



AcademyHealth

Advancing Research, Policy and Practice

State Strategies for Coverage

**Harvard/Kennedy School Health Care
Delivery Policy Program**

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**STATE
COVERAGE
INITIATIVES**

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State Coverage Initiatives**

State Coverage Initiatives (SCI)

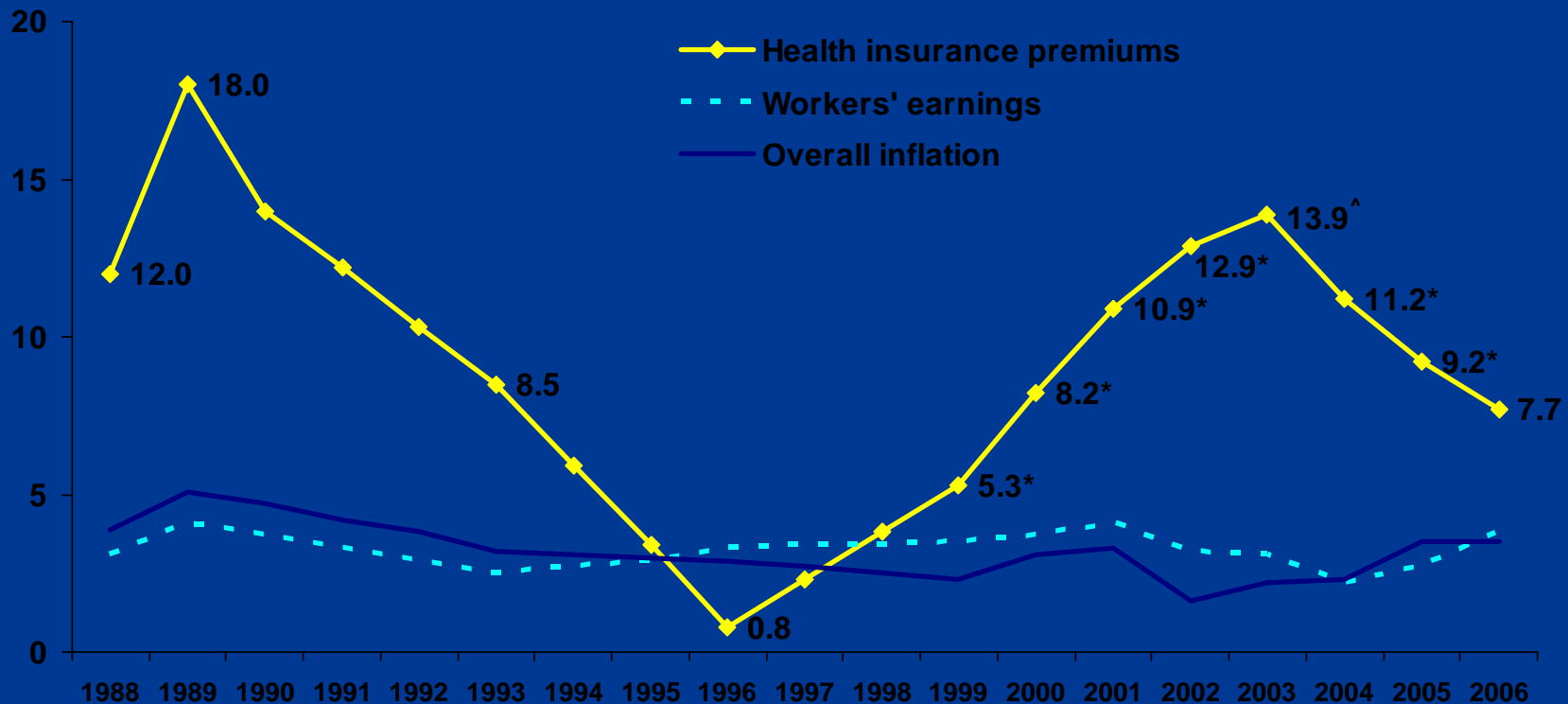
- An Initiative of The Robert Wood Johnson Foundation
- Direct technical assistance to states
 - State specific help, research on state policy makers' questions
 - Convening state officials
 - Web site: <http://statecoverage.net>
 - Coverage Matrix
 - Publications
- Grant funding

Drivers of State Health Reform

Efforts

- Continued increase in number of uninsured
- Declines in employer-sponsored insurance
- Health insurance becoming increasingly unaffordable for working families
- Improved economic outlook coupled with increased state revenues
- Lack of national consensus
- Greater political will among Governors and legislators to tackle the problem

