STATE COMPREHENSIVE ACCESS INITIATIVES

Statement of
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INTRODUCTION

The inability of low- and middle-income families to afford health insurance is a problem that is reaching crisis proportions. The symptoms of this fundamental problem are pervasive. They include steady erosion of group coverage among low-wage workers, weak and unstable individual insurance markets, growing numbers of uninsured and under-insured families, and growing reliance on SCHIP and Medicaid.

With only further deterioration of private coverage on the horizon, a number of states have designed and implemented new programs intended to support insurance coverage and to close gaps in coverage for low- and middle-income families. In the past several years, New York, Maine, Vermont, and Massachusetts have launched major new initiatives to help low-income and/or low-wage working families obtain coverage. These states join the ranks of states such as Minnesota, Oregon, and Washington, which for many years have funded programs for low-income adults who are ineligible for Medicaid or SCHIP.[2]

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[1] The opinions expressed here are solely those of the witness, and should not be attributed to Mathematica Policy Research, Inc., its Directors, Board, employees, or clients.

[2] Minnesota's program, MinnesotaCare, offers subsidized coverage to families with children up to 275 percent FPL under Medicaid and childless adults up to 175 percent FPL. MinnesotaCare receives federal Medicaid and SCHIP matching funds for qualified enrollees. However, coverage for adults without children with incomes between 75 percent and 175 percent FPL is entirely state-funded, and benefits for these enrollees are limited.

However, the newer generation of statewide reforms differs in significant ways from the earlier state programs, which were designed as alternatives to private coverage for adults whose incomes are too high for Medicaid but much too low to purchase individual coverage. Specifically, the newer generation of programs focuses on organizing private insurance markets for small groups and individuals as a precondition for subsidies.

At present, all of these programs coexist with struggling private markets for small group and individual coverage. But the programs in Maine and Massachusetts, especially, recognize that the new state-structured program could ultimately dominate these markets. As market leaders, these programs could gain the economic leverage necessary to constrain cost and improve quality, while offering a more stable system of coverage for individual residents and workers in small firms.

STATE INITIATIVES TO ORGANIZE AND SUPPORT MARKETS

New York. Operating since 2001, Healthy New York is a state program that provides comprehensive health benefits to more than 130,000 small-group enrollees, sole proprietors, and uninsured workers. Low-wage employers may buy Healthy NY coverage for all workers, regardless of income.[3] In addition, previously uninsured individuals and sole proprietors with family incomes less than 250 percent of the federal poverty level (FPL)—in 2008, $26,000 per year for single adults and $56,000 for families of four—are eligible to enroll, if they worked at some time in the past 12 months.

Widely regarded as a model for initiatives to expand private insurance, Healthy NY provides reinsurance as the means to reduce premiums: the state pays 90 percent of claims between $5,000 and $75,000 per year. Premiums averaged $204 per month for individual

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Oregon operates the Family Health Insurance Assistance Program (FHIAP), which was created in 1997 with state-only dollars to address the needs of families who do not qualify for Medicaid or Medicare. In 2002, the program was included in the Oregon Health Plan 2 Waiver and began to receive federal matching funds. FHIAP provides a premium subsidy on a sliding scale to individuals (families and adults without children) with income below 185 percent FPL. FHIAP will pay employee contributions to group premiums if the enrollee is offered group insurance; otherwise FHIAP enrolls members in commercial individual coverage.

Washington operates Basic Health, which provides subsidized coverage to approximately 100,000 state residents with income below 200 percent FPL. Monthly premiums are based on family size, income, age, and health plan choice; subsidies are scaled to income. BH includes several small sub-programs, including a "financial sponsors" program that allows a third party to pay the BH premium, and an employer-sponsored program that allows employers to pay the BH premium. As of Fall 2006, about 28,000 BH enrollees had financial sponsors, and 250 BH enrollees were enrolled in the employer-sponsored program. BH is also available to foster parents and homecare agency workers or individual providers employed by clients of the state's Medicaid Aging and Disability program (Robert Wood Johnson Foundation's State Coverage Initiatives Program, http://www.statecoverage.net/profiles/washington.htm#other, accessed March 3, 2008).

