Providing Access to Health Care to the Uninsured: State Policy Options

Louisiana Task Force on the Working Uninsured
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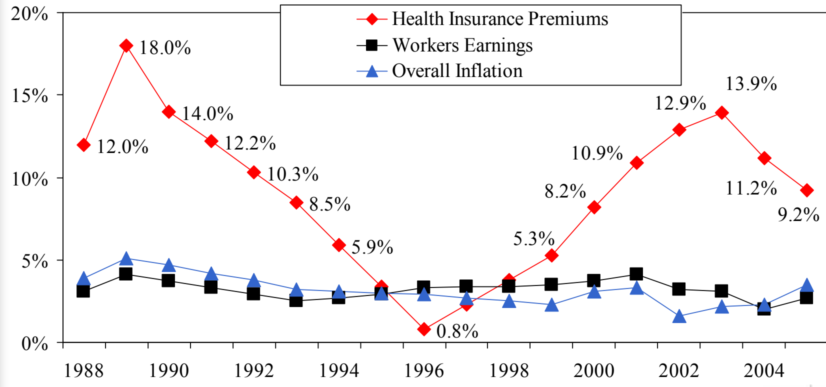
Recent state initiatives for covering the uninsured fall into three + categories…

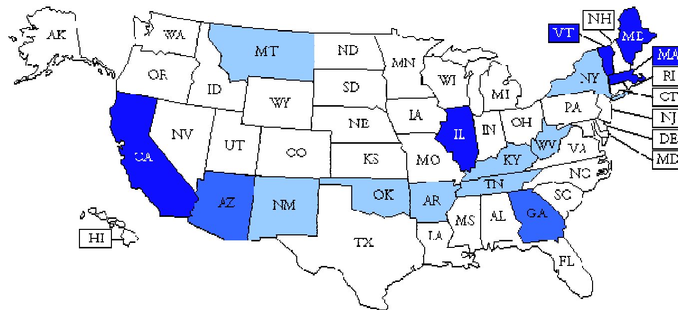
- Making new insurance options more affordable
  - Increasing employer-offered insurance
  - Making new private insurance options more affordable.
  - Assist low-income uninsured via Medicaid & related government sponsored programs
- Comprehensive
  - Includes strategies addressing access, cost and quality.
- Covering children
- Supporting the health care safety net

Health Premiums Rising 3-5 Times Faster than Inflation and Wages, 1988-2005



Source: KFF/HRET and Bureau of Labor Statistics; Paul Fronstin, EBRI for NCSL 4/06

Selected Examples of Health Access Programs



"Comprehensive" programs
Tax incentives, examples
Affordable small business & individual programs
Not highlighted in this presentation (state may have similar features)

Compiled by NCSL for 9/18/06 Louisiana PowerPoint only

Making small business and individual insurance more affordable

- Montana
- Kentucky
- New York
- West Virginia
- Tennessee
- New Mexico
- Oklahoma
- Arkansas

Make small business insurance more affordable: Montana

- The Small Business Health Care Affordability Act
  - Targets small businesses
  - New purchasing pool, State Health Insurance Purchasing Pool, to obtain health insurance.
  - Pool insurance will be subsidized on a sliding scale basis.
  - Tax credits to small businesses that are currently offering health insurance.
  - Program is funded by a tobacco tax.
  - Other states have group purchasing arrangements (AR, CA, KS, OH, TX, NM, WI.) Kansas plans a subsidized pool.

Make small business insurance more affordable: Kentucky

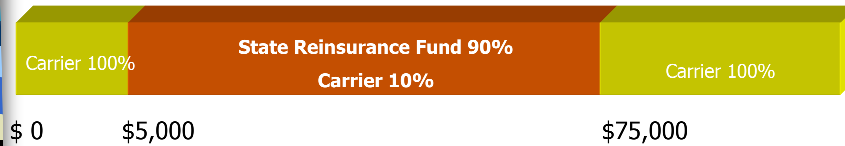
- Insurance Coverage, Affordability and Relief to Small Employers (ICARE) Program
- Small employers (2-25 employees) who have been uninsured for at least 12 months.
- Employer pays at least 50% of premiums and the state pays $40 per employee per month. The incentive will be reduced each year by $10.
- Small employers who offer insurance and pay 50% or more of the premium with at least 1 employee in the group with a high-cost medical condition will receive an incentive to remain insured - $60 per employee per month which will be reduced each year by $15.

