 2 of Formerly Uninsured Persons		
Total	542.8	100.0%
Small Group	132.1	24.3%
Large Group	56.8	10.5%
Individual	330.6	60.9%
Uninsured	23.4	4.3%
Initial Coverage Status of Persons Who Are Uninsured under Proposal 2		
Total	152.0	100.0%
Small Group	108.3	71.2%
Individual Coverage	20.4	13.4%
Uninsured	23.4	15.4%

Source: Mathematica Policy Research.

However, the vast majority of people who would be uninsured under Proposal 2 (86 percent) are currently insured (lower panel of Table III.3). Responding to increased premiums that would result from merging the individual and small group markets and list-rating small group workers, 71 percent would have dropped small group coverage, and 13 percent would

¹⁷ The compliance rate is the number of compliant persons statewide divided by the number of non-exempt persons. If individuals do not know ex ante that they may be exempt from the mandate and assume that the mandate also applies to them, the number of uninsured under Proposal 2 would decline 81 percent, from 152,000 to 106,000 people.

have dropped individual coverage. Thus, the smaller number of people who would be uninsured under Proposal 2 reflects a substantial loss of coverage among people who are now insured, offset by a larger coverage gains among people who are currently uninsured.

1. Enrollment by Age

Young adults would account for a large proportion of residents who would enroll in individual coverage through the Connector. Approximately 41 percent of those who would enroll in individual coverage are aged 19 to 29 (Table III.4). Small group enrollees in the Connector would also be younger compared with workers and dependents in large group or self-insured employer plans. Nearly 47 percent would be workers or dependents under age 30, compared with 39 percent in other employer plans.

Table III.4. Estimated Sources and Distribution of Coverage by Age of Enrollee: Proposal 2, FY2010

	Total (000s)	Percent of Individuals			
		Under Age 19	Age 19–29	Age 30–44	Age 45–64
Total	5,663.0	29.3%	18.4%	21.9%	30.4%
Small groups	803.8	20.3%	26.2%	26.3%	27.2%
Other employer plans ^a	3,290.8	25.6%	14.8%	24.1%	35.5%
Individual coverage	582.6	11.0%	41.3%	21.0%	26.7%
Medicaid, SCHIP, or Basic Health	833.8	68.8%	10.6%	10.3%	10.3%
Uninsured	152.0	7.9%	11.5%	19.8%	60.7%

Source: Mathematica Policy Research.

^a Includes insured large groups, self-insured small and large groups, PEBB, FEHBP, military, and COBRA.

Older workers would account for most of the uninsured under Proposal 2: 61 percent of the residents who would be uninsured are age 45 and 64 years old, and 80 percent are age 30 or older. Fewer than 20 percent of those who would be uninsured under Proposal 2 are children (8 percent) or adults under age 30 (12 percent).

While list rating of small groups would have the greatest impact on the age distribution of those who would lose coverage (or remain uninsured) under Proposal 2, other factors have an impact as well. For example, residents who currently have individual coverage or coverage through an association plan tend to be healthier than workers and dependents enrolled in small group plans. Consequently, these healthier individuals would face higher premiums for the same coverage in a merged market. In addition, some individuals might drop coverage if they are currently enrolled in a very low-premium plan, with no equivalent available in the Connector.

2. Enrollment by Family Income

Nearly all low-income residents would be insured under Proposal 2. Sixty percent of those who would enroll in individual coverage have income below 200 percent FPL. Among those who would enroll in small-group coverage, 34 percent have income below 200 percent FPL.

In contrast, residents who would be uninsured generally have higher incomes than those who are uninsured currently. Just 3 percent of those who would be uninsured under Proposal 2 have income below the federal poverty level; 7 percent have income below 200 percent FPL (Table III.5). Two-thirds of those who would be uninsured (67 percent) have income above 300 percent FPL.

Table III.5. Estimated Sources and Distribution of Coverage by Family Income: Proposal 2, FY 2010

	Total (000s)	Percent of Individuals			
		0–100% FPL	101–200% FPL	201–300% FPL	Above 300% FPL
Total	5,663.0	19.6%	14.8%	11.4%	54.2%
Small groups	803.8	17.7%	16.2%	15.8%	50.4%
Other employer plans ^a	3,290.8	6.8%	8.8%	11.9%	72.5%
Individual coverage	582.6	39.5%	20.6%	9.8%	30.2%
Medicaid, SCHIP, or Basic Health	833.8	61.1%	34.8%	3.7%	0.5%
Uninsured	152.0	3.3%	3.2%	26.8%	66.8%

Source: Mathematica Policy Research.

^a Includes insured large groups, self-insured small and large groups, PEBB, FEHBP, military, and COBRA.

3. Enrollment by Health Status

Reflecting new coverage in the Connector, the average health status of residents enrolled in individual coverage would change. Currently, just 23 percent of residents with individual coverage report good, fair, or poor health status (versus excellent or very good), compared with 42 percent of those who would take individual coverage under Proposal 2 (Table III.6). Those who would enroll in small group coverage report about the same health status as those who are currently enrolled in either association or small group coverage combined: 33 percent report good, fair, or poor health status, compared with 31 percent in the current case.

Those who would be uninsured under Proposal 2 are generally healthier than those who are uninsured now. About 44 percent of residents who would be uninsured under Proposal 2 report excellent or very good health, compared with 49 percent in the current case. This change reflects a net movement of less healthy uninsured individuals to covered status, as well as the inclusion of Basic Health in the Connector. Nearly 60 percent of Basic Health enrollees report good, fair, or poor health, compared with just 36 percent among the population overall.

Table III.6. Estimated Number and Percent of People Reporting Good, Fair, or Poor Health by Source of Coverage: Proposal 2, FY 2010

	Current Case		Proposal 2	
	Number (000s)	Percent of Total	Number (000s)	Percent of Total
Total	2,011.4	35.5%	2,011.4	35.5%
Small groups ^a	204.7	30.5%	261.2	32.5%
Other employer plans ^b	928.6	28.8%	954.0	29.0%
Individual coverage ^c	65.3	22.9%	243.5	41.8%
Medicaid, SCHIP, or Basic Health	530.9	57.8%	481.0	57.7%
Uninsured	278.2	49.4%	67.2	44.2%

Source: Mathematica Policy Research.

^a Includes small groups insured in market or association plans in the current case.

^b Includes insured large groups, self-insured small and large groups, PEBB, FEHBP, military, and COBRA.

^c Includes WSHIP in the current case.

4. Change in Insured Status of Residents Eligible for Medicaid, SCHIP, or Basic Health

Most currently uninsured people who qualify for Medicaid or SCHIP (95 percent) or Basic Health (also 95 percent) would take individual or group coverage in the Connector (Table III.7). Conversely, relatively few people who would drop coverage under Proposal 2 have income low enough to qualify for these programs.¹⁸

Table III.7. Estimated Medicaid, SCHIP, and Basic Health Eligible People and Enrollees: Proposal 2, FY2010

	Current Case (000s)	Proposal 2 (000s)	Percent Change from Current Case
Medicaid or SCHIP enrolled	833.8	833.8	0.0%
Basic Health enrolled	106.0	-	-
Uninsured	542.8	152.0	-73.0%
Medicaid or SCHIP eligible	66.8	3.3	-95.1%
Basic Health eligible ^a	332.4	15.4	-95.4%
Other	143.6	133.3	-7.1%

Source: Mathematica Policy Research.

^a Refers to eligibility for Basic Health *subsidies* in the Connector. All small group workers and individuals are eligible to take up the equivalent of Basic Health coverage through the Connector.

¹⁸ Individuals enrolled in Medicaid/SCHIP in the current case are assumed to remain enrolled in these programs under Proposal 2. Individuals currently enrolled in Basic Health would continue to enroll in the Basic Health-equivalent plan through the Connector, with no change in their benefits or the premiums they pay.

As a result, the composition of the uninsured population would change significantly under Proposal 2. Just 18,700 (12 percent) of the 152,000 uninsured residents would be eligible for Medicaid, SCHIP, or Basic Health subsidies, compared with 399,200 (74 percent) of the 542,800 uninsured who are eligible for these programs in the current case.

D. SOURCES OF FUNDS

The two biggest drivers of changes in spending on health insurance and health care services under Proposal 2 are (1) previously uninsured taking up coverage, either through their small group employers or as individuals, and (2) older small group workers either dropping coverage or moving from more comprehensive coverage with lower cost-sharing to less comprehensive coverage with higher cost-sharing.

Under Proposal 2, the previously uninsured who take up coverage would spend less money out-of-pocket per dollar of services they consume, since they would pay only cost sharing and for relatively little care that would not be covered. However, they are also likely to seek more care, increasing their total expenditures for covered services, in particular.

In contrast, when facing steep increases in premiums under Proposal 2, some older small group workers would drop coverage. When responsible for all of their medical expenses, their out-of-pocket expenditures would increase, while spending in small group plans would decline.

For small groups, the net effect of younger, previously uninsured persons taking coverage while older workers either drop or take less coverage is a significant decrease in insured expenditures (Table III.8). Small group spending on health insurance and health care would decline 46 percent, as younger workers replace older workers in the insurance pool and some workers choose higher cost-sharing plans. Expenditures among residents with individual coverage would increase 5 percent, reflecting new enrollment in these plans. Note that large group spending also would increase slightly (1 percent) under Proposal 2, as the individual mandate induces large group workers who had previously declined coverage to accept it. Overall, consumers would pay slightly more out of pocket, as workers variously drop coverage or take it up.

Finally, expenditures in both small group and individual health plans reflect the significant expansion of state subsidies (an increase of 125 percent). Many of the newly insured (in either small group or individual coverage) are eligible for Basic Health subsidies, resulting in \$428 million in the State spending 770.2 million when Proposal 2, compared with \$342.2 million currently. The requirement that small employers adopt Section 125 plans, combined with the increase in enrollment, would increase the use of pre-tax dollars to pay premiums by 61 percent.

E. FINANCIAL IMPACT ON INDIVIDUALS

The financial impacts on Washington residents vary widely due to the significant gains and losses of coverage that occur under Proposal 2. Because some older individuals and small group workers would drop coverage, average expenditures (premiums plus out-of-pocket costs) would be lower among workers who obtain group coverage through the Connector (by \$315 or 24

percent) (Table III.9). This result primarily reflects the lower average age of small-group covered workers under Proposal 2.

Table III.8. Estimated Total Expenditures by Source of Funds: Proposal 2, FY2010

	Current Case (millions)	Proposal 2 (millions)	Percent Change from Current Case
Total	\$24,945.4	\$24,615.7	-1.3%
Affected plans and programs			
Small groups	\$2,919.5	\$1,583.3	-45.8%
Large groups and self-insured plans	\$11,064.9	\$11,235.2	1.5%
Individual coverage ^a	\$546.0	\$571.7	4.7%
State premium subsidies for Basic Health/Connector	\$342.2	\$770.2	125.1%
Federal tax expenditures for Section 125 plans	\$604.7	\$974.3	61.1%
Out of pocket	\$3,214.9	\$3,227.7	0.4%
Unaffected plans and programs			
Federal programs ^b	\$2,606.5	\$2,606.5	--
State programs other than Basic Health ^c	\$3,389.8	\$3,389.8	--
PEBB (non-state employees)	\$256.9	\$256.9	--

Source: Mathematica Policy Research.

Notes: All estimates include medical expenditures and the net cost of private insurance. Other governmental and private costs for plan administration are excluded. Medicaid and SCHIP allocations assume FY2009 federal matching rates.

^a Includes WSHIP in the current case.

^b Includes FEHBP, military, and federal financing of Medicaid and SCHIP.

^c Includes PEBB for state employees and state financing of Medicaid and SCHIP.

Table III.9. Estimated Change in Average Individual Expenditures: Proposal 2, FY 2010

	Same Coverage			New or Changed Coverage			Uninsured		
	Number of People (000s)	Dollar Change	Percent Change	Number of People (000s)	Dollar Change	Percent Change	Number of People (000s)	Dollar Change	Percent Change
Current coverage									
Small group plan	566.5	-\$315	-23.9%	na	na	na	104.3	\$1,263	96.1%
Individual plan ^a	175.1	-\$401	-15.3%	89.6	-\$1,838	-70.0%	20.4	-\$55	-2.1%
Basic Health ^b	na	na	na	106.0	\$124	19.2%	na	na	na
Uninsured	na	na	na	519.4	\$170	15.3%	23.4	\$703	63.2%

Source: Mathematica Policy Research.

Notes: Unaffected programs (not shown) include FEHBP, military, Medicaid, SCHIP, and PEBB. "na" indicates that the category is not applicable.

^aIncludes WSHIP.

^bBasic Health would no longer exist as an independent entity under Proposal 2. However, individuals currently covered by Basic Health who choose coverage through the Connector could keep the Basic Health plan design.

Conversely, among workers who drop small group coverage (generally, older workers with, therefore, relatively high average health care costs), average out-of-pocket spending would increase by \$1,263. They would pay nearly twice as much as they do currently (96 percent more)—largely reflecting their inability to predict expenditures when uninsured. Currently uninsured residents who obtain coverage through the Connector also would pay somewhat more on average (15 percent), reflecting both new payment of premiums and low out of pocket expenditures when uninsured. Because those who become insured through the Connector are healthier than those who remain uninsured, average spending among the uninsured would increase 63 percent, although spending among those who remain uninsured would not change.

Washington residents who currently buy individual coverage would benefit the most under Proposal 2. Average spending on premiums plus out-of-pocket costs for those who obtain group coverage in the Connector would drop \$1,838 (70 percent), largely reflecting their employers' new contributions to coverage. Those who continue to purchase individual coverage through the Connector also would spend less, by \$401 or 15.3 percent.

To assess the effect of Proposal 2 on representative individual residents, we also looked at the change in expenditures for the median individual. Relative to the median individual in a coverage category, half of those in that category would experience a smaller change in expenditures and half would experience a larger change.

The median worker with small-group coverage would see lower expenditures under Proposal 2. Total expenditures would drop \$100 for the median worker who retains coverage, largely due to lower (list-rated) premiums (Table III.10). Workers who drop coverage also would pay less, offsetting higher out-of-pocket spending with no payment for premiums—although they obviously would be assuming more financial risk.

Table III.10. Estimated Change in Total Expenditures for the Median Individual: Proposal 2, FY 2010

Current coverage	Same Coverage		New or Changed Coverage		Uninsured	
	Number of People (000s)	Change in Expenditures	Number of People (000s)	Change in Expenditures	Number of People (000s)	Change in Expenditures
Small group plan	566.5	-\$100	na	na	104.3	-\$74
Individual plan ^a	175.1	-\$638	89.6	-\$1,290	20.4	-\$1,277
Basic Health Plan	na ^b	na ^b	106.0	\$0	na	na
Uninsured	na	na	519.4	\$645	23.4	\$0

Source: Mathematica Policy Research.

Notes: Unaffected programs (not shown) include FEBHP, military, Medicaid, SCHIP, and PEBB. "na" indicates that the category is not applicable.

^aIncludes WSHIP.

^bBasic Health would no longer exist as an independent entity under Proposal 2. However, individuals currently covered by Basic Health who choose coverage through the Connector could keep the Basic Health benefit design.

The median resident with individual coverage also would pay less. The median expenditure among residents who retain individual coverage would be \$638 less than in the current case. Among those who obtain small group coverage under Proposal 2, the median worker would pay \$1,290 less, reflecting his employer's contribution to premiums. The median resident who currently has individual coverage but would drop coverage under Proposal 2 would pay \$1,277 less, reflecting their low out-of-pocket costs relative to the premium they currently pay. Only the median resident who is now uninsured would pay more (\$645) under Proposal 2, reflecting new premiums for coverage in the Connector as well as relatively low out-of-pocket expenditures when uninsured.

F. FINANCIAL IMPACT ON EMPLOYERS

Under Proposal 2, small employers would contribute about 3 percent of payroll for coverage, compared with 5 percent in the current case (Table III.11). Overall, small employer contributions would decline by more than \$1.1 billion, reflecting the transition to list rating and, in response, the many older workers who drop coverage. Small employers that currently offer coverage would see their contributions drop from about 13 percent of covered workers' wages to 6 percent under Proposal 2—again, reflecting the changed composition of their covered workforce.

Table III.11. Current Employer Contributions to Coverage as a Percent of Payroll and Estimated Change: Proposal 2, FY 2010

	Current Case Contributions as a Percent of Payroll	Proposal 2	
		Change in Contributions (millions)	Percent of Payroll
Total	8.3%	-\$995.8	7.6%
Small employers			
All employees	5.4%	-\$1,149.3	2.7%
Covered employees	12.6%	-\$1,149.3	5.6%
Self-insured and large employers			
All employees	8.4%	\$153.5	8.6%
Covered employees	11.4%	\$153.5	11.1%
Public employers (PEBB)	28.2%	nc	nc

Source: Mathematica Policy Research.

Note: "nc" indicates no change.

Proposal 2 does not directly affect larger or self-insured employers. However, they also would see a small change in expenditure as additional workers, when prodded by the mandate, take up coverage that is currently offered. Large and self-insured employers would pay \$154 million more toward coverage for their workers; as a percent of payroll, their payments would not change appreciably.

CHAPTER IV

PROPOSAL 3: THE HEALTH PARTNERSHIP

As envisioned in Senate Bill 6221 (2008), the State would develop a Health Partnership to make comprehensive health coverage available to all non-institutionalized residents if they are not eligible for a federal or federal-state program.¹⁹ The bill also would expand eligibility for the Medicaid program. The Health Partnership would replace all other state-funded programs that currently provide health coverage to low-income residents.²⁰

The health plans available through the Health Partnership would offer benefits similar to those currently available through the Public Employees Benefit Board (PEBB). Carriers would bid to offer coverage, either statewide or in selected regions. The Health Partnership would administer a fee-for-service (FFS) plan which would be available statewide. Residents could enroll in either the FFS option or any of the networks available in their geographic area. All eligible applicants would be guaranteed issue.

The Health Partnership would designate bidding networks as lowest-cost, low-cost, or higher-cost, based on their per member per month (pmpm) cost bids. All plans would offer the same minimum set of benefits; higher-cost network plans could offer less cost-sharing, additional benefits, or both. Subscribers to the lowest-cost or low-cost networks would pay no premium for coverage. Subscribers to higher-cost networks would pay a premium equal to the difference between the pmpm bids of the higher-cost network they selected and the lowest-cost network in their geographic area. Low-income subscribers would qualify for financial assistance to help them pay the cost sharing that their plan requires.

A combination of payroll taxes and premiums would finance coverage in the Health Partnership. The payroll tax on employers would be 9 to 12 percent of Social Security wages,

¹⁹ In addition to Medicare (which is not considered in this report) for qualified disabled persons under age 65, these programs include TRICARE, CHAMPUS, FEBHP, Medicaid, and SCHIP. The State would enroll all residents in Medicaid or SCHIP who are eligible. All others would be enrolled in the HP.

²⁰ Discontinued programs include Basic Health, PEBB, WSHIP, and CHP.

and employees under age 65 would pay 2 to 4 percent of Social Security wages. Self-employed individuals pay a tax of 9–10 percent of Social Security wages.

A. KEY ASSUMPTIONS AND FINDINGS

As with each of the proposals, a number of assumptions were made in modeling Proposal 3. The key assumptions underlying the simulation estimates for Proposal 3 are as follow:

- PEBB is the model for the Health Partnership. The networks currently available in PEBB are the successful bidders in the Health Partnership. They offer the same benefits and (age adjusted) premiums as in the 2009 program.²¹ The Health Partnership’s FFS option is the Uniform Medical Plan, which offers broad geographic coverage and a large network of providers. Premiums in the Health Partnership are based on current premiums for PEBB plans, adjusted for the age.
- Employers do not offer competing coverage. Coverage through the Health Partnership is independent of a resident’s employment status. Because employers would derive no advantage from continuing to offer a plan, we assume they no longer do so. Consequently, all nonfederal employer-based coverage—including coverage in self-insured plans—is terminated. We assume that this strategy complies with ERISA.²²
- FEHBP and military coverage continue (as does Medicare). Residents with this coverage are excused from the payroll tax.
- Residents who do not enroll in a Health Partnership plan are assumed to become enrolled in the lowest cost plan available in their area when they present for any covered medical service. Individuals who are enrolled in state programs without federal matching funds are enrolled in the Partnership on the same basis as other residents.
- Non-worker families pay the same premiums for coverage in the Health Partnership as families with one or more workers. There is no assessment or surcharge to account for nonworking families not having paid a tax on wages to support the Health Partnership.
- Subsidies are based on income and anticipated health expenditures. Deductibles are waived for families with income below 200 percent of the federal poverty level, and

²¹ Health Partnership premiums are adjusted to reflect the age distribution of all Washington residents aged 18 to 64, which differs from the age distribution of current PEBB enrollees.

²² The federal Employee Retirement Income Security Act (ERISA) preempts state regulation with respect to employer-sponsored health and welfare plans. In general, any state action that affects employer-sponsored plans—including incentives for employers to modify or terminate coverage—may be scrutinized for ERISA compliance. As a general reference, see: P.A. Butler (January 2009), Including Employer Financing in State Health Reform Initiatives (<http://www.statecoverage.org/files/Jan%202009%20ERISA%20Update%20FINAL.pdf>, accessed 3/18/09).

out-of-pocket expenses (for insured or uninsured services) are capped at 5 percent of income.²³

- Medicaid eligibility for adults with children under age 19 is increased to 200 percent FPL.²⁴ Income disregards are used to determine eligibility, as in the current program.
- Individuals who are enroll in the Health Partnership but are eligible for either Medicaid or SCHIP are referred to those programs, and all are enrolled. All expenditures for those programs are federally matched at the current (FY 2009) rates.

Key findings related to Proposal 3 are as follow:

- Reflecting the intention of Proposal 3 that all residents would enroll in either the Health Partnership, Medicaid, or SCHIP, Proposal 3 would cover everyone under age 65 who is now uninsured, as well as all residents who are currently insured.
- Most residents would enroll in the Health Partnership. However, 40 percent would either remain in Medicaid or SCHIP, or would become newly enrolled in those programs.
- New Medicaid enrollees would include many more adults than currently, and at higher incomes. Nevertheless, nearly half of Medicaid enrollees (48 percent) would be children.
- Just 18 percent of Health Partnership enrollees would have income below 200 percent FPL; these enrollees would pay no deductible for covered health services.
- Assessments in the range of 1-2 percent for employees and approximately 6 percent for employers and self-employed workers would provide the minimum revenue needed to finance the Health Partnership as well as additional state spending for Medicaid and SCHIP.
- While some residents would pay more in the Health Partnership, others would pay less. In general, the extent to which individuals pay more is related to their higher incomes and, therefore, higher payroll tax liability under Proposal 3. Conversely, the

²³ As defined in the Household Component of the Medical Expenditure Panel Survey (MEPS-HC), uninsured expenditures may include spending on the services of any medical provider (including, for example, acupuncturists, massage therapists, homeopathic/naturopathic/herbalists, and other alternative/complementary care providers) as well as uninsured medical supplies (such as glasses, contact lenses, hearing aids, or other medical supplies), but exclude expenditures for nonprescription drugs and other over-the-counter items.

²⁴ SB 6221 (2008) would require the Department of Medical Assistance to submit Medicaid state plan amendments to expand the categorically needy Medicaid program to cover families and aged, blind, and disabled individuals up to two hundred percent of the federal poverty level, effective January 1, 2010. We assume this provision is effective as of July 1, 2009.

extent to which residents pay less is largely attributable to the high premiums they currently pay. Average expenditures would increase \$443 (36 percent) for residents who currently have group coverage when they enroll in the Health Partnership (reflecting their higher wages compared with those who currently are uninsured), and decrease \$1,069 (41 percent) for residents who currently have individual coverage (reflecting the high premiums they currently pay). Among residents who are now uninsured and would become newly enrolled in Medicaid/SCHIP, average expenditures would fall more than 70 percent.

- Employers would no longer contribute directly to coverage but would pay payroll taxes instead. We estimate that employers would need to pay 7.5 percent of Social Security wages (about 6 percent of total wages) to finance Proposal 3, while employed workers would pay 1.7 percent. However, this amount is less than employers now pay in the aggregate, and much less than employers currently pay for the workers they cover.

B. CHANGES IN PREMIUMS

In the Health Partnership, enrollees pay only the difference between the low or lowest-cost plan available to them and the plan that they select. In general, this difference is modest, resulting in enrollee payments for coverage that, in the aggregate, account for about 12 percent of Health Partnership premiums. About 19 percent of policyholders in the Health Partnership would enroll in a low- or lowest-cost plan, and would pay no premiums for coverage.

We assume that employers that currently sponsor a Section 125 plan would continue to do so, to fund their employees' premium payments (if any) for coverage in the Health Partnership. As a result, federal tax expenditures finance about 1 percent of Health Partnership premiums.

C. CHANGES IN COVERAGE

All Washington residents, if not enrolled in FEHBP or military coverage, would be enrolled in the Health Partnership, Medicaid, or SCHIP. Individuals who are eligible for coverage in the federally-matched Medicaid and SCHIP programs are automatically referred to these programs. No resident would be uninsured.

An estimated 3.2 million Washington residents would become enrolled in the Health Partnership (Table IV.1). These include all persons who are currently enrolled in employer-sponsored or individual coverage, PEBB, WSHIP, Basic Health, or other state-sponsored programs for low-income residents that are generally referred to as Medicaid, but for whom state expenditures are not federally matched. They also include some residents who are currently uninsured.

Table IV.1. Estimated Number of Persons under Age 65 by Coverage Status: Proposal 3, FY 2010

	Current Case		Proposal 3		Percent change in number of persons
	Number of persons (000s)	Percent	Number of persons (000s)	Percent	
Total	5,663.0	100.0%	5,663.0	100.0%	--
Total insured	5,120.2		5,663.0		10.6%
Health Partnership	--		3,172.5		na
Medicaid or SCHIP	703.9		2,290.8		225.5%
Medicaid	693.0		2,272.5		227.9%
SCHIP	10.9		18.2		67.9%
FEHBP and military	199.8		199.8		nc
Uninsured	542.8		--		-100.0%
<i>Discontinued sources of coverage:</i>					
Employer sponsored coverage and COBRA	3,412.3		--		-100.0%
Individual coverage and WSHIP	285.1		--		-100.0%
PEBB	283.3		--		-100.0%
Basic Health	106.0		--		-100.0%
Other state programs ^a	129.9		--		-100.0%

Source: Mathematica Policy Research.

Note: "na" indicates category that is not applicable; "nc" indicates no change.

^a Includes CHP, GAU, ADATA, Refugees, and AEM.

Enrollment in Medicaid and SCHIP would increase, as everyone who is eligible would become enrolled. An estimated 2.3 million adults would be enrolled in Medicaid, more than three times the current level of enrollment in this program (an increase of 225 percent). Approximately 18,000 children would be enrolled in SCHIP, about 68 percent more than are enrolled currently. Overall, about 40 percent of residents under age 65 would be enrolled in either Medicaid or SCHIP.

Obviously, most of those who would be enrolled in Medicaid are not currently enrolled in these programs: about 69 percent of Medicaid or SCHIP enrollees would be new to these programs (Table IV.2). Some are currently uninsured and eligible, but not enrolled. But many are newly eligible due to the expansion of Medicaid for categorically needy adults below 200 percent FPL. These persons may be currently uninsured or insured; if insured, they generally are enrolled in either employer-sponsored plans or in other state-funded public programs.

Table IV.2. Estimated Number of Persons Enrolled in Medicaid or SCHIP by New or Current Enrollment, and Compared with the Health Partnership: Proposal 3, FY 2010

	Number of Persons (000s)	Percent	Percent of Medicaid or SCHIP enrollment, respectively
Total persons under age 65^a	5,663.0	100.0%	na
Health Partnership	3,172.5	56.0%	na
Medicaid or SCHIP	2,290.8	40.5%	100.0%
Current enrollees ^b	703.9	12.4%	30.7%
New enrollees	1,586.9	28.0%	69.3%

Source: Mathematica Policy Research.

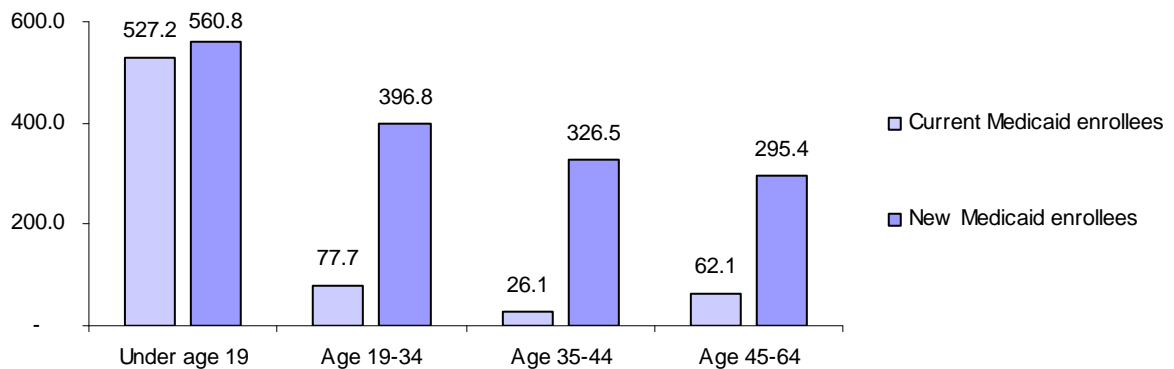
Note: "na" indicates category that is not applicable.

^a Includes FEHBP and military enrollees not shown separately.

^b Current Medicaid enrollees include only those categorically eligible for coverage.

1. Enrollment by Age

The impact of expanded Medicaid eligibility is apparent in the age distribution of residents who would become enrolled. While the number of children in Medicaid would more than double (adding 561,000 children), the relative increase in enrolled adults would be even greater (Figure IV.1). More than 1 million adults aged 19 to 64 would newly enroll in Medicaid.

Figure IV.1. Estimated Number of Current and New Medicaid Enrollment through the Health Partnership, by Age, FY 2010 (000s)

Source: Mathematica Policy Research.

As a result, not only would more adults enroll, but they would be older than those who are enrolled currently. Among residents who would newly enroll in Medicaid, 64 percent would be adults (Table IV.3). More than one-third (39 percent) would be over age 35, and 19 percent

would be over age 45. Among current Medicaid enrollees, just 24 percent are adults and 13 percent are over age 35.

Table IV.3. Enrollment in the Health Partnership by Age and Plan Type, FY 2010

	Total (000s)	Less than 19	Age 19-34	Age 35–44	Age 45–64
Total^a	5,663.0	29.3%	24.7%	15.6%	30.4%
Health Partnership	3,172.5	14.5%	28.6%	16.2%	40.7%
Medicaid or SCHIP	2,290.8	48.3%	20.7%	15.4%	15.6%
Medicaid	2,272.5	47.9%	20.9%	15.5%	15.7%
Current Medicaid enrollees	693.0	76.1%	11.2%	3.8%	9.0%
New Medicaid enrollees	1,579.5	35.5%	25.1%	20.7%	18.7%
SCHIP	18.2	100.0%	--	--	--
Current SCHIP enrollees	10.9	100.0%	0.0%	0.0%	0.0%
New SCHIP enrollees	7.4	100.0%	0.0%	0.0%	0.0%

Source: Mathematica Policy Research.

^a Includes FEHBP and military enrollees not shown separately.

Nevertheless, Medicaid enrollees would be younger than residents enrolled in the Health Partnership. Approximately 41 percent of Health Partnership enrollees would be age 45 or older (compared with 16 percent of Medicaid enrollees). Fewer than 15 percent would be children.

2. Enrollment by Income

The income levels of people who would enroll in the Health Partnership reflect the sorting of many lower-income residents into Medicaid and SCHIP, as the Health Partnership would refer all residents who are eligible to those programs. More than three-quarters of Health Partnership enrollees (76 percent) would have income above 300 percent FPL (Table IV.4). Just 18 percent would have income below 200 percent FPL and would pay no deductible for covered health services. These enrollees (under 200 percent FPL) represent the only state expenditure for health coverage that would not draw federal match.

Table IV.4. Estimated Number of Enrollees by Family Income by Source of Coverage and Family Income, FY 2010

	Number (000s)	0–200% FPL	201–300% FPL	Above 300% FPL
Total^a	5,663.0	34.3%	11.4%	54.2%
Health Partnership	3,172.5	18.4%	5.9%	75.8%
Medicaid or SCHIP	2,290.8	57.1%	18.5%	24.3%

Source: Mathematica Policy Research.

^a Includes FEHBP and military enrollees not shown separately.

Under Proposal 3, Medicaid and SCHIP would include a much larger proportion of middle-income residents. More than half of enrollees (57 percent) would have income below 200 percent FPL, the nominal ceiling on Medicaid and SCHIP eligibility. However, all others (about 43 percent of enrollees) would have income above 200 percent FPL—reflecting the application of income disregards.²⁵

3. Enrollment by Health Status

Consistent with the higher incomes of enrollees in the Health Partnership, most would be predominantly healthy—and much healthier than those enrolled in Medicaid or SCHIP. Just 29 percent of residents who would enroll in the Health Partnership report their health status as good, fair, or poor (versus excellent or very good), compared with 44 percent of those who would enroll in Medicaid or SCHIP.

Table IV.5. Estimated Number and Percent of Persons Reporting Good, Fair, or Poor Health by Source of Coverage: Proposal 3, FY 2010

	Total (000s)	Good, Fair, or Poor
Total^a	5,663.0	35.5%
Health Partnership	3,172.5	29.3%
Medicaid or SCHIP	2,290.8	43.9%

Source: Mathematica Policy Research.

^a Includes FEHBP and military enrollees not shown separately.

D. SOURCES OF FUNDS

Both sources of funds for health care and health insurance and the level of total spending would change significantly under Proposal 3. Nearly all private insurance would be offered through the Health Partnership. State financial obligations in the Health Partnership would consist of (1) paying networks the risk adjusted premium bid of the low- and lowest-cost networks, and (2) paying deductibles for enrollees with income below 200 percent FPL as well as out-of-pocket expenses that exceed 5 percent of family income. In addition, the State would pay the costs of enrolling all categorically eligible individuals and families in Medicaid and SCHIP; as now, these expenditures would be federally matched.