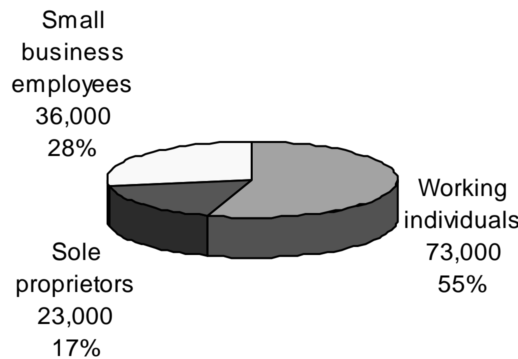
[3] Eligible small groups (with 2 to 50 employees) cannot have provided health insurance (or have contributed substantially to coverage if offered) for the last 12 months, and employers and must certify that at least 30 percent of employees are paid $36,500 or less. Qualifying employers must offer HNY coverage to all employees who make $36,500 or less per year and work 20 or more hours per week, pay at least half of single premium; at least 50 percent of employees must enroll in Healthy NY or have other coverage.

coverage in July 2006— well below market premiums.[4] All HMOs in New York State are required to offer the Healthy NY product, which includes inpatient and outpatient hospital, maternity coverage, physician services, laboratory, radiology, and preventive services—but excludes mental health, substance abuse, home health, physical therapy, and chiropractic services. Prescription drugs are covered with an optional rider.[5]

New York uses its tobacco settlement funds to finance Healthy NY. However, the cost of Healthy NY to the state has consistently been much lower than was initially anticipated. New York introduced the program in the context of its substantial regulation of the private insurance market—where both small group and individual coverage are continuously guaranteed issue and private carriers are required to use pure community rating (varying premiums only for geographic location and family size). These market rules ensure access to private coverage for residents with health problems and probably have mitigated adverse selection into Healthy NY. In 2006, 17 health plans offered 311 Healthy NY products to New York state residents.

FIGURE 1

HEALTHY NEW YORK ENROLLMENT, 2006



Source: EP&P Consulting, Report on the Healthy NY Program 2006 (January 2007).

Maine. Maine created the Dirigo Choice program to make a small group and individual insurance product more affordable by subsidizing low-income enrollees' premiums and deductibles. At the time the program was enacted in 2003, Maine had the nation's second highest employer premium costs, adjusted for the quality of benefits; the nation's second-

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[4] EP&P Consulting, Report on the Healthy NY Program 2006 (January 2007). Prepared for the State of New York Insurance Department (http://www.ins.state.ny.us/website2/hny/reports/hnyepp2006.pdf, accessed March 3, 2008).

[5] In 2006, the pharmacy benefit option had an annual maximum benefit of $3,000 per person, a $100 deductible, and copayments of $10 for generic drugs and $20 for brand name drugs, plus the difference in cost between generic and brand name drugs. In addition there was an inpatient hospital copayment of $500, 20 percent coinsurance (up to $200) for surgical services, and $20 copayment for physician visits and tests. EP&P Consulting, *Ibid*.

highest personal health care spending per capita (behind Massachusetts and tied with New York); and extraordinary inflation in health insurance premiums.[6] Workers and families affiliated with small businesses and self-employed workers accounted for more than half of the state's uninsured residents.

Dirigo Choice is intended to offer a bridge between the private insurance market and MaineCare, the state's integrated Medicaid and SCHIP program. Eligibility for MaineCare was expanded to make include childless adults below the poverty level and low-income parents of children up to 200 percent FPL. Workers and dependents who enroll through a small employer may also enroll in MaineCare if they qualify; in these cases, MaineCare covers the enrollee's Dirigo Choice premium payments, deductibles, and other cost sharing, as well as MaineCare benefits that Dirigo Choice does not cover.[7]

Maine residents at any income level may enroll in Dirigo Choice, which now offers three benefit designs that differ in the level of the deductible. Those with family income below 300 percent FPL qualify for discounted premiums and deductibles, and also a lower out-of-pocket maximum. The discounts and out-of-pocket limits are based on a sliding scale relative to income. For workers and dependents enrolled through a small employer, only the employee share of the premium is discounted. Enrollees with family income at or above 300 percent FPL pay the full monthly premium (or the employee share if group-enrolled), deductible, and other cost sharing. Dirigo Choice products entail relatively high deductibles—$1,250, $1,750, and $2,500 for singles; and $2,500, $3,500, and $5,000 for families. All Dirigo Choice products are HSA-qualified when unsubsidized. Benefits are comprehensive, with no waiting period for preexisting conditions.