-Budget bill HB 380, signed 2006

Make small business insurance more affordable - New York

- Program: Provide publicly-funded or other type of financed reinsurance for private coverage to assume a portion of insurer's high-cost claims.
- 20% of people account for 80% of health spending
- State subsidizes costs for expensive people with the goal of lowering premiums for all
- State requires all HMOs to offer product
- Small firms w/ low-wage workers, low income self-employed, uninsured workers w/o access to employer sponsored insurance may enroll

NY Reinsurance subsidy



$ 0 $5,000 $75,000

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

Lessons from NY Reinsurance

- “Product” vs “Program”
- Perceived efficiency and value of program
  - Uses 24 HMOs;
  - required to enroll all applicants and use community rating
- Getting participation requires long-term partnership to build trust that coverage will continue to be there
- Challenge – mostly individuals vs. small groups
- Market oversight key feature to assure State Reinsurance contributions result in lower premiums

Source: Alice Burton, presentation at NCSL annual meeting on August 14, 2006.

- **West Virginia Small Business Plan**
- Allows small businesses access to the buying power of the Public Employees Insurance Agency (PEIA) through a public/private partnership between PEIA and insurance companies. PEIA is the largest self-insured plan, providing insurance to public employees, state universities, and colleges, as well as county boards of education
- Allows participating carriers to access PEIA's reimbursement rates, enabling the new small business coverage cost to be reduced significantly.
- Created by the 2004 legislature in Senate Bill 143.
- Program enrollment began in January 2005. There are 1,000 enrolled representing 200 businesses. (August '06)

- Cover Tennessee - market based public/private partnership plan for small employers and uninsured workers. Below 250 % FPL. Law signed 6/12/2006
  - Basic, major medical coverage to uninsured workers for $150 a month, shared equally by the individual, employer and state government.
  - Largely replacing former "TennCare" Medicaid coverage.
- Cover Rx - Age18 and over. Formulary based.
- Cover Kids - open to kids 18 or younger. Independent of Medicaid. Title 21 funds.
- Access Tennessee - high risk pool

Medicaid coverage for low-income workers

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

Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC)

- Aims to cover an additional 50,000 residents with incomes at or below 185 percent FPL.
- Funded by state general fund revenues generated by a tobacco tax, plus federal Medicaid matching funds and employer and employee contributions.
- The O-EPIC Premium Assistance Program will pay part of the health plan premiums for eligible employees working for qualified Oklahoma small businesses (with 25 or fewer employees). Participation in this program is voluntary. Enrollment began in Nov 2005.
- The O-EPIC Public Product Health Care Plan is a safety net for people who cannot access private health coverage through their employer. This plan extends coverage to uninsured self-employed individuals, workers whose employers do not provide health coverage, workers who are not eligible to participate in their employer's health plan, sole proprietors not eligible for small group health coverage, and the unemployed who are currently seeking work. Enrollment began in spring 2006.

- New health plan initiative providing low-cost basic health insurance through an employer based benefit program in conjunction with the state.
- Uninsured adults up to 200% federal poverty through employer-sponsored coverage.
- Financed through: employer contribution, employee contribution (based on income), Medicaid (match from unused SCHIP dollars).
- Benefits similar to basic commercial plan.

- Approved March 2006
- Increase health insurance coverage through a public/private partnership that will provide a "safety net" benefit package to approximately 50,000 uninsured individuals over 5 years.
- Targeted at businesses with fewer than 50 employees that have not offered health coverage in at least one year prior to enrollment.
- Funding comes from fees collected from employers, state tobacco settlement funds and federal Medicaid dollars.
- Will begin with a pilot in late 2006 for up to 25,000 participants. Second phase may go up to 80,000.

Medicaid's changing role & impact of Deficit Reduction Act

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

- **DRA: S. 1932 signed by President Bush on February 8, 2006**
- **NCSL Report:** http://www.ncsl.org/statefed/health/ReconDocs0206.htm

Dependent coverage changes…

- expand definition of dependents in state laws for purposes of health insurance (e.g. include children 19 or older; grandchildren; dependent parents; domestic partners, etc.)
- State examples: Utah, NJ (up to age 30), NM, CO (unmarried dependents); Maine (dependent parents and unmarried same-sex and opposite-sex partners); Texas (grandchildren)
- no state funding required.
- May bring in disproportionate numbers of unhealthy older dependents.
- Effect on overall coverage – significant for one of the fastest growing segments of the uninsured—those between the ages of 19 and 23.