Health Care Premiums Outpace Worker's Wages = Health Coverage Increasingly Unaffordable



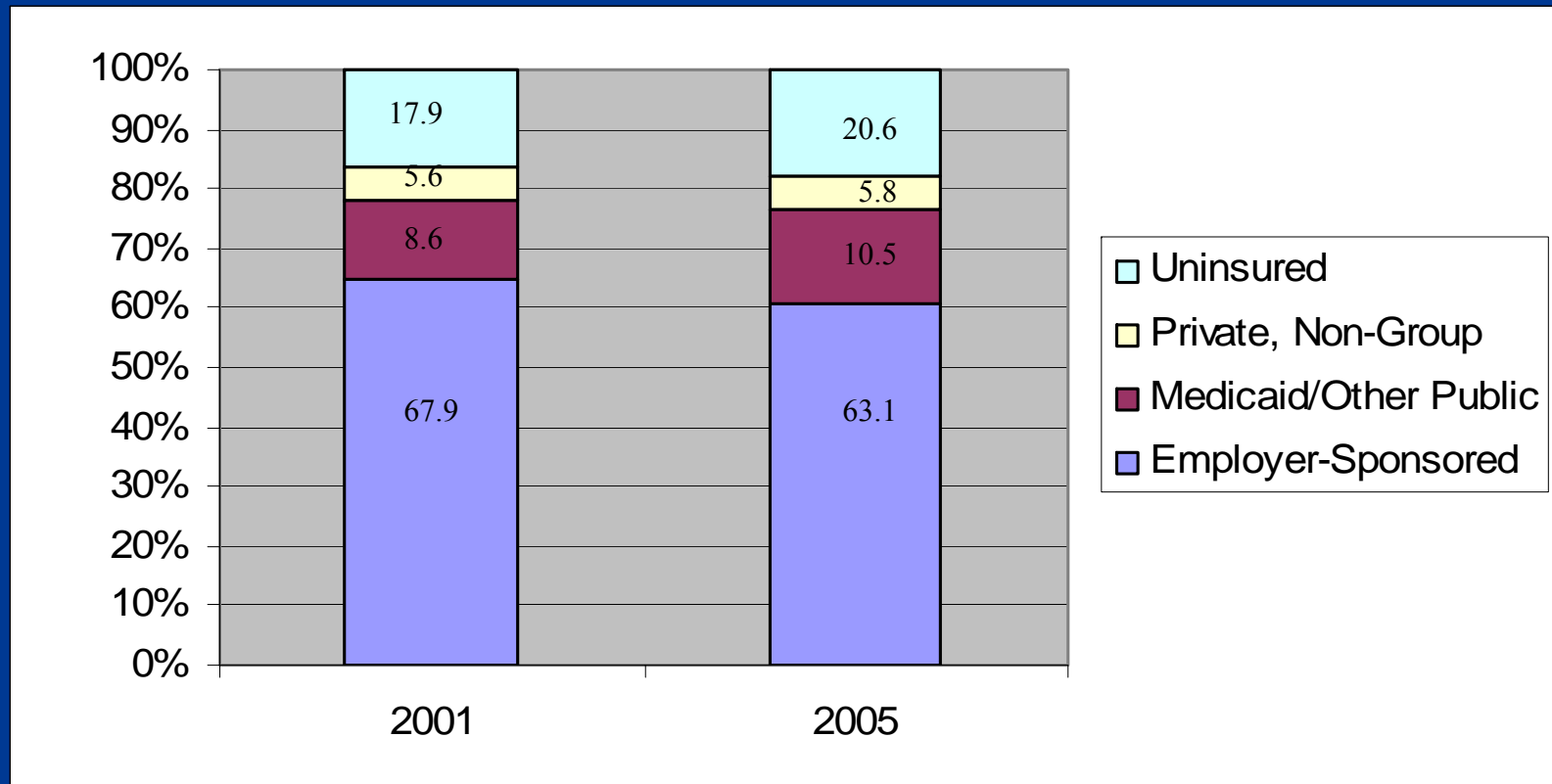
* Estimate is statistically different from the previous year shown at $p < 0.05$.

^ Estimate is statistically different from the previous year shown at $p < 0.1$.

Note: Data on premium increases reflect the cost of health insurance premiums for a family of four. Historical estimates of workers' earnings have been updated to reflect new industry classifications (NAICS).