Reflecting these obligations, total state spending for health care under Proposal 3 would be nearly four times the level of state spending in the current case, increasing approximately 283 percent (Table IV.6). Most of the increase in expenditures relates to funding the Health Partnership, which would replace a number of other sources of state expenditure—including

²⁵ While income disregards could be eliminated, reducing Medicaid and SCHIP enrollment under Proposal 3, this approach would have the effect of reducing federal funds and increasing the state funds needed to finance the Health Partnership.

especially PEBB and a number of state-funded low-income assistance programs that currently operate without federal matching funds.

Table IV.6. Estimated Total Expenditures by Source of Funds: Proposal 3, FY 2010

	Current case (millions)	Proposal 3 (millions)	Percent change
Total	\$24,945.4	\$24,058.3	-3.6%
Health Partnership	na	\$13,419.8	na
State	na	\$11,630.9	na
Individual	na	\$1,788.9	na
State subsidies for out-of-pocket expenses	na	\$49.7	na
Affected sources of funds:			
Federal programs (including FEHB and military)	\$2,606.5	\$4,632.9	77.7%
Medicaid	\$1,715.5	\$3,738.1	117.9%
SCHIP	\$13.8	\$17.7	28.0%
Federal tax expenditures on section 125 plans	\$604.7	\$164.6	-72.8%
State (including Health Partnership)	\$3,988.9	\$15,289.9	283.3%
Medicaid and related state-only programs	\$1,986.8	\$3,600.1	81.2%
Basic Health	\$342.2	--	-100.0%
SCHIP	\$7.2	\$9.3	28.0%
PEBB-State employees	\$1,395.7	--	-100.0%
PEBB-other	\$256.9	--	-100.0%
Employer-sponsored	\$13,984.4	--	-100.0%
Small group (association, HIP, and other)	\$2,919.5	--	-100.0%
Large group or self-insured	\$11,064.9	--	-100.0%
Individual (including Health Partnership)	\$546.0	\$1,788.9	227.6%
Private non-group	\$524.4	\$0.0	-100.0%
WSHIP	\$21.7	\$0.0	-100.0%
Out of Pocket	\$3,214.9	\$2,182.0	-32.1%
Unaffected sources of funds:			
FEHB+Military	\$877.1	\$877.1	nc

Source: Mathematica Policy Research.

Notes: "na" indicates no change calculated for a new program; "nc" indicates no change.

State expenditures for Medicaid and SCHIP also would rise—respectively, 81 percent and 28 percent as all categorically eligible residents would be enrolled in the program. Federal spending for Medicaid would increase still faster (118 percent); unlike the current case, all residents enrolled in Medicaid or SCHIP would draw federal matching funds.

Reflecting Medicaid's low provider reimbursement rates, overall Medicaid spending would rise much less than the decline in private insurance spending that it replaces. As a result, total spending for health care services would decline approximately 3 percent. We assume that the Health Partnership plans would not succumb to cost shifting as providers' Medicaid caseloads increased. However, the incentives for cost shifting in Proposal 3 would be intense, if (as we assume) Medicaid continues to pay approximately half the rates paid by the Partnership plans.

Assuming some cost shifting to Partnership plans would eliminate the cost savings estimated for Proposal 3, and might actual increase total spending by a few percentage points.

Finally, payment of individual premiums for coverage in the Health Partnership would increase, replacing current contributions to group coverage as well as premiums for individual coverage or WSHIP. The amount households pay for premiums (an estimated \$1.8 billion) reflects expenditures to “buy up” coverage in plans not designated as the low- or lowest-cost plan available to them. Out-of-pocket expenditures for health care would decline by nearly one-third (32 percent), as uninsured residents gained coverage and many insured residents gained more comprehensive coverage in the Health Partnership.

Under Proposal 3, the Health Partnership would be financed from a payroll tax on employers, employees, and self-employed individuals. The proposal calls for minimum assessments on Social Security wages of 2-4 percent for employees, 9-12 percent for employers, and 9-10 percent for self-employed workers.

We estimate that assessments below these ranges likely would be required to finance the Health Partnership as it is proposed (and also assuming no cost shifting to Health Partnership plans from Medicaid and SCHIP). (Table IV.7). Specifically, assessments in the range of 1-2 percent for employees and approximately 6 percent for employers and self-employed workers would provide the minimum revenue needed to finance the Health Partnership (including both premiums and out-of-pocket subsidies), *as well as* additional state spending for Medicaid and SCHIP (Table IV.8).

E. FINANCIAL IMPACT ON INDIVIDUALS

While some residents would pay more in the Health Partnership, others would pay less. In general, the extent to which individuals pay more is largely related to their higher incomes and, therefore, higher payroll tax liability under Proposal 3. Conversely, the extent to which they pay less is largely attributable to high premiums (for those with individual coverage, especially) in the current case.

For the 2.6 million workers currently covered by their employers and who would move into the Health Partnership, average expenditures—including premiums, out-of-pocket costs, and the new payroll tax—would increase by \$443, or 36 percent (Table IV.8). In contrast, average expenditures for the 221,000 persons transitioning from individual coverage into the Health Partnership would drop by \$1,069, or 41 percent.

Residents who would newly enroll in Medicaid or SCHIP also would pay much less under Proposal 3, due both to premium relief, lower out-of-pocket costs, and little or no tax liability at the income levels that qualify them for these programs. Among those currently enrolled in group or individual coverage, expenditures would fall 72 and 87 percent, respectively, due to the elimination of premiums. Currently uninsured individuals enrolling in Medicaid/SCHIP would also see a sharp decrease in annual spending (\$874, or 79 percent), due to reduced out-of-pocket expenses. While those who are currently covered through Medicaid/SCHIP see no change in benefits, their annual expenditures would increase modestly as a result of the payroll tax.

Table IV.7. Estimated Financing for Proposal 3, FY 2010

	Total (millions)	State share (millions)
State obligation:		
Total obligation	\$20,949.5	\$15,289.9
Health Partnership premiums	\$13,584.3	\$11,630.9
Medicaid and SCHIP	\$7,365.1	\$3,609.4
Subsidies for out-of-pocket expenses	\$49.7	\$49.7
Payroll taxes paid for state employees	\$382.3	\$382.3
Current expenditure	\$5,718.2	\$3,737.6
Medicaid and SCHIP	\$3,723.4	\$1,994.1
Basic Health	\$342.2	\$289.2
PEBB-State employees	\$1,395.7	\$1,228.2
PEBB-other	\$256.9	\$226.1
State obligation net of current spending		\$11,934.6
New State Revenue:		
Estimated total revenue		\$11,934.6
Estimated payroll taxes (percent of Social Security wages)		
Employed workers (1.7 percent)		\$2,160.7
Employers (7.5 percent)		\$9,723.0
Self-employed workers (7.5 percent)		\$50.7

Source: Mathematica Policy Research. Projected nominal wages are derived from the Office of Financial Management, State of Washington (<http://www.ofm.wa.gov/trends/tables/fig102.asp>, accessed 12/15/2008). Basic Health financing projections were provided by the Health Care Authority (May 22, 2008).

Notes: State contributions to PEBB are estimated as 88 percent of total premiums. FY2010 wages are the average of CY2009 and CY2010 projected wages. Social Security wages are estimated as 83 percent of total projected wages (See: http://www.ssa.gov/OACT/TR/TR08/V_programatic.html#121260).

Expenditures for Health Partnership enrollees would be nearly evenly distributed among premiums, payroll taxes, and out-of-pocket costs under Proposal 3. In the aggregate, enrollees would spend \$1.69 billion (33 percent of total expenditures) on premiums, \$1.77 billion (35 percent) on payroll taxes, and \$1.61 billion (32 percent) on out-of-pocket costs (Figure IV.2).

The distribution of expenditures within coverage categories tells much the same story as the pattern of average expenditures. Under Proposal 3, the median worker with group coverage would spend \$292 more (Table IV.9). Some higher-income workers would spend much more (20 percent of group-covered workers would spend at least \$1,568 more in the Health Partnership; data not shown) due to their higher payroll taxes. Those who are currently uninsured also would pay more in the Health Partnership, with a median increase of \$611 per year, also chiefly attributable to the payroll tax.

Table IV.8. Estimated Change in Average Individual Expenditures: Proposal 3, FY 2010

Current Coverage	Health Partnership			Medicaid or SCHIP		
	Number of People (000s)	Change in Amount Paid	Percent Change	Number of People (000s)	Change in Amount Paid	Percent Change
Group plan ^a	2,553.5	\$443	35.5%	1,248.1	-\$902	-72.3%
Individual plan ^b	221.0	-\$1,069	-40.7%	64.1	-\$2,284	-87.0%
Medicaid or SCHIP	na	na	na	703.9	\$34	16.7%
Other state program ^c	51.5	-\$31	-19.8%	78.4	-\$19	-12.4%
Uninsured	346.5	\$41	3.7%	196.3	-\$874	-78.6%

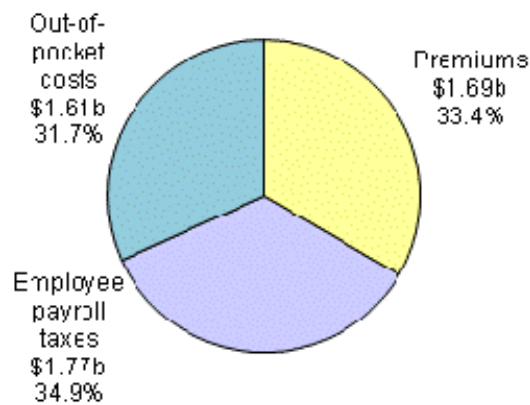
Source: Mathematica Policy Research.

Note: "na" indicates category that is not applicable. Individual expenditures include premiums, out-of-pocket expenditures, and payroll taxes paid. Enrollees in military or FEHBP plans are unaffected except for the payroll tax on dependents' taxable earnings. The increase in average per person expenditures due to taxes paid was \$296 (29.3%) for this group.

^aIncludes small groups, large groups, self-insured plans, association plans, COBRA, PEBB, and Basic Health.

^bIncludes WSHIP.

^cIncludes CHP, GAU, ADATA, Refugees, and AEM.

Figure IV.2. Estimated Health Partnership Enrollee Payments as Premiums, Payroll Taxes, and Out-of-Pocket Costs: Proposal 3, FY 2010

Source: Mathematica Policy Research.

Table IV.9. Estimated Change in Total Expenditures for the Median Individual: Proposal 3, FY 2010

Current coverage	Health Partnership		Medicaid or SCHIP	
	Number of People (000s)	Change in Amount Paid	Number of People (000s)	Change in Amount Paid
Group plan ^a	2,553.5	\$292	1,248.1	-\$511
Individual plan ^b	221.0	-\$1,023	64.1	-\$1,815
Medicaid or SCHIP	na	na	703.9	\$0
Other state program ^c	51.5	\$0	78.4	\$19
Uninsured	346.5	\$611	196.3	-\$5

Source: Mathematica Policy Research.

Note: "na" indicates category that is not applicable. Individual expenditures include premiums, out-of-pocket expenditures, and payroll taxes paid. Enrollees in military or FEHBP plans were unaffected except for the payroll tax on dependents' taxable earnings. The change in expenditures was \$0 for the median enrollee in these plans.

^aIncludes small groups, large groups, self-insured plans, association plans, COBRA, PEBB, and Basic Health.

^bIncludes WSHIP.

^cIncludes CHP, GAU, ADATA, Refugees, and AEM.

However, total expenditures would fall under Proposal 3 for most residents with individual coverage and also for some group-covered workers. Eighty percent of persons moving from individual coverage into the Health Partnership would see savings of \$162 per year or more (data not shown), with savings of \$1,023 for the median person.

Expenditures also would decline for most people enrolling Medicaid or SCHIP under Proposal 3. Savings would range from \$5 per year for the median uninsured person who enrolls, by \$511 and \$1,815 per person for the median resident currently enrolled in group or individual coverage, respectively.

F. FINANCIAL IMPACT ON EMPLOYERS

Employers that currently offer coverage and also cover a large proportion of their workers would spend much less on employee health care under Proposal 3. They would no longer subsidize employee premiums but instead would be responsible for a share of the payroll tax. Conversely, employers that do not currently offer coverage, or cover a relatively low percentage of their workers, would pay more.

Proposal 3 calls for a payroll tax on Social Security wages. In Table IV.10, we express this new tax liability as a percent of total (Medicare) wages, so that the estimates are comparable to those that we present for Proposals 4 and 5. Note that while payroll tax rates on Social Security wages are the same for all employers (7.2 percent) and employed workers (1.6 percent) under

Proposal 3, when expressed as a percent of total wages, they vary across employers due to differences in wages that exceed the Social Security taxable maximum.

We estimate that nonfederal employers in Washington would pay about \$3.3 billion less under Proposal 3 than they do currently (Table IV.10). On average, their contributions to health insurance currently equal 8.3 percent of payroll; under Proposal 3, they would pay 6.2 percent of payroll.

Table IV.10. Estimated Change in Employer Expenditures for Premium Contributions as a Percent of Total Payroll: Proposal 3, FY 2010

	Current Contributions as a Percent of Payroll	Change in Contributions under Proposal 3 (in millions)	Proposal 3 Contributions as a Percent of Payroll
Total	8.3%	-\$3,262.2	6.2%
Small employers			
All employees	5.4%	\$391.1	6.3%
Covered employees	12.6%	-\$2,332.0	6.4%
Self-insured and large employers			
All employees	8.4%	-\$2,517.3	6.1%
Covered employees	11.4%	-\$4,297.6	6.1%
Public employers (PEBB)	28.2%	-\$1,136.0	6.5%

Source: Mathematica Policy Research.

Note: Estimates include contributions to premiums and new payroll tax liability. Federal employment (not shown) is not affected and assumed not to be subject to payroll taxation.

Available data allow us to observe employees but not their employers, so it is not possible to calculate exactly what employers that currently offer coverage pay as a percent of their total payroll—including wages paid to enrolled workers as well as workers who are either ineligible for coverage or eligible but not enrolled. However, it is clear that employers that currently offer coverage and also cover a high proportion of their workers would see a significant reduction in expenditures under Proposal 3, while employers that do not currently offer coverage would pay more as a result of the proposal's payroll tax financing.

Among workers who are offered and take small group coverage, employer contributions currently equal 12.6 percent of their wages. Under Proposal 3, their employers would pay 6.4 percent of their wages as a payroll tax (49 percent less). However, small employers as a whole would pay more (6.3 percent of payroll, compared with 5.4 percent currently), as employers that do not offer coverage begin to pay a payroll tax to support the Health Partnership. Employers that offer a health plan also would begin to pay on behalf of workers who either ineligible for their plan or do not take it up.

Large employers—who universally sponsor a health plan—and public employers in PEBB would save substantially under Proposal 3. In total, large and self-insured employers would pay nearly \$2.5 billion for health benefits—the difference between 8.4 percent of payroll currently and 6.1 percent under Proposal 3. Payments on behalf of currently covered workers would drop from 11.4 percent of their wages currently to 6.1 percent under Proposal 3. Public employers would see the most significant reduction in expenditures for covered workers: their contributions would drop from 28.2 percent of wages currently to 6.5 percent under Proposal 3.

CHAPTER V

PROPOSAL 4: SINGLE-PAYER PLAN

Proposal 4 would establish a single payer for most health care expenditures in the State. All eligible residents under age 65 would be automatically enrolled in the single-payer plan. The plan is financed from general state revenues; there are no premiums for coverage.

A. KEY ASSUMPTIONS AND FINDINGS

To model Proposal 4, it was necessary to make a number of assumptions about how small firms and individuals would behave. The key assumptions underlying our estimates for Proposal 4 are as follow:

- All residents under age 65 are eligible if not otherwise enrolled in a federal program—Medicare, FEHBP, or military coverage. These individuals are assumed to continue coverage in these programs.
- Residents who are currently enrolled in a state health care program—including Medicaid, SCHIP, Basic Health or WSHIP—are enrolled in the single payer plan.
- Because workers and dependents are automatically enrolled in the single payer plan, employers have no compelling reason to sponsor a health insurance plan. Therefore, both public and private employers that currently offer coverage—including large and self-insured employers—terminate their plans. We assume that this strategy complies with ERISA.²⁶

²⁶ The federal Employee Retirement Income Security Act (ERISA) preempts state regulation with respect to employer-sponsored health and welfare plans. In general, any state action that affects employer-sponsored plans—including incentives for employers to modify or terminate coverage—may be scrutinized for ERISA compliance. As a general reference, see: P.A. Butler (January 2009), Including Employer Financing in State Health Reform Initiatives (<http://www.statecoverage.org/files/Jan%202009%20ERISA%20Update%20FINAL.pdf>, accessed 3/18/09).

- Recognizing PEBB’s generally comprehensive benefit design, employers do not offer supplemental insurance for services that the single-payer plan covers.²⁷ If employers offer supplemental coverage, over expenditure estimates would be conservative.
- Covered benefits are the same as those available to state employees in PEBB.
- Per enrollee, the administrative cost of the single-payer plan is 2.5 times Medicare’s fee-for-service administrative cost, reflecting the additional activities (such as negotiating with providers and conducting public hearings) that would be required of the single payer plan but are not reported as a direct cost of administering the Medicare program. Coincidentally, administrative cost calculated this way, relative to estimated medical cost, is approximately equal to the current cost of PEBB administration.
- Eligibility for Medicaid and SCHIP is extended to all categorically eligible residents with income below 150 percent FPL. (This provision of Proposal 4 eliminates the SCHIP program, which covers children from 200 to 300 percent FPL.) Income disregards apply, as in the current case, in effect extending Medicaid coverage to higher-income families, if working.
- Medicaid- or SCHIP-eligible residents are automatically enrolled in the single-payer program, which provides wrap-around coverage for Medicaid services not covered in the PEBB benefit design.
- The single payer plan maintains PEBB provider payment rates, reduced to capture expected administrative savings to providers associated with needing to bill fewer carriers. However, because providers still need to bill multiple Medicare and FEHBP carriers, provider administrative savings are assumed to be half of the administrative savings estimated for the Canadian national health plan compared with the United States.
- Providers are reimbursed for Medicaid enrollees at the same rates as for other enrollees in the single-payer plan. The state continues to receive federal matching for state expenditures to provide services to Medicaid enrollees. No adjustment in rates is made to capture potential cost-shifting from public programs in the current case.^{28, 29}

²⁷ This assumption, in effect, mirrors the “exclusive coverage” provision of the Canadian national health plan, which precludes private insurers from offering additional or competing coverage for services that the national health plan covers—in general, all hospital and physician care. Unlike the benefit design envisioned for the single payer plan, the Canadian national plan covers these services with no cost sharing.

²⁸ This assumption may be equivalent to assuming a windfall gain for providers in rural areas, where the absence of competition may enable greater cost shifting in the current case. However, the need to increase supply of providers might justify maintaining higher payments in underserved areas.

Key findings are as follow:

- Approximately 5.5 million Washington residents would be enrolled in the single payer plan, including all residents who are currently enrolled in employer coverage, state programs, or individual health insurance plans.
- All uninsured Washington residents under age 65 would gain coverage—approximately 542,800 adults and children. Including people who are homeless in Washington State and probably undercounted in population estimates, this estimate might increase by as many as 24,000 additional people (about 4 percent).
- Of the 5.5 million residents enrolled in the single payer plan, approximately 1.4 million (25 percent) would be Medicaid/SCHIP enrollees.
- Total spending for health care services would increase approximately 4 percent. Overall, state spending (including the single payer plan and state expenditures for Medicaid) would increase more than 375 percent.
- State spending for Medicaid would increase 47 percent, but just 25 percent compared with combined State spending for Medicaid, SCHIP, and Basic Health in the current case. To the extent that homeless residents are not currently enrolled in Medicaid, state spending for Medicaid might increase as much as 52 percent.
- No specific revenue source for this expenditure is proposed. However, with a payroll tax structured like that for Proposal 3, we estimate that employers and self-employed workers would need to pay 9.9 percent of Social Security wages and employees would need to pay 2.2 percent of Social Security wages to finance Proposal 4.
- Assuming payroll tax financing as described above, workers with group coverage, who would constitute 70 percent of enrollees in the single payer plan, would see very little change in expenditures. Under Proposal 4, their average expenditures would increase just 3.4 percent; at the median, covered worker would pay an additional \$158 per year, reflecting their relatively high wages and therefore, higher

²⁹ Whether hospitals (or other providers) shift cost to privately insured patients to offset low public reimbursement is a matter of longstanding controversy. In theory, hospitals can obtain higher reimbursement rates from payers whose demand for care is less sensitive to price—for example, when there is no alternative source of care or when the payer is otherwise unable to reduce the use of a hospital in response to higher charges. However, they may not succeed in offsetting all or even most of the difference in public payments relative to costs. In some cases, lower reimbursement rates may trigger efforts to improve cost efficiency. For example, see: (1) J. Zwanziger, G. Melnick, and A. Bamezai (2000), “Can Cost Shifting Continue in a Price Competitive Environment?” *Health Economics*, vol. 9, pp. 211-225; (2) J. Zwanziger and A. Bamezai (January/February 2006), “Evidence of Cost Shifting in California Hospitals,” *Health Affairs*, vol. 25, no.1, pp. 197-203; and (3) D. Chollet, G. Gimm, and B. Gilman (2008), *Analysis of Financial Performance and Cost Shifting in West Virginia’s General Acute Hospitals*. Report to the West Virginia Health Care Authority. Mathematica Policy Research, Inc.

tax liability. Residents with individual coverage and residents who are uninsured would pay much less than they do currently.

- Again assuming payroll tax financing as described above, employers as a whole would pay slightly less for health insurance than in the current case. However, for employees that are currently covered, both large and small employers would pay substantially less: 8.1 to 8.4 percent, compared with 11.4 to 12.6 percent of their covered workers' wages currently. However, small employers on the whole (including many small employers that do not offer coverage or cover all of their workers) would pay more under Proposal 4, because they would contribute to coverage for all of their workers.

B. CHANGES IN PREMIUMS

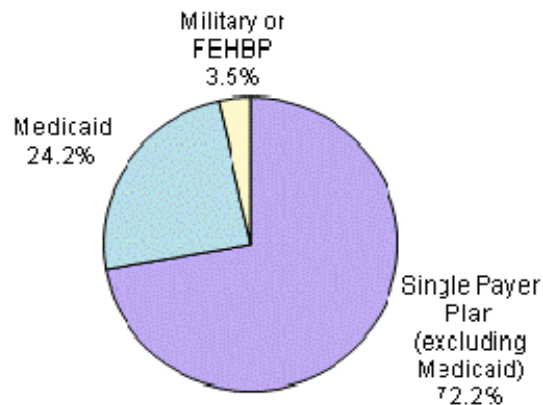
Proposal 4 would eliminate all premiums for health insurance for residents who are eligible for (and automatically enrolled in) the single payer plan. As a result, employers and workers would discontinue contributions to coverage, and individuals would no longer pay premiums for private coverage, WSHIP, or Basic Health.

Only residents enrolled in federal programs—Medicare, FEHBP, or military coverage—would continue to pay premiums. By assumption, their premiums would not change.

C. CHANGE IN COVERAGE

The single-payer plan would cover nearly 5.5 million Washington residents—96 percent of the population under age 65 (Figure V.1). Of these, nearly 1.4 million residents would be eligible for Medicaid—24 percent of all residents under age 65 and 25 percent of enrollees in the single payer plan. Including people who are homeless in Washington State and probably undercounted in population estimates, this estimate might increase by as many as 24,000 additional people (about 4 percent).

Figure V.1. Estimated Percent of People under Age 65 by Source of Coverage under Proposal 4, FY 2010



Source: Mathematica Policy Research.

Currently, about 939,800 residents under age 65 are enrolled in Medicaid, SCHIP, Basic Health, or a number of other low-income assistance programs generally categorized as Medicaid but financed by the state without federal matching funds. Under the single-payer plan, approximately 1.4 million residents would be enrolled in Medicaid. Some new Medicaid enrollees are currently uninsured; others are low-income residents who are currently insured, many in large employer group plans. On net, an additional 454,000 Washington residents would enroll in the Medicaid portion of the single payer program relative to those who are currently enrolled in the various state programs that finance health care for low-income residents—49 percent more than the number currently enrolled in these programs. All would draw federal matching funds.

Although limiting eligibility for public assistance in the single payer plan would effectively eliminate Washington’s relatively small SCHIP program, many more children would enroll in Medicaid compared with children currently enrolled in public assistance programs. Under this proposal, an additional 171,500 children under age 19 would enroll in Medicaid, compared with children currently enrolled in state programs. They would account for more than half (54 percent) of all Medicaid enrollees in the single payer plan.

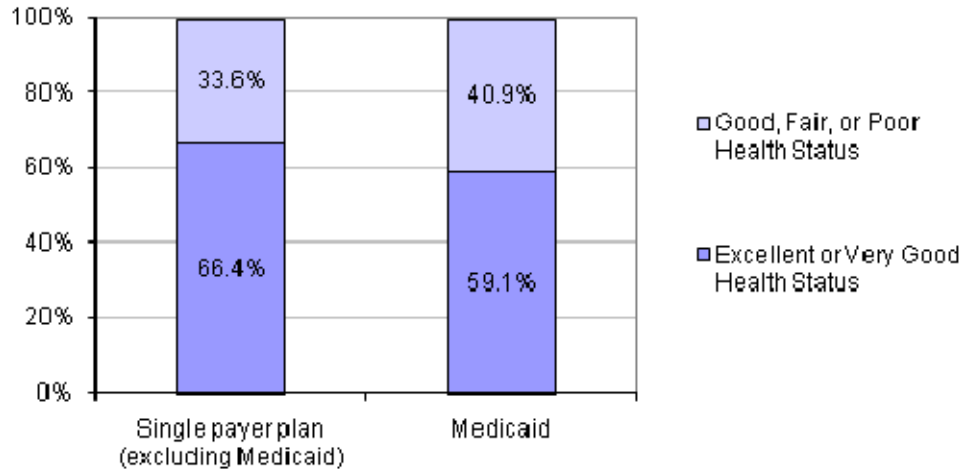
Table V.1. Estimated Number of People Under Age 65 Enrolled in State Programs for Low-Income Residents by Enrollee Age: Proposal 4, FY 2010

	Current case: Medicaid, SCHIP, Basic Health, and other low-income assistance programs		Single Payer Plan: Medicaid		Change (000s)	Percent Change
	Number (000s)	Percent	Number (000s)	Percent		
Total	939.8	100.0%	1,373.2	100.0%	453.8	46.1%
Under age 19	573.9	61.1%	745.4	54.3%	171.5	29.9%
Age 19-34	164.4	17.5%	311.2	22.7%	156.9	89.3%
Age 35-44	86.8	9.2%	203.5	14.8%	121.3	134.4%
Age 45-64	114.6	12.2%	113.1	8.2%	4.1	-1.3%

Source: Mathematica Policy Research.

Medicaid also would cover a disproportionate share of residents with relatively low reported health status, who would receive fuller coverage for necessary care than other single-payer plan enrollees. About 41 percent of residents who would be enrolled in Medicaid report good, fair, or poor health status—compared with 34 percent of other residents who would be enrolled in the single payer plan (Figure V.2).

Figure V.2. Estimated Percent of Single Payer Enrollees and Enrollees in Medicaid by Self-Reported Health Status: Proposal 4, FY 2010



Source: Mathematica Policy Research.

D. SOURCES OF FUNDS

Consistent with estimates of expenditure change for the other proposals, the change in expenditures for Proposal 4 reflect behavioral responses to changes in benefit design among people who are (1) currently insured and move into either the single-payer plan or Medicaid, or (2) currently uninsured and become insured in either the single-payer plan or Medicaid. In addition, expenditures under the single payer plan reflect a number of other factors:

- Reduced administrative cost relative to small group and individual coverage in the current case, but higher administrative cost than estimated currently for large group or self-insured plans.
- Increased Medicaid payment rates, consistent with rates paid by the single payer plan for other enrollees. On average, this adjustment increases estimated Medicaid expenditures per member per month by 66 percent.³⁰
- Reduced reimbursement rates paid to providers relative to current commercial rates, consistent with assumptions about providers' reduced administrative cost. Overall,

³⁰ This adjustment was derived from estimates net revenue per expenses for commercial carriers versus Medicaid, as reported in: Milliman, Inc. (May 2006), "Payment Level Comparison between Public Programs and Commercial Health Plans for Washington State Hospitals and Physicians" (https://www.premera.com/stellent/groups/public/documents/pdfs/dynwat%3B19064_1015788200_3256.pdf, accessed December 12, 2008). The adjustment (1.66) was calculated as the weighted average of the median ratio of net revenues per expenses for commercial carriers versus Medicaid, reported separately for hospitals (1.38) and physicians (1.78). The physician ratio was applied to all non-hospital providers receiving payments from Medicaid.

this adjustment is assumed to reduce single-payer plan expenditures for all enrollees (including Medicaid enrollees) by 5 percent.³¹

Under Proposal 4, estimated total expenditures would increase about 4 percent relative to current expenditures (Table V.2). Largely reflecting the refinancing of private coverage state-wide, state expenditures—including expenditures to support the single payer plan—would be more than four times the current level of state expenditures, rising about 377 percent. State spending for Medicaid would increase 47 percent, reflecting enrollment of all eligible residents under reduced eligibility rules, as well as higher reimbursement rates. Relative to the State's current combined spending for Medicaid, SCHIP, and Basic Health, spending (for Medicaid) would increase about 25 percent.

Table V.2. Estimated Total Expenditures by Source of Funds: Proposal 4, FY 2010

	Current case (millions)	Proposal 4 (millions)	Percent Change
Total	\$ 24,945.4	\$25,889.0	3.8%
Single payer plan	na	\$16,097.8	na
Affected sources of funds:			
Federal programs (including FEHB and military)	\$2,606.5	\$3,915.4	50.2%
Medicaid	\$1,715.5	\$3,038.3	77.1%
SCHIP	\$13.8	--	-100.0%
Federal tax expenditures for section 125 plans	\$604.7	--	-100.0%
State (including single payer plan)	\$3,988.9	\$19,024.0	376.9%
Medicaid	\$1,986.8	\$ 2,926.1	47.3%
Basic Health	\$342.2	--	-100.0%
SCHIP	\$7.2	--	-100.0%
PEBB-State employees	\$1,395.7	--	-100.0%
PEBB-other	\$256.9	--	-100.0%
Employer-sponsored	\$13,984.4	--	-100.0%
Small group ^a	\$2,919.5	--	-100.0%
Large group or self-insured	\$11,064.9	--	-100.0%
Individual	\$546.0	--	-100.0%
Private non-group	\$524.4	--	-100.0%
WSHIP	\$21.7	--	-100.0%
Out of Pocket	\$3,214.9	\$2,949.7	-8.2%
Unaffected sources of funds:			
FEHB and military	\$877.1	\$877.1	nc

Source: Mathematica Policy Research

Notes: "na" indicates a category that is not applicable; "nc" indicates no change.

^a Includes commercial, association, and HIP coverage.

³¹ Reflecting providers' ongoing need to bill multiple payers (including Medicare and FEHB carriers) this adjustment is assumed to be one-half of the difference in the provider administrative cost rate (per total cost) by type of service between the U.S. average and the Canadian health care system, as calculated in: S. Woolhandler et al. (August 21, 2003), "Costs of Health Care Administration in the United States and Canada," *New England Journal of Medicine* 349 (8): 768-775.

To the extent that homeless residents are not currently enrolled in Medicaid, state spending would presumably increase somewhat more than represented in Table V.2. At the likely extreme, if no homeless residents are currently enrolled in Medicaid, and when enrolled each would represent twice the level of state expenditure compared with other Medicaid enrollees, State expenditures for Medicaid enrollees in the single payer plan would increase 52 percent (data not shown)—that is, an additional 2 to 3 percentage points more than the 47 percent increase reported above.

Under proposal 4, federal expenditures for Medicaid would increase by 77 percent, an infusion of an additional \$1.3 billion in federal funding for the state. Compared with current federal expenditures for Medicaid and SCHIP enrollees combined, federal spending in Washington would increase about 76 percent.

Conversely, the loss of employer-based coverage under the single payer plan would entail a loss of federal tax expenditures for employee contributions to coverage sheltered in Section 125 plans. These funds would represent additional taxable income to residents and an outflow of federal funds—although this amount is much less than the magnitude of new federal Medicaid funding expected under Proposal 4. We estimate that residents would lose approximately \$605 million in federal funds as a result of this change. Net of the loss of these funds, estimated total federal expenditures in Washington would increase 22 percent.

While Proposal 4 would entail the state finding funds to finance an additional \$15 billion in state expenditures, no specific revenue source for this expenditure is proposed. For the purpose of comparing with other proposals in this report, we estimated the net expenditure that Proposal 4 would represent if it were financed as a payroll tax wages, assuming the same relative distribution of payroll tax rates among employed workers, employers, and self-employed workers as for Proposal 3. To finance Proposal 4, we estimate that employers and self-employed workers would need to pay 9.9 percent of Social Security wages and employees would need to pay 2.2 percent of Social Security wages (Table V.3).³²

E. FINANCIAL IMPACT ON INDIVIDUALS

This section offers estimates of impacts on Washington residents, depending on their current source of coverage or whether they are uninsured. Estimated changes in average individual payments for health care and health insurance under Proposal 4—including an assumed payroll tax to finance net State expenditures—are presented in Table V.4. The estimated percentage of Social Security wages needed to finance Proposal 4 is converted to an estimated percentage of total wages, to achieve comparability with the financing estimates in other chapters. Among workers with group coverage, who would constitute 70 percent of enrollees in the single payer plan, average expenditures would change very little. Under Proposal 4, their average expenditures would increase just \$44 (3.4 percent).

³² Relative to Proposal 3, the payroll tax needed to finance the single payer plan is 0.52 percentage points higher for individuals and 2.34 percentage points higher for employers and self-employed workers.