Bare bones or "Mandate-Light" policies

- Reduce premiums (about 7%) by decreasing the number of covered services. Allow for the sale of health insurance policies that are exempt from state-mandated benefits.
- 13 states including AR, CO, FL, GA, KY, MD, MN, MT, NJ, ND, TX and UT.
- May crowd-out those who previously had more comprehensive insurance.
- Impact on the safety net.
- Initially, these plans don't sell well. Tie in to HSAs.
- Effect on overall coverage - Not clear yet. Since many efforts are new, they may develop over time.

Tax incentives & credits

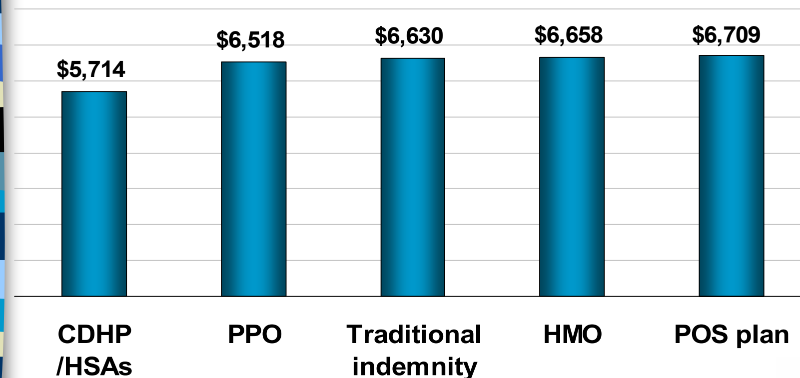
- In the past, state tax incentives have not been very successful at increasing coverage because, in part, the value of the incentive relative to the price of coverage is so small. To increase effectiveness - increase cost benefit and timeliness.
- **Kentucky** 1998 Chap. 496 (HB 315) allows individual income tax deductions for payments for health insurance.
- **Georgia** HB 389 of 2005 Provides an additional tax credit equal to $500 per eligible new full time employee for one year. Does not require employer to pay health insurance if they do not provide health insurance for other existing employees. Begins with jobs created Jan. 1, 2006; ends Dec. 2010
- **Arizona** HB 2177 of '06 (signed law August '06) Creates a premium tax credit for small business (2-25 employees) & Individuals up to 250% FPL. Cap of $5 million. Credit is the lesser of fifty percent of the premium or $1,000 for coverage on a single person, $500 dollars for coverage on a child or $3,000 for family coverage.

Consumer Directed Health Care

- Health Savings Accounts established in federal law 12/8/03. They are tax-free financial accounts designed to help individuals save for future health care expenses.
- In 2005, among all firms offering health insurance coverage, 2.3% offered an HSA qualified plan with about 810,000 enrolled.
- According to an industry survey, 40% of new HSA buyers had incomes of $50,000 or less and at least 30% were previously uninsured.
- State laws and regulations passed in 2004-06 now play a role in the use of health savings accounts, through insurance regulation, measures that encourage development or offering of HSAs, and/or laws that provide state tax exemptions to parallel federal tax treatment, as well as laws to improve transparency of pricing.
- For more information go to http://www.ncsl.org/programs/health/hsa.htm

Large employers saving money with Consumer-Directed Health (CDHPs)

Average cost per employee **[Mercer NCSL, Apr. 2006]**



- If consumers are to spend their own $$, they want to know the real and comparative price. Prices rarely are available.
- No federal law applies to private market.
- Almost 30 states have some law or program related to medical price disclosure.
  - Example: **CA** AB 1045 - hospitals must disclose top 25 procedures; results on state website.

- **Maine**'s Dirigo Health Reform
- **Massachusetts** Universal Health Care Reform
- **Vermont** Catamount Health
- **Illinois** AllKids (for children only)
- **California** & San Francisco (Sept. '06)

Maine: Dirigo Health

- Aims to provide every citizen access to health care by 2008.
- A new health plan called "Dirigo Choice" that anybody can buy into.
- A new health system designed to improve quality and lower costs;
- Expansion of the state's Medicaid program.

Maine's Dirigo and MaineCare Eligibility

Source: State Coverage Initiative, Alice Burton, presentation December 2005.