Currently, about 14,000 Mainers are enrolled in Dirigo Choice: 58 percent were uninsured (33 percent) or underinsured (25 percent) before enrolling.[8] About 700 small firms are enrolled in Dirigo Choice, averaging seven employees each; 43 percent had not previously offered health benefits to employees.

Unlike New York, Maine has struggled with funding for this program. The program's authorizing legislation requires it to prove that the Dirigo reform legislation has reduced medical costs—either as improved system efficiency or reduced uncompensated care—to warrant an assessment on carriers who, in turn, are expected to negotiate lower rates with providers consistent with lower medical cost. While the program has successfully made this case each year, carriers and health plan administrators continue to oppose this method of funding.

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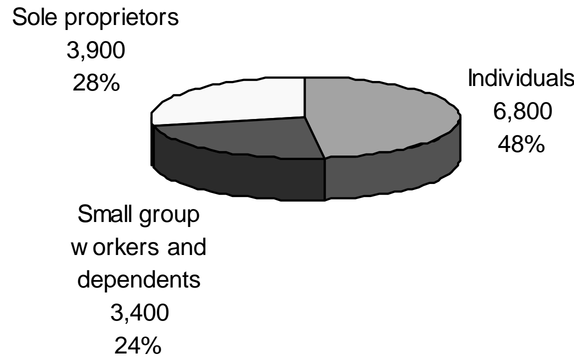
[6] Employers were acutely concerned about premium growth; average per member per year small group premiums increased 33 percent in 2001 and 29 percent in 2002. See: Debra J. Lipson, James M. Verdier, and Lynn Quincy (December 2007). Leading the Way? Maine's Initial Experience in Expanding Coverage through Dirigo Health Reforms. Mathematica Policy Research, Inc. (http://www.mathematica-mpr.com/publications/PDFs/dirigooverview.pdf, accessed March 3, 2008).

[7] Others—individuals and sole proprietors—who are eligible for MaineCare may not enroll in Dirigo Choice.

[8] Karynlee Harrington, Executive Director, Dirigo Health Agency. Personal communication, March 3, 2008.

FIGURE 2

DIRIGO CHOICE ENROLLMENT, JANUARY 2008



Source: Dirigo Health Agency.

Vermont. In May 2006, Vermont enacted Catamount Health, introducing a new health plan into the commercial market available only to residents who are uninsured. The benefit package resembles a standard Blue Cross Blue Shield PPO with a $250 deductible. Enrollment in Catamount Health began October 1, 2007.

The state subsidizes premiums and cost sharing on a sliding scale for Vermonters under 300 percent FPL. The program is financed through a combination of individual premiums, an assessment on employers, and new tobacco taxes. Assessments on employers are $1 per day for each worker not offered and eligible for group coverage and who is uninsured or has inadequate coverage. The first eight employees are exempt from the assessment in 2007 and 2008; the exemption will be reduced to six employees in 2009 and to four employees in 2010 and thereafter.

The legislation also offers premium assistance for workers and dependents who are eligible for Medicaid, SCHIP, or the Catamount Health Plan, and who have access to approved employer coverage.[9]

[9] The Catamount Health Plan is one part of a much larger piece of legislation that also sets out guiding principles for affordable access to care for all Vermont residents and guidelines for cost containment that focus on chronic disease prevention and effective management. The legislation also increased reimbursements for evaluation and management procedures (generally office visits) and for the care coordination program under Medicaid and the Vermont Health Access Plan (VHAP) for adults below 150 percent FPL. In addition, to the extent permitted, rates will be increased for Medicaid and other state program providers using the quality and performance measures developed in the Vermont Blueprint for Health. See: Robert Wood Johnson Foundation's State Coverage Initiatives Program (May 2006), Vermont Moves Toward Universal Coverage (http://www.statecoverage.net/stateside0506.htm, accessed March 3, 2008).

As in New York and Maine, insurance coverage in Vermont remains voluntary. Nevertheless, Vermont estimates that approximately 25,000 of the 60,000 uninsured persons in the state will enroll in Catamount Health. If Vermont does not reach its goal of 96 percent coverage by 2010, the state will consider enacting an individual mandate, requiring all residents to obtain coverage.

Massachusetts. In 2006, Massachusetts enacted arguably the most comprehensive set of health reforms in the nation. Implementation of the plan began in late 2006; by May 2007, more than 100,000 previously uninsured people had gained coverage. Massachusetts' plan has seven key components:[10]

- ***Individual Mandate***. All adults are required to purchase health insurance. The mandate is enforced through the state income tax.
- ***Employer Requirements***. Employers with 11 or more employees must provide health insurance coverage or pay a "fair share" contribution of $295 per full-time employee. These employers also must offer a Section 125 "cafeteria plan" permitting workers to purchase health care with pre-tax dollars. A Free Rider surcharge will be imposed on employers who do not provide health insurance and whose employees use free care.
- ***Commonwealth Health Insurance Connector***. A new Connector offers affordable, quality insurance products to small businesses and individuals. The Connector Board approved plans offered by seven of the state's health insurers that provide a range of coverage options, including a specially designed, lower-cost product for 19-26 year-olds.
- ***Commonwealth Care Health Insurance Program*****.** Commonwealth Care provides sliding-scale subsidies to individuals with incomes up to 300 percent of the federal poverty level for the purchase of health insurance. Individuals with incomes less than 150 percent of the federal poverty pay no premiums. Commonwealth Care plans have no deductibles, and are offered by the managed care organizations that participate in the Medicaid program. As of January 11, 2008, 169,000 low-income adults had enrolled in Commonwealth Care plans.[11]
- ***MassHealth (Medicaid) Expansion***. Massachusetts extended Medicaid coverage to children up to 300 percent of the federal poverty level and raised Medicaid enrollment caps for adults. By February 2008, MassHealth enrollment had increased by 90,000.[12]

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[10] See: Kaiser Commission on the Medicaid and the Uninsured (June 2007), Massachusetts Health Care Reform Plan: An Update (http://www.kff.org/uninsured/upload/7494-02.pdf, accessed March 3, 2008).

[11] Doug Trapp (February 11, 2008), Massachusetts Health System Reform Feeling the Pinch, AMNews (http://www.ama-assn.org/amednews/2008/02/11/gvsb0211.htm, accessed March 3, 2008).

[12] *Ibid.*

- ***Insurance Market Reforms.*** Massachusetts merged its individual and small-group insurance markets—so that the same products and rates are available to individuals and to small groups. The cost of health insurance premiums for small employers was expected to increase by about 1.5 percent, with premiums for individuals falling 15 percent.

- ***Preservation of the Safety Net***. The state's Uncompensated Care Pool, which reimburses providers for uncompensated care, is converted into a new Health Safety Net Trust Fund. The Health Safety Net Trust Fund combines Uncompensated Care Pool funds with other Medicaid funds, including Medicaid Disproportionate Share Hospital (DSH) funds. A new fee schedule will standardize provider reimbursements payable by the Fund. As more uninsured gain coverage and uncompensated care drops, funds will be shifted into the health insurance subsidy program.

While Massachusetts already has had signal success in enrolling previously uninsured residents in coverage, affordability remains an enormous challenge. In 2007, the state estimated that 20 percent of uninsured residents would be exempted from the individual mandate on the basis of the state's newly adopted affordability standards. Still, the Connector achieved extremely low premium increases for 2008: July 1 premiums for the lowest cost plan available through Commonwealth Choice for the average 37-year-old, uninsured Massachusetts resident are just five percent more than in 2007 ($194 per month, compared with $184 in 2007) and about half as much as premiums before the state's health care reforms (estimated at $335 for a 37-year-old individual, with much lower benefits).[13]

BUILDING TOWARD A NATIONAL SYSTEM

Coinciding with and following Massachusetts' enactment of sweeping reforms, a number of states embarked on serious discussion of similarly major efforts to improve access to coverage. With the leadership of their Governors, at least six states—California, Illinois, Minnesota, New Mexico, Pennsylvania, and Washington—debated major reform legislation, including (in California and New Mexico) an individual mandate. Proposals to develop a statewide program guaranteeing access to coverage for all residents were introduced and are pending in eleven states.[14]

However, the states face a number of significant obstacles in building a system of coverage for all residents—including a maze of federal laws and program rules that pose major risks for a preemptive challenge of their reforms, unintended tax consequences for residents, and/or loss of significant federal funding. States that would attempt to engineer major reforms to bolster

[13] See: Jon Kingsdale (February 15, 2008), About the Connector (http://www.mahealthconnector.org/portal/site/connector/menuitem.dc4d8f38fdd4b4535734db47e6468a0c?fiShown=default, accessed March 3, 2008.

[14] These states are: California, Delaware, Hawaii, Iowa, Maryland, Minnesota, Missouri, New Mexico, New York, Ohio, and Rhode Island. See: National Conference of State Legislatures (March 3, 2008), Health Reform Bills 2007-2008 (http://www.ncsl.org/programs/health/universalhealth2007.htm, accessed March 3, 2008).

employer-based coverage must navigate ERISA, COBRA, HIPAA and various provisions of the Internal Revenue Code (IRC) that govern the tax-qualification of employer-sponsored coverage.

States that would build a broader system of individual coverage must confront the possible loss of significant tax preferences for employer-based coverage. Massachusetts' reform—requiring employers with at least 11 employees to offer a Section 125 plan to fund individual coverage if the employer does not otherwise offer group coverage—must run a gauntlet of federal rules that if not carefully heeded could cause significant unintended tax consequences for employers and employees.

States that might wish to follow the example of New York, Maine, Vermont, and Massachusetts may not have nearly as strong a base of Medicaid and SCHIP eligibility in place. Not only do many states confront the prospect of less federal funding to support coverage expansions, they view future federal funding of even their current programs to be at serious risk.

Finally, many states fear the implications of action when neighboring states—many with major population centers spanning their borders—may do nothing. These fears variously include in-migration of people in need of affordable health insurance coverage and out-migration of employers seeking to avoid any role in sponsoring or financing coverage. Many states also fear the exit of insurance carriers that view state efforts to expand coverage as competition, unwarranted government intrusion, or both.

The federal government's exclusive oversight of employer-sponsored health plans as well as its role as the source of funding for the states' largest public insurance programs—Medicaid and SCHIP—already bind the states in a loose federal structure of health care financing. However, for the past forty years, the federal government has given to the states broad authority both to develop their Medicaid and SCHIP programs, and subsequently also to comply with federal HIPAA rules governing private insurance in ways that fit their unique circumstances and resources. Consequently, the states—which are closest to the day-to-day problems of failed access—have become responsible for developing a more comprehensive approach to ensure access, but in general have neither a clear scope of authority nor the resources to do so.

With few if any exceptions, building state reforms to a national system will require federal leadership—both to define the vision of a national system and to coordinate federal rules and regulations that conflict with that vision. But there are strong reasons to locate important details of major reform at the state level—including the more immediate accountability of state officials to consumers and providers, and the states' long experience with insurance market oversight and consumer protection.

To build state efforts toward a national system, at least four areas of federal law would need scrutiny and potential change to be consistent with a national system guaranteeing all Americans access to affordable coverage:

- **ERISA**. The limits of ERISA, which protects employer-sponsored plans from state regulation, should be clarified. This would include, but would not be limited to, clarification of the states' authority to develop "pay or play" rules, which assess employers that do not provide health coverage for their workers in order to fund public coverage.

- **HIPAA**. Minimum insurance rules should be established to make good on HIPAA's promise of access to coverage regardless of health status. These might include continuous guaranteed issue and community rating of individual coverage, as well as specification of permitted rating factors and potentially also limits on rate variation. Confronted with such rules, many states would need to consider designing more comprehensive management of their individual health insurance market and might also require individuals to maintain coverage—such as Massachusetts already has done and other states are considering.

- **IRC**. Federal tax provisions that disadvantage the purchase of individual coverage should be revised, particularly in the context of new federal rules that would govern insurance rating and issue of coverage. In addition, federal rules regarding use of Section 125 plans to purchase "creditable" individual coverage should be clarified to minimize the risk of inadvertent tax consequences for employers and workers.

- **Medicaid and SCHIP**. Categorical eligibility rules should be eliminated, and federal funding should be rationalized and extended to assist families that cannot reasonably afford private health insurance. Consistent with supporting continuous coverage, crowd-out rules—which presume extended gaps in coverage, requiring low-income adults and children to be uninsured in order to obtain affordable public coverage—should be modified or eliminated.

With a consistent vision of continuous access to coverage and leadership at the federal level, the states can be expected to follow through, developing real systems of coverage that would be fairer to consumers and insurers and also more stable as group coverage continues to change with the economy and the nature of employment.