Table V.3. Estimated Financing for Proposal 4, FY 2010

	Total (millions)	State Share (millions)
State obligation		
Total obligation	\$22,568.0	19,529.8
Single payer plan	\$16,097.8	\$16,097.8
Medicaid	\$5,964.4	\$ 2,926.1
New payroll taxes for state employees	\$505.8	\$505.8
Current expenditure		
Current expenditure	\$5,718.2	\$3,737.6
Medicaid and SCHIP	\$3,723.4	\$1,994.1
Basic Health	\$342.2	\$289.2
PEBB-State employees	\$1,395.7	\$1,228.2
PEBB-other	\$256.9	\$226.1
New State Revenue		
State obligation net of current spending		\$15,792. 2
Estimated payroll taxes (percent of Social Security wages)		\$15,792. 2
Employers (9.9 percent)		\$12,865.7
Employed workers (2.2 percent)		\$2,859.1
Self-employed workers (9.9 percent)		\$67.1

Source: Mathematica Policy Research.

Table V.4. Estimated Change in Average Individual Expenditures: Proposal 4, FY 2010

	Proposal 4					
	Single Payer Plan			Medicaid or SCHIP		
	Number of People (000s)	Change in Amount Paid	Percent Change	Number of People (000s)	Change in Amount Paid	Percent Change
Current coverage						
Group plan ^a	3103.3	\$44	3.4%	698.3	-\$344	-33.3%
Individual plan ^b	246.6	-\$1,477	-55.2%	38.5	-\$1,804	-78.2%
Medicaid or SCHIP	223.8	\$608	317.3%	480.0	\$40	18.9%
Other state program ^c	282.6	\$376	49.9%	47.1	\$260	136.0%
Uninsured	433.5	-\$442	-38.7%	109.3	-\$618	-61.8%

Source: Mathematica Policy Research.

Note: Enrollees in military or FEHBP plans are unaffected except for an assumed payroll tax on dependents' taxable earnings. The increase in average per person expenditures was \$404 (40 percent) for these individuals.

^aIncludes small and large groups, self-insured plans, association plans, COBRA, PEBB, and Basic Health.

^bIncludes WSHIP.

^cIncludes CHP, GAU, ADATA, Refugees, and AEM.

Some individuals currently enrolled in Medicaid or SCHIP—those with income above 150 percent or who are not categorically eligible—also would pay more.³³ These individuals would enroll in the single payer plan and, we assume, they (or their spouses or parents) would be subject to the payroll tax if they work. Average expenditures among these residents increase \$608—over three times the very low amounts that they currently pay (237 percent more).

Conversely, among residents with individual coverage or those who are uninsured, average expenditures would fall. Average expenditures among the 246,600 people who move from individual coverage to the single payer plan would fall by \$1,477, or 55 percent. Average expenditures among residents who are currently uninsured individuals would fall by \$442, or 39 percent. Many low-income residents would newly enroll in Medicaid through the single payer plan; average spending among these people would fall significantly—by \$1,804 (78 percent) among those who currently have individual coverage, \$618 (62 percent) among those who are currently uninsured, and \$344 (33 percent) among those who currently have group coverage.

For most individuals, the increase in spending (if any) would be modest—as indicated by the change in expenditures for the median individuals in Table V.5. Among all those whom the single payer plan would cover, the change in spending for the median person would range from a savings of \$1,605 per year (if currently covered by an individual plan) to an additional expenditure of \$158 per year (if no longer enrolled in Medicaid or SCHIP and their wages are taxable).

F. FINANCIAL IMPACT ON EMPLOYERS

In this section, we continue our assumption that Proposal 4 would be financed by a payroll tax on Social Security wages structured like that in Proposal 3. To improve comparability among the proposals in how employer contributions or tax payments for coverage are presented, we converted employers' presumed payroll tax liability for Proposal 4 (9.9 percent of Social Security wages) to an effective rate on total (Medicare) wages.

Assuming this particular financing method, employers would pay slightly less for health insurance under Proposal 4 (8.2 percent of payroll) than they do currently (8.3 percent) (Table V.5). But for employees that are currently covered, both small and large employers would pay substantially less than they pay currently. Currently, large and small employers currently contribute 11.4 to 12.6 percent of their covered workers' wages to finance health insurance; under Proposal 4 they would pay 8.1 to 8.4 percent.

³³ These individuals include currently enrolled pregnant women with income above 150 percent FPL (if they work or are the dependent of a worker) and the working parents of SCHIP-enrolled children or Medicaid-enrolled children above 150 percent FPL.

Table V.5. Estimated Change in Total Expenditures for the Median Individual: Proposal 4, FY 2010

	Proposal 4			
	Health Partnership		Medicaid or SCHIP	
	Number of People (000s)	Change in Amount Paid	Number of People (000s)	Change in Amount Paid
Current coverage				
Group plan ^a	3,103.3	-\$227	698.3	-\$393
Individual plan ^b	246.6	-\$1,605	38.5	-\$1,499
Medicaid or SCHIP	223.8	\$158	480.0	\$0
Other state program ^c	282.6	\$67	47.1	\$107
Uninsured	433.5	\$0	109.3	\$0

Source: Mathematica Policy Research.

Note: Enrollees in military or FEHBP plans were unaffected except for the payroll tax on dependents' earnings. The change in expenditures was \$0 for the median enrollee in these plans.

^aIncludes small groups, large groups, self-insured plans, association plans, COBRA, PEBB, and Basic Health.

^bIncludes WSHIP.

^cIncludes CHP, GAU, ADATA, Refugees, and AEM.

Table V.6. Estimated Change in Employer Expenditures for Premium Contributions as a Percent of Total Payroll: Proposal 4, FY 2010

	Current Contributions as a Percent of Payroll	Change in Contributions under Proposal 4 (millions)	Proposal 4 Contributions as a Percent of Payroll
Total	8.3%	-\$119.4	8.2%
Small employers			
All employees	5.4%	\$1,271	8.4%
Covered employees	12.6%	-\$2,332.0	8.4%
Self-insured and large employers			
All employees	8.4%	-\$365.8	8.1%
Covered employees	11.4%	-\$2,656.5	8.1%
Public employers (PEBB)	28.2%	-\$1,024.9	8.7%

Source: Mathematica Policy Research.

Overall (including payments for all workers, not only covered workers), large employers would pay slightly less for coverage than they do currently. However, small employers—who are less likely to offer coverage—would pay more, because they would contribute to coverage for all of their workers. As a result, small-employer contributions overall would rise from 5.4 percent of payroll currently to 8.4 percent under Proposal 4. Public employers' spending for PEBB would fall by the largest proportion: under Proposal 4, they would pay 8.7 percent of payroll, versus 28.2 percent for covered workers currently.

CHAPTER VI

PROPOSAL 5: THE GUARANTEED HEALTH BENEFIT PROGRAM

The guaranteed health benefit program (GHBP) would provide coverage for preventive care services and catastrophic health costs to most residents of Washington State.³⁴ A payroll tax on employers and workers would fund the program, and eligibility for Basic Health would be expanded to families with incomes less than 300 percent of the federal poverty level (FPL).

The GHBP would cover allowed charges for medically necessary care in excess of \$10,000 per individual per year, as well as preventive services—including annual physicals, screenings, and immunizations.³⁵ Individuals could purchase “basic coverage” for expenses below \$10,000 from private insurers, either through their employers or in the individual market.

A. KEY ASSUMPTIONS AND FINDINGS

Modeling the impact of the GHBP on the market for basic coverage and total health care expenditures in Washington entailed a number of assumptions, as follow:

- Policyholders do not consider dropping basic coverage in response to the availability of GHBP preventive and catastrophic coverage.
- Employers and workers share reduced premiums for basic coverage in proportion to the share of premiums that they currently pay.

³⁴ The Guaranteed Health Benefit Program is described in SB 6603 (2008). Individuals would be ineligible to participate only if they (1) are enrolled in a federal or federal-state program (Medicare, Medicaid, SCHIP, FEHBP, or military coverage); (2) have resided in the state for less than six months; or (3) are confined to a government-owned institution.

³⁵ SB 6603 (2008) also provides for one annual dental visit per year. In order to be consistent with other estimates of the cost of this proposal provided to the Office of the Insurance Commissioner, we assumed that the GHBP would not cover the cost of an annual dental visit.

- Insurers maintain the same loss ratio for basic coverage as for full coverage in the current case.
- The income effect on workers' demand for coverage net of the payroll tax is negligible.
- Because Basic Health premiums are unchanged, there is no new demand for the program among individuals who are currently eligible (but not enrolled). However, individuals currently enrolled in Basic Health may drop coverage to enroll in employer-sponsored insurance as the dependent of a newly covered working family member.
- Employers that currently offer coverage do not change their decisions about eligibility in response to GHBP. That is, workers who are currently ineligible for coverage in an offering firm remain ineligible.

The number of individuals without basic coverage would decline significantly under Proposal 5, as premiums declined—especially for older individuals and workers in firms where employees are on average older. Total expenditures would rise modestly.

Specific key findings include the following:

- Proposal 5 would reduce premiums for group and individual coverage significantly. Consequently, the number of people without basic coverage would fall by 63 percent, as some small employers newly offer coverage and many people respond to lower premiums by taking individual coverage. More than half of uninsured workers who had previously rejected an employer offer of coverage would enroll in group coverage at the new, lower premiums.
- Approximately 8,500 individuals newly eligible for Basic Health would enroll in that program.
- Young adults account for a disproportionate percentage of residents who would remain uninsured except for GHBP coverage. While young adults represent just 25 percent of the population under 65, they would account for 85 percent those without basic coverage. More than two-thirds of residents who would remain without basic coverage have incomes less than 100 percent FPL.
- Health care expenditures would rise by 2 percent, driven by the availability of benefits through the GHBP and the take-up of coverage by the currently uninsured. Out-of-pocket spending would fall by 26 percent.
- Most workers and other residents who currently have coverage would see lower expenditures for health care. Workers and dependents with group coverage (two-thirds of the population under 65 and nearly 90 percent of those with GHBP coverage) would see their average expenditures drop \$137.

- Employers that currently offer coverage would pay much less for health care. Small employers would see contributions for their covered workers drop from 12.6 percent of these workers' wages to 4.3 percent. Large insured and self-insured employers would see their spending for health care drop from 11.4 percent of covered workers' wages to 3.5 percent. Employers that do not offer coverage or that do not cover most of their workers would begin to pay 3.4 percent of the wages of their uninsured workers.

B. CHANGES IN PREMIUMS

Under Proposal 5, premiums for basic coverage would be less than premiums (for full coverage) are currently. Because the GHBP would cover both preventive and catastrophic care, plans offering basic coverage would no longer pay costs (net of enrollee cost sharing) above \$10,000.

Nearly all residents would experience lower premiums, but the difference would be greatest for older groups and individuals, who currently have the highest medical expenses. Currently, fewer than 14 percent of workers employed in firms with an average employee age under 45 have insured medical expenses that exceed \$10,000. This compares with 11 to 34 percent of workers with insured medical expenses that exceed \$10,000 in firms with average age 45 or older (Table VI.1).

Table VI.1 Estimated Percent of People with Medical Expenses Above \$10,000 and Premium Reductions by Age: Proposal 5, FY 2010

Age	Group Coverage		Individual Coverage	
	Percent with Expenditures Exceeding \$10,000	Average Premium Reduction	Percent with Expenditures Exceeding \$10,000	Average Premium Reduction
19–29	0.2%	25.8%	2.3%	10.9%
30–34	13.6%	27.7%	0.0%	6.4%
35–39	11.9%	26.0%	3.4%	8.3%
40–44	9.7%	25.7%	0.5%	13.3%
45–49	12.9%	45.6%	6.5%	19.3%
50–54	21.4%	47.3%	10.9%	24.5%
55–59	11.1%	43.3%	11.2%	14.1%
60–64	33.9%	44.0%	10.2%	18.4%

Source: Mathematica Policy Research.

Note: For group coverage, column 1 refers to the average age of employees in a group plan.

Reflecting this systematic difference in the probability very high medical expenses, workers in younger groups would see smaller reductions in premiums under Proposal 5 than workers in older groups. For workers in firms where the average age is under 45, premiums would be 26 to 28 percent lower than in the current case, compared with 43- to 47-percent lower premiums in firms where the average age is 45 or older.

Because individual coverage is underwritten (and cost sharing is typically greater), relatively few persons with individual coverage have very high insured medical expenses. Consequently, the effect of the GHBP on individual premiums would be less. Nonetheless, the same basic pattern would prevail—that is, younger individuals would see less change in their premiums than older individuals. Premiums for individuals under 45 would drop 6 to 13 percent, while premiums for individuals aged 45 or older would drop 14 to 25 percent.

C. CHANGES IN COVERAGE

Responding to lower premiums for basic coverage, the number of individuals who are uninsured (except for GHBP) would fall by 63 percent, as some small-group employers begin to offer coverage and many residents begin to purchase individual coverage (Table VI.2). Enrollment in small group plans would increase by 22 percent, while enrollment in individual coverage would increase by 34 percent. Enrollment in large-group and self-insured plans also would increase as more workers take up a standing offer of coverage when the required contribution is lower. Reflecting expanded eligibility for Basic Health, enrollment in that program would increase by 8 percent, adding 8,500 individuals with incomes between 201 and 300 percent FPL to the program.

Table VI.2. Estimated Number of People under Age 65 by Coverage Status: Proposal 5, FY 2010

	Current Case		Proposal 5		Percent Change from Current Case
	Number (000s)	Percent	Number (000s)	Percent	
Total	5,663.0	100.0%	5,663.0	100.0%	0.0%
Small groups	670.8	11.8%	816.9	14.4%	21.8%
Other employer plans ^a	3,224.6	56.9%	3,312.9	58.5%	2.7%
Individual coverage ^b	285.1	5.0%	383.2	6.8%	34.4%
Basic Health	106.0	1.9%	114.5	2.0%	8.0%
Medicaid or SCHIP	833.8	14.7%	833.8	14.7%	0.0%
Uninsured except for GHBP	542.8	9.6%	201.8	3.6%	-62.8%

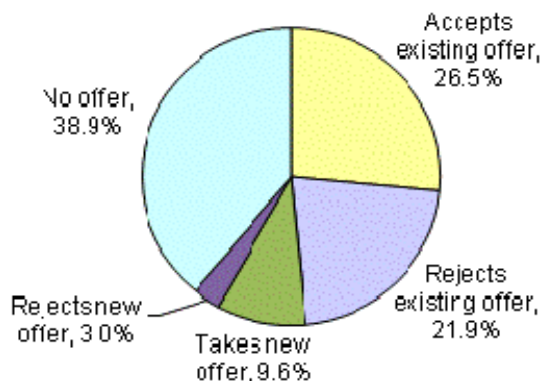
Source: Mathematica Policy Research.

^a Includes insured large groups, self-insured small and large groups, PEBB, FEHBP, military, and COBRA.

^b Includes WSHIP.

The response of currently uninsured workers to lower premiums for basic coverage is summarized in Figure VI.1. Some employers would begin to offer coverage, but the greater impact would occur as more workers take coverage when offered. Of the 311,700 currently uninsured workers, 37 percent would become insured through group coverage under this proposal. Most of these workers (27 percent) would accept an existing offer of coverage; about 10 percent would receive and take up a new offer of coverage.

Figure VI.1. Estimated Responses of Currently Uninsured Workers to Offers of Group Coverage: Proposal 5, FY 2010



Source: Mathematica Policy Research.

Note: "Accepts existing offer" indicates workers who, having previously turned down offers of coverage, would now take coverage at the reduced premium. "Rejects existing offer" is defined analogously.

1. Enrollment by Age

Because young adults would see relatively little change in premiums under Proposal 5, they would account for most residents who would remain uninsured. Adults aged 19 to 34 represent just 25 percent of the population under 65, but they would account for 85 percent of those without basic coverage under Proposal 5 (Table VI.3). In contrast, very few residents without basic coverage (about 1 percent) would be age 45 or older.

2. Enrollment by Family Income

Currently, higher-income residents are much more likely than lower-income residents to have an offer of employer-sponsored coverage. This would remain true under Proposal 5: approximately 58 percent of workers and dependents who would be enrolled in small-group coverage and 73 percent of those with other employer coverage would have income above 300 percent FPL (Table VI.4). It follows that most residents who would remain uninsured (except for GHBP) under Proposal 5 are at lower levels of income. More than two-thirds of those who would remain uninsured have income below 100 percent FPL; 92 percent have income below 200 percent FPL.

Table VI.3. Estimated Sources and Distribution of Coverage by Age of Enrollee: Proposal 5, FY2010

	Total (000s)	Percent of Individuals			
		Under Age 19	Age 19–34	Age 35–44	Age 45–64
Total	5,663.0	29.3%	24.7%	15.6%	30.4%
Small groups	816.9	19.3%	28.6%	17.2%	34.9%
Other employer plans ^a	3,312.9	25.9%	20.9%	17.7%	35.5%
Individual coverage ^b	383.2	14.0%	34.9%	15.0%	36.1%
Basic Health	114.5	0.0%	49.8%	22.5%	27.8%
Medicaid or SCHIP	833.8	68.8%	13.4%	7.5%	10.3%
Uninsured except for GHBP	201.8	6.4%	85.0%	7.2%	1.4%

Source: Mathematica Policy Research.

^a Includes insured large groups, self-insured small and large groups, PEBB, FEHBP, military, and COBRA.

^b Includes WSHIP.

Table VI.4. Estimated Sources and Distribution of Coverage by Family Income: Proposal 5, FY 2010

	Total (000s)	Percent of Individuals			
		0–100% FPL	101–200% FPL	201–300% FPL	Above 300% FPL
Total	5,663.0	19.6%	14.8%	11.4%	54.2%
Small groups	816.9	11.2%	11.5%	18.9%	58.4%
Other employer plans ^a	3,312.9	6.7%	8.8%	11.9%	72.5%
Individual coverage	383.2	20.7%	19.9%	11.6%	47.8%
Basic Health	114.5	57.9%	32.2%	9.9%	0.0%
Medicaid, SCHIP, Basic Health	833.8	61.1%	34.8%	3.7%	0.5%
Uninsured except for GHBP	201.8	68.5%	23.3%	5.6%	2.6%

Source: Mathematica Policy Research.

^a Includes insured large groups, self-insured small and large groups, PEBB, FEHBP, military, and COBRA.

3. Enrollment by Health Status

As uninsured residents gain health insurance coverage under Proposal 5, the average health status of the population enrolled in individual coverage, in particular, would change—consistent with the generally poorer health status of Washington’s uninsured population. One third (33 percent) of residents who would obtain individual coverage under Proposal 5 report good, fair, or poor health status, compared with just 23 percent of residents with individual coverage currently (Table VI.5). In contrast: the average health status among those with group coverage would change relatively little: self-reported health status among workers and dependents who

would gain group coverage under Proposal 5 is similar to that among currently insured workers and dependents.

Table VI.5. Estimated Number Percent of People Reporting Good, Fair, or Poor Health by Source of Coverage: Proposal 5, FY 2010

	Current Case		Proposal 5	
	Number (000s)	Percent of Total	Number (000s)	Percent of Total
Total	2,008.5	35.5%	2,008.5	35.5%
Small groups	204.4	30.5%	257.7	31.6%
Other employer plans ^a	928.8	28.8%	958.2	28.9%
Individual coverage ^b	65.4	22.9%	125.9	32.9%
Basic Health	62.7	59.2%	67.5	59.0%
Medicaid or SCHIP	481.1	57.7%	481.1	57.7%
Uninsured except for GHBP	266.1	49.0%	118.0	58.5%

Source: Mathematica Policy Research.

^a Includes insured large groups, self-insured small and large groups, PEBB, FEHBP, military, and COBRA.

^b Includes WSHIP.

While currently uninsured residents who would gain coverage under Proposal 5 are less healthy, on average, than those who are currently covered, they are nevertheless healthier than those who would remain without basic coverage. Consequently, 59 percent of those who would remain uninsured report good, fair, or poor health, compared with 49 percent currently.

D. SOURCES OF FUNDS

With increased coverage and no cost sharing for preventive and catastrophic care under Proposal 5, health care expenditures in Washington State would rise by 2 percent (Table VI.6). This increase reflects greater demand for preventive services, as well as greater demand for covered services among residents with relatively low health status and very high expenses—including many who gain coverage under Proposal 5. Out-of-pocket spending would fall by 26 percent.

As GHBP would pay for the most expensive care, the costs borne directly by employers, workers, and the State would drop. The cost of small group coverage would be 26 percent less, while the cost to large groups and self insured plans would be nearly 35 percent less. With the reduction in employee contributions for basic group coverage, federal tax expenditures for Section 125 plans also would fall. Spending for individual coverage would be only modestly lower (7 percent), reflecting the effect of underwriting on premiums in the current case. Spending on Basic Health and PEBB would drop significantly—by 36 and 42 percent, respectively.

Table VI.6. Estimated Total Expenditures by Source of Funds: Proposal 5, FY2010

	Current Case (millions)	Proposal 5 (millions)	Percent Change from Current Case
Total	\$24,945.4	\$25,531.4	2.3%
Affected plans and programs			
Small groups	\$2,919.5	\$2,154.0	-26.2%
Large groups and self-insured plans	\$11,064.9	\$7,210.3	-34.8%
Individual coverage ^a	\$546.0	\$505.9	-7.4%
Basic Health	\$342.2	\$218.7	-36.1%
PEBB	\$1,652.7	\$965.1	-41.6%
Guaranteed Health Benefit	\$0.0	\$7,101.5	na
Federal tax expenditures for Section 125 plans	\$604.7	\$403.6	-33.3%
Out of pocket	\$3,214.9	\$2,371.8	-26.2%
Unaffected plans and programs			
State financing of Medicaid and SCHIP	\$1,994.1	\$1,994.1	--
Federal programs ^b	\$2,606.5	\$2,606.5	--

Source: Mathematica Policy Research.

Note: All estimates include medical expenditures and the net cost of private insurance. Other governmental and private costs for plan administration are excluded. Medicaid and SCHIP allocations assume FY2009 federal matching rates. "na" indicates no change calculated for a new program.

^a Includes WSHIP.

^b Includes FEHBP, military, and federal financing of Medicaid and SCHIP.

Net of current State expenditure, Proposal 5 would result in an additional state expenditure of \$6.6 billion (Table IV.7) Financing for this expenditure would rely on a graduated payroll tax levied on total (Medicare) wages. Four payroll tiers define the payroll tax rate that employers would pay, ranging from total payroll less than \$100,000 (tier 1) to payroll that exceeds \$1 million (tier 4); most employers are in tier 4 and would pay the highest rate on payroll. We estimate that the tax rates on total payroll that would be needed to finance Proposal 4 range from 2.2 percent (in tier 1) to 3.7 percent (tier 4).

Workers also would pay a tax on wages. We scaled this rate so that the ratio of employer to employee payments relative to wages would never be less than 2 to 1. The estimates that follow assume that workers pay a payroll tax of 0.7 percent on their total wages.

E. FINANCIAL IMPACT ON INDIVIDUALS

For most workers and other residents who currently have coverage, annual expenditures on health care would be lower under the GHBP than in the current case. The savings represent a combination of lower premiums and out-of-pocket costs (both resulting from coverage of preventive care and catastrophic costs by the GHBP) partly offset by the burden of the payroll tax. In dollar terms, the savings would be greatest for workers either switching from individual coverage to group coverage (\$755 per year) or retaining individual coverage (\$623 per year) (Table VI.8). Those with group coverage (constituting nearly two thirds of the population under

65 and nearly 90 percent of those with GHBP coverage) would save \$137 per year on average. Those enrolled in Basic Health would experience the largest percentage decline in average expenditures: 32 percent.

Table IV.7. Estimated Financing for Proposal 5, FY 2010

	Total (millions)	State Share (millions)
State obligation:		
Total obligation	\$12,223.9	\$10,350.9
Medicaid and SCHIP	\$3,723.4	\$1,994.1
Basic Health	\$218.7	\$184.9
PEBB - State Employees	\$902.5	\$794.2
PEBB - Other	\$62.6	\$55.1
Guaranteed Health Benefit Plan	\$7,101.5	\$7,101.5
New payroll taxes for state employees	\$215.2	\$221.2
Current expenditure		
Medicaid and SCHIP	\$5,718.2	\$3,737.6
Basic Health	\$3,723.4	\$1,994.1
PEBB - State Employees	\$342.2	\$289.2
PEBB - Other	\$1,395.7	\$1,228.2
PEBB - Other	\$256.9	\$226.1
State obligation net of current spending		\$6,613.3
New revenue:		
Estimated payroll taxes (percent of Medicare wages)		\$6,613.3
Employed workers (0.7 percent)		\$1,151.4
Employers and self-insured workers (2.2 to 3.7 percent)		\$5,461.9

Source: Mathematica Policy Research. Projected nominal wages are derived from the Office of Financial Management, State of Washington (<http://www.ofm.wa.gov/trends/tables/fig102.asp>, accessed 12/15/2008). Basic Health financing projections were provided by the Health Care Authority (May 22, 2008).

Notes: FY2010 wages are the average of CY2009 and CY2010 projected wages.

While per person spending would decline for most groups, it would increase \$857 (75 percent) per year for the 341,000 currently uninsured individuals who would obtain new coverage. Most of the increase would be attributable to spending on premiums, especially premiums for individual coverage. (Working dependents with military/FEHBP coverage would also spend \$111, or 11 percent, more, attributable entirely to the payroll tax.)

Table VI.8. Estimated Change in Average Individual Expenditures: Proposal 5, FY 2010

Current Coverage	Proposal 5					
	Same Coverage (Basic)			Same Coverage (Basic)		
	Number of People (000s)	Change in Amount Paid	Percent Change	Number of People (000s)	Change in Amount Paid	Percent Change
Group plan ^a	3,695.6	-\$137	-10.8%	na	na	na
Individual plan ^b	187.8	-\$623	-5.0%	97.3	-\$755	-24.1%
Basic Health	106.0	-\$207	-32.0%	na	na	na
Uninsured except for GHBP coverage	201.8	-\$204	-19.1%	341.0	\$857	75.3%

Source: Mathematica Policy Research.

Note: Enrollees in military or FEHBP plans are unaffected except for the payroll tax on dependents' taxable earnings. The increase in annual per person expenditures was \$111 (11.0 percent) for this group. Similarly, Medicaid/SCHIP enrollees were responsible for payroll taxes that increase average expenditures by \$49 (24.9 percent) for this group.

^aIncludes insured small groups, large group or self-insured plans, association plans, COBRA, and PEBB.

^bIncludes WSHIP.

The median persons with group, individual, and Basic Health coverage would all spend less under the GHBP, with savings ranging from \$40 per year for the median person with group coverage to \$787 for the median worker switching from individual to group coverage (Table VI.9). In contrast, the median currently uninsured individual would pay more. Those who would respond to lower premiums by taking basic coverage would pay substantially more (\$1,277)—largely reflecting their premiums for new coverage, which is more likely to be individual coverage than group (data not shown). Among individuals who remain uninsured (except for GHBP coverage), relatively few have costs that exceed the GHBP's catastrophic threshold. Therefore, despite new coverage for primary and catastrophic care from the GHBP, the median uninsured individual would pay slightly more (\$53)—although on average, individuals who remain uninsured would pay less.

F. FINANCIAL IMPACT ON EMPLOYERS

Employers that currently offer coverage would pay much less for health care. Small employers would see contributions for their covered workers drop from 12.6 percent of these workers' wages to 4.3 percent (Table VI.10). Large insured and self-insured employers would see their spending for health care drop from 11.4 percent of covered workers' wages to 3.5 percent. Public employers—who characteristically pay a much larger proportion of compensation in benefits—would see the greatest savings: those who participate in PEBB would see their contributions drop from 28.2 percent to 3.5 percent.

Table VI.9. Estimated Change in Total Expenditures for the Median Individual: Proposal 5, FY 2010

Current Coverage	Proposal 5			
	Same Coverage (Basic)		New Coverage (Basic)	
	Number of People (000s)	Change in Amount Paid	Number of People (000s)	Change in Amount Paid
Group plan ^a	3,695.6	-\$40	na	na
Individual plan ^b	187.8	-\$530	97.3	-\$787
Basic Health	106.0	-\$124	na	na
Uninsured except for GHBP coverage	201.8	\$53	341.0	\$1,277

Source: Mathematica Policy Research.

Note: Coverage under Proposal 5 refers to coverage for services not otherwise paid by the GHBP. Enrollees in military or FEHBP plans were unaffected except for the payroll tax on dependents' taxable earnings. The change in expenditures was an increase of \$78 for the median enrollee in these plans. Expenditures for the median Medicaid/SCHIP enrollee increase \$16 due to payroll taxes.

^aIncludes small groups, large groups, self-insured plans, association plans, COBRA, and PEBB.

^bIncludes WSHIP.

Table VI.10. Estimated Change in Employer Expenditures for Premium Contributions as a Percent of Payroll: Proposal 5, FY 2010

	Current Contributions as a Percent of Payroll	Change in Contributions under Proposal 5 (millions)	Proposal 5 Contributions as a Percent of Payroll
Total	8.3%	-\$7,529.4	3.5%
Small employers			
All employees	5.4%	-\$872.2	3.4%
Covered employees	12.6%	-\$1,541.6	4.3%
Self-insured and large employers			
All employees	8.4%	-\$5,363.4	3.4%
Covered employees	11.4%	-\$6,224.8	3.5%
Public employers (PEBB)	28.2%	-\$1,073.0	3.5%

Source: Mathematica Policy Research.

Notes: Estimates include contributions to premiums and new payroll tax liability. Federal employment (not shown) is not affected and assumed not to be subject to payroll taxation.

Employers that do not offer coverage or that do not cover most of their workers would, of course pay more under Proposal 5—as these workers obtained coverage from the GHBP for primary and catastrophic care. Small employers would begin to pay 3.4 percent of wages paid to workers not now insured (data not shown, but equal to the average across all small groups). Large employers and self-insured employers also would begin to pay 3.4 percent of the wages of their uninsured workers.

CHAPTER VII

COMPARATIVE RESULTS

In this chapter, we summarize and compare the key results of the proposals presented in Chapters II through VI. Specifically, we consider the relative impacts of each proposal on:

- The number of residents who would remain uninsured—and consequently, the likely impact on hospital charity care
- The scope of coverage available to persons with coverage and potential impacts on consumer choice
- Estimated economic impact—specifically, the net cost of the proposal to employers and the level of federal expenditures in the state

Finally, as requested by the Legislature, we briefly consider a number of topics that relate to the proposals' potential impacts on the value of care provided in Washington State and incentives to improve cost effectiveness and quality.

A. CHANGES IN COVERAGE AND TOTAL COST, AND IMPACTS ON HOSPITAL CHARITY CARE

The proposals vary significantly in their impacts on the number of people who would gain coverage—or conversely, who would either remain or become uninsured. Proposal 1 would have relatively little impact on the number of uninsured, while Proposal 2 would reduce the number of uninsured by nearly three-quarters—to 2.7 percent of the population under age 65 (Table VII.1). Proposals 3 and 4 would cover all residents under age 65.

Each of the proposals would entail change in total expenditures—as well as changes in the distribution of cost among payers, as summarized in Table VII.1. However, none would involve large increases in cost, and some would reduce total expenditures for health care:

- Proposal 1 would authorize carriers to sell reduced-benefit plans in the small group and individual markets and change the rating of young adults for all products. This proposal would reduce the number of uninsured residents by about 10 percent, due primarily to re-rating individual coverage for young adults to favor those aged 24 to 34; 8.6 percent of the nonelderly population would remain uninsured. The low coverage impact of this proposal would not appreciably change total spending for health care.

Table VII.1. Percent Uninsured and Total Expenditure, and Percent Change: Proposals 1-5, FY 2010

	Percent Uninsured	Total Expenditure (billions)	Percent Change in Uninsured	Percent Change in Total Expenditure
Current case	9.9%	\$24.9	nc	nc
Proposal 1: Reduced regulation	8.5%	\$25.0	-11.1%	0.1%
Proposal 2: Connector	2.7%	\$24.6	-72.0%	-1.3%
Proposal 3: Health Partnership	0.0%	\$24.1	-100.0%	-3.6%
Proposal 4: Single payer	0.0%	\$25.9	-100.0%	3.8%
Proposal 5: Guaranteed Health Benefit	3.6% ^a	\$25.5	-62.8% ^a	2.3%

Source: Mathematica Policy Research

Note: ""nc" indicates no change.

^a All residents, if not enrolled in a federal or DSHS program, would have GHBP coverage; "uninsured" residents would have no basic coverage other than preventive services under the GHBP.

- Proposal 2 would form a Health Insurance Connector as the intermediary for all small group and individual coverage in a merged market for these products. Small-group workers would have unrestricted choice among all Connector products, and they would be rated in the Connector just as individuals would be (that is, list-rated). Carriers would rate young adults under age 30 as a single rate class; otherwise rate bands in the current market would remain unchanged. Basic Health would be folded into the Connector; all individuals and small group workers and dependents with family income below 200 percent FPL would receive premium subsidies equivalent to that in Basic Health currently. As in Massachusetts, all residents would be required to obtain coverage. This proposal would reduce the number of uninsured by 72 percent. Reflecting substantial coverage displacement (many older workers would drop group coverage when it is list-rated, while many uninsured young adults would enroll in individual coverage), total expenditures would drop slightly, by about 1 percent.
- Proposal 3 would form a Health Partnership to make comprehensive health coverage available to all non-institutionalized residents. Eligibility for Medicaid would be expanded, but otherwise, the Health Partnership would replace all other state-funded programs that currently provide health coverage. Enrollment in the Health Partnership would be payroll-tax funded; enrollees could "buy up" to a more costly plan in the

Health Partnership by paying a premium. Benefits would be uniform, similar to those currently available through PEBB. All eligible residents would be auto-enrolled in the Health Partnership and, therefore, insured. In addition, all residents eligible for Medicaid would be referred to that coverage. Reflecting lower reimbursement rates in the Medicaid program relative to current commercial rates, total expenditures would drop slightly, by 3 to 4 percent.

- Proposal 4 would form a statewide single payer plan. All residents under age 65 would be automatically enrolled, if not otherwise enrolled in a federal program. Covered benefits would be uniform and similar to those currently available through PEBB. Eligibility for Medicaid would be extended to all categorically eligible residents with income below 150 percent FPL; the single-payer plan would provide wrap-around coverage for Medicaid services not covered in the PEBB benefit design. The single payer plan would not differentiate Medicaid enrollees except to provide additional wrap-around coverage for some services; therefore, we assume that providers would be reimbursed for Medicaid enrollees at the same rates as for other enrollees in the single-payer plan. This proposal would cover all residents; no resident would remain uninsured. Reflecting commercial payment rates to health care providers for Medicaid enrollees on the same basis as all other covered residents, total expenditures would increase moderately, by about 4 percent.
- Proposal 5 would establish a Guaranteed Health Benefit Plan (GHBP), which would provide coverage for preventive and catastrophic services for all noninstitutionalized residents if not enrolled in a federal or DSHS program. The GHBP would cover allowed charges for medically necessary care in excess of \$10,000 per individual per year, as well as preventive services—including annual physicals, screenings, and immunizations. A payroll tax on employers and workers would fund the program, and eligibility for Basic Health would be expanded to families with incomes less than 300 percent FPL. This proposal would reduce the proportion of residents who are uninsured (except for GHBP) by nearly 63 percent; about 4 percent of the population under age 65 would remain uninsured. Reflecting the take up of new coverage and greater use of services that GHBP would fully cover, total expenditures would rise slightly, by about 2 percent.

The Legislature requested that we consider how each of the proposals might affect the demand for hospital charity care. In fact, each might affect charity care in somewhat different ways:

- Proposal 1 would target young adults who in general are low users of care. However, because they are more likely to be uninsured, they may be relatively high users of charity care. Nevertheless, because Proposal 1 would have little impact on coverage, it probably would have little impact on current levels of charity care
- Proposal 2 would substantially reduce the number of uninsured, especially among low-income residents not eligible for Medicaid or SCHIP. However, reflecting the transition to defined contribution health plans in small firms that offer coverage, older workers whose incomes exceed levels eligible for subsidy would be at greater

risk of being uninsured. As a result, Proposal 2 could reduce the use of hospital charity care, but increase hospital bad debt, when uninsured older residents present for care.

- Proposal 3 would provide coverage to all residents under age 65, and would greatly expand enrollment in Medicaid or SCHIP. However, it would retain these programs' relatively low reimbursement rates. To the extent that Medicaid and SCHIP reimbursements do not cover hospitals' cost of providing care, Proposal 3 might have surprisingly little net impact on current levels of hospital charity care, when defined to include unreimbursed cost for low-income patients.
- Proposal 4 would cover all residents under age 65, and also increase Medicaid reimbursement to commercial rates. As a result, it would probably have the greatest impact on hospital charity care, effectively eliminating hospital charity care for residents under age 65.
- Proposal 5 would fully cover care above \$10,000 per person per year for, in effect, all residents not otherwise covered for these services. As a result, it could eliminate much hospital charity care—to the extent that it relates high-cost cases. However, it would not address the use of lower-cost outpatient care by patients who would, except for GHBP, remain uninsured.

B. SCOPE OF COVERAGE AND CONSUMER CHOICE

Most of the proposals would provide access to comprehensive coverage, equivalent to either current small-group coverage (Proposal 2) or coverage that is currently available in PEBB (Proposals 3 and 4).

Proposal 1 is the exception. It would allow insurers to offer to small employers “bare bones” plans that would be exempt from a number of mandated benefits, including:

- Services provided by various licensed providers
- Services related to various specific conditions (including diabetes and chemical dependency)
- Various specific services (including preventive and diagnostic services, and emergency medical care)
- Women's health care services (including maternity care, and medically appropriate preventive and follow-up care).

Similarly, Proposal 1 would allow insurers to sell plans to individuals under age 35 that would exclude coverage of chiropractors as well as coverage of some services (such as prostate screening, colorectal exams, and mental health services).³⁶

The proposals would affect consumer choice in different ways:

- Proposal 1 would cause the least change, with respect either to choice among health plans or among providers. While it would allow the sale of reduced benefit plans that are not currently available in the market, employer offer and take up of these plans would, at least initially, be quite low. For workers and individuals who enroll in reduced-benefit plans, Proposal 1 could reduce consumer choice among both providers and treatment options, as well as among plans (including reduced benefit plans) with different cost sharing options.
- Proposal 2 would allow workers insured in small group plans to choose among any plans offered through the Connector. Individuals also would potentially have greater choice of plans: coverage would be guaranteed issue and, like small-group workers, individuals could choose among any of the plans offered through the Connector. While a limited number of plan designs would be offered through the Connector (we assumed the 12 HIP benefit designs), we found no evidence that Massachusetts residents perceive their Connector (which also limits the plans that are available) as significantly limiting plan choice or that they enroll outside the Connector to obtain greater choice. There is no obvious reason that consumer choice among providers would be different from the current case among residents who are currently insured; residents who gain coverage probably would gain greater choice among providers and treatment options.
- Proposal 3 would offer residents a number of plan choices in most if not all areas of the state, equivalent to the plan choices currently available in PEBB. Enrollees in the Health Partnership presumably would have the same choices of providers as PEBB enrollees do currently. Because all residents who are now uninsured (and many or all who are underinsured) would obtain comprehensive coverage, their options for care would be significantly expanded. However, Medicaid enrollees might have greater difficulty in finding providers to serve them, as the number of Medicaid enrollees increased and the program maintained the current, low level of provider reimbursement.
- Proposal 4 would replace private insurers with a single payer system with a uniform benefit design; residents would no longer have choice among health plans. However, like Proposal 3, Proposal 4 would provide all residents who are now uninsured (and many or all who are underinsured) with comprehensive coverage, significantly expanding their options for care. The single payer plan presumably

³⁶ While proposal 1 would also allow carriers to sell products that exclude coverage for preventive services and prescription drugs, our estimates assume that carriers would continue to cover preventive services as well as generic drugs.

would allow enrollees to seek care from any licensed provider, and it would pay the same rates for all enrollees—including those enrolled in Medicaid. Thus, Proposal 4 could maximize consumer choice among providers. However, unless the single payer system focused on developing regional and state-wide systems of integrated care management, consumers could lose the option to obtain that service.

- Proposal 5 would provide preventive and catastrophic coverage for the vast majority of residents who are either privately insured or uninsured. There is no obvious reason that it would affect the range of plans currently available to consumers, either as groups or individuals. By reducing premiums for basic coverage, Proposal 5 would encourage the purchase and take-up of private insurance, expanding options for care among the significant number of uninsured residents who would gain coverage.

C. ESTIMATES OF ECONOMIC IMPACT

The primary source of economic impacts associated with the proposals would relate to any change in federal spending in Washington State, either spending for programs (Medicaid or SCHIP) or reductions in households' federal tax liability (sometimes called federal tax expenditures) related especially to changes in employer-based coverage. Additional state spending for Medicaid and SCHIP draws federal matching funds to support local delivery of health care services—with positive economic impacts. Also, when households shelter a higher percentage of premiums and health care expenditures from federal taxation, they are able to spend more on other goods and services, stimulating economic activity.

A change in spending within the state by government, employers, or households can have important redistributive effects, but little net impact on measures of total economic activity. If employer-paid premiums are redirected toward other economic activity (assuming no significant federal tax consequences), the immediate net economic impact is low. Similarly, changes in employee payments for health insurance, when not tax sheltered, may increase disposable income available for other goods and services, but with no net impact on economic activity. Of course, both employers and households could direct reduced spending for health insurance and health care services into investment that, over time, would yield an increase in net economic activity. The scope of this report, however, does not allow for consideration of such longer-term potential consequences.

Changes in federal spending and tax expenditures associated with each proposal are reported in Table VII.2, together with the estimated change in economic output that would result.³⁷ Each of the proposals would have very different impacts on net federal spending, and therefore, on immediate economic activity (measured as the production of paid goods and services, or economic output) in Washington:

- Proposal 1 would neither affect any federal program nor induce significant new offer of employer based coverage. As a result, it would have no impact on federal

³⁷ Estimates of changes in economic output are based on the Bureau of Economic Analysis (BEA) Regional Input-Output Modeling Systems (RIMS-II), as described in Appendix C.

spending in the state, and consequently, no particular impact on overall economic activity.

Table VII.2. Estimated Change in Aggregate Economic Output: Proposals 1 through 5, FY 2010 (millions)

	Proposal 1: Reduced regulation	Proposal 2: Connector	Proposal 3: Health Partnership	Proposal 4: Single payer	Proposal 5: Guaranteed health benefit
Total change in economic output	\$ -	\$536.6	3,914.5	\$2,063.3	\$ (291.9)
Change in federal program expenditures	\$ -	\$ -	\$2,026.4	\$1,308.9	\$ -
New economic output	\$ -	\$ -	\$4,553.4	\$2,941.1	\$ -
Change in federal tax expenditures	\$ -	\$369.7	\$ (440.1)	\$ (604.7)	\$ (201.1)
New economic output	\$ -	\$536.6	\$ (638.9)	\$ (877.8)	\$ (291.9)

Source: Mathematica Policy Research.

- Proposal 2 would result in reduced total expenditures on health care as young workers and dependents would gain coverage through the Connector, and older workers and dependents would drop coverage in response to list-rated coverage. This difference in total expenditure would represent a redirection of spending to other goods and services, producing little net change in economic activity. However, households' aggregate federal tax liability would drop by \$370 million, due to greater use of Section 125 plans to shelter premiums. This federal tax expenditure would stimulate an estimated \$536 million in new economic activity.
- Proposal 3 would have the greatest impact on economic activity in Washington. By significantly expanding Medicaid enrollment, it would increase federal spending by more than \$2 billion, stimulating \$4.6 billion in new economic activity. Because households would see an increase in aggregate taxable income, federal tax payments would rise (by \$440 million), reducing economic activity in the state by an estimated \$640 million. However, the increase in federal expenditures related to greater Medicaid enrollment would substantially exceed the reduction in federal tax expenditures. On net, Proposal 3 would increase economic activity in Washington by an estimated \$3.9 billion.
- Proposal 4 also would generate increased federal spending—due both to the expansion of Medicaid eligibility to many more low-income adults and also to an increase in provider reimbursement rates to current commercial rates. However, additional federal spending under Proposal 4 (\$1.3 billion) would be about one-third less than that under Proposal 3 (\$2.0 billion), despite much higher Medicaid reimbursements under Proposal 4. Compared with Proposal 3, fewer residents would be enrolled in Medicaid, and both federal and state spending for the program would be less. As a result, additional economic activity, while significant (\$2.9 billion), would be less than under Proposal 3 (\$4.5 billion). In addition, many

residents' would see an increase in taxable income, generating an increase in aggregate federal tax payments (\$605 million) that would decrease economic activity by nearly \$880 million. Nevertheless, on net, Proposal 4 would stimulate an estimated \$2.1 billion of new economic activity.

- Proposal 5 would have a relatively small impact on economic activity in the state. Its effects would be due only to a change in households' federal tax liability. By reducing the premiums that employees pay toward premiums (and, therefore, tax-sheltered income), Proposal 5 would increase households' aggregate taxable income and, therefore, their federal tax liability. Federal tax payments would increase by an estimated \$200 million, reducing economic activity by about \$292 million.

D. IMPROVING COST EFFECTIVENESS AND QUALITY

As requested, we reviewed six topics of particular interest to the Legislature, in order to provide additional background for comparing the proposals. These topics are:

- Improved health outcomes
- Evidence-based services
- Prevention and early intervention
- Chronic disease management
- Medical homes
- Financial incentives for providers and consumers

While each topic is important in its own right, they are strongly interrelated. Taken together, they provide important insights into the challenge of improving health care quality and cost-effectiveness while expanding coverage.

We prepared an Issue Brief for each topic; these are included in Appendix C. Here we briefly discuss the implications of the proposals with respect to the concerns described in each Issue Brief.

1. Improved Health Outcomes

There is a strong relationship between health insurance coverage and better health outcomes for both children and adults. Insured people generally experience better health outcomes—overall, with respect to care provided in particular settings, and for a wide range of acute and chronic health conditions. Conversely, people who are uninsured generally receive less care—either preventive care or care for acute or chronic conditions—and they have limited access to effective care management.

Insurance should make it easier for people to obtain health services that are known to produce better outcomes—presuming that it covers services that are known to be effective. These would include specific preventive and screening services, drug benefits, and disease management programs that have been proven effective. Insurance that covers only basic acute care needs or that leaves individuals or families with large out-of-pocket costs can keep people with greater health care needs or low incomes from obtaining effective care.

In addition, the potential for making significant improvements in population health is greater if coverage is widespread and continuous. Adequate insurance coverage can promote continuity of care and play an important part in reducing disparities in health care among the population.

In general, the proposals that would generate the greatest increase in the number of persons who are insured—with relatively comprehensive benefits and affordable cost sharing—would probably have the greatest impact on health outcomes. Specifically:

- Proposal 1 would have little impact on coverage and, therefore, would contribute little to improved health outcomes. Most Washingtonians who are uninsured would remain so. Changes in rating of young adults would encourage the youngest adults to move to policies with greater cost sharing or reduced benefits—including policies that would omit coverage for preventive services and prescription drugs. Neither result would suggest improved health outcomes.
- Proposal 2 would substantially increase health insurance coverage. Most of the population that is now uninsured would enroll in commercial small group or individual coverage, including especially young adults with low income who would qualify for a subsidy to enroll in coverage through the Connector. However, many older residents who are now uninsured would drop coverage under Proposal 2, and would become uninsured. On balance, health outcomes may not be improved.
- Both Proposals 3 and 4 would ensure that every resident is enrolled in comprehensive coverage. In addition, under Proposal 3, the Health Partnership would cap out-of-pocket costs for low-income families as a percentage of income and greatly expand eligibility for Medicaid or SCHIP coverage. Proposal 4 also would expand Medicaid coverage, especially for low-income adults. Presuming a reasonably adequate supply of services—especially for those enrolled in Medicaid—either proposal could generate a significant improvement in health outcomes. On net, because Proposal 4 would increase reimbursement to Medicaid providers to commercial levels, it might provide the most vulnerable residents somewhat better access to care and, therefore, offer better prospects for improving health outcomes.
- Proposal 5 would ensure that every resident has access to primary care services, and also ensure that very high expenditures (over \$10,000 per year) are covered. Adequate primary care that would increase early detection of disease may improve health outcomes, if follow-up care is also accessible. Many residents who are now uninsured would respond to the much lower premiums under Proposal 5 by buying

2. Evidence-Based Care

As health care costs continue to grow, so has the importance of improving the effectiveness and efficiency of health care delivery. In large part, this means reducing the underuse, overuse, and misuse of alternative medical treatments and technologies. Empirical evidence based on comparative effectiveness research can guide clinical practice, and as well as consumer and payer decisions about seeking and paying for health care.

Important initiatives to put evidence-based medicine into practice are already underway in Washington State and across the country. However, efforts to encourage evidence-based practice have produced different results in different settings and localities, and among different populations. To be successful, these efforts entail new approaches to provider and consumer education as well as investment in developing new information and reporting systems.

As the proposals are currently specified, only Proposal 3 would focus on the delivery of evidence-based care. It would establish an administrative process intended to promote evidence-based practice and exempt certain evidence-based services from cost sharing. Other proposals might incorporate similar provisions, and in that event, those that would provide the most comprehensive coverage for the largest number of people through a common administrative system—Proposals 3 and 4—probably would have the greatest chance of improving the delivery of evidence-based services. For example:

- Under Proposal 3, the Health Partnership could require carriers to demonstrate that their network of providers adheres to accepted evidence-based protocols as a condition for participating in the Partnership.
- Under Proposal 4, the single payer plan could require adherence to accepted evidence-based protocols as a basis for reimbursing providers.

Under Proposal 5, the GHBP might also focus on the delivery of evidence-based care, specifically for preventive services and high-cost diagnoses. The GHBP would pay for most of these services and would be well-positioned to develop targeted initiatives expanding evidence-based practice. Assuming that (like Medicare) GHBP would contract with carriers as intermediaries, it might negotiate with these carriers to adopt consistent policies and incentives, encouraging a continuum of evidence-based practice for care below the GHBP threshold.

The Connector (Proposal 2) also could pursue the measures to encourage evidence-based care, similar to the Health Partnership (Proposal 3). However, because it would cover less than one-quarter of the population under age 65 under a common administrative system capable of instituting and enforcing consistent incentives for evidence-based practice, it potentially could have much less impact than either the Health Partnership or the single payer plan.

Nevertheless, even with a common administrative system, the effort that would be required to establish criteria for participating plans and providers related to evidence-based practice should not be minimized. A great deal of effort would remain to build the necessary coalition among all players in the delivery system, develop and agree on standards and guidelines for care, develop common data and reporting systems, and develop common goals and the payment systems that would support them.

3. Preventive Services

Clinical preventive services can substantially improve health outcomes. Expanding health coverage could increase use of appropriate preventive care, if preventive services are covered with little or no cost sharing.

Evidence of clinical effectiveness is critically important for guiding the delivery of cost-effective preventive care. Some preventive services (for example, appropriate vaccinations) are known to reduce costs, but others do not reduce cost and some increase costs. Some preventive services are known to be effective for particular patient populations—but they can cause more harm than benefit for patients at low risk of developing a disease.

Most of the proposals would provide comprehensive coverage of preventive services. The exception is Proposal 1, which would authorize carriers to sell to young adults policies that omit coverage of many preventive services, including mammograms, prostate cancer screening, and coverage for women's health care services—including medically appropriate preventive care and follow-up visits. However, it is unlikely that carriers would sell products that exclude coverage for all of the services that Proposal 1 would allow—and for preventive services, in particular.³⁸

4. Chronic Disease Management

Disease management (DM) programs identify patients with costly chronic conditions (such as diabetes or asthma) and encourage them to follow good self-care behaviors. Some programs focus providers and patients on adherence to specific evidence-based care guidelines. DM programs have multiplied quickly, but there is no consensus that chronic disease management generally improves health outcomes or reduces costs.

The potential for improvements in both quality and cost-effectiveness is large; some believe that there is potential also for cost savings. Observing that relatively few people with chronic illnesses account for most health care costs, they reason that chronic disease management might reduce health expenditures (and also improve health outcomes) by avoiding the need for hospitalization and other acute care.

While Proposal 3 includes provisions that would provide enrollees with information about chronic disease management programs, none of the proposals otherwise explicitly addresses chronic disease management. Nevertheless, most of the proposals could incorporate provisions at least as strong as those in Proposal 3. In that event, those that would serve most residents

³⁸ See: Milliman, Inc., Report to the Office of the Insurance Commissioner: Blue Ribbon Commission on Marketplace Reaction to Potential Changes in Benefit Mandate and Rate Regulations, January 2007.

through a common administrative system—Proposals 3 and 4—probably would have the greatest chance of encouraging widespread and consistent use of chronic disease management. Of course, even within a common administrative system, considerable effort still would be required to build the necessary coalitions, standards and guidelines, common data and reporting systems, and payment systems.

In contrast to Proposals 3 and 4:

- As it is currently specified, Proposal 2 might have a uniquely perverse effect on the prospects for improving chronic disease management, if older workers—who are more likely to have chronic diseases—drop coverage in response to the re-rating of association and small group coverage in a merged market.
- Proposal 1 would have little impact coverage and offer no new opportunities to encourage chronic disease management.
- Proposal 5 might have little impact on chronic disease management but could be uniquely vulnerable to the system’s continued failure to manage chronic diseases effectively. It would pay for the highest cost care, but would have no necessary impact on the interval of care between preventive services and catastrophic care. However, if the GHBP contracted with carriers as intermediaries, it might also negotiate with them to improve chronic care management—reducing GHBP’s financial exposure while also improving health outcomes.

5. Medical Homes

A medical home is a source of comprehensive primary care. It focuses on helping patients to manage their health care better. The medical home model, in its fullest application, uses integrated data systems and performance reporting to continuously improve access to care, patient and provider communication, and quality.

This medical home model is central to current efforts to reform health care. It is seen as addressing the fragmentation, inefficiency, and uneven quality of care that in general characterizes the current health system. By improving prevention and continuity of care, medical homes might also reduce costs.

To convert their practices to the medical home model, primary care providers must overcome significant obstacles, including limits on their own time, the need to build electronic records systems, high standards to qualify as a medical home, and potential resistance from consumers and specialty providers. Additional costs might outweigh the savings that medical homes generate by reducing unnecessary treatment, avoidable hospitalizations, duplicative testing, or other inefficiencies.

Comprehensive models of medical homes that focus on everyone in the community—children, adults, and the elderly—are just now being evaluated. Emerging evidence about whether medical homes are effective and the features that can improve effectiveness should help states build programs and incentives to expand the supply and use of medical homes.

While Proposal 3 would provide assistance to enrollees to select a medical home, none of the proposals otherwise address the development of medical homes. As with incentives to promote evidence-based care and use of chronic disease management, the proposals that would serve most residents through a common administrative system—Proposals 3 and 4—might have the greatest chance of fostering the development of medical homes. In either proposal, the administrative agency (for the Health Partnership or the single payer system, respectively) could develop consistent funding and incentives for all participating health plans and/or providers.

Because Proposal 3 would probably encourage contracting with provider networks and/or multi-specialty group practices by plans that participate in the Health Partnership, it might offer greater potential for the development of medical homes—presuming that the efforts required to build the necessary coalitions, agreements, and systems are actively pursued and adequately funded. In contrast, Proposal 4 (as it is currently specified) would establish a fee-for-service model with no clear incentives to develop medical homes.

6. Financial Incentives

Carefully-designed financial incentives can promote the effective use of health services and discourage the use of marginally effective or inappropriate services. However, to develop provider and consumer trust in incentives, they must be based on valid, empirical evidence. Efforts to link financial incentives to consumer choice and provider performance should focus on populations and conditions where there is the greatest need for improvement.

Financial incentives that improve care and save cost present important challenges for administrators, providers, and consumers. For health plan administrators, designing and using effective financial incentives can be technically challenging and expensive. For providers, reporting on performance can be time-consuming. For consumers, choosing among plans, providers, and treatment options can be difficult. If not designed carefully, financial incentives that rely on consumer cost sharing can produce negative health outcomes, especially among low-income people and others with serious health conditions.

None of the proposals specifically addresses the constructive use of financial incentives—although Proposal 3 authorizes the Health Partnership board to offer consumer incentives related to use of evidence-based services and healthy lifestyles. Because Proposals 2, 3, 4, and 5 all would establish an administrative entity that would (or could) negotiate with health plans (Proposals 2, 3, and 5) or providers (Proposal 4), these proposals could consider options for developing consistent financial incentives for both providers and consumers. Proposals 3 and 4 would serve the largest number of residents under a single administrative structure for the broadest range of services and, therefore, might have greatest prospects for establishing consistent financial incentives and adequately compensating providers for reporting performance—once again, presuming that efforts to build the necessary coalitions, agreements, and systems are actively pursued and adequately funded.

APPENDIX A

**SUMMARY OF WASHINGTON STATE
HEALTH CARE REFORM PROPOSALS**

Features	Proposal 1 Small Employer and Young Adult Proposals	Proposal 2 Massachusetts Model	Proposal 3 Washington Health Partnership	Proposal 4 Single-Payer Plan	Proposal 5 Guaranteed Health Benefit Program
Eligible for change	<p>Insured small employer groups 2-50, including those covered in association plans or enrolled in commercial insurance products or HMOs</p> <p>Adults aged 19-34 in individual plans</p> <p>Uninsured small groups and young adults who become insured</p>	<p>Small employer groups with 2-50 employees, including those insured through association plans</p> <p>Residents currently insured as individuals.</p> <p>Currently uninsured residents who do not have an offer of subsidized coverage from a large group employer.</p> <p>All BH and WSHIP enrollees, including undocumented adult immigrants.</p> <p>All HIP enrollees.</p> <p>IHS-eligible Native Americans are subject to all requirements, on same basis as other residents.</p>	<p>Adult permanent residents (12 months or more)</p> <p>All children < 18 and pregnant women, regardless of residency status (if not eligible for Medicaid/SCHIP)</p> <p>Employees and non-Medicare retirees of state government, public institutions of higher education, or political subdivisions of the state</p> <p>Workers covered under collective bargaining agreements, at expiration of the agreement or within a participating group.</p> <p>Basic Health Program (intent is to fold in and replace)</p> <p>Undocumented immigrants, including children currently enrolled in CHP</p> <p>IHS-eligible Native Americans are enrolled in the Partnership on same basis as other residents.</p> <p>Homeless and transient persons</p>	<p>All residents under age 65 and not currently covered by Medicare.</p> <p>IHS-eligible Native Americans</p> <p>Homeless and transient persons.</p> <p>Undocumented adults and children</p>	<p>Resident for at least 6 months, and not categorically ineligible.</p> <p>Children born in WA and residing with an eligible guardian (if not eligible for Medicaid/SCHIP)</p> <p>WA resident students attending school in another state. IHS-eligible Native Americans</p> <p>Homeless and transient persons</p> <p>Institutionalized persons in private facilities (e.g., nursing homes).</p> <p>Undocumented adults and children (no citizenship eligibility requirement)</p>
Excluded or nonparticipating	<p>Self-insured employers</p> <p>Federal employees</p> <p>Military employees</p> <p>Large-group employees, including PEBB and other HCA groups.</p> <p>Uninsured small groups and individuals who remain uninsured</p>	<p>Self-insured employers</p> <p>Insured large employers</p> <p>Federal employees</p> <p>Military personnel with federal/military retiree health plans.</p> <p>Institutionalized persons</p> <p>Residents over age 65 or enrolled in Medicare</p> <p>State, local-government, and school employees and retirees currently covered under HCA-administered plans</p> <p>Homeless and transient persons</p>	<p>Federal employees.</p> <p>Active military personnel or retirees with federal/military health coverage.</p> <p>Institutionalized persons</p> <p>Persons eligible for Medicaid or SCHIP, to include categorically needy persons to 200% FPL.</p>	<p>Medicare enrollees</p> <p>Federal employees and retirees</p> <p>Military employees and retirees</p>	<p>Medicare enrollees</p> <p>Federal employees and retirees</p> <p>Military employees and retirees</p> <p>Institutionalized persons in government-operated facilities</p> <p>Medicaid/DSHS enrollees</p>

Features	Proposal 1 Small Employer and Young Adult Proposals	Proposal 2 Massachusetts Model	Proposal 3 Washington Health Partnership	Proposal 4 Single-Payer Plan	Proposal 5 Guaranteed Health Benefit Program
Current public program enrollees	No change for enrollees in: <ul style="list-style-type: none"> • Medicaid/SCHIP • CHP • Basic Health • WSHIP • HIP 	No change : <ul style="list-style-type: none"> • Medicaid/SCHIP programs • CHP (Children’s Health Program) Basic Health enrollees are transferred to the Connector. WSHIP enrollment is frozen, and current WSHIP enrollees enter the Connector on the same basis as other individual enrollees. The current WSHIP assessment on carriers is retained to reinsure high-cost enrollees in the Connector. The Connector replaces the HIP.	PEBB coverage is discontinued. PEBB enrollees are offered coverage in the Health Partnership on the same terms as other enrollees. Basic Health is discontinued (intent). CHP is discontinued; enrollees may enroll in the Partnership on the same terms as other enrollees. WSHIP is discontinued; enrollees may enroll in the Partnership on the same terms as other enrollees. Eligibility for the categorically needy Medicaid program is expanded to cover families and aged, blind, and disabled individuals up to 200% FPL. The Health Partnership refers all Medicaid- or SCHIP-eligible enrollees to those programs.	The single-payer plan covers participants in current state programs on the same basis as other residents.	Covered on the same basis as other residents, with wrap-around coverage for services not covered by the GB Program: <ul style="list-style-type: none"> • Basic Health (expanded to 300% FPL) • WSHIP • HIP • Medicaid continues with no change. • CHP (for undocumented children) continues with no change.
Individual responsibility	No change from the current case.	All WA residents \geq age 18 must have creditable coverage if deemed affordable. Affordability is defined as premiums \leq 5% of gross family income.	All eligible residents enroll. Those who do not select a network or the fee-for-service option are auto-enrolled in the lowest-cost network. Those who enroll in a higher-cost network plan pay premiums equal to the difference between their selected plan premium and benchmark premium.	Eligible individuals are automatically enrolled. There are no premiums for coverage.	All eligible residents enroll. That is, residents need not act affirmatively to participate in the program.
Role of employers	No change from the current case.	Employers with 2–50 employees must offer a Section 125 plan for payment of either employee contributions to coverage or individual premiums. Employers voluntarily offer coverage to workers; no contribution is required for small-group coverage (see small group rules).	Employers are assessed as much as 12 percent of total Social Security wages. Employers voluntarily discontinue their health plans for all workers.	Employers voluntarily discontinue their health plans for all workers.	Employers voluntarily set benefits limit to 10K. Employers pay a graduated tax on total (Medicare) wages, rising as total payroll is larger; employees pay a proportionately lower tax on wages.

Features	Proposal 1 Small Employer and Young Adult Proposals	Proposal 2 Massachusetts Model	Proposal 3 Washington Health Partnership	Proposal 4 Single-Payer Plan	Proposal 5 Guaranteed Health Benefit Program
Role of private insurers	No change from the current case.	<p>Each participating carrier must offer all health plan options approved by the Connector Board.</p> <p>Carriers that currently serve only BH or Medicaid may offer Connector plans only to persons receiving premium assistance.</p> <p>HSA-qualified plans sold through the Connector must arrange or otherwise identify an HSA for each enrolled individual.</p> <p>Insurers participating in Connector participate in reinsurance plan for all insured lives, as may be necessary to stabilize premiums.</p>	<p>Guaranteed issue to all applicants.</p> <p>Relationship to the Partnership:</p> <ul style="list-style-type: none"> Private insurers submit bids to provide regional network plans with covered services. The Partnership Board pays the qualifying lowest-cost networks their risk-adjusted per-member per-month premium bids and pays qualifying higher-cost networks the premium bid of the lowest-cost network. Selected private plans administer the Partnership's self-funded statewide fee-for-service option. May cede coverage for vaccines and chronic care prescription drugs to a self-insured Partnership drug plan, which in turn may join a multi-state purchasing group or consortium. <p>All qualifying network plans must meet or exceed an 88 percent minimum loss ratio.</p>	<p>No role with respect to covered services.</p> <p>Private insurers may offer supplemental benefits <i>only</i> for services not covered by the single payer plan. (Supplemental coverage is not modeled.)</p>	<p>Disability, health, and HMO carriers may bid to provide GB Program benefits. and (with existing insurance rules) may offer coverage for any services that the GB Program does not cover.</p> <p>Enrollees with routine coverage will have the same carrier for the GB Program.</p> <p>Participating carriers must guarantee issue GB Program.</p> <p>Carriers that do not participate in the GB Program do not offer competing coverage.</p> <p>The program may authorize self-funded arrangements in areas where residents have fewer than two plan options.</p>

Features	Proposal 1 Small Employer and Young Adult Proposals	Proposal 2 Massachusetts Model	Proposal 3 Washington Health Partnership	Proposal 4 Single-Payer Plan	Proposal 5 Guaranteed Health Benefit Program
Small group rules	<p>Significant rating and mandatory-benefit changes as specified below (see "Rating").</p> <p>Current market minimum participation and minimum employer contribution standards for small groups apply.</p>	<p>Individual, small-group, and association coverage may be offered only through the Connector.</p> <p>Guaranteed issue of individual coverage in the Connector</p> <p>As allowed under state law, carriers may apply a 9-month waiting period on pre-ex conditions with a 6-month look back.</p> <p>No minimum contribution for employers</p> <p>Employees have unrestricted choice of plans</p> <p>Current market minimum participation standard for small groups applies.</p> <p>Small employers that participate in the Connector may not offer another (non-Connector) plan to eligible employees.</p> <p>Reduced pre-ex and portability standards apply to all plans, including plans offered through the Connector.</p>	<p>Not applicable: group coverage is discontinued.</p>	<p>Not applicable: group coverage is discontinued.</p>	<p>No change in the market for "routine" coverage, that is coverage for services other than preventive, and below the \$10,000 attachment point for the GB Program.</p>

Features	Proposal 1 Small Employer and Young Adult Proposals	Proposal 2 Massachusetts Model	Proposal 3 Washington Health Partnership	Proposal 4 Single-Payer Plan	Proposal 5 Guaranteed Health Benefit Program
Rating	Carriers can establish a separate rate class for young adults in all individual products. Rates cannot vary by age in the rate class. ³⁹ Rate bands for enrollees 35-64 are subject to the 1:3.75 rate band on age. ⁴⁰ Current regulation requiring that rating factors produce premiums for identical groups that differ only by amounts attributable to plan design will continue.	Adjusted community rating in small group to include geography, age (5-year increments), family size and use of wellness activities Age-group band is not to exceed 3.75:1 Individuals under age 30 may be rated in separate pool not subject to 3.75:1 band Group and individual enrollees pay list (age-adjusted individual) rates in the Connector.	Rates for otherwise comparable coverage may vary by location (network plan designs may be region-specific). Pure community rating: no variation by health status, age, gender, or other factors. Rate adjustments for 2-adult, 1adult+child/ren, and 2 adults+child/ren families are uniform across network plans and the indemnity option, and patterned on current PEBB rate adjustments.	Not applicable.	Not applicable; individuals do not pay premiums for GB coverage
Administrative cost	No change from the current case.	The Connector applies a surcharge to all Connector plans. Broker fees + the surcharge for Connector administration are assumed to equal current broker fees. Carriers' administrative cost rates equal the current case.	Network plans must meet or exceed an 88 percent medical loss ratio. The Partnership's cost of administering the statewide self-insured FFS plan equals WA carriers' current pmpm costs for administration of Medicare FFS. The Partnership incurs administrative costs to manage enrollment, autoenrollment, and other functions equal to Medicare's FFS administrative cost per enrollee (estimated at \$150 per member per year in 2007) adjusted to WA State wage levels. ⁴¹	Nonmedical cost is estimated as 2.5 times Medicare's FFS administrative cost experience per enrollee (estimated at \$150 per member per year in 2007) adjusted to WA State wage levels. ¹	The Health Care Authority's (HCA) nonmedical cost to operate the GB Program is estimated as Medicare's FFS administrative cost experience per enrollee (estimated at \$150 per member per year in 2007) adjusted to WA State wage levels, plus 1% of capitation payments to operate a reinsurance system. ¹ Capitation payments allow participating carriers 11% administrative cost. No net aggregate cost for use of brokers/agents.

³⁹ In addition, the proposals would allow carriers offering HSA-qualified HDHPs to pool the medical experience of these plans separately in setting adjusted community rates. NonHSA-eligible products would be adjusted-community rated over each carrier's small group pool, excluding enrollees in HSA-eligible products. However, available data do not support modeling either increases in rate adjustments over time (+/-8%) or an easing of the process by which greater rate adjustments may be made.

⁴⁰ While the proposal intends, in effect, to expand the rate band for individuals age 35-64, actuarial analysis of medical cost data in Washington suggests that the current rate band is, at most, mildly restrictive. Therefore, we assume that separating out adults age 19-34 and allowing rates at age 64 to be 3.75 times the rate at age 35 would not change rates for adults 35-64.

⁴¹ A study conducted for the Kaiser Family Foundation estimated that the administrative cost of the Medicare program for fee-for service beneficiaries was \$133 per beneficiary in 2002—about half that per FEHBP enrollee (<http://www.kff.org/medicare/upload/The-Federal-Employees-Health-Benefits-Program-Program-Design-Recent-Performance-and-Implications-for-Medicare-Reform-Report.pdf>). Updated by the CPI, this amount would be 13% higher in 2007 (that is, \$150 per enrollee).

Features	Proposal 1 Small Employer and Young Adult Proposals	Proposal 2 Massachusetts Model	Proposal 3 Washington Health Partnership	Proposal 4 Single-Payer Plan	Proposal 5 Guaranteed Health Benefit Program
Subsidy schedule	No change from the current case.	<p>Eligible for subsidy:</p> <ul style="list-style-type: none"> All individual enrollees with family gross income below 200% FPL. Small-group enrollees with family gross income below 200% FPL. Individuals eligible for benefits under section 210 of the federal trade act of 2002 at 26 U.S.C. Sec. 35(c). <p>The BH subsidy schedule applies to employee contributions and individual premiums.</p> <p>Individuals who choose a high-deductible plan for which subsidy exceeds premium have excess funds deposited in a health savings account.</p>	<p>The Partnership fully subsidizes the lowest-cost plans.</p> <p>The Partnership subsidizes purchase of higher-cost plans up to the cost of the benchmark lowest-cost plan.</p> <p>Subsidies ensure that the out-of-pocket maximum in the lowest-cost plans does not exceed 10 percent of gross family income. The out-of-pocket maximum in higher-cost plans is unsubsidized.</p> <p>Enrollees with family income below 200 percent FPL pay no deductible.</p>	No premiums are required.	Enrollees pay 1% of Medicare wages as a payroll tax, but no premiums to enroll in the GB Program.
Covered benefits and cost sharing	<p>Premium levels for “bare bones” individual and small group plans, respectively, are adjusted to reflect expected cost of exempted mandates among currently insured persons.</p> <p>Bare bones plans are marketed with the same range of cost sharing options as comprehensive plans.</p> <p>Carriers do not market plans with all of the exemptions allowed. Instead, bare bones plans continue to include coverage for preventive services and prescription drugs, as well as for federally mandated benefits (i.e., pregnancy and maternity services as required by the Pregnancy Discrimination Act).</p> <p>For modeling purposes, HIP products do not change to include “bare bones” options.</p>	<p>Connector plans include:</p> <ul style="list-style-type: none"> Current HIP products, excluding high-deductible plans that are not HSA-qualified. The BH benefit <p>All Connector plans cover small-group mandated benefits.</p> <p>Participating (insured) employers may not offer supplemental benefits for services covered by Connector plans.</p>	<p>Minimum benefits are those currently provided to state employees in PEBB.</p> <p>Deductibles and POS cost sharing are modeled after PEBB plans.</p> <p>Prenatal, well-baby, well-child, recommended adult preventive, and chronic care services not subject to POS cost sharing.</p>	Covered benefits equal those available to state employees in PEBB. (Two estimates will be provided, respectively including and excluding dental benefits.) Medicaid/SCHIP provide wrap-around coverage for Medicaid/SCHIP mandatory populations up to 150% of FPL	Covered benefits equal those available to state employees in PEBB for preventive services and services above \$10,000. Private insurers and self-insured employers may offer supplemental coverage for nonpreventive services below \$10,000 attachment point.

Features	Proposal 1 Small Employer and Young Adult Proposals	Proposal 2 Massachusetts Model	Proposal 3 Washington Health Partnership	Proposal 4 Single-Payer Plan	Proposal 5 Guaranteed Health Benefit Program
Payment of providers	Premium levels for “bare bones” individual plans for young adults are adjusted to reflect actuarial cost of exempted mandates as estimated in the research literature by type of service.	No change from the current case.	Contracting insurance carriers or networks continue provider negotiation as today. The fee-for-service option pays average network rates. Out-of state providers are paid the same rates as in-state providers.	Providers are reimbursed at the current commercial market average, minus a provider administrative savings adjustment. Administrative savings for providers are reflected in provider payment levels, which are reduced by 5.4% to 9.6%, by type of service. ⁴² No discount for administrative savings is assumed for prescription drugs or medical services and equipment, which are transacted in the national market.	The GB program reimburses providers for covered services at the current market average. Out-of state providers are paid the same rates as in-state providers.
Specific sources of saving or cost avoidance	No change from the current case.	No change from the current case.	Incentives for enrollees to choose low-cost plans.	None proposed.	None proposed.
Quality improvement	No change from the current case.	None modeled.	None modeled.	Not modeled.	Not modeled.
Sources of revenue	No change from the current case.	All federal, state, and consumer sources of revenue continue as in the current case. Current-case WSHIP assessment on carriers continues, in order to fund reinsurance in the Connector. Additional state funds to support: <ul style="list-style-type: none"> Premium subsidies for residents under 200% FPL enrolled in small-group or individual coverage. Reinsurance for newly insured residents enrolled in the Connector. 	State contributions to premium and subsidized cost sharing are funded by a payroll tax on Social Security wages: <ul style="list-style-type: none"> Employees < age 65 pay 2-4% Self-employed workers < age 65 pay 9-10%. Employers pay 9-12 percent. Secondary sources of funding are: <ul style="list-style-type: none"> Individual premiums for enrollment in higher-cost networks Public programs, including those drawing federal funds, which continue to be funded as previously. 	By assumption, the single-payer plan is financed from state general revenues. Federal matching is obtained for all eligible residents enrolled in the single-payer plan.	Employers are assessed on total wages: <ul style="list-style-type: none"> 3% up to \$500,000 4% from \$500,000 to \$1 million 5% over \$1 million Employees pay 1% of Medicare wages. Residents earning wages in another state pay 1% of Medicare wages.

⁴² Reflecting the fact that providers will continue to contend with multiple payers via Medicare, FEHBP, and military health plans, this rate is equal to one-half of the difference in the provider administrative cost rate (per total cost) by type of service between the U.S. average and the Canadian health care system, as calculated in: S. Woolhandler et al. (August 21, 2003), “Costs of Health Care Administration in the United States and Canada,” *New England Journal of Medicine* 349 (8): 768-775.

APPENDIX B

**DETAILED ESTIMATES OF PROJECT
CHANGES IN COVERAGE AND EXPENDITURES:
ALL PROPOSALS, FY 2010**

Table B1: Estimated Number of Persons by Source of Coverage and Percent Distribution by Age, Poverty Status, and Self-Reported Health Status: Current Case FY 2010

	Number of Person (000s)	Under Age 19	Age 19-34	Age 35-44	Age 45-64	Under 200%FPL	201-300% FPL	Over 300% FPL	Excellent or Very Good Health Status	Good, Fair, or Poor Health Status
Total	5,663.0	29.3%	24.7%	15.6%	30.4%	34.3%	11.4%	54.2%	64.5%	35.5%
New plans or programs:										
Reduced benefit plans										
Small group (ERB)	--	--	--	--	--	--	--	--	--	--
Individual (IRB)	--	--	--	--	--	--	--	--	--	--
Connector										
Small group	--	--	--	--	--	--	--	--	--	--
Individual	--	--	--	--	--	--	--	--	--	--
Health Partnership (excluding Medicaid and SCHIP)	--	--	--	--	--	--	--	--	--	--
Single payer (excluding Medicaid and SCHIP)	--	--	--	--	--	--	--	--	--	--
Other sources of coverage:										
Small groups (association, HIP, and other)	670.8	21.7%	26.6%	17.7%	34.0%	19.5%	19.6%	60.8%	69.5%	30.5%
Small group COBRA	25.4	33.6%	19.6%	10.2%	36.5%	42.8%	13.9%	43.3%	60.6%	39.4%
Self-insured employer plans	1,136.3	26.2%	23.4%	17.4%	32.9%	11.9%	11.2%	76.9%	71.7%	28.3%
Other insured group and other association	1,486.9	22.2%	21.4%	20.0%	36.4%	13.4%	11.8%	74.8%	71.1%	28.9%
Other COBRA	93.0	30.7%	14.7%	10.8%	43.8%	36.2%	12.7%	51.1%	64.0%	36.0%
PEBB - State employees	270.7	35.2%	12.8%	14.5%	37.5%	17.8%	11.2%	71.1%	79.8%	20.2%
PEBB - other	12.6	6.6%	12.4%	0.0%	81.0%	15.5%	11.8%	72.6%	56.0%	44.0%
Military or FEHBP	199.8	45.2%	9.7%	9.1%	36.1%	26.5%	18.6%	54.9%	62.6%	37.4%
Medicaid	693.0	76.1%	11.2%	3.8%	9.0%	97.4%	2.6%	0.0%	46.8%	53.2%
SCHIP	10.9	100.0%	0.0%	0.0%	0.0%	0.0%	96.0%	4.0%	72.9%	27.1%
Basic Health ^a	106.0	0.0%	49.5%	23.2%	27.4%	99.0%	1.0%	0.0%	40.8%	59.2%
Other state programs ^b	129.9	27.6%	26.3%	27.9%	18.1%	95.6%	1.9%	2.5%	15.8%	84.2%
Individual coverage	280.9	15.9%	13.4%	21.4%	49.4%	15.3%	12.3%	72.4%	77.8%	22.2%
WSHIP	4.2	26.6%	8.9%	8.5%	56.0%	15.7%	9.5%	74.9%	31.4%	68.6%
Uninsured	542.8	7.3%	66.6%	10.0%	16.1%	70.7%	11.3%	17.9%	51.0%	49.0%

^a Includes enrollee premiums for Basic Health.

^b Includes CHP, GAU, ADATA, Refugees, and AEM.

Table B2: Estimated Number of Persons by Source of Coverage and Percent Distribution by Age, Poverty Status, and Self-Reported Health Status: Proposal 1, FY 2010

	Number of persons (in thousands)	Under Age 19	Age 19-34	Age 35-44	Age 45-64	Under 200%FPL	201-300% FPL	Over 300% FPL	Excellent or Very Good Health Status	Good, Fair, or Poor Health Status
Total	5,663.0	29.3%	24.7%	15.6%	30.4%	34.3%	11.4%	54.2%	64.5%	35.5%
New plans or programs:										
Reduced benefit plans										
Small group (ERB)	2.8	4.8%	70.8%	18.0%	6.4%	75.9%	11.2%	13.0%	75.2%	24.8%
Individual (IRB)	24.4	0.0%	100.0%	0.0%	0.0%	60.6%	5.9%	33.5%	75.1%	24.9%
Connector										
Small group	--	--	--	--	--	--	--	--	--	--
Individual	--	--	--	--	--	--	--	--	--	--
Health Partnership (excluding Medicaid and SCHIP)										
Single payer (excluding Medicaid and SCHIP)	--	--	--	--	--	--	--	--	--	--
Other sources of coverage:										
Small groups (association, HIP, and other)	670.8	21.7%	26.6%	17.7%	34.0%	19.5%	19.6%	60.8%	69.5%	30.5%
Small group COBRA	25.4	33.6%	19.6%	10.2%	36.5%	42.8%	13.9%	43.3%	60.6%	39.4%
Self-insured employer plans	1,136.3	26.2%	23.4%	17.4%	32.9%	11.9%	11.2%	76.9%	71.7%	28.3%
Other insured group and other association	1,486.9	22.2%	21.4%	20.0%	36.4%	13.4%	11.8%	74.8%	71.1%	28.9%
Other COBRA	93.0	30.7%	14.7%	10.8%	43.8%	36.2%	12.7%	51.1%	64.0%	36.0%
PEBB - State employees	270.7	35.2%	12.8%	14.5%	37.5%	17.8%	11.2%	71.1%	79.8%	20.2%
PEBB - other	12.6	6.6%	12.4%	0.0%	81.0%	15.5%	11.8%	72.6%	56.0%	44.0%
Military or FEHBP	199.8	45.2%	9.7%	9.1%	36.1%	26.5%	18.6%	54.9%	62.6%	37.4%
Medicaid	693.0	76.1%	11.2%	3.8%	9.0%	97.4%	2.6%	0.0%	46.8%	53.2%
SCHIP	10.9	100.0%	0.0%	0.0%	0.0%	0.0%	96.0%	4.0%	72.9%	27.1%
Basic Health ^a	106.0	0.0%	49.5%	23.2%	27.4%	99.0%	1.0%	0.0%	40.8%	59.2%
Other state programs ^b	129.9	27.6%	26.3%	27.9%	18.1%	95.6%	1.9%	2.5%	15.8%	84.2%
Individual coverage	313.7	14.3%	22.5%	19.1%	44.2%	19.2%	12.2%	68.6%	77.4%	22.6%
WSHIP	4.3	25.4%	12.8%	8.1%	53.6%	18.0%	10.3%	71.6%	30.0%	70.0%
Uninsured	482.6	8.1%	62.6%	11.2%	18.1%	72.5%	11.6%	15.9%	48.0%	52.0%

^a Includes enrollee premiums for Basic Health.

^b Includes CHP, GAU, ADATA, Refugees, and AEM.

Table B3: Estimated Number of Persons by Source of Coverage and Percent Distribution by Age, Poverty Status, and Self-Reported Health Status: Proposal 2, FY 2010

	Number of persons (in thousands)	Under age 19	Age 19-34	Age 35-44	Age 45-64	Under 200%FPL	201-300% FPL	Over 300% FPL	Excellent or Very Good Health Status	Good, Fair, or Poor Health Status
Total	5,663.0	29.3%	24.7%	15.6%	30.4%	34.3%	11.4%	54.2%	64.5%	35.5%
New plans or programs:										
Reduced benefit plans	--	--	--	--	--	--	--	--	--	--
Small group (ERB)	--	--	--	--	--	--	--	--	--	--
Individual (IRB)	--	--	--	--	--	--	--	--	--	--
Connector	1,386.5	16.4%	40.7%	15.9%	27.0%	44.9%	13.3%	41.9%	63.6%	36.4%
Small group	803.8	20.3%	35.8%	16.6%	27.2%	33.8%	15.8%	50.4%	67.5%	32.5%
Individual	582.6	11.0%	47.5%	14.9%	26.7%	60.1%	9.8%	30.2%	58.2%	41.8%
Health Partnership (excluding Medicaid and SCHIP)	--	--	--	--	--	--	--	--	--	--
Single payer (excluding Medicaid and SCHIP)	--	--	--	--	--	--	--	--	--	--
Other sources of coverage:										
Small groups (association, HIP, and other)	--	--	--	--	--	--	--	--	--	--
Small group COBRA	--	--	--	--	--	--	--	--	--	--
Self-insured employer plans	1,136.3	26.2%	23.4%	17.4%	32.9%	11.9%	11.2%	76.9%	71.7%	28.3%
Other insured group and other association	1,578.5	20.9%	22.9%	20.1%	36.1%	15.3%	11.7%	73.0%	70.5%	29.5%
Other COBRA	93.0	30.7%	14.7%	10.8%	43.8%	36.2%	12.7%	51.1%	64.0%	36.0%
PEBB - State employees	270.7	35.2%	12.8%	14.5%	0.0%	17.8%	11.2%	71.1%	79.8%	20.2%
PEBB - other	12.6	6.6%	12.4%	0.0%	81.0%	15.5%	11.8%	72.6%	56.0%	44.0%
Military or FEHBP	199.8	45.2%	9.7%	9.1%	36.1%	26.5%	18.6%	54.9%	62.6%	37.4%
Medicaid	693.0	76.1%	11.2%	3.8%	9.0%	97.4%	2.6%	0.0%	46.8%	53.2%
SCHIP	10.9	100.0%	0.0%	0.0%	0.0%	0.0%	96.0%	4.0%	72.9%	27.1%
Basic Health ^a	--	--	--	--	--	--	--	--	--	--
Other state programs ^b	129.9	27.6%	26.3%	27.9%	18.1%	95.6%	1.9%	2.5%	15.8%	84.2%
Individual coverage	--	--	--	--	--	--	--	--	--	--
WSHIP	--	--	--	--	--	--	--	--	--	--
Uninsured	152.0	7.9%	18.1%	13.2%	127.5%	6.5%	26.8%	66.8%	55.8%	44.2%

^a Includes enrollee premiums for Basic Health.

^b Includes CHP, GAU, ADATA, Refugees, and AEM.

Table B4: Estimated Number of Persons by Source of Coverage and Percent Distribution by Age, Poverty Status, and Self-Reported Health Status: Proposal 3, FY 2010

	Number of persons (in thousands)	Under age 19	Age 19-34	Age 35-44	Age 45-64	Under 200%FPL	201-300% FPL	Over 300% FPL	Excellent or Very Good Health Status	Good, Fair, or Poor Health Status
Total	5,663.0	29.3%	24.7%	15.6%	30.4%	34.3%	11.4%	54.2%	64.5%	35.5%
New plans or programs:										
Reduced benefit plans	--	--	--	--	--	--	--	--	--	--
Small group (ERB)	--	--	--	--	--	--	--	--	--	--
Individual (IRB)	--	--	--	--	--	--	--	--	--	--
Connector	--	--	--	--	--	--	--	--	--	--
Small group	--	--	--	--	--	--	--	--	--	--
Individual	--	--	--	--	--	--	--	--	--	--
Health Partnership (excluding Medicaid and SCHIP)	3,172.5	14.5%	28.6%	16.2%	40.7%	18.4%	5.9%	75.8%	70.7%	29.3%
Single payer (excluding Medicaid and SCHIP)	--	--	--	--	--	--	--	--	--	--
Other sources of coverage:										
Small groups (association, HIP, and other)	--	--	--	--	--	--	--	--	--	--
Small group COBRA	--	--	--	--	--	--	--	--	--	--
Self-insured employer plans	--	--	--	--	--	--	--	--	--	--
Other insured group and other association	--	--	--	--	--	--	--	--	--	--
Other COBRA	--	--	--	--	--	--	--	--	--	--
PEBB - State employees	--	--	--	--	--	--	--	--	--	--
PEBB - other	--	--	--	--	--	--	--	--	--	--
Military or FEHBP	199.8	45.2%	9.7%	9.1%	36.1%	26.5%	18.6%	54.9%	62.6%	37.4%
Medicaid	2272.5	47.9%	20.9%	15.5%	15.7%	57.6%	18.0%	24.4%	56.0%	44.0%
SCHIP	18.2	100.0%	--	--	--	--	88.0%	12.0%	73.8%	26.2%
Basic Health ^a	--	--	--	--	--	--	--	--	--	--
Other state programs ^b	--	--	--	--	--	--	--	--	--	--
Individual coverage	--	--	--	--	--	--	--	--	--	--
WSHIP	--	--	--	--	--	--	--	--	--	--
Uninsured	--	--	--	--	--	--	--	--	--	--

^a Includes enrollee premiums for Basic Health.

^b Includes CHP, GAU, ADATA, Refugees, and AEM.

Table B5: Estimated Number of Persons by Source of Coverage and Percent Distribution by Age, Poverty Status, and Self-Reported Health Status: Proposal 4, FY 2010

	Number of persons (in thousands)	Under age 19	Age 19-34	Age 35-44	Age 45-64	Under 200%FPL	201-300% FPL	Over 300% FPL	Excellent or Very Good Health Status	Good, Fair, or Poor Health Status
Total	5,663.0	29.3%	24.7%	15.6%	30.4%	34.3%	11.4%	54.2%	64.5%	35.5%
Reduced benefit plans										
Small group (ERB)	--	--	--	--	--	--	--	--	--	--
Individual (IRB)	--	--	--	--	--	--	--	--	--	--
Connector										
Small group	--	--	--	--	--	--	--	--	--	--
Individual	--	--	--	--	--	--	--	--	--	--
Health Partnership (excluding Medicaid and SCHIP)	--	--	--	--	--	--	--	--	--	--
Single payer (excluding Medicaid and SCHIP)	4,090.1	20.1%	26.2%	16.2%	37.5%	23.6%	5.8%	70.6%	66.4%	33.6%
Other sources of coverage:										
Small groups (association, HIP, and other)	--	--	--	--	--	--	--	--	--	--
Small group COBRA	--	--	--	--	--	--	--	--	--	--
Self-insured employer plans	--	--	--	--	--	--	--	--	--	--
Other insured group and other association	--	--	--	--	--	--	--	--	--	--
Other COBRA	--	--	--	--	--	--	--	--	--	--
PEBB - State employees	--	--	--	--	--	--	--	--	--	--
PEBB - other	--	--	--	--	--	--	--	--	--	--
Military or FEHBP	199.8	45.2%	9.7%	9.1%	36.1%	26.5%	18.6%	54.9%	62.6%	37.4%
Medicaid	1,373.2	54.3%	22.7%	14.8%	8.2%	67.6%	27.1%	5.3%	59.1%	40.9%
SCHIP	--	--	--	--	--	--	--	--	--	--
Basic Health ^a	--	--	--	--	--	--	--	--	--	--
Other state programs ^b	--	--	--	--	--	--	--	--	--	--
Individual coverage	--	--	--	--	--	--	--	--	--	--
WSHIP	--	--	--	--	--	--	--	--	--	--
Uninsured	--	--	--	--	--	--	--	--	--	--

^a Includes enrollee premiums for Basic Health.

^b Includes CHP, GAU, ADATA, Refugees, and AEM.

Table B6: Estimated Number of Persons by Source of Coverage and Percent Distribution by Age, Poverty Status, and Self-Reported Health Status: Proposal 5, FY 2010

	Number of persons (in thousands)	Under age 19	Age 19-34	Age 35-44	Age 45-64	Under 200%FPL	201-300% FPL	Over 300% FPL	Excellent or Very Good Health Status	Good, Fair, or Poor Health Status
Total	5,663.0	29.3%	24.7%	15.6%	30.4%	34.3%	11.4%	54.2%	64.5%	35.5%
Reduced benefit plans										
Small group (ERB)	--	--	--	--	--	--	--	--	--	--
Individual (IRB)	--	--	--	--	--	--	--	--	--	--
Connector										
Small group	--	--	--	--	--	--	--	--	--	--
Individual	--	--	--	--	--	--	--	--	--	--
Health Partnership (excluding Medicaid and SCHIP)	--	--	--	--	--	--	--	--	--	--
Single payer (excluding Medicaid and SCHIP)	--	--	--	--	--	--	--	--	--	--
Other sources of coverage:										
Small groups (association, HIP, and other)	816.9	19.3%	28.6%	17.2%	34.9%	22.7%	18.9%	58.4%	68.4%	31.6%
Small group COBRA	25.4	33.6%	19.6%	10.2%	36.5%	42.8%	13.9%	43.3%	60.6%	39.4%
Self-insured employer plans	1,136.3	26.2%	23.4%	17.4%	32.9%	11.9%	11.2%	76.9%	71.7%	28.3%
Other insured group and other association	1,575.2	21.4%	22.4%	20.1%	36.1%	14.8%	11.7%	73.5%	70.9%	29.1%
Other COBRA	93.0	30.7%	14.7%	10.8%	43.8%	36.2%	12.7%	51.1%	64.0%	36.0%
PEBB - State employees	270.7	35.2%	12.8%	14.5%	37.5%	17.8%	11.2%	71.1%	79.8%	20.2%
PEBB - other	12.6	6.6%	12.4%	0.0%	81.0%	15.5%	11.8%	72.6%	56.0%	44.0%
Military or FEHBP	199.8	45.2%	9.7%	9.1%	36.1%	26.5%	18.6%	54.9%	62.6%	37.4%
Medicaid	693.0	76.1%	11.2%	3.8%	9.0%	97.4%	2.6%	0.0%	46.8%	53.2%
SCHIP	10.9	100.0%	0.0%	0.0%	0.0%	0.0%	96.0%	4.0%	72.9%	27.1%
Basic Health ^a	114.5	0.0%	49.8%	22.5%	27.8%	90.1%	9.9%	0.0%	41.0%	59.0%
Other state programs ^b	129.9	27.6%	26.3%	27.9%	18.1%	95.6%	1.9%	2.5%	15.8%	84.2%
Individual coverage	365.5	14.6%	36.0%	15.1%	34.3%	39.0%	11.8%	49.2%	70.3%	29.7%
WSHIP	17.8	1.7%	11.9%	14.6%	71.8%	73.3%	8.0%	18.7%	1.5%	98.5%
Uninsured	201.8	6.4%	85.0%	7.2%	1.4%	91.9%	5.6%	2.6%	41.5%	58.5%

^a Includes enrollee premiums for Basic Health.

^b Includes CHP, GAU, ADATA, Refugees, and AEM.

Table B.7: Estimated Number and Percent of Persons under Age 65 by Source of Coverage: Proposals 1 through 5, FY 2010

	Current case - Number of persons (in thousands)	Percent of Total	Proposal 1 - Number of persons (in thousands)	Percent of Total	Percent change	Proposal 2 - Number of persons (in thousands)	Percent of Total	Percent change	Proposal 3 - Number of persons (in thousands)	Percent of Total	Percent change	Proposal 4 - Number of persons (in thousands)	Percent of Total	Percent change	Proposal 5 - Number of persons (in thousands)	Percent of Total	Percent change
Total	5,663.0	100.0%	5,663.0	100.0%	nc	5,663.0	100.0%	nc	5,663.0	100.0%	nc	5,663.0	100.0%	nc	5,663.0	100.0%	nc
New plans or programs:																	
Reduced benefit plans																	
Small group (ERB)	--		2.8	0.1%	na												
Individual (IRB)	--		24.4	0.4%	na												
Connector																	
Small group	--		--			1,386.5	24.5%	na									
Individual	--		--			803.8	14.2%	na									
Health Partnership (excluding Medicaid and SCHIP)	--		--			582.6	10.3%	na									
Single payer (excluding Medicaid and SCHIP)	--		--						3,172.5	56.0%	na	4,090.1	72.2%	na			
Other sources of coverage:																	
Small groups (association, HIP, and other)	670.8	11.8%	670.8	11.8%	nc	--	--	-100.0%	--	--	-100.0%	--	--	-100.0%	816.9	14.4%	21.8%
Small group COBRA	25.4	0.4%	25.4	0.4%	nc	--	--	-100.0%	--	--	-100.0%	--	--	-100.0%	25.4	0.4%	0.0%
Self-insured employer plans	1,136.3	20.1%	1,136.3	20.1%	nc	1,136.3	20.1%	nc	--	--	-100.0%	--	--	-100.0%	1,136.3	20.1%	0.0%
Other insured group and other association	1,486.9	26.3%	1,486.9	26.3%	nc	1,578.5	27.9%	6.2%	--	--	-100.0%	--	--	-100.0%	1,575.2	27.8%	5.9%
Other COBRA	93.0	1.6%	93.0	1.6%	nc	93.0	1.6%	nc	--	--	-100.0%	--	--	-100.0%	93.0	1.6%	0.0%
PEBB - State employees	270.7	4.8%	270.7	4.8%	nc	270.7	4.8%	nc	--	--	-100.0%	--	--	-100.0%	270.7	4.8%	0.0%
PEBB - other	12.6	0.2%	12.6	0.2%	nc	12.6	0.2%	nc	--	--	-100.0%	--	--	-100.0%	12.6	0.2%	0.0%
Military or FEHBP	199.8	3.5%	199.8	3.5%	nc	199.8	3.5%	nc	199.8	3.5%	nc	199.8	3.5%	nc	199.8	3.5%	0.0%
Medicaid	693.0	12.2%	693.0	12.2%	nc	693.0	12.2%	nc	2,272.5	40.1%	227.9%	1,373.2	24.2%	98.2%	693.0	12.2%	0.0%
SCHIP	10.9	0.2%	10.9	0.2%	nc	10.9	0.2%	nc	18.2	0.3%	67.9%	--	--	-100.0%	10.9	0.2%	0.0%
Basic Health ^a	106.0	1.9%	106.0	1.9%	nc	--	--	-100.0%	--	--	-100.0%	--	--	-100.0%	114.5	2.0%	8.0%
Other state programs ^a	129.9	2.3%	129.9	2.3%	nc	129.9	2.3%	nc	--	--	-100.0%	--	--	-100.0%	129.9	2.3%	0.0%
Individual coverage	280.9	5.0%	313.7	5.5%	11.7%	--	--	-100.0%	--	--	-100.0%	--	--	-100.0%	365.5	6.5%	30.1%
WSHIP	4.2	0.1%	4.3	0.1%	4.5%	--	--	-100.0%	--	--	-100.0%	--	--	-100.0%	17.8	0.3%	327.7%
Uninsured	542.8	9.6%	482.6	8.5%	-11.1%	152.0	2.7%	-73.0%	--	--	-100.0%	--	--	-100.0%	201.8	3.6%	-62.8%

Source: Mathematica Policy Research

^a Includes enrollee premiums for Basic Health.

^b Includes CHP, GAU, ADATA, Refugees, and AEM.

Note: "na" indicates no change calculated for a new program; "nc" indicates no change.

Table B.8: Estimated Expenditures by Source of Funds: Proposals 1 through 4, FY 2010

	Current case (in millions)	Percent of Total	Proposal 1 (in millions)	Percent of Total	Percent change	Proposal 2 (in millions)	Percent of Total	Percent change	Proposal 3 (in millions)	Percent of Total	Percent change	Proposal 4 (in millions)	Percent of Total	Percent change	Proposal 5 (in millions)	Percent of Total	Percent change
Total	\$ 24,945.4	100.0%	\$ 24,981.3	100.0%	0.1%	\$ 24,615.7	100.0%	-1.3%	\$ 24,058.3	100.0%	-3.6%	\$ 25,889.0	100.0%	3.8%	\$ 25,531.4	100.0%	2.3%
Federal	\$ 3,211.2	12.9%	\$ 3,211.2	12.9%	nc	\$ 3,580.8	14.5%	11.5%	\$ 4,797.5	19.9%	49.4%	\$ 3,915.4	15.1%	21.9%	\$ 3,010.1	11.8%	-6.3%
Federal programs	\$ 2,606.5	10.4%	\$ 2,606.5	10.4%	nc	\$ 2,606.5	10.6%	nc	\$ 4,632.9	19.3%	77.7%	\$ 3,915.4	15.1%	50.2%	\$ 2,606.5	10.2%	nc
Medicaid	\$ 1,715.5	6.9%	\$ 1,715.5	6.9%	nc	\$ 1,715.5	7.0%	nc	\$ 3,738.1	15.5%	117.9%	\$ 3,038.3	11.7%	77.1%	\$ 1,715.5	6.7%	nc
SCHIP	\$ 13.8	0.1%	\$ 13.8	0.1%	nc	\$ 13.8	0.1%	nc	\$ 17.7	0.1%	28.0%	\$ -	--	-100.0%	\$ 13.8	0.1%	nc
FEHB+Military	\$ 877.1	3.5%	\$ 877.1	3.5%	nc	\$ 877.1	3.6%	nc	\$ 877.1	3.6%	0.0%	\$ 877.1	3.4%	0.0%	\$ 877.1	3.4%	nc
Federal tax expenditures on section 125 plans	\$ 604.7	2.4%	\$ 604.7	2.4%	nc	\$ 974.3	4.0%	61.1%	\$ 164.6	0.7%	-72.8%	\$ -	--	-100.0%	\$ 403.6	1.6%	-33.3%
State	\$ 3,988.9	16.0%	\$ 3,988.9	16.0%	nc	\$ 4,416.9	17.9%	10.7%	\$ 15,289.9	63.6%	283.3%	\$ 19,024.0	73.5%	376.9%	\$ 10,279.4	40.3%	157.7%
Medicaid	\$ 1,986.8	8.0%	\$ 1,986.8	8.0%	nc	\$ 1,986.8	8.1%	nc	\$ 3,600.1	15.0%	81.2%	\$ 2,926.1	11.3%	47.3%	\$ 1,986.8	7.8%	nc
Basic Health Plan	\$ 342.2	1.4%	\$ 342.2	1.4%	nc	\$ -	--	-100.0%	\$ -	--	-100.0%	\$ -	--	-100.0%	\$ 218.7	0.9%	-36.1%
SCHIP	\$ 7.2	0.0%	\$ 7.2	0.0%	nc	\$ 7.2	0.0%	nc	\$ 9.3	0.0%	28.0%	\$ -	--	-100.0%	\$ 7.2	0.0%	nc
PEBB-State employees	\$ 1,395.7	5.6%	\$ 1,395.7	5.6%	nc	\$ 1,395.7	5.7%	nc	\$ -	--	-100.0%	\$ -	--	-100.0%	\$ 902.5	3.5%	-35.3%
PEBB-other	\$ 256.9	1.0%	\$ 256.9	1.0%	nc	\$ 256.9	1.0%	nc	\$ -	--	-100.0%	\$ -	--	-100.0%	\$ 62.6	0.2%	-75.6%
Health Partnership									\$ 11,630.9	48.3%	na						
State Subsidies to Private Insurance						\$ 770.2	3.1%	na									
State Subsidies for Out-of-Pocket Expenses									\$ 49.7	0.2%	na						
Single payer												\$ 16,097.8	62.2%	na			
GHB															\$ 7,101.5	27.8%	na
Employer-sponsored	\$ 13,984.4	56.1%	\$ 13,987.6	56.0%	0.0%	\$ 12,818.5	52.1%	-8.3%	\$ -	--	-100.0%	\$ -	--	-100.0%	\$ 9,364.3	36.7%	-33.0%
Small group (association, HIP, and other)	\$ 2,919.5	11.7%	\$ 2,922.7	11.7%	0.1%	\$ 1,583.3	6.4%	-45.8%	\$ -	--	-100.0%	\$ -	--	-100.0%	\$ 2,154.0	8.4%	-26.2%
Large group	\$ 7,021.0	28.1%	\$ 7,021.0	28.1%	nc	\$ 7,191.3	29.2%	2.4%	\$ -	--	-100.0%	\$ -	--	-100.0%	\$ 4,386.6	17.2%	-37.5%
Self-insured	\$ 4,043.9	16.2%	\$ 4,043.9	16.2%	nc	\$ 4,043.9	16.4%	nc	\$ -	--	-100.0%	\$ -	--	-100.0%	\$ 2,823.8	11.1%	-30.2%
Individual	\$ 546.0	2.2%	\$ 611.4	2.4%	12.0%	\$ 571.7	2.3%	4.7%	\$ 1,788.9	7.4%	227.6%	\$ -	--	-100.0%	\$ 505.9	2.0%	-7.4%
Private non-group	\$ 524.4	2.1%	\$ 589.6	2.4%	12.4%	\$ 571.7	2.3%	9.0%	\$ -	--	-100.0%	\$ -	--	-100.0%	\$ 471.0	1.8%	-10.2%
WSHIP	\$ 21.7	0.1%	\$ 21.7	0.1%	nc	\$ -	0.0%	-100.0%	\$ -	--	-100.0%	\$ -	--	-100.0%	\$ 34.9	0.1%	61.0%
Health Partnership			\$ -						\$ 1,788.9	7.4%	na						
Out of Pocket	\$ 3,214.9	12.9%	\$ 3,182.3	12.7%	-1.0%	\$ 3,227.7	13.1%	0.4%	\$ 2,182.0	9.1%	-32.1%	\$ 2,949.7	11.4%	-8.2%	\$ 2,371.8	9.3%	-26.2%

Source: Mathematica Policy Research

Note: "na" indicates no change calculated for a new program; "nc" indicates no change.

APPENDIX C

**ISSUE BRIEFS:
IMPROVING THE COST EFFECTIVENESS
AND QUALITY OF HEALTHCARE
IN WASHINGTON STATE**

ISSUE BRIEF 1

DOES HEALTH INSURANCE COVERAGE IMPROVE HEALTH OUTCOMES?

OVERVIEW

There is a strong relationship between health insurance coverage and better health outcomes for both children and adults. Health outcomes for insured populations are better—overall, with respect to care provided in particular settings, and for a wide range of acute and chronic health conditions.

Insurance helps people to obtain specific services that improve health outcomes. Such services include preventive and screening services, prescription drug benefits, and mental health care services. Insurance also improves health outcomes by improving the continuity of necessary care.

Vulnerable populations are at much greater risk of poor health outcomes when they are uninsured. Vulnerable populations may include racial and ethnic minorities, people who are poor, people with disabilities, and people with limited education.

Expanded coverage can improve social and economic well-being more broadly by averting developmental problems in children, increasing workforce productivity, decreasing use of hospital services, and decreasing costs to public programs.

EXTENSIVE RESEARCH EVIDENCE LINKS THE LACK OF INSURANCE TO POOR HEALTH OUTCOMES

People who are uninsured generally receive less care, including preventive care and care for acute and chronic conditions. Uninsured adults report lower levels of self-perceived wellness and functioning and are more likely to die prematurely.^{1, 2, 3}

Preventive care. Uninsured young children generally have lower immunization rates.⁴ Uninsured adults are less likely to receive preventive services or appropriate screenings such as mammograms, pap smears, or prostate screening. In turn, inadequate prevention and screening makes the contracting of preventable illness, missed diagnoses, and delays in treatment more likely.^{5, 6, 7}

Acute conditions. People who are uninsured may receive emergency care for severe illness and injury, but their health outcomes generally are poorer. Uninsured children are 70 percent less likely than insured children to receive medical care for common childhood conditions such as a sore throat, or for emergencies such as a ruptured appendix. When hospitalized, uninsured children are at greater risk of dying than children with insurance.^{8, 9}

Acute outcomes for uninsured adults also are worse. For example, one study found that uninsured adults are approximately 20 percent less likely to receive care following an automobile accident and are at greater risk of death.^{10, 11} At-risk adults without insurance have higher rates of stroke and greater risk of death than at-risk adults with insurance.¹² Adult stroke victims without insurance are more likely to have neurological impairment,

longer hospital stays, and are at greater risk of dying than adult stroke victims with insurance.¹⁵

Chronic conditions and serious illness. People without insurance have limited access to both services and effective care management. Parents of uninsured children are more likely to report unmet need for mental health services for their children.¹⁴ Uninsured children also are less likely to receive treatment for chronic conditions such as diabetes and asthma.¹⁵ In addition, children with special health care needs who do not have adequate insurance coverage are more likely to forego needed care. They have more limited access to a medical home, community-based services, and services to make transitions to adulthood.^{16, 17}

Because uninsured people are less likely to have a usual source of care, they generally have poorer control of chronic conditions such as hypertension.^{18, 19} Even when aware that they have a chronic condition, uninsured adults are less likely to have a usual source of care or regular check-ups than adults who are insured.²⁰ As a result, they have more emergency department visits; report greater short-term reductions in health; and if they return to full health, take longer to do so.^{21, 22}

The prognosis for uninsured cancer patients also is worse than for insured patients. In general, uninsured cancer patients die sooner after diagnosis than those with insurance coverage, largely because they are less likely to be diagnosed in early stages of the disease. However, even when diagnosed at similar stages, uninsured patients with certain types of cancer die sooner than insured patients.^{23, 24}

LACK OF INSURANCE CREATES SOCIAL AND ECONOMIC COSTS

Undiagnosed and untreated illnesses and conditions can result in high costs to both individuals and society. When health conditions are untreated, children lose opportunities for normal development, and educational achievement may be affected.²⁵

Poorer health, disability, and premature death among uninsured workers have economic consequences for families, employers, and the overall economy. Having health insurance at any time over the course of a year reduces workers' likelihood of missing work.²⁶ National estimates of productivity losses are substantial, especially when added to the costs of avoidable health care.²⁷

SPECIFIC CHARACTERISTICS OF INSURANCE ARE ASSOCIATED WITH BETTER HEALTH OUTCOMES

Several characteristics of insurance coverage are associated with better health outcomes:

- ***Continuous and Comprehensive Coverage.*** Adults with continuous insurance coverage have better health status and are at lower risk of premature death. Similarly, children with continuous coverage are more likely to visit a doctor, receive preventive care, and have prescriptions filled.^{28, 29, 30} Conversely, lapses and gaps in coverage contribute to health disparities for people with low educational attainment and the poor.³¹

- **Coverage of Preventive and Screening Services.** Ensuring access to the full range of appropriate and effective preventive services is essential for achieving the full health benefits of insurance coverage. Coverage for preventive services can also reduce racial and ethnic disparities in health outcomes.³¹
- **Coverage of Prescription Drugs.** Limited coverage or high out-of-pocket costs for medication is associated with a decline in older adults' self-reported health status. Adults with certain chronic conditions who restrict their medications because of cost are at greater risk of heart attacks and strokes.³² Low-income adults are especially likely to fail to comply with drug regimens because of cost.³³ Conversely, adults with chronic conditions are more likely to follow drug regimens when they have insurance that covers prescription drugs.³⁴
- **Coverage of Mental Health Services.** Adults with health insurance that covers mental health services are more likely to receive mental health treatment that is consistent with medical guidelines. Receiving care for depression especially improves outcomes.³⁵ When uninsured, people with mental illness rely heavily on emergency room services, with significant cost to the community.^{36, 37} Adults who have insurance that does not cover mental health services are more likely than uninsured adults to receive treatment for their condition, but they are less likely to receive adequate treatment.^{38, 39}
- **Affordable Cost Sharing.** Health insurance alone does not result in better health outcomes. Instead, it helps people establish and maintain access to appropriate care, which can lead to better outcomes. Even among people who are insured, high cost sharing (including deductibles, coinsurance, and copayments) can create barriers to obtaining care, reducing their use of necessary health care services.^{40, 41}

CONSIDERATIONS FOR WASHINGTON STATE

Health insurance leads to better outcomes when it is affordable and helps consumers to use health care appropriately. Washington State should consider measures that:

- Encourage, if not require, health insurance coverage of services that are strongly linked to better health outcomes—including preventive and screening services, drug benefits, and mental health services.
- Maintain and expand efforts to ensure widespread and continuous coverage, promoting continuity of care and reducing disparities in health care among the population.

NOTES

¹ Baker, D., J. Sudano, J. Albert, E. Borawski, and A. Dor. “Loss of Health Insurance and the Risk for Decline in Self-Reported Health and Physical Functioning.” *Medical Care*, vol. 40, no. 11, 2002, pp. 1126–1131.

² Institute of Medicine (IOM). *Care Without Coverage: Too Little Too Late*. Washington, DC: National Academy Press, 2002.

³ Dorn, S. “Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality.” Washington, DC: Urban Institute, 2008.

⁴ Becton, J.L., L. Cheng, and L.Z. Nieman. “The Effect of Lack of Insurance, Poverty, and Pediatrician Supply on Immunization Rates Among Children 19–35 Months of Age in the United States”. *J Eval Clin Pract.*, vol. 14, no. 2, 2008, pp. 248–53.

⁵ Robinson, J., and V. Shavers. “The Role of Health Insurance Coverage in Cancer Screening Utilization.” *Journal of Health Care Poor Underserved*, vol. 19, no. 3, 2008, pp. 842–56.

⁶ DeVoe, J.E., A. Graham, L. Krois, J. Smith, and G.L. Fairbrother. “Mind the Gap in Children’s Health Insurance Coverage: Does the Length of a Child’s Coverage Gap Matter?” *Ambulatory Pediatrics*, vol. 8, no. 2, 2008, pp. 129–34.

⁷ For example, failure of an individual with diabetes to receive timely eye exams can result in preventable blindness (See IOM. *Hidden Costs, Value Lost: Uninsurance in America*. Washington, DC: National Academy Press, 2003).

⁸ Todd, J., C. Armon, A. Griggs, S. Poole, and S. Berman. “Increased Rates of Morbidity, Mortality, and Charges for Hospitalized Children with Public or No Health Insurance as Compared with Children with Private Insurance in Colorado and the United States.” *Pediatrics*, vol. 118, no. 2, 2006, pp. 577–85.

⁹ Kaiser Family Foundation (KFF). “Children’s Health—Why Health Insurance Matters.” Washington, DC: KFF, 2002.

¹⁰ Doyle, J. “Health Insurance, Treatment, and Outcomes: Using Auto Accidents as Health Shocks.” *The Review of Economics and Statistics*, vol. 87, no. 2, 2005, pp. 256–270.

¹¹ A more recent study found that race and insurance status independently predict death following trauma. Based on records of more than 310,000 trauma patients across 700 hospitals in the United States, this study supports other research that shows racial disparities in health outcomes. However, insurance status was a stronger predictor of death after trauma. (See Haider, A., D. Chang, E. Efron, E. Haut, M. Crandall, and E. Cornwell. “Race and Insurance Status as Risk Factors for Trauma Mortality.” *Archives of Surgery*, vol. 143, no.10, 2008, pp 945-949).

¹² Fowler-Brown, A., G. Corbie-Smith, J. Garrett, and N. Lurie. “Risk of Cardiovascular Events and Death—Does Insurance Matter?” *Journal of General Internal Medicine*, vol. 22, no. 4, 2007, pp. 502–507.

¹³ Shen, J.J., and E.L. Washington. “Disparities in Outcomes Among Patients with Stroke Associated with Insurance Status.” *Stroke*, vol. 28, 2007, pp. 1010–16.

¹⁴ Derigne, L., S. Porterfield, and S. Metz. “The Influence of Health Insurance on Parent’s Reports of Children’s Unmet Mental Health Needs.” *Maternal and Child Health Journal*, May 16, 2008 [Epub ahead of print].

¹⁵ KFF 2002; Ibid.

¹⁶ Oswald, D.P., J. N. Bodurtha, J.H. Willis, and M.B. Moore. “Underinsurance and Key Health Outcomes for Children with Special Health Care Needs.” *Pediatrics*, vol. 119, no. 2, Epub 2007, pp. e341–7.

¹⁷ Tu, H.T., and P.J. Cunningham. “Public Coverage Provides Vital Safety Net for Children with Special Health Care Needs.” *Issue Brief* 98, 2005, pp. 1–7.

¹⁸ Jiang, H., P. Muntner, J. Chen, E.J. Roccella, R.H. Streiffer, and P.K. Whelton. “Factors Associated with Hypertension Control in the General Population of the United States.” *Archives of Internal Medicine*, vol. 62, 2002, pp. 1051–8. Available from: archinte.ama-assn.org/cgi/content/abstract/162/9/1051.

¹⁹ Having a usual source of care promotes earlier detection of conditions and ongoing use of the recommended care that can improve health outcomes. Conversely, people without a usual source of care are at greater risk for preventable health problems, additional chronic disease, and disability (IOM 2003).

²⁰ Ayanian, J., J. Weissman, E. Schneider, and J. Ginsburg. “Unmet Health Needs of Uninsured Adults in the United States.” *Journal of the American Medical Association*, vol. 284, no. 16, 2000, pp. 2061–2069.

²¹ Hadley, J. “Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition.” *Journal of American Medical Association*, vol. 297, no. 10, 2007, pp. 1073–1084.

²² For example, uninsured individuals with diabetes are less likely to receive recommended professional services, such as receiving regular foot or dilated eye exams than individuals with insurance. (See Nelson, K., M. Chapko, G. Reiber, and E. Boyko. “The Association between Health Insurance Coverage and Diabetes Care.” *Health Services Research*, vol. 40, no. 2, 2005, pp. 361–372.) Uninsured patients with renal disease have more severe renal failure when they begin dialysis than insured patients (See Kausz, A., T. Gregorio, P. Obrador, R. Ruthazer, et al. “Late Initiation of Dialysis Among Women and Ethnic Minorities in the United States.” *Journal of the American Society of Nephrology*, vol. 11, no. 12, 2000, pp. 2351–2357) and they are less likely to have received treatment for other related health problems such as anemia before dialysis. Uninsured individuals with HIV are less likely to be able to maintain effective drug therapies, which improve survival. In general, having health insurance of any kind can reduce the number of deaths among individuals with HIV by up to 85 percent over a six-month period (IOM 2003).

²³ IOM 2003.

²⁴ One study, conducted in Kentucky, found significantly lower three-year survival rates among uninsured patients diagnosed with prostate, breast, colorectal, and lung cancers, compared with patients who had private health insurance (See McDavid, K., T. Tucker, A. Sloggett, and M. Coleman. “Cancer Survival in Kentucky and Health Insurance Coverage.” *Archives of Internal Medicine*, vol. 163, 2003, pp. 2135–44). Halpern and others found that uninsured people were significantly more likely to be diagnosed with advanced-stage cancer compared with privately insured patients—in particular for those cancers that can be detected early by a screening or symptom assessment, such as breast, colorectal, lung, and melanoma cancers (See Halpern, M., E. Ward, A. Pavluck, N. Schrag, J. Bian, and A. Chen. “Association of Insurance Status and Ethnicity with Cancer Stage at Diagnosis for 12 Cancer Sites: A Retrospective Analysis.” *Lancet Oncol.*, Vol. 9, no. 3, 2008, pp. 222–31).

²⁵ Ibid; and Tu and Cunningham 2005.

²⁶ Loftland, J., and K. Frick. “Effect of Health Insurance on Workplace Absenteeism in the U.S. Workforce.” *Journal of Occupational and Environmental Medicine*, vol. 48, no. 2, 2006, pp. 13–21.

²⁷ For example, the IOM estimated in one year, using 2001 dollars, that continuous coverage for all Americans would result in annual economic gains estimated between \$65 and \$130 billion (IOM 2003).

²⁸ KFF 2002

²⁹ Olson, L.M., S.F. Tang, and P.W. Newacheck. "Children in the United States with Discontinuous Health Insurance Coverage." *New England Journal of Medicine*, vol. 353, no. 4, 2005, pp. 382–91.

³⁰ For example, children with gaps in health care coverage are less likely to receive appropriate asthma care (See Halterman, J.S., G. Montes, L.P. Shone, and P.G. Szilagyi. "The Impact of Health Insurance Gaps on Access to Care Among Children with Asthma in the United States." *Ambulatory Pediatrics*, vol. 8, no. 1, 2008, pp. 43–9).

³¹ Agency for Healthcare and Research Quality (AHRQ). *National Healthcare Disparities Report*. Rockville, MD: AHRQ, 2007.

³² Heisler, M., K. Langa, E. Eby, M. Fendrik, M. Kabeto, and J. Piette. "The Health Effects of Restricting Prescription Medication Use Because of Cost." *Medical Care*, vol. 42, no. 7, 2004, pp. 626–634.

³³ Mojtabai, R., and M. Olfson. "Medication Costs, Adherence, and Health Outcomes Among Medicare Beneficiaries." *Health Affairs*, vol. 22, no. 4, 2003, pp. 221–229.

³⁴ Huttin, C., J. Moeller, and R. Stafford. "Patterns and Costs for Hypertension Treatment in the United States." *Clinical Drug Investigation*, vol. 20, no. 2, 2000, pp. 151–156.

³⁵ Wang, P., P. Berglund, and R. Kessler. "Recent Care of Common Mental Disorders in the United States." *Journal of General Internal Medicine*, vol. 15, 2000, pp. 284–292.

³⁶ Ballargeon, J., C. Thomas, B. Williams, C. Begley, S. Sharma, B. Pollock, et al. "Medical Emergency Department Utilization Patterns Among Uninsured Patients with Psychiatric Disorders." *Psychiatric Services*, vol. 59, no. 7, 2008, pp. 808–811.

³⁷ Tu and Cunningham 2005

³⁸ Wang et al. 2007, pp. 284–292

³⁹ Wang, P., O. Demier, and R. Kessler. "Adequacy of Treatment for Serious Mental Illness in the United States." *American Journal of Public Health*, vol. 92, no. 1, 2002, pp. 92–98.

⁴⁰ AHRQ. "Consumer Financial Incentives: A Decision Guide for Purchasers." AHRQ Publication No. 290-06-0023-2, 2007.

⁴¹ Hibbard, J., J. Greene, and M. Tusler. "Does Enrollment in a CDHP Stimulate Cost-Effective Utilization?" *Medical Care Research and Review*, vol. 65, no. 4, 2008, pp. 437–449.

ISSUE BRIEF 2

SERVICES BASED ON EMPIRICAL EVIDENCE

OVERVIEW

Evidence-based medicine refers to the systematic use of findings from clinical and health services research in health care. It is increasingly seen as central to improving the quality and effectiveness of health care and reducing unnecessary spending. Policymakers see evidence-based medicine as a way to address variations in medical care that reflect significant underuse, overuse, and misuse of alternative treatments and technologies.

There is growing emphasis on the need for comparative effectiveness research to identify what works best among treatment alternatives. Nevertheless, a range of initiatives to put evidence-based medicine into practice are already underway. The potential for quality improvement and savings is great. However, these programs can have different results in different settings and localities, or among different populations. Putting evidence-based medicine into practice requires the development of new information and reporting systems, as well as new approaches to provider and consumer education.

THE SCIENTIFIC BASE TO SUPPORT EFFECTIVE HEALTH CARE IS GROWING

Good research comparing the effectiveness of tests, procedures, and treatments is generally difficult and expensive. As a result, the evidence base to support medical decision making is limited¹.

In both public and private sector, there is growing interest in evidence-based medicine to control costs and improve the quality of health care.^{2,3} Legislation introduced in the Congress would expand or recast federal support for comparative effectiveness research.^{4,5}

Currently, a number of federal, state, and private sector organizations are pursuing comparative effectiveness research, as well as projects designed to put evidence-based medicine into practice:

- The Agency for Healthcare Research and Quality (AHRQ), along with other federal agencies such as the Veterans Health Administration and the National Institutes of Health are actively involved in the development and dissemination of strong research evidence about the effectiveness of health care interventions. AHRQ's Effective Health Care program focuses especially on interventions related to the severe health problems of people enrolled in Medicare, Medicaid, or the State Children's Health Insurance Program.⁶ Research institutions and health plans across the country participate in AHRQ Centers for Education and Research.⁷
- Some states—and also some managed care organizations and the Veterans Health Administration—have adopted programs that link coverage or payment for diagnostic tests, treatments, or technologies to evidence of effectiveness. For

example, the Drug Effectiveness Review Project is a collaborative partnership among states (including Washington State) and other government and non-profit organizations. This project conducts evidence-based reviews to help state Medicaid programs make decisions about which drugs to cover and under what circumstances.⁸

- Some health plans use “value-based” benefit designs that reward consumers and providers for choosing more effective service and treatment options.^{9,10}
- Washington initiated a Health Technology Assessment Program in 2006 to use clinical evidence to evaluate whether health services are proven safe, effective and cost-effective¹¹. The program relies on assessments of scientific evidence and an independent clinical committee to help the state purchase proven, cost-effective care in a consistent manner across state agencies. Using an open and transparent process, the Health Care Authority has conducted seven assessments, to date, and three other assessments are in progress.

ADOPTING MORE EFFECTIVE MEDICAL PRACTICES COULD IMPROVE QUALITY AND REDUCE COST

Research conducted in the United States and in other countries indicates that evidence-based medicine can increase medical effectiveness, improve the quality of care, and reduce spending. For example:

- A recent study comparing two alternative treatments for stable coronary artery disease found that patients treated with only a drug regimen have similar survival rates and occurrence of heart attacks, compared with patients who, in addition, had angioplasty and insertion of a stent.¹² Other research has compared the effectiveness of newer, more expensive drugs with older ones; examined whether diagnostic tests increase the likelihood of earlier detection of treatable conditions; and examined whether surgical procedures reduce short or longer term mortality compared with alternative treatments.¹³
- Research on medical practice patterns and patient outcomes in Medicare found that more conservative use of services for some prevalent conditions may both improve care and reduce spending.¹⁴ Medicare spending—and perhaps all health spending in the country—might be cut by about 30 percent if the more conservative practice styles used in the lowest-spending one-fifth of the country could be adopted nationwide.¹⁵
- However, efforts to adopt evidence-based medicine may not always reduce spending.¹⁶
- While evidence-based practices can reduce the inappropriate use of services, they may also increase delivery of services that had been underused.

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- Evidence-based practice may require additional resources for care coordination, monitoring, patient counseling, and provider and consumer education.

Finally, areas of the country where medical providers already deliver care efficiently might see little improvement in quality or reductions in cost. For example, in the Pacific Northwest, per capita use of Medicare services is lower than in many areas of the South or Northeast, suggesting that the potential for savings from more conservative evidence-based medicine may be less.

THERE ARE OBSTACLES TO PUTTING COMPARATIVE EFFECTIVENESS EVIDENCE INTO PRACTICE

Applying a broad base of scientific evidence about when, where, and how to use medical care will not lead automatically to more effective health care delivery. Experts have identified numerous barriers to the development of evidence-based practice.¹⁷ Some lessons learned include the following:

- New education and information programs may be needed. Providers and consumers need to understand the reasoning behind decisions that affect their treatment options to avoid distrust.^{18, 19}
- Training and technical assistance is important in helping providers change practice patterns.²⁰
- Efforts to implement evidence-based practice need to be sustained, coordinated, and accountable—requiring sufficient and stable resources. Inconsistent signals to practitioners undermine efforts to reduce variations in practice.²¹

CONSIDERATIONS FOR WASHINGTON STATE

Putting medical evidence and findings from comparative effectiveness research into practice is critically important for improving health care quality and efficiency. Washington State can play an important role in promoting the use of evidence in health care delivery in several ways:

- Seek and support additional opportunities (like the Drug Effectiveness Review Program), to coordinate and collaborate with other state, regional and national organizations involved in this work.
- Cooperate with regional and national agencies, health plans, and providers to identify practice areas where the effectiveness research is strong.
- Seek ways to incorporate incentives for evidence-based practice into coverage and payment strategies for Medicaid and other programs administered by the State, and to encourage it in other private health insurance plans.

NOTES

¹ Moon, M., B. Smith, and S. Gustafson. “Creating a Center for Evidence-Based Medicine.” MedPAC Report No. 08-1. July 2007.; CBO. Research on the Comparative Effectiveness of Medical Treatments: Issues and Options for an Expanded Federal Role. Washington, DC: CBO, 2007

² For examples, recent reports from the Congressional Budget Office and the Medicare Payment Advisory Commission have urged that health care reforms include a focus on more effective health care delivery. In its June 2007 report, MedPAC observed that “there is no independent entity in the U.S. whose sole mission is to compare the benefits, risks, and costs of alternative services and make this information publicly available. ...[Such research] is costly to generate and sponsors have difficulty recouping the costs of producing the research because other users will not pay to use the research once it is publicly available.” Medicare Payment Advisory Commission (MedPAC). “Producing Comparative Effectiveness Information.” Also, CBO. Research on the Comparative Effectiveness of Medical Treatments: Issues and Options for an Expanded Federal Role. Washington, DC: CBO, 2007. Summarized in Orszag, Peter, and Philip Ellis. “The Challenge of Rising Health Care Costs—A View from the Congressional Budget Office.” *New England Journal of Medicine*, vol. 357, 2007, pp. 1793–95. Report to the Congress: Promoting Greater Efficiency in Medicare, June 2007, p.41.

³ Also in the private sector, there have been recent policy statements regarding comparative effectiveness research including the Blue Cross and Blue Shield Association, (see <http://www.bcbs.com/issues/transparency/background/improving-health-care-value.html>); The Advanced Medical Technology Association, (see: <http://www.advaamed.org/NR/rdonlyres/66E43D28-1F5F-4028-99CC-256A7BE25D53/0/AdvaMedCEPrinciples22102407.pdf>) ; The National Business Group on Health, (see <http://www.aha.org/aha/content/2007/pdf/0704-uhp-nbgh.pdf>); as well as The Alliance for Better Health Care, (see www.amcp.org/data/legislative/analysis/ABHC%20statement%20on%20clinical%20effectiveness.pdf).

⁴ Comparative effectiveness research and technology assessments are also being actively investigated in other countries; often, as in the Netherlands, United Kingdom, and Australia, comparative effectiveness information is incorporated into decisions about benefits coverage in national health plans. The International Network of Agencies for Health Technology Assessment, along with 47 member agencies from 23 countries, is addressing issues of the effectiveness and comparative effectiveness of medical technologies, devices, and therapeutics.

⁵ Some proposals focus on clinical effectiveness research, while others would also support research on the cost-effectiveness of treatment alternatives. In Testimony before the Subcommittee on Health of the Committee on Ways and Means (2007) MedPAC called for the establishment of an entity whose primary mission would be to sponsor studies that compare the clinical effectiveness of a service with its alternatives. CBO presented arguments for limiting research on clinical effectiveness, but also discussed the need for sound evidence on the cost effectiveness of treatment alternatives, stating that “Ultimately. . . achieving the greatest possible gains in efficiency of the health sector would require assessing both the benefits and costs of different treatments to see whether the assed benefits of more-expensive options were worth their added costs Having the new or expanded entity analyze cost-effectiveness would also lend more legitimacy to that approach and would promote a consistent and transparent methodology for such calculations. Those considerations argue for having the entity assess cost-effectiveness (CBO 2007).

⁶ See <http://effectivehealthcare.ahrq.gov>.

⁷ The HMO Research Network in Seattle, in collaboration with the Group Health Center for Health Studies, is one of the participating AHRQ Centers for Education & Research on Therapeutics.

⁸ Hoadley, J., J. Crowley, D. Bergman, and N. Kaye. “Understanding Key Features of the Drug Effectiveness Review Project (DERP) and Lessons for State Policy Makers.” Issue Brief #3, March 2006.

⁹ Silow-Carroll, A., and T. Alteras. “Value-Driven Health Care Purchasing: Case Study of Wisconsin’s Department of Employee Trust Funds.” The Commonwealth Fund: Publication no. 1056, 2007; Silow-Carroll, A., and T. Alteras. “Value-Driven Health Care Purchasing: Case Study of Minnesota’s Smart Buy Alliance.” The Commonwealth Fund: Publication no. 1054, 2007; and Chernew, M.E., A.B. Rosen, and M. Fendrick. “Value-Based Insurance Design.” *Health Affairs*, vol. 26, no. 2, 2007, w195–w203. Web Exclusive <http://content.healthaffairs.org>). This is also discussed further in Issue brief 6: Financial Incentives for Providers and Consumers

¹⁰ See also the companion issue brief in this series “Financial Incentives for Providers and Consumers.” (Issue brief 6).

¹¹ RCW 70.14.100 et seq.; www.hta.hca.wa.gov

¹² CBO 2007

¹³ Ibid.

¹⁴ CBO 2007.

¹⁵ Fisher, E. “More Care is Not Better: Regional Differences Show That Spending More Does Not Improve –and May Hurt Patients. More Accountability May Help.” Issue 7, January 2005. National Institute for Health Care Management: Washington DC.

¹⁶ For example, evaluations of programs that apply evidence-based treatment protocols in treating patients with heart disease, diabetes, and asthma found that some programs did not generate any savings while others saved payers up to \$6.50 for each dollar they invested serious chronic conditions such as heart failure (See Issue Brief 4)

¹⁷ Santa, J., and M. Gibson. “Designing Benefits with Evidence in Mind.” EBRI Issue Brief, No 290, February 2006; MedPAC 2008

¹⁸ Medicare Payment Advisory Commission (MedPAC). “Report to Congress: Medicare Payment Policy.” March 2006; Santa 2006

¹⁹ MedPAC March 2006; Santa 2006

²⁰ MedPAC, March 2006

²¹ Arguing for a national center on health care improvement, contractors to MedPAC emphasize the need to establish and maintain credibility with providers and consumers, and the link to stable funding. MedPAC 2006; CBO, 2007.

ISSUE BRIEF 3

PREVENTIVE SERVICES

Preventive services are designed to identify potential medical conditions in order to promote earlier and more effective treatment. Preventive services include screening, counseling, immunizations, and administration of medications that can prevent illness.

OVERVIEW

- Systematic reviews by independent experts provide strong evidence that clinical preventive services can substantially improve health outcomes.
- To be effective, preventive services must be targeted to particular patient populations. Preventive screenings and services can cause more harm than benefit when provided to patient populations at low risk of developing a disease.
- While some preventive services can reduce health care costs, many do not and some increase costs. Nonetheless, many preventive services are viewed as cost-effective because they save lives or increase the quality of life for less than the cost of common treatments.
- Expanding health coverage could increase use of appropriate preventive care, if preventive services were covered with little or no cost sharing.

APPROPRIATE USE OF PREVENTIVE CLINICAL SERVICES CAN IMPROVE HEALTH OUTCOMES

The U.S. Preventive Services Task Force (USPSTF) recommends 24 clinical preventive services. For these services, empirical evidence indicates that the health benefits of receiving the services outweigh the risks.^{1, 2} For example, the task force strongly recommends screening for colorectal cancer for adults ages 50 or older because there is compelling evidence that appropriate screening, testing, and treatment can decrease the incidence of colon cancer and associated death.^{3, 4} Similarly, the Advisory Committee on Immunization Practices (ACIP) has identified 17 vaccines (such as hepatitis B and measles/mumps/rubella) for which the health benefits outweigh any associated risks, especially for children.^{5, 6}

BECAUSE THE RISKS FOR SOME PREVENTIVE SERVICES OUTWEIGH THE BENEFITS, USE OF PREVENTIVE SERVICES SHOULD BE EVIDENCE-BASED AND TARGETED TO APPROPRIATE POPULATIONS

Many preventive services have side-effects or other risks, such as physical harm from an invasive screening process. The USPSTF has identified 19 preventive services for which the health risks for using the service outweigh the benefits for particular population groups. For example, it recommends against ovarian cancer screening for women, where a high rate of false-positive results can lead to further tests or procedures with serious complications.^{7, 8} The USPSTF has identified another 32 services for which there is not enough evidence to

conclude whether the services provide net benefits to the patients.^{9,10} Finally, the task force recommends that many of the preventive services that offer net benefits be provided only to specific populations at high risk for the associated disease.

WHILE SOME PREVENTIVE SERVICES CAN REDUCE HEALTH COSTS, MANY DO NOT AND SOME CAN SUBSTANTIALLY INCREASE COSTS

Preventive services have an intrinsic appeal: if a disease can be detected in its early stages or prevented all together, it follows that the cost of treating the disease would be reduced or eliminated. However, only a few services have been shown to reduce lifetime total costs.¹¹

The National Commission on Prevention Priorities reviewed 21 services that the USPSTF recommended through December 2004 and four immunizations that ACIP recommends.^{12, 13} It found only five services that reduced costs, including tobacco-use screening and childhood immunizations.¹⁴ The other 16 services increased costs.¹⁵

Many preventive services increase costs because

- The costs of screening for a disease can outweigh financial savings if relatively few people have the disease;
- Some interventions targeted at personal behavior (such as intensive diet counseling) may not change behavior enough to offset the costs of the intervention;¹⁶ and
- Better health care helps people with serious chronic illnesses (most notably the elderly) to live longer, thereby accruing more health care expenses.^{17, 18}

Nevertheless, many preventive services that do not reduce lifetime total costs may be cost-effective ways to improve health.¹⁹

Finally, targeted efforts that combine access to preventive services with more comprehensive programs to improve community health may yield significant cost savings. For example, by one estimate, net savings from well-designed, community-based disease prevention programs throughout the country could yield a national return on investment of more than 5 to 1 in five years.^{20, 21}

EXPANDING HEALTH COVERAGE CAN INCREASE USE OF PREVENTIVE SERVICES, PARTICULARLY IF COVERAGE FOR THESE SERVICES REQUIRES LITTLE OR NO COST TO THE CONSUMER

People with health insurance are more likely to seek preventive services and receive them in a timely manner.²² For example:

- Insured people are four times more likely to have their blood pressure checked regularly than people who are uninsured.²³

-
- Insured women are 17 times more likely to receive a mammogram than women who are uninsured.²⁴
 - Insured people are much more likely to be screened for different types of cancer and, as a result, are more likely to have their cancer diagnosed in earlier stages.²⁵

However, even with insurance, many people do not use preventive services at recommended rates. Nationally, the population uses preventive services at about half the recommended rate, although most Americans are insured.²⁶

The specific design of the insurance programs affects whether consumers use preventive services. Cost sharing (such as deductibles, coinsurance, or copayments) reduces the likelihood of using preventive services. For this reason, Medicare has minimized or eliminated cost sharing for some preventive services, including influenza immunization, cardiovascular screening blood tests, and diabetes screening tests. Similarly, employer-sponsored insurance (including high-deductible plans) often cover preventive services before enrollees reach their deductible.²⁷ Nevertheless, the services that private insurers and Medicare cover do not always reflect USPSTF recommendations.²⁸ Some preventive services that they cover may not be evidence-based or efficiently targeted.

CONSIDERATIONS FOR WASHINGTON STATE

Appropriate and effective preventive services are an important component of health coverage. Washington State can promote the effective use of preventive services by

- Encouraging carriers to cover preventive services that are known to provide net health benefits, particularly those that are cost-saving or cost-effective;
- Encouraging minimum cost sharing for proven (evidence-based) preventive services; and
- Encouraging appropriate targeting of evidence-based preventive services.

NOTES:

¹ Housed at the Agency for Healthcare Research and Quality (AHRQ), the USPSTF is the leading panel of experts in prevention and primary care in the United States. It conducts rigorous, impartial assessments of scientific evidence for the effectiveness of a broad range of clinical preventive services, including screening, counseling, and preventive medications.

² U.S. Preventive Services Task Force (USPSTF). *The Guide to Clinical Preventive Services*. Rockville, MD: AHRQ, 2007; and Salinsky, E. “Clinical Preventive Services: When is the Juice Worth the Squeeze?” *NHPPF Issue Brief* 806, August 24, 2005, pp. 1–30.

³ Colorectal cancer is the fourth most common form of cancer in the United States and has the second highest mortality rate, accounting for about 130,000 new cases and 56,000 deaths in 2000. Screening allows physicians to detect colon cancer in early stages and remove polyps before they become life threatening. See AHRQ. *Systematic Evidence Review #7: Screening for Colorectal Cancer in Adults*. Rockville, MD: AHRQ, 2002.

⁴ AHRQ, 2002.

⁵ ACIP is an independent panel of 15 immunization experts that provides recommendations to the Department of Health and Human Services on routine administration of vaccines to children and adults.

⁶ Center for Disease Control and Prevention. *A Comprehensive Immunization Strategy to Eliminate Transmission of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices*. Washington, DC: U.S. Department of Health and Human Services, 2005; Center for Disease Control. *Measles, Mumps, and Rubella—Vaccine Use and Strategies for Elimination of Measles, Rubella, and Congenital Rubella Syndrome and Control of Mumps: Recommendation of the Advisory Committee on Immunization Practices*. Washington, DC: U.S. Department of Health and Human Services, 1998; and Salinsky 2005, pp. 1–30.

⁷ Although screening can correctly identify ovarian cancer at early stages, screening frequently falsely identifies women as having the disease (USPSTF, 2007).

⁸ USPSTF 2007; Salinsky 2005, pp. 1–30; and USPSTF. *Screening for Ovarian Cancer: Brief Evidence Update*. Rockville, MD: AHRQ, 2003.

⁹ It is important to note that preventive services that USPSTF currently considers inconclusive may actually provide net benefits that have not yet been quantified with rigorous study.

¹⁰ USPSTF 2007; and Salinsky, 2005, pp. 1–30.

¹¹ Cohen J., P. Neumann, and M. Weinstein. “Does Preventive Care Save Money? Health Economics and the Presidential Candidates.” *New England Journal of Medicine*, vol. 358, no. 7, 2008, pp. 661 – 663; and Maciosek, M. V., A. B. Coffield, N. M. Edwards, T. J. Flottemesch, M. J. Goodman, and L. I. Solberg. “Priorities Among Effective Clinical Preventive Services: Results of a Systematic Review and Analysis.” *American Journal of Preventive Medicine*, vol. 31, no. 1, July 2006, pp. 52–61.

¹² The National Commission on Prevention Priorities, established by the Partnership for Prevention, is a 24-member panel of decision makers from health insurance plans, employer groups, academia, clinical practice, and government health agencies. Partnership for Prevention is a membership organization of businesses, nonprofit organizations, and government agencies advancing policies and practices to prevent disease.

¹³ Maciosek et al. 2006, pp. 52–61.

¹⁴ The other three services are (1) the discussion of using aspirin to prevent cardiovascular events for men over age 40 and women over age 50, (2) pneumococcal immunization, and (3) vision screening for adults.

¹⁵ Maciosek et al. 2006, pp. 52–61.

¹⁶ Maciosek et al. 2006, pp. 52–61.

¹⁷ An analysis of Medicare data based on a sample of about 100,000 beneficiaries found that interventions to reduce hypertension and diabetes among the elderly—interventions that are cost effective—did not reduce health care spending overall. Interventions to reduce obesity, however, were found to result in overall savings (Goldman et al., 2006)

¹⁸ Goldman, Dana, David Cutler, Baoping Shang, and Geoffrey Joyce. “The Value of Elderly Disease Prevention.” *Forum for Health Economics and Policy*, vol. 9, no. 2, 2006, pp. 1.

¹⁹ For example, 15 of the 24 preventive services recommended by the USPSTF cost less than \$35,000 per QALY (Maciosek et al. 2006, pp. 52–61.) A Quality Adjusted Life Year (QALY) is a way of measuring disease burden, including both the quality and the quantity of life lived, as a means of quantifying the benefit of a medical intervention. Many common treatments for existing illnesses cost more than \$35,000 per QALY (Cohen et. al. 2008, pp. 661 – 663). Cost-benefit analyses commonly use \$75,000 per QALY as a cut-off point for determining whether a service is cost-effective (Salinsky 2006, pp. 1 – 30).

²⁰ Trust for America’s Health is a partnership of research organizations and major health foundations. It estimates that a \$10 investment per person in Washington could yield savings of \$343.7 million, net of intervention costs.

²¹ Levi, Jeffrey, Laura Segal, and Chrissie Juliano. *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings*. Washington, DC: Trust for America’s Health, 2008.

²² Institute of Medicine. *Coverage Matters: Insurance and Health Care*. Washington, DC: Institute of Medicine, 2001; Powell-Griner, E., J. Bolen, and S. Bland. “Health Care Coverage and Use of Preventive Services Among the Near Elderly in the United States.” *American Journal of Public Health*, vol. 89, no. 6, June 1999, pp. 882–6; and Sudano, J. J., Jr, and D. W. Baker. “Intermittent Lack of Health Insurance Coverage and Use of Preventive Services.” *American Journal of Public Health*, vol. 93, no. 1, January 2003, pp. 130–7.

²³ DeVoe, J. E., G. E. Fryer, R. Phillips, and L. Green. “Receipt of Preventive Care Among Adults: Insurance Status and Usual Source of Care.” *American Journal of Public Health*, vol. 93, no. 5, May 2003, pp. 786–91.

²⁴ Ibid.

²⁵ Ward, E., M. Halpern, N. Schrag, V. Cokkinides, C. DeSantis, P. Bandi, R. Siegel, A. Stewart, and A. Jemal. “Association of Insurance with Cancer Care Utilization and Outcomes.” *CA: A Cancer Journal for Clinicians*, vol. 58, no. 1, January/February 2008, pp. 9–31.

²⁶ McGlynn, E. A., S. M. Asch, J. Adams, J. Keesey, J. Hicks, A. DeCristofaro, and E. A. Kerr. “The Quality of Health Care Delivered to Adults in the United States.” *New England Journal of Medicine*, vol. 348, no. 26, June 26, 2003, pp. 2635–45.

²⁷ Kaiser Family Foundation and Health Research and Education Trust. *Employer Health Benefits 2007 Annual Survey*. Chicago: HRET and Kaiser Family Foundation, 2007.

²⁸ Salinsky 2005, pp. 1–30.

ISSUE BRIEF 4:**CHRONIC DISEASE MANAGEMENT****OVERVIEW**

Chronic disease management (DM) refers to various programs that identify patients with costly chronic conditions (such as diabetes or asthma) and encourage them to follow good self-care behaviors. DM strategies range from educating patients on appropriate self-care strategies (such as diet, exercise, and adherence to self-monitoring, medical appointments, and medications) to developing customized plans for coordinating care for patients with multiple chronic conditions. Some DM programs also try to improve providers' adherence to evidence-based care guidelines.

DM programs have multiplied quickly, but there is no consensus that chronic disease management generally improves health outcomes or reduces costs.¹ Nevertheless, available evidence indicates that *relatively* effective disease management programs:

- Use individualized case management
- Focus on hospital discharges as key opportunities to improve health outcomes
- Reduce patient cost-sharing for effective treatments to encourage adherence

CHRONIC DISEASE MANAGEMENT FOCUSES ON IMPROVING QUALITY OF CARE AND HEALTH OUTCOMES WHILE REDUCING COSTS.

DM programs focus on two central concerns in health care:

- *High cost patients.* Relatively few people with chronic illnesses account for most health care costs. In 2004, more than 75 percent of all medical spending was attributed to the roughly 50 percent of the noninstitutionalized population that had one or more chronic conditions.²
- *Hospitalizations.* Many patients with chronic diseases are hospitalized for acute events that they might have avoided with appropriate treatment or recommended self-care.^{3,4} Acute inpatient hospitalizations are a major driver of total health care expenditures.

By avoiding the need for hospitalization and other acute care, chronic disease management might reduce health expenditures and also improve health outcomes.

THERE IS NO CONSENSUS ABOUT WHETHER CHRONIC DISEASE MANAGEMENT IS EFFECTIVE OR REDUCES COST

In 2007, more than half of U.S. employers offering health insurance said that DM programs in general were effective in reducing health costs.⁵ However, research evidence is mixed regarding DM's impacts on the quality of care, health outcomes, and cost.

For example, there are widely-accepted, evidence-based guidelines for the care of patients with congestive heart failure but programs aiming to implement these guidelines have had mixed results:

- Some DM programs have reduced hospitalization rates and post-discharge mortality for congestive heart failure by 5 to 25 percent.⁶ Other programs have shown no positive impacts on post-hospital mortality.^{7,8}
- Some programs have produced enough savings through reduced hospitalizations to at least cover program costs⁹ but others have not.^{10,11}

More broadly, a review of disease management programs for heart disease, diabetes, and asthma, and other conditions found that some programs did not generate any savings while others saved payers up to \$6.50 for each dollar they invested.¹²

One recent demonstration involving nearly 20,000 Medicare enrollees found that DM *increased* costs on average by 11 percent across the 15 study sites and that none of the sites produced net savings. The sites charged an average of \$155 per enrollee per month for care coordination services, outweighing any savings from the intervention.¹³ Similarly, another large-scale demonstration in a Medicare setting found that disease management did not produce savings once the costs of the interventions were included.¹⁴

In 2004, the Congressional Budget Office concluded that there was insufficient evidence to discern whether chronic disease management reduces costs.¹⁵ A more recent systematic review conducted for the Agency for Healthcare Research and Quality also concluded that more evidence is needed.¹⁶

Conclusions about the effectiveness of DM programs may be inconsistent because the programs focus on different interventions and populations, and the quality or fidelity of program implementation may be uneven.¹⁷ In addition, the programs use varying methods, some more valid than others, to report results.¹⁸ To address the second problem, the National Committee for Quality Assurance is developing standards for assessing DM impacts and may incorporate these standards into its program to accredit DM interventions.¹⁹

CERTAIN FEATURES MAY HELP DM PROGRAMS SUCCEED

Although there is no evidence that chronic disease management systematically improves health outcomes or reduces costs, three specific features appear to contribute to relatively effective programs:

1. ***Individualized case management.*** Successful DM programs follow a common strategy in planning care.²⁰ Specifically, they conduct an initial assessment with the patient to develop a clear, practical plan that addresses the patient's identified chronic illness(es). They implement the plan with a focus on client education, relationship building with physicians, and monitoring to ensure each step of the plan is completed. Finally, they periodically assess the status of the intervention and adjust the plan as necessary.
2. ***Focus on hospital discharges.*** Many chronically ill patients who experience an unplanned hospitalization return to the hospital or the emergency room within months after an earlier hospital stay. This pattern may reflect a number of problems: the patients' acute problems were not resolved by the time they were discharged, they lack self-care skills, their social support is inadequate, or they see multiple providers who do not communicate with one other. Comprehensive discharge planning can reduce the likelihood that a patient will return to the hospital in the first 6 months after being discharged.²¹ Effective discharge planning includes: (a) a skilled nurse working with the patient, physician, and caregiver to develop a discharge protocol that is tailored to the patient's specific conditions and capabilities, (b) in-person nurse visits during and after the hospitalization, and (c) detailed discharge summaries of treatment plans, progress toward goals, and on-going concerns.²²
3. ***Reducing out-of-pocket expenses for recommended care.*** Higher out of pocket expenses can discourage people from seeking appropriate and effective care.²³ Reducing cost sharing for services or medications that are consistent with a patient's DM plan can increase adherence to the plan. For example, reducing co-payments for medications can increase adherence by 7 to 14 percent.²⁴

CONSIDERATIONS FOR WASHINGTON STATE

Chronic disease management in public programs and private insurance plans could improve health care in Washington State. With public and private partners, Washington can take a leadership role in efforts to build on lessons learned and recommendations from past and ongoing DM programs, using and validating best practices to the extent that they are known:

- Washington State could design and pilot DM programs to test best practices, and monitor their costs and outcomes. Evaluation of these programs, using valid evaluation methods, could inform and promote more effective programs in Washington and elsewhere.

- When reliable evaluations identify cost-effective practices, Washington State could develop specific requirements in its contracts with health plans or disease management vendors to ensure that their chronic care programs follow best practices.

NOTES:

¹ In 2005, more than half of U.S. workers were enrolled in a health plan that offers at least one DM program [Kaiser Family Foundation (KFF) and Health Research and Educational Trust (HRET). *Employer Health Benefits Annual Survey*. Washington, DC: KFF, 2005]. More than 20 state Medicaid agencies have instituted DM programs (A. Holmes, A., R. Ackermann, A. Zillich, B. Katz, S. Downs, and T. Inui. “The Net Fiscal Impact of a Chronic Disease Management Program: Indiana Medicaid.” *Health Affairs*, vol. 27, no. 3, 2008, pp. 855–864). The Washington State Insurance Pool (WSHIP) recently expanded its DM programs to cover diabetes, asthma, coronary artery disease, and congestive heart failure [Washington State Health Insurance Pool. “WSHIP Care Management Programs.” Available at https://www.wship.org/Docs/WSHIP%20Care%20Management%20Program%20Description%2006-30-08%20AM%20proofed%20_3.pdf. July 2008.]

² Centers for Disease Control and Prevention (CDC). *The Burden of Chronic Diseases and Their Risk Factors*. Atlanta, GA: CDC, 2004.

³ Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press, 2001.

⁴ Russo, Allison, H. Joanna Jiang, and M. Barrett. “Trends in Potentially Preventable Hospitalizations among Adults and Children, 1997–2004.” *Statistical Brief* #36, August 2007.

⁵ KFF and HRET. *Employer Health Benefits Annual Survey*. Washington, DC: KFF, 2007.

⁶ R. Holland, J. Battersby, K. Hegarty, E. Lenaghan, J. Smith, and L. Hay. “A Systematic Review of Multidisciplinary Interventions in Heart Failure.” *Heart*, vol. 91, no. 7, July 2005, pp. 899–906.

⁷ R. Clark, S. Inglis, F. McAlister, J. Cleland, and S. Stewart. “Telemonitoring or Structured Telephone Support Programmes for Patients with Chronic Heart Failure: Systematic Review and Meta-Analysis.” *BMJ*, vol. 334, no. 7600, May 2007, pp. 942–952.

⁸ R. DeBusk, N. Miller, K. Parker, A. Brandura, H. Kraemer, D. Cher, J. West, M. Fowler, and G. Greenwald. “Care Management for Low-Risk Patients with Heart Failure: A Randomized Controlled Trial.” *Annals of Internal Medicine*, vol. 141, no. 8, October 2004, pp. 606–613.

⁹ M. Rich, V. Beckham, C. Wittenberg, C. Leven, K. Freedland, R. Carney. “A Multidisciplinary Intervention to Prevent the Readmission of Elderly Patients with Congestive Heart Failure.” *New England Journal of Medicine*, vol. 333, no. 18, November 2, 1995, pp. 1190–1195.

¹⁰ A.S. Laramee, S. Levinsky, J. Sargent, R. Ross, P. Callas. “Case Management in a Heterogeneous Congestive Heart Failure Population: a Randomized Controlled Trial.” *Archives of Internal Medicine*, vol. 163, no. 7, April 2003, pp. 809–817.

¹¹ Chen, Arnold, and Melanie Au. “Medicaid Evidence-Based Decisions Project (MED): Rapid Review of the Disease Management Literature.” Princeton, NJ: Mathematica Policy Research, February 6, 2008.

¹² H. Dove and I. Duncan. “Paper 3: Estimating Savings, Utilization Rate Changes, and Return on Investment: Selective Literature Review of Care Management Interventions.” Schaumburg, Illinois: Society of Actuaries, 2005.

¹³ D. Peikes, R. Brown, A. Chen, J. Schore. “Third Report to Congress on the Evaluation of the Medicare Coordinated Care Demonstration.” Washington, DC: Mathematica Policy Research, Inc., January, 2008.

¹⁴ The LifeMasters demonstration targeted Medicare enrollees in Florida who were also eligible for Medicaid. Evaluation of the demonstration found that disease management increased net costs by about \$100 per enrollee, after factoring in the \$127 average cost of the intervention. (K. Stewart, D. Esposito, R. Brown. “Evaluation of Medicare Disease Management Programs: LifeMasters Final Report of Findings.” Washington, DC: Mathematica Policy Research, Inc., September, 2008).

¹⁵ Congressional Budget Office (CBO). “An Analysis of the Literature on Disease Management Programs.” Washington, DC: CBO, 2004.

¹⁶ K. McDonald, V. Sundaram, D. Bravata, R. Lewis, N. Lin, S. Kraft, M. McKinnon, H. Paguntalan, and D. Owens. “Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies: Volume 7: Care Coordination.” Agency for Healthcare Research and Quality Publication No. 04(07)-0051-7, June 2007.

¹⁷ Similar barriers to evaluating the effectiveness of value-based purchasing strategies are discussed in Issue Brief #6.

¹⁸ How best to ascertain the true effects of a disease management program is a complex subject because it is difficult to calculate an appropriate benchmark against which to compare actual medical expenditures. Robust designs randomly assign beneficiaries to treatment groups that receive care coordination and to control groups that do not – and then compare expenditures for these two groups. Commercial DM vendors have often not used such methods, which can be expensive and time consuming, and may report overly optimistic or inflated results for their programs.

¹⁹ National Committee for Quality Assurance. “New Disease Management Quality Measures Released for Public Comment.” Available at www.ncqa.org/tabid/800/Default.aspx August 18, 2008.

²⁰ R. Brown and A. Chen. “Disease Management Options: Issues for State Medicaid Programs to Consider.” Princeton, NJ: Mathematica Policy Research, Inc., April 2004.

²¹ M. Naylor, D. Brooten, R. Campbell, B. Jacobsen, M. Mezey, M. Pauly, J. Schwartz. “Comprehensive Discharge Planning and Home Follow-up of Hospitalized Elders.” *Journal of the American Medical Association*, vol. 281, no. 7, February 1999, pp. 613-620.

²² Naylor (1999), pp. 613-620. J. Minott. “Reducing Hospital Readmissions.” Washington, DC: AcademyHealth, January 2008.
http://www.academyhealth.org/publications/Reducing_Hospital_Readmissions.pdf

²³ See ‘Financial Incentives for Providers and Consumers’, Issue Brief in this series.

²⁴ M. Chernew, M. Shah, A. Wegh, S. Rosenberg, I. Juster, A. Rosen, M. Sokol, K. Yu-Isenberg, and M. Fendrick. “Impact of Decreasing Copayments on Medication Adherence within a Disease Management Environment.” *Health Affairs*, vol. 27, no. 1, 2008, pp. 103–112.

ISSUE BRIEF 5

MEDICAL HOMES

OVERVIEW

A medical home is defined as a source of comprehensive primary care—from the provision of preventive services to the management of chronic illnesses. It supports a trusting, ongoing relationship between patients and primary care providers helping patients to manage their health care better. Ideally, medical homes use integrated data systems and performance reporting to continuously improve access, communication, and quality.¹

The concept of a medical home is central to current efforts to reform health care; it is increasingly seen as a possible solution to the fragmentation, inefficiency, and uneven quality of care in the current health system. As of June 2008, legislatures in 26 states and the District of Columbia introduced 108 bills that include some concept of a medical home; 10 of these states introduced 20 bills to start demonstration projects.² Washington State recently passed legislation directing the Department of Health to establish a Medical Home Collaborative that promotes the adoption of medical homes in various primary care settings throughout the state.³

Key research findings related to medical homes include the following:

- Effective primary care can improve quality of care. By improving prevention and continuity of care, it might also reduce costs.
- For decades, medical homes have been a model for coordinating health care for children, particularly children with special health care needs. More comprehensive models that also focus on adults and the elderly are just now being evaluated.
- Providers face many obstacles when converting to a medical home and these obstacles are larger for small practices. Practices may need both technical assistance and payments to help them make the transition.
- Medical homes are more expensive than traditional primary care practices because they require additional staff time and investments in electronic systems. Currently it is unclear whether these additional costs outweigh the savings that medical homes might generate by reducing unnecessary treatment, avoidable hospitalizations, duplicative testing, or other inefficiencies.

MEDICAL HOMES SUPPORT EFFECTIVE PRIMARY CARE.

The major national physician societies most involved in primary care recently agreed on seven principles that define their vision for a medical home:⁴

1. Each patient has an ongoing relationship with a primary care physician.

2. The physician leads a team that collectively takes responsibility for patients.
3. The physician takes a whole-person orientation, providing preventive services as well as care for both chronic and acute illnesses.
4. Care is coordinated, facilitated by information technology.
5. Care is of high quality; for example, it follows evidence-based care guidelines.
6. Patients have enhanced access to care through systems such as open scheduling and expanded hours.
7. Payment recognizes the added value that medical homes provide to patients.⁵

The medical home model is based on evidence that a strong primary care system can improve quality.⁶ Those who report usually visiting the same primary care physician for their care are:⁷

- More likely than those who do not to be satisfied with their care,⁸
- More likely to use recommended preventive services such as mammograms,⁹
- Less likely to be hospitalized,¹⁰ and
- Less likely to die prematurely.¹¹

States (as well as countries) with more primary physicians per capita generally have better health outcomes and lower costs.^{12, 13, 14, 15} Conversely, areas with more specialists relative to the number of primary care physicians have higher overall medical spending per person, but not better scores on effectiveness or quality measures. That is, access to care is not better, quality is not higher, health outcomes are not better, and patients are not more satisfied in areas with relatively more specialists.¹⁶

MEDICAL HOMES ARE PROMISING, BUT HAVE NOT BEEN RIGOROUSLY EVALUATED

Although some rigorous evaluations of medical homes are planned, none have been completed. Therefore, it is unknown whether medical homes actually improve quality and reduce costs, and under what conditions. The Centers for Medicare and Medicaid Services (CMS) will start a medical home demonstration project for 400,000 Medicare beneficiaries in January 2010. Results from this evaluation should be available in three to five years. In addition, many state Medicaid agencies and private insurers have initiated smaller medical home pilot projects, some of which will be evaluated.

To date, two studies suggest the potential value of medical homes, although neither was done with sufficient methodological rigor to prove medical homes' success:

- **North Carolina.** Since 1998, the state’s Medicaid program has paid primary care practices \$2.50 per Medicaid patient per month above normal fees to coordinate care for these patients. In addition, the Medicaid program has paid \$3 per patient per month to network offices that provide case management across multiple practices. One analysis indicated that this program saved the state \$124 million in 2004, but this may be an overestimate.^{17, 18}
- **Geisinger Health System.** Geisinger is an integrated health care system comprising nearly 700 physicians in clinical practices, hospitals, and other medical facilities in Pennsylvania. In 2006, Geisinger began paying \$1,800 per physician and an additional \$5,000 per 1,000 Medicare patients to practices in two sites to help finance components of a medical home—including expanded access to services, use of nurse care coordinators, care management support, and electronic health records. Early results show a 20 percent reduction in hospital admissions and a 7 percent reduction in total medical costs.¹⁹

PRIMARY CARE PROVIDERS FACE OBSTACLES WHEN DEVELOPING MEDICAL HOMES

To convert their practices to the medical home model, primary care providers must overcome significant obstacles, including limits on their own time, the need to improve their use of information technology, high standards to qualify as a medical home, and potential resistance from consumers and specialty providers. As a result, medical homes can be slow to develop. For example, some practices participating in TransforMED, a national medical homes demonstration project, had not implemented all elements of a medical home after a year and were not expected to implement all elements within two years.²⁰

Limited time. Many primary care physicians find it difficult to take on the additional responsibilities that medical homes require. Physicians participating in TransforMED cited time constraints as one of the main obstacles to implementing medical home principles. One provider described the problem as follows: “We are trying to manage our day-to-day operations while at the same time improving the care we provide. We have a time and energy problem.”²¹

Limited infrastructure. Many practices, particularly small ones, do not have the infrastructure needed to implement aspects of medical homes. For example, nationally, even among practices with 20 or more physicians, only about 40 percent of practices sufficiently use electronic medical records to meet a comprehensive definition of a medical home.²² Smaller practices are even less likely to use electronic records. To meet the infrastructure requirements of medical homes, clinical practices need financial capital and expertise. Smaller practices may need to be creative in sharing the costs of adopting and maintaining IT systems with other practices.

Expansive criteria for a medical home. Several groups have developed specific criteria for determining whether a practice qualifies as a medical home. For example, for the TransforMED demonstration project, the American Academy of Family Physicians developed 42 specific measures—from electronic registries to expanded service hours. These expansive criteria made it difficult for some practices to fully meet the definition of a

medical home.²³ The National Committee for Quality Assurance's (NCQA) definition of a comprehensive medical home is also expansive, but allows practices to qualify for different levels of medical homes. All homes must meet 5 of 10 core elements, which include tracking referrals and following evidence-based care guidelines for at least three conditions. However, practices that take on additional capabilities, such as using electronic systems to write prescriptions, may qualify as more comprehensive medical homes.^{24,25}

Resistance from consumers and specialty providers. Consumers might resist what appears to be another form of “gate-keeping,” restricting their access to specialists or particular services and facilities. In addition, physicians in specialty practices might resist efforts to manage or limit patients’ access to specialty care or services, and have little incentive to communicate with the medical homes doctors to help them coordinate care.²⁶

BECAUSE MEDICAL HOMES PROVIDE ADDITIONAL SERVICES, THEY MIGHT INCREASE TOTAL HEALTH CARE COSTS

Public and private insurers do not explicitly reimburse many of the enhanced services envisioned for a medical home, or they pay little for these services.²⁷ Additional services such as coordinating across specialists or talking with patients via telephone or email require resources—including physician and auxiliary staff time, and information technology.

Building and sustaining medical homes with such additional services entails additional payments to medical home providers.²⁸ Current pilot projects pay between \$3 and \$10 per member per month to providers who undertake the expanded responsibilities of a medical home.²⁹ CMS expects to pay \$27 to \$100 per member month for its medical home demonstration, depending on the severity of the patient’s illnesses and the level of medical home for which the practice qualifies.³⁰ These rates are higher than those that other insurers are paying in their demonstrations in part because care coordination is more difficult for seniors with multiple chronic illnesses.

Various approaches have been taken to increase payments to medical homes, and no one approach has yet gained general acceptance.³¹ Most fee-for-service payers add a flat per-member, per-month fee to the regular fee-for-service payments, regardless of the additional services provided to the patient that month. But some fee-for-service payers have created new billing codes for medical home services. None of the programs have addressed how to ensure, through financial incentives or other means, that medical specialists will cooperate with primary care physicians to coordinate care.

If medical homes do not reduce hospitalizations and other services enough to offset their additional operating costs, they will increase total health care costs. For example, while proponents believed disease management would generate savings of 20 percent or more, the evaluation of the Medicare Coordinated Care Demonstration Project showed that, in 10 of 15 sites, care coordination increased the total costs. While a few sites were likely cost neutral, none of the sites generated savings, and overall, they increased total expenditures by 11 percent.³²

CONSIDERATIONS FOR WASHINGTON STATE

Washington State recently passed legislation directing the Department of Health to establish a Medical Home Collaborative to encourage the development of medical homes throughout the state. Because few such projects have been evaluated, the state has reason to move forward carefully, building on the experiences of other states, private insurers, and federal agencies.

However, there are some lessons already available to help inform the further development of medical homes:

- The criteria for a medical home need to be both clearly defined and feasible. The definition that the Medical Home Collaborative is to develop should recognize that some components will be more feasible to achieve than others. That is, not all types of practices will be able to meet the full range of requirements that have been recommended for comprehensive medical homes. The NCQA criteria for medical homes could serve as a basis for developing a tiered definition for Washington State, categorizing different types of medical homes.³³ Such a definition would also help the State evaluate pilot projects to identify the core set of features common to successful medical homes.
- The state should encourage financing for medical homes that is both adequate and stable. For example, the state could encourage insurers to reimburse additional costs associated with effective medical homes that meet the state's definition. In addition, the state could reimburse providers in public programs for specific medical home expenses. Reimbursement policy should reflect both sides of the equation: the payments need to be large enough to encourage providers to adopt medical home capabilities, but small and targeted enough that cost-neutrality, or even net savings, can reasonably be expected.

NOTES

¹ Fisher, Elliot. “Building a Medical Neighborhood for the Medical Home.” *New England Journal of Medicine*, vol. 359, no. 12, 2008, pp. 1202–1204.

² Iglehart, John. “No Place Like Home—Testing a New Model of Care Delivery.” *New England Journal of Medicine*, vol. 359, no. 12, 2008, pp. 1200–1202.

³ House Bill 2549, effective June 12, 2008.

⁴ American College of Physicians. “Joint Principles of the Patient-Centered Medical Home.” <http://www.medicalhomeinfo.org/Joint%20Statement.pdf>. Accessed September 29, 2008.

⁵ The American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association released these joint principles in March 2007. These organizations represent approximately 333,000 physicians.

⁶ For example, see [Beal, A., M. Doty, S. Hernandez, K. Shea, and K. Davis. “Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from the Commonwealth Fund 2006 Health Care Quality Survey.” New York, June 2007.]

⁷ These are differences after controlling for other factors that can influence service use and health, such as age.

⁸ Starfield, B., and L. Shi. “The Medical Home, Access to Care, and Insurance: A Review of Evidence.” *Pediatrics*, vol. 113, no. 5, 2004, pp. 1493–1498.

⁹ Blewett L., P. Johnson, B. Lee, and P. Scal. “When a Usual Source of Care and Usual Provider Matter: Adult Prevention and Screening Services.” *Journal of General Internal Medicine*, vol. 23, no. 9, 2008, pp. 1354–1360.

¹⁰ Starfield and Shi 2004, pp. 1493–1498.

¹¹ Franks, P. and K. Fiscella. “Primary Care Physicians and Specialists as Personal Physicians: Health Care Expenditures and Mortality Experience.” *Journal of Family Practice*, vol. 47, no. 2, 1998, pp. 105–109.

¹² Baicker, K. and A. Chandra. “Medicare spending, the physician workforce, and beneficiaries’ quality of care” *Health Affairs* (April, 2004): 184-196; and Medicare Payment Advisory Commission. “Report to Congress: Reforming the Delivery System.” Washington, DC: Medicare Payment Advisory Commission, June 2008.

¹³ The strength of a country’s primary care system is measured by an index based on four dimensions of primary care: (1) first-contact care, (2) person-focused care over time, (3) comprehensive care, and (4) coordinated care.

¹⁴ Starfield, B., L. Shi, and J. Macinko. “Contribution of Primary Care to Health Systems and Health.” *The Milbank Quarterly*, vol. 83, no. 5, 2005, pp. 457–502.

¹⁵ Starfield 2005.

¹⁶ MedPAC 2008.

¹⁷ These savings were calculated by comparing actual expenditures to projected expenditures based on 2000–2002 data. These projections may not be accurate.

¹⁸ Lodh, M. “ACCESS Cost Savings – State Fiscal Year 2004 Analysis.” Phoenix, AZ: Mercer Government Human Services Consulting, March 2005.

¹⁹ Paulus, R., K. Davis, and G. Steele. “Continuous Innovation in Health Care: Implications of the Geisinger Experience.” *Health Affairs*, vol. 27, no. 5, 2008, pp. 1235–45.

²⁰ Sullivan, D. “TransforMED Tries to Rebuild Family Medicine.” *Family Practice Management*, May 2007.

²¹ Sullivan 2007.

²² Rittenhouse D., L. Casalino, R. Gillies, S. Shortell, and B. Lau. “Measuring the Medical Home Infrastructure in Large Medical Groups.” *Health Affairs*, vol. 27, no. 5, 2008, pp. 1246–1258.

²³ Sullivan 2007.

²⁴ National Committee for Quality Assurance (NCQA). *Standards and Guidelines for Physician Practice Connections—Patient-Centered Medical Home*. Washington, DC: NCQA, 2008.

²⁵ National Committee for Quality Assurance. “PPC-PCMH Content and Scoring Summary.” Available at <http://www.ncqa.org/tabid/631/Default.aspx>.

²⁶ Fisher 2008, pp. 1202–1204.

²⁷ MedPAC 2008.

²⁸ American College of Physicians 2008; and Goroll, Allan, R. Berenson, S. Schoenbaum, and L. Gardner. “Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care.” *Journal of General Internal Medicine*, vol. 22, no. 3, 2007, pp. 410–415.

²⁹ Bailit, Michael. “National Reimbursement Models and Alignment with Washington State Initiatives.” PowerPoint presentation delivered to the Washington Primary Care Coalition, September 15, 2008; and Iglehart 2008, pp. 1200–1202.

³⁰ Maxfield, M., D. Peikes, R. Shapiro, H. Pham, A. O’Malley, S. Scholle, P. Torda. “Design of the CMS Medical Home Demonstration: Draft.” Princeton, NJ: Mathematica Policy Research, Inc., October, 2008.

³¹ Bailit 2008.

³² Peikes, D., and R. Brown. “Third Report to Congress on the Evaluation of the Medicare Coordinated Care Demonstration.” Princeton, NJ: Mathematica Policy Research, Inc., January, 2008.

³³ NCQA 2008.

ISSUE BRIEF 6

FINANCIAL INCENTIVES FOR PROVIDERS AND CONSUMERS

OVERVIEW

Insurers, self-insured employers, and public programs can use various financial incentives to promote the effective use of health services and discourage the use of marginally effective or inappropriate services.

These incentives may be targeted to providers or consumers. Provider incentives may include using performance standards and/or public reporting of quality of cost measures to establish payments.¹ Consumer incentives are intended to make people more aware of cost and value when they use health care.

While evidence about the impacts of financial incentives in public or private insurance plans is limited, some lessons can be drawn:

- In general, financial incentives work best when targeted to a particular population, type of service, or health condition.
- Financial incentives that improve care and save cost present important challenges for administrators, providers, and consumers. For health plan administrators, designing and using effective financial incentives can be technically challenging and expensive. For providers, reporting on performance can be time consuming. For consumers, choosing among plan, provider, and treatment options can be difficult.
- If not carefully designed, financial incentives can have unintended adverse consequences—including worse health outcomes and higher long-term costs.

FINANCIAL INCENTIVES FOR CONSUMERS AFFECT HOW THEY USE HEALTH SERVICES

Financial incentives can influence consumers' choices about seeking care and using cost-effective services. The use of financial incentives assumes that consumers make better decisions about health care when they have access to good information about costs to help guide their choices and also have to bear a greater portion of the costs.²

Cost sharing (including coinsurance and copayments) affects health care use and expenditures.³ However, when people respond to greater cost sharing by reducing their use of services, they are likely to forego health services that are necessary and effective, as well as services that are more discretionary or ineffective.

Higher coinsurance rates may not have significant health consequences for people of average income and overall health status. But for people in poor health or who have low income, cost sharing can lead to worse health outcomes. People with health problems, as well as those with lower income and education who are enrolled in high-deductible health

plans, are more likely to forgo or delay care.^{4, 5} Vulnerable populations are especially likely to experience negative health outcomes related to cost sharing.^{6, 7} Alternatively, financial incentives can shift greater cost to consumers with serious health problems, without significantly changing the overall costs of care.⁸

VALUE-BASED PURCHASING USES FINANCIAL INCENTIVES FOR PROVIDERS AND CONSUMERS

Many health plans, self-insured employers, provider organizations, and public programs (including Medicare) use financial incentives that are linked to measures of “value.” These encompass both quality and efficiency measures. Recently, these strategies have come to be known generally as value-based purchasing, which includes “pay-for-performance” systems.⁹

Value-based purchasing may focus on incentives for providers, consumers, or both. Efforts that focus on providers typically classify plans or providers according to evidence-based measures of quality and efficiency and may also consider measures of consumer experience or satisfaction. They use this information to select specific providers, determine how much they are paid, or both. Health plans with provider arrangements based on a salaried model may take a somewhat different approach.

Efforts that focus on consumers offer lower premiums or less cost sharing for selecting more efficient and higher quality plans. More specialized efforts focus on patients with specific diagnoses and reduce or eliminate cost sharing when these patients participate in evidence-based treatment plans.¹⁰

Value-based incentives for consumers and providers generally have focused on specific medical conditions, such as diabetes or heart disease.¹¹ However, performance measures vary widely across programs, and the structure and amount of the financial incentives also vary.¹²

VALUE-BASED PURCHASING HAS HAD MIXED RESULTS

There is great potential for improving quality and efficiency by aligning financial incentives with performance that meets standards based on evidence of treatment effectiveness.¹³ Indeed, some value-based programs have met with success, stabilizing insurance costs while removing barriers to appropriate care.^{14, 15} However, available evidence on the effects of pay-for-performance systems is mixed: while some systems show positive effects, others fail to show improvements in quality or efficiency.^{16, 17}

One reason that some pay-for-performance may not have shown significant impact may be that the size of the financial rewards is relatively small.¹⁸ However, the Medicare Payment Advisory Commission has recommended to minimize disruption of care large-scale pay-for-performance incentives should initially involve only a small portion of total reimbursement. Over time, as better measures are developed and providers are able to build the infrastructure they will need, more aggressive use of pay-for performance could be put in place.¹⁹

In addition, most quality measures used in pay-for-performance systems focus on appropriate testing or treatment for specific conditions. Because these services are sometimes underused, better performance can increase service use and costs.

Value-based systems have encountered additional problems related variously to consumer education, provider capacity, and continuity of care. For example:

- Consumers might believe that higher prices mean higher quality, leading them to select inefficient, lower quality, and higher premium health plans.²⁰
- Incentive programs are based on data reporting and can be resource intensive. They require computer hardware and software and systems for data reporting, auditing, and data security. Providers treating a high percentage of vulnerable patients or physicians in solo or small practices may not be able to afford to collect and report the necessary data accurately, efficiently, and reliably.²¹
- Changing to new evidence-based treatment protocols can disrupt care, causing adverse outcomes and ultimately greater cost. This may be a particular problem for people with serious, chronic illnesses who have close ties to their care providers.²² Careful targeting of incentives can protect more vulnerable consumers by identifying individuals who would most benefit from specialized care—but it may also entail additional costs. Targeting requires significant technical and clinical expertise, as well as resources for communication and patient education.²³ In addition, providing high-quality, effective care can be expensive, even when it is targeted.²⁴

INCENTIVES TARGETED TO PROVIDERS CAN HAVE UNINTENDED SYSTEM-LEVEL CONSEQUENCES

To achieve positive outcomes, pay-for-performance systems need to guard against a number of potentially dangerous unintended consequences. For example:

- Payment incentives can lead providers to focus on what will affect their “scores” and neglect aspects of care that are not being measured.²⁵
- Providers may feel that it is more difficult to provide recommended care to some types of patients—for example, patients with limited education or literacy skills or with multiple chronic diseases. Consequently, they may respond to financial incentives or public reporting of performance by avoiding the most vulnerable patients—including those who are the most severely ill.²⁶ Adjusting incentives to reward providers who take on patients who require more care or specialized care can mitigate adverse consequences. However, it requires a more complicated system of incentives.
- Incentive systems that reward only high-performance providers can widen gaps in performance among providers. While those at the top are rewarded, lower

payments to those at the bottom may reduce their ability to invest in improving their performance. This can be avoided by rewarding providers not only on absolute measures of achievement (so that high-performance providers maintain a high level of care) but also on improvements in performance.²⁷

CONSIDERATIONS FOR WASHINGTON STATE

Building effective financial incentives offers opportunities and challenges. There is substantial evidence that both consumers and health care providers respond to financial incentives. But when not designed carefully, financial incentives can cause serious problems—including reduced access to care for the most vulnerable populations.

To improve the quality and efficiency of health care delivery:

- Policies that link financial incentives to consumer choice and provider performance should focus on populations and conditions where there is the greatest need for improvement.
- Financial incentives should be based on valid and reliable evidence of medical effectiveness.
- Financial incentives for consumers should be designed to avoid the potential negative outcomes of high cost sharing. These incentives especially affect low-income people who are sick. Consumer education to support good decisions about using care may be most challenging for these patients.

NOTES:

¹ The way that health plans pay providers is often complicated, and sorting out financial incentives can be difficult. Health plans can pay providers retrospectively through fee-for-service, or prospectively in set amounts designed to cover the costs of patient care. Retrospective payment encourages the provision of additional services to patients, because providers are paid for each treatment or service. Prospective payment encourages more efficient treatment patterns because it is a sort of fixed budget, but it also potentially discourages providers from offering services, including needed services, to patients. Most commercial provider payment systems represent hybrid approaches. For instance, fee-for-service payment may be combined with payment bonuses or withholds based on specified quality or satisfaction performance measures. Providers would, in this case, have conflicting financial incentives – providing more services would increase revenues, but providing too many, or lower quality services could lead to penalties.

² Hibbard, J, J. Greene, and M. Tusler. “Does Enrollment in a CDHP Stimulate Cost-Effective Utilization?” *Medical Care Research and Review*, vol. 65, no. 4, 2008, pp. 437–449.

³ Gruber, J. *The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond*. Washington, DC: The Henry J. Kaiser Family Foundation, 2006; Pauly, M. “The Truth About Moral Hazard and Adverse Selection.” *Center for Policy Research Policy Briefs*, no. 36, 2007, Center for Policy Research, Maxwell School, Syracuse University; and Congressional Budget Office (CBO). *Consumer-Directed Health Plans: Potential Effects on Health Care Spending and Outcomes*. Washington DC: CBO, 2006.

⁴ For example, recent research shows that enrollees in consumer-directed plans with relatively low deductibles are more likely to start using available information about costs and quality of health services than enrollees in high-deductible plans, while those in the high-deductible plans were more likely than those in the lower deductible plans to delay seeking care because of cost. See Dixon, A., J. Greene, and J. Hibbard. “Do Consumer-Directed Health Plans Drive Change In Enrollees’ Health Care Behavior?” *Health Affairs*, vol. 27, no. 4, 2008, pp. 1120–1131.

⁵ Hibbard et al. 2008; Fronstin, P., and S. Collins. “Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey.” *Employee Benefit Research Institute Issue Brief*, no. 288, 2005; and Dixon et al. 2008, pp. 1120–1131.

⁶ Higher cost sharing that keeps vulnerable populations from seeking appropriate health care can lead to the use of more expensive forms of care, such as emergency room care or hospitalization. See Ku, L., and V. Wachino. “The Effect of Increased Cost-Sharing in Medicaid: A Summary of the Research Findings.” Washington, DC: Center on Budget and Policy Priorities, 2005.

⁷ Gruber 2006; CBO 2006; and Hibbard et al. 2008, pp. 437–449.

⁸ Tu, Ha, and P. Ginsburg. “Benefit Design Innovations: Implications for Consumer-Directed Health Care.” *Issue Brief* no. 109, 2007.

⁹ Most commercial health maintenance organizations (HMOs) use pay-for-performance incentives in their provider contracts. See Rosenthal, M., B. Landon, S. Normand, R. Frank, and A. Epstein. “Pay for Performance in Commercial HMOs.” *The New England Journal of Medicine*, vol. 355, 2006, pp. 1895–902.

¹⁰ Chernew, M.E., A.B. Rosen, and M. Fendrick. “Value-Based Insurance Design.” *Health Affairs*, vol. 26, no. 2, 2007, w195–w203. Web Exclusive <http://content.healthaffairs.org>.

¹¹ Tu et al. 2007.

¹² These performance measures typically focus on clinical quality, use of information technologies (such as computerized pharmacy ordering), volume of services provided, and patient experience and satisfaction. See Rosenthal et al. 2006, pp. 1895–902; and Rosenthal, M. Testimony before the House Subcommittee on Employer-Employee Relations Hearing on Examining Pay-for-Performance Measures and Other Trends in Employer-Sponsored Health Care. May 17, 2005.

¹³ Medicare Payment Advisory Commission (MedPAC). *Data Book 2007*. Washington DC: MedPAC; and Congress of the United States, Congressional Budget Office (CBO). *Budget Options 2007*. Washington DC: CBO.

¹⁴ Silow-Carroll, A., and T. Alteras. “Value-Driven Health Care Purchasing: Case Study of Wisconsin’s Department of Employee Trust Funds.” The Commonwealth Fund: Publication no. 1056, 2007; Silow-Carroll, A., and T. Alteras. “Value-Driven Health Care Purchasing: Case Study of Minnesota’s Smart Buy Alliance.” The Commonwealth Fund: Publication no. 1054, 2007; and Chernew et al. 2007, w195–w203.

¹⁵ Testimony of Meredith B. Rosenthal, Ph.D., Assistant Professor of Health Economics and Policy, Harvard School of Public Health. House Subcommittee on Employer-Employee Relations Hearing on Examining Pay-for-Performance Measures and other Trends in Employer-Sponsored Health Care: May 15, 2005.

¹⁶ Many pay-for-performance systems are relatively new, and because they vary in design and include differing enrollee populations receiving health care in a wide range of delivery systems, it is difficult to evaluate their impacts on care delivery, costs, or outcomes. In addition, designing and operating pay-for-performance systems requires expertise and infrastructure; as a result, the systems are more common in large, integrated health organizations, which may also have more resources to devote to quality improvement. This makes it difficult to determine whether improvements are the result of pay-for-performance systems rather than better overall performance in the organizations that are implementing them (Rosenthal 2005). The pay-for-performance system is, moreover, only one facet of wider efforts to improve quality and efficiency, which makes it difficult to evaluate its contribution to changes in provider practice. For example, an analysis of pay-for-performance systems in large commercial health plans contracting with physician groups in Massachusetts over a three-year period found that there was no significant difference in increases in quality of care delivered under these systems compared with the overall trend in toward quality improvement for plans in general. See Pearson, S., E. Schneider, K. Kleinman, K. Coltin, and J. Singer. “The Impact of Pay-for-Performance on Health Care Quality in Massachusetts, 2001-2003.” *Health Affairs*, vol. 27, no. 4, 2008, pp. 1167–1176.

¹⁷ CBO 2007; Rosenthal, M., and R. Dudley. “Pay-for-Performance: Will the Latest Payment Trend Improve Performance?” *JAMA*, vol. 297, no. 7, 2007, pp. 740–744; Schatz, M. “Does Pay-for-Performance Influence the Quality of Care?” *Curr Opin Allergy Clin Immunol*, vol. 8, no. 3, 2008, pp. 213–221; and Bokhour, B., J. Burgess, J. Hook, B. White, D. Berlowitz, M. Guldin, M. Meterko, and G. Young. “Incentive Implementation in Physician Practices: A Qualitative Study of Practice Executive Perspectives on Pay-for-Performance.” *Medical Care Research and Review*, vol. 63, no. 1, 2006, supp: 73S–95S.

¹⁸ Rosenthal, M, R. Frank, L. Zhonghe, and A. Epstein. “Early Experience with Pay for Performance” *JAMA*, vol. 294, 2005, pp. 1788-1793.

¹⁹ MedPAC Report to the Congress March 2005.

²⁰ Agency for Healthcare Research and Quality (AHRQ). “Consumer Financial Incentives: A Decision Guide for Purchasers.” AHRQ Publication No. 290-06-0023-2. Rockville, MD: AHRQ, 2007.

²¹ Rosenthal et al. 2006, pp. 1895–902.

²² For example, some health plans require higher coinsurance, or do not cover many name-brand drugs when cost substitutes are available as a means of controlling drug costs. Even though the restrictions may be consistent with evidence regarding clinical effectiveness, these formularies can lead some consumers with chronic conditions to stop taking needed medications best suited for their particular condition, causing avoidable adverse outcomes and, in the long run, increased medical costs (AHRQ 2007).

²³ Chernew et al. 2007, w195–w203; and AHRQ 2007.

²⁴ Chernew et al. 2007, w195–w203.

²⁵ Hahn, J. “Pay-for-Performance in Health Care.” Washington, DC: Congressional Research Service, 2006.

²⁶ Burack, J.H., P. Impellizzeri, P. Homel, J.N. Cunningham, W.C. Nugent, F.L. Grover, S.J. Lahey, C.E. Anagnostopoulos, and M.C. Oz. “Public Reporting of Surgical Mortality: A Survey of New York State Cardiothoracic Surgeons.” *The Annals of Thoracic Surgery*, vol. 68, no. 4, 1999, pp. 1195-1202; and Shen, Y. “Selection Incentives in a Performance-Based Contracting System.” *Health Services Research*, vol. 28, no. 2, 2003, pp. 535–552.

²⁷ Hahn 2006; and Rosenthal and Dudley 2007, pp. 740–744.

APPENDIX D

METHODS

This appendix provides details on the methods of modeling coverage and expenditures under each proposal, as well as how the economic impact of each proposal was estimated.

A. MODELING CHANGES IN COVERAGE AND EXPENDITURES

The change in the number of people with health insurance and the costs associated with that coverage were estimated using a microsimulation model. This model predicts the change in individuals' behavior when faced with a change in the price or availability of coverage and aggregates changes in individual behavior to estimate total change in the state. The microsimulation process involves two major steps: developing estimates of the current case and then developing and implementing the microsimulation logic that drives estimates for each proposal. Each step is described below.

1. The Current Case

In order to create a baseline against which changes in coverage and expenditures under each proposal could be measured, a "current case" must be developed. The current case is a picture of the population under the age of 65, including sources of coverage and expenditures for health care services and insurance, assuming no policy change. It is projected to the year (FY2010) in which each of the proposals will be compared. For this study, development of the current case itself required microsimulation in order to estimate enrollment in HIP.⁴³ The current case for this study is the Basic HIP simulation that Mathematica developed for the HIP Board Studies.

⁴³ In our earlier report to the Health Insurance Partnership (HIP) Board, we compare estimated coverage assuming full operation of the HIP that was scheduled to open in January 2009 with coverage assuming no HIP. See: Chollet, D, J. Ballou, T. Bell, J. Matthisen, A. Lischko, V. Wilson, K. Pollitz, and K. Lucia. *Health Insurance Partnership Board Studies: Enrollment, Cost, and Implementation of a Preliminary Expanded Partnership*, October 2008 (http://www.hca.wa.gov/documents/legreports/E2SHB1569_HIP_Prelim_Report.pdf, accessed 2/1/09).

a. Data Sources

The 2006 State Population Survey (SPS) is the primary database for development of the current case and microsimulation of the proposals. The SPS includes person-level information about the family, socioeconomic, and coverage characteristics of a representative sample of the noninstitutionalized population in Washington.⁴⁴ To supplement the SPS with information about premiums and insurance plan design, we used data from two additional surveys: the Medical Expenditure Panel Survey Household Component (MEPS-HC) and the Medical Expenditure Panel Survey Insurance Component (MEPS-IC).

The MEPS-HC provides individual- and family-level information on employee contributions to premiums, policy premiums, and medical cost experience. The household sample is not large enough to support state-level estimates, but it does support multi-state regional estimates. To develop a sample that is representative of Washington (when reweighted to state population characteristics) and also of sufficient size to achieve good statistical precision, we used the West and Midwest subsamples of the MEPS-HC and combined two years of the survey (2004 and 2005).

The MEPS-IC provides information about employee eligibility and enrollment in insured and self-insured employer-sponsored coverage, and employer contributions to premiums. The MEPS-IC sample of private establishments does support Washington-specific estimates, although sometimes with low statistical precision. To obtain Washington-specific information from the MEPS-IC, we asked the federal agency that sponsors the survey—the Agency for Healthcare Research and Quality (AHRQ)—on behalf of the HIP Board to produce estimates from the Washington State employer sample. To obtain sufficient statistical precision, three years of the Washington State sample were combined (2003-2005). AHRQ provided estimates of the distribution of Washington State establishments by self-insured status, offer of a Section 125 plan, and employer contribution to premiums. Information about the percent of workers eligible for coverage in offering firms in Washington State was obtained from tabulations available on AHRQ’s MEPS-IC website.

b. Database Construction

To focus on populations of primary interest with respect to the policies to be simulated, we created a data set that excluded elderly persons (65 or older), as well as those enrolled as policyholders in federal or military health care plans (dependents in these plans are retained in the database). The MEPS-HC data were statistically matched to SPS data, assigning to people represented in SPS the premium and cost sharing reported by MEPS-HC individuals with similar characteristics—age, gender, source of insurance coverage, residence in a

⁴⁴ The SPS sample frame is similar to that used by the Census to conduct the Current Population Survey (CPS). The CPS excludes patients in long-term hospitals and other health facilities, as well as inmates of penal or other institutions. Individuals residing in group quarters (such as a rooming house, staff quarters at a hospital, or a halfway house) are not considered to be institutionalized and, therefore, are included in the survey. It is unlikely that either survey adequately represents homeless or transient individuals.

metropolitan statistical area (MSA), race/ethnicity, self-reported health status, income level, marital status, whether living with children, industry and firm size of employment, and education. MEPS-HC premiums and expenditures (total and out-of-pocket) were benchmarked by payer type to average per-member-per-month (pmpm) premiums and medical expenditures in Washington State.

The enhanced SPS data were then re-weighted to match both (a) Washington's population (by region, age, race, and gender) as projected to 2010 by the OFM, and (b) public program enrollment (Medicaid, SCHIP, and other public programs) as projected by the state Department of Social and Health Services (DSHS) and the Washington State Caseload Forecast Council, assuming children's eligibility for Medicaid and SCHIP eligibility was expanded to 300 percent FPL. Private insurance premiums and medical expenditures were projected to 2010 by the average rate of change observed from 2003 to 2007, as reported to the Office of the Insurance Commissioner (OIC). WSHIP enrollment and expenditures also were extrapolated from 2003-2007 trends.

Finally, each observed worker was assigned coworkers to form a "synthetic firm." Following econometric estimation of employer offer (described below), potential coworkers in the SPS were identified by whether they were offered group coverage, geographic region, and firm size. These potential coworkers were assigned to the observed worker in proportion to their occurrence in the population. In firms that offer coverage, coworkers included those who are eligible and ineligible for coverage, benchmarked to the distribution of the eligible percent of workers by firm size reported in MEPS-IC.

c. Simulated HIP Coverage

The current case is a representation of the Washington health care system in 2010; it assumes that the HIP is operating and available to low-wage small employers. In simulating enrollment in the HIP, we first estimated which eligible employers would offer coverage and then which eligible employees, when offered coverage, would take it up. Assumptions about employer and employee behavior were developed by estimating econometric models to predict employer offer and individual take-up of (respectively) small group coverage, large group coverage, individual coverage, and Basic Health.⁴⁵

For each worker in the simulation, a group premium was calculated for each of the twelve HIP plans, for four types of coverage (single, adult plus spouse, adult plus children, family). Ordinary least squares (OLS) techniques and premium quotes (for HIP and non-HIP plans) obtained by the HIP Board for a set of small group profiles were used to estimate premium quotes for each eligible small group.

⁴⁵ Because predictive accuracy is of overriding importance in simulations, in all cases model specifications were judged first on the basis of their ability to predict accurately; related criteria for model selection included model fit (how well the model explained the data) and the plausibility of the estimated effects (for example, whether predicted relationships between prices and take-up comport reasonably with those estimated in other states). Not all models were necessary for all proposals. For example, Proposal 3 did not require estimates of employer offer.

For workers in firms with a potential HIP offer, the required employee contribution was calculated as the total HIP premium minus the employer contribution, adjusted for the HIP subsidy (if eligible) and use of a Section 125 plan.⁴⁶ The HIP subsidy was applied to the total employee contribution to premium, including family premiums if the worker selects family coverage. Expected OOP expenditures under each HIP plan also were calculated for each worker, based on observed total expenditure (as a proxy for the worker's best estimate of expenditure when insured) and the benefit design of each HIP plan. The microsimulation entailed estimating the probability of worker take up for each potential offer and each family type, adjusting the take-up probability differences in cost-sharing based on response estimates reported in the literature.⁴⁷

2. Simulation of the Reform Proposals

Microsimulation logic was prepared for each proposal reflecting the assumptions laid out in Chapters 2 through 6. The logic for each proposal was applied to the current-case data to simulate whether individuals would choose to enroll in coverage (if uninsured in the current case) or change their current source of coverage (if insured in the current case). The unique aspects of each proposal's logic are summarized briefly here.

a. Proposal 1: Reduced Regulation

Employer offer and worker take up were estimated using the behavioral equations estimated from the current case. Changes in employer and employee decisions to offer and take coverage, respectively, are driven by changes in projected premiums and out-of-pocket expenses controlling for worker characteristics. Only employers that do not currently offer coverage are eligible to offer an ERB plan. Workers in these firms are offered a reduced-benefit small group (ERB) plan only if the employer is willing to pay a premium at least equal to the ERB premium and at least 75 percent of coworkers would accept ERB coverage when offered. Employer offer and worker take up are estimated using the same behavioral equations as estimated for the current case simulation.

Carriers offer young adults aged 19 to 34 reduced-benefit individual (IRB) plans. For both IRB and standard individual plans, carriers no longer age-adjust premiums for adults in this age group. Use of a 19-34 year rate band has the effect of increasing premiums for adults aged 19-24, and decreasing premiums for adults aged 25-34 year olds. By assumption, it does not change premiums for adults aged 35-64.

⁴⁶ To estimate the impact of Section 125, each worker was assigned a marginal personal income tax rate based on the last dollar of family income.

⁴⁷ Daniel Polsky, Rebecca Stein, Sean Nicholson, and M. Kate Bundorf (October 2005). "Employer Health Insurance Offerings and Employee Enrollment Decisions." *Health Services Research* 40(5), Part I: 1259-1277. The authors report several cost-sharing effects. Because approximately 80 percent of offered workers in Washington take up coverage from an alternative source after declining an employer's offer, we use the estimated effect of taking up employer offer measured against another offer, as opposed to the effect measured against remaining uninsured.

Young adults with individual coverage in the current case respond to premium increases or decreases consistent with the behavioral parameters estimated for the current case simulation. Insured young adults who experience a premium increase and would drop their current health plan are assumed to maintain standard coverage, but with higher cost sharing, if they had expenditures in the prior year for a condition that an IRB plan would exclude. Other insured young adults (with no prior-year expenditures for an excluded condition) who would drop their current coverage in response to a premium increase consider purchasing an IRB plan. Uninsured young adults facing lower standard premiums are assumed first to consider taking a standard plan at the lower premium and then to consider taking an IRB plan.

b. Proposal 2: Health Insurance Connector

As for Proposal 1, employer offer and worker take parameters were estimated from the current case, and changes in employer and employee decisions are driven by changes in projected premiums and out-of-pocket expenses. Eligible small group workers receive an offer of Connector coverage if the employer is willing to offer coverage to the target worker and at least 75 percent of coworkers would be willing to take some Connector plan. In determining employee contributions to premium, previously offering employers were assumed to continue to make the same dollar contribution as in the current case previously. To accommodate the new mandate, the likelihood of taking coverage was adjusted upward for non-exempt residents who were not predicted to take coverage voluntarily; residents who still were not predicted to acquire coverage even after this adjustment were deemed non-compliant.

Carriers would no longer age-adjust premiums for adults aged 19 to 29. Use of a 19–29 year rate band had the effect of slightly increasing premiums for adults aged 19–24 while decreasing premiums for adults aged 25–29. By assumption, the use of a broader rate band for young adults had no effect on how carriers rated older adults.

c. Proposal 3: Health Partnership

The PEBB plans currently offered in Washington State were assumed to constitute the range of coverage options available under Proposal 3, with the Uniform Medical Plan representing the fee-for-service option. Current PEBB premiums were adjusted to reflect the age distribution of Washington State. To do this, a regression relationship between current premiums and the age distribution of policyholders was estimated. The coefficients of this regression were then applied to the expected age distribution of Washington State in 2010 to estimate new age-adjusted premiums for each of the PEBB plans to determine the adjusted prices that residents would consider in choosing a Health Partnership plan.

Resident take up was estimated as a function of net premiums charged, using the same behavioral equations as estimated for the current case. Net premiums charged to residents were zero for the lowest-cost plan and the fee-for-service option; otherwise they were the difference between the plan's age-adjusted full premium and the full premium for the lowest-cost plan. Individuals and families were assumed to take the most comprehensive coverage they were willing to pay for. Take-up decisions for persons eligible for but not enrolled in

Medicaid were also estimated; any Medicaid-eligible resident who was inclined to take up the Health Partnership was assumed to enroll in Medicaid.

d. Proposal 4

All residents eligible for the single payer plan were automatically enrolled in that plan. As in Proposal 3, when eligible for Medicaid (under new eligibility rules), residents were automatically referred to Medicaid and enrolled. The scope of covered services among individuals who are insured in the current case was adjusted to reflect the PEBB (Uniform Medical Plan) benefit.

Medicaid reimbursement rates are adjusted to commercial levels. This adjustment was derived from estimates net revenue per expenses for commercial carriers versus Medicaid.⁴⁸ The adjustment (1.66) was calculated as the weighted average of the median ratio of net revenues per expenses for commercial carriers versus Medicaid, reported separately for hospitals (1.38) and physicians (1.78). The physician ratio was applied to all non-hospital providers receiving payments from Medicaid.

e. Proposal 5

Estimating changes in coverage and costs for Proposal 5 required determining how much premiums for employer-sponsored and individual coverage would fall upon the introduction of the Guaranteed Health Benefit Program. To assess this, changes in out-of-pocket expenditures and total medical expenditures (excluding the cost of preventive care) were estimated at the individual level; these new expenditure estimates were then aggregated to determine the change in total expenditures and hence, at a constant loss ratio, the corresponding change in total premiums. The original premiums at the individual level were then adjusted by multiplying them by the ratio of new total premiums to original total premiums.

Employer offer and worker/individual take up were estimated as a function of the new premiums, using the same behavioral equations as estimated for the current case. It was assumed that all employers previously offering coverage continued do so. The expansion of Basic Health coverage to 300 percent FPL required using the Basic Health take-up model to estimate take-up by previously uninsured residents newly eligible for Basic Health.

3. Induced Demand for Health Services

Changes in coverage affect an individual's expenditures on health care in two ways. First, a change in coverage may affect the share of total health care costs paid by the federal government, the state, and private sources (including out-of-pocket costs and the employer share of premiums). For example, a previously-uninsured person who gains Medicaid

⁴⁸ See: Milliman, Inc. (May 2006), "Payment Level Comparison between Public Programs and Commercial Health Plans for Washington State Hospitals and Physicians" (https://www.premera.com/stellent/groups/public/documents/pdfs/dynwat%3B19064_1015788200_3256.pdf, accessed December 12, 2008).

coverage will cause a drop in statewide out-of-pocket spending and a commensurate increase in state and federal spending. Changes in coverage also have second-order effects, as a reduction in out-of-pocket costs will induce greater demand for medical services. The estimates of expenditures under Proposals 1 through 5 include the effects of this induced demand.

We assume that for each decrease of \$1.00 in out-of-pocket costs, an individual would demand an additional \$0.62 of medical services; similarly, an increase of \$1.00 in out-of-pocket costs decrease total demand by \$0.62. This estimate was calculated as the weighted average of induction factors by type of service derived from the RAND Health Insurance Experiment.⁴⁹ Weights were calculated as the proportion of national medical spending among people under 65 by type of service (excluding vision and dental) as reported in the Household Component of the 2005 MEPS. Individuals who did not face a change in out-of-pocket costs were assumed to have an unchanged level of expenditures.

B. ECONOMIC IMPACT ANALYSIS

Estimates of the economic impact of each proposal are based on regional input-output (I-O) multipliers developed by the Bureau of Economic Analysis (BEA), which summarize the relationship between different industries in each state.⁵⁰ The multipliers allow initial changes in demand in one industry to be converted into a final impact on the state's economy, by estimating how an increase in spending in one industry affects related industries. The RIMS II multipliers used for this analysis are widely used to estimate the economic effects of policy changes, and have been shown to provide similar estimates to those produced using more expensive surveys. The multipliers used to estimate the economic impact of each proposal are based on national data from 1997 that BEA modifies to reflect Washington State's industrial structure and trading patterns.

The economic impact analysis assumes that changes in the *distribution* of spending by households and by the state without changes in the total *amount* of spending will not have a net impact on total economic activity. That is, if the state has larger expenditures on health care that are offset by smaller expenditures in other areas, or an individual pays more of their salary for health care premiums but this additional expenditure is offset by less spending on other goods, the net impact is assumed to be close to zero. However, a change in the absolute level of spending in the state is assumed to have an effect on aggregate economic output; these changes will arise from increases or decreases in the amount of federal dollars

⁴⁹ See: E. C. Hustead et al., "Medical Savings Accounts: Cost Implications and Design Issues." Washington, DC: American Academy of Actuaries, May 1995 (http://www.actuary.org/pdf/health/msa_cost.pdf, accessed 11/29/08). Some services, such as those delivered in an inpatient hospital, are less sensitive to cost sharing, and are estimated to increase demand by \$0.30 for each dollar reduction in out-of-pocket costs. However, services such as prescription drugs are more sensitive to cost sharing and are expected to increase demand for services by \$1.00 for each \$1.00 reduction in out-of-pocket costs.

⁵⁰ Available at <http://www.bea.gov/regional/rims/index.cfm>. More detail about the multipliers and their use can be found in the RIMS II User Handbook, available at <http://www.bea.gov/scb/pdf/regional/perinc/meth/rims2.pdf>.

flowing into or out of the state. In the proposals, this occurs when (1) state spending on Medicaid and SCHIP is increased, which brings new federal dollars into the state economy that would not otherwise be available, and (2) when more or less participation in Section 125 plans increase or decrease the amount of federal taxes paid by households.

1. Changes in Medicaid and SCHIP Spending

For each proposal, the change in federal spending on Medicaid and SCHIP was calculated using the estimates in Appendix Table B.8. The initial change in federal spending was converted to a final change in state output using a weighted multiplier of two health care industries, hospitals and ambulatory care (RIMS II industries 52 and 53). Weights were calculated as the proportion of national medical spending among people under 65 by type of service (excluding vision, prescription drugs, durable medical equipment and dental) as reported in the Household Component of the 2005 MEPS.⁵¹

2. Changes in Section 125 Spending

The change in federal taxes remitted by households was calculated using the change in Section 125 spending on Appendix Table B.8. The initial change in federal taxes paid was converted to a final change in state output using the RIMS II household multipliers.

⁵¹ In both Proposals 2 and 3, increases in Medicaid and SCHIP spending occur when previously-uninsured individuals become eligible for Medicaid/SCHIP. We assumed that these newly-eligible individuals would have patterns of health care spending similar to all individuals under 65, rather than similar to the existing Medicaid population which includes many disabled individuals.