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

- **Plan to cover 95% of the uninsured in 3 years**
- Preserves federal Medicaid funding
- Simplifies health insurance for small businesses
- Reforms Uncompensated Care
- Promotes financial stability of health care system
- Rewards cost-effective, high quality care
- Everyone "plays their part": Encourages shared responsibility: government, individuals, employers, health care providers

- MA Legislature presentation on final bill 4/3/06

Mass. Continued: Strategies, 1

- Commonwealth **Health Insurance Connector**:
  - New State Authority
  - Makes it easier to find affordable policies
  - Reduces administrative burden for small business
  - Allows more people to buy insurance with pre-tax dollars
  - Allows part-time and seasonal employees to combine employer contributions in the Connector
  - Allows for portability for policies

Mass. Continued: Strategies, 2

- **<u>Market Reforms</u>**:
  - Merger of the non-group and small-group markets

- **<u>New Products</u>**:
  - Existing high-deductible plans can now be tied to Health Savings Accounts
  - Family plans to allow young adults to stay on the policy for two years beyond loss of dependent status, or until age 25, whichever occurs first
  - Industry can develop special products for 19-26 year olds, offered through the Connector

Mass. Continued: Strategies, 3

Subsidies:

- Commonwealth Care Health Insurance Program (CCHIP):
  - Sliding-scale subsidies to individuals with incomes below 300% of the Federal Poverty Level (FPL) = $48,000 for a family of 3
- Insurance Partnership Program
  - Existing Program; eligibility for employee participation raised from 200% to 300% FPL

Mass. Continued: Strategies, 4

- **Medicaid**:
  - Coverage of children up to 300% FPL – parents can buy cheaper individual or couples' policies
  - Raise enrollment caps on Essential, CommonHealth, HIV program
  - Restore all benefits cut in 2002- including dental and vision services
- Reforms Uncompensated Care Pool
- Meets the conditions of the Medicaid Waiver

Mass. Strategies, 5:

Shared Responsibility

- Mandate: Individuals must have health insurance as of July 1, 2007
- Employers who don't make a "fair and reasonable" contribution will be required to make a per-worker contribution capped at $295 per full-time equivalent employee, per year. (Free rider surcharge)
- $20 M for public health and prevention programs.
- Public funding to reduce disparities.

Opposing views

- "opens door for widespread regulation"
- "political interference in personal health decisions"
- "imposes new burdens on business"

- Cato Institute "No Miracle in Massachusetts" June 2006

Vermont: Catamount Health Program

- Everyone who is uninsured for 12 months or more will have access to, and help pay for, a comprehensive health insurance package.
- A standard plan (classic PPO 50% model) will be offered by the private sector and subsidized (sliding scale) for anyone under 300 percent of poverty.
- Subsidize employer sponsored insurance for eligible people.
- state funding from Medicaid waiver financing, two increases in the tobacco tax, and from an assessment on employers for employees who either are not offered insurance or who are offered insurance, chose not to enroll, and are uninsured. $365 per FTE who is uninsured.
- Focus on managing chronic disease.
- H 861 and H 895, both signed by the Governor in 2006.

- Updated per VT staff, Sept, 2006

Illinois All Kids

- Recent expansions
  - Coverage for Children expanded from 185% FPL to 200% FPL
  - Phased in coverage for parents from 49% FPL to 133% FPL (waiver allows 185%)
- November 2005 – Covering All Kids Health Insurance Act.
  - All uninsured children (under 19) eligible
  - Premiums on sliding scale basis by income. (Family of 4 earning $40K will pay $40/month per child)
  - $45 million estimated cost to be financed through savings from shift to PCCM (primary care case mgm't)
  - State applying for waivers to receive federal funding under Medicaid or SCHIP

Illinois All Kids, continued

- Eligibility
  - Under the age of 19
  - Without health insurance for period of time. (at least 6 months)
  - Child of a parent who lost employment that had health insurance.
  - A newborn whose parent or guardian does not have insurance.
  - Someone who lost coverage under medical assistance or SCHIP.
  - State can consider "affordability" of privately offered insurance coverage. If deemed not affordable - eligible.
- Benefits
  - Same as SCHIP.
  - Buy-in for employer coverage.

- State Examples: MA, NJ and NY have bad debt and charity care pools for uncompensated care. 36 states support health centers. Many states have loan forgiveness programs for providers working in underserved areas.
- Presence of safety net providers improves both access to care and health outcomes. For example, communities with CHCs have lower infant mortality rates, lower rates of low-birth-weight babies, higher rates of women obtaining mammograms and pap smears, and higher rates of women receiving early prenatal care.
- Providing health insurance coverage may be more effective in ensuring access - ??
- Wouldn't be coverage but access. This strategy appears to have a positive impact on health outcomes. However, some studies suggest that providing health insurance coverage may be more effective.

- Bills in 6 states this year, but most stalled.
- **California SB840** was approved by the Assembly and Senate. If signed by the Governor (who opposes the bill) it would provide comprehensive medical, dental, vision, hospitalization and prescription drug coverage to every California resident in a single payer system.
- **City-Only plan:**
  San Francisco Health Access Plan (signed 8/7/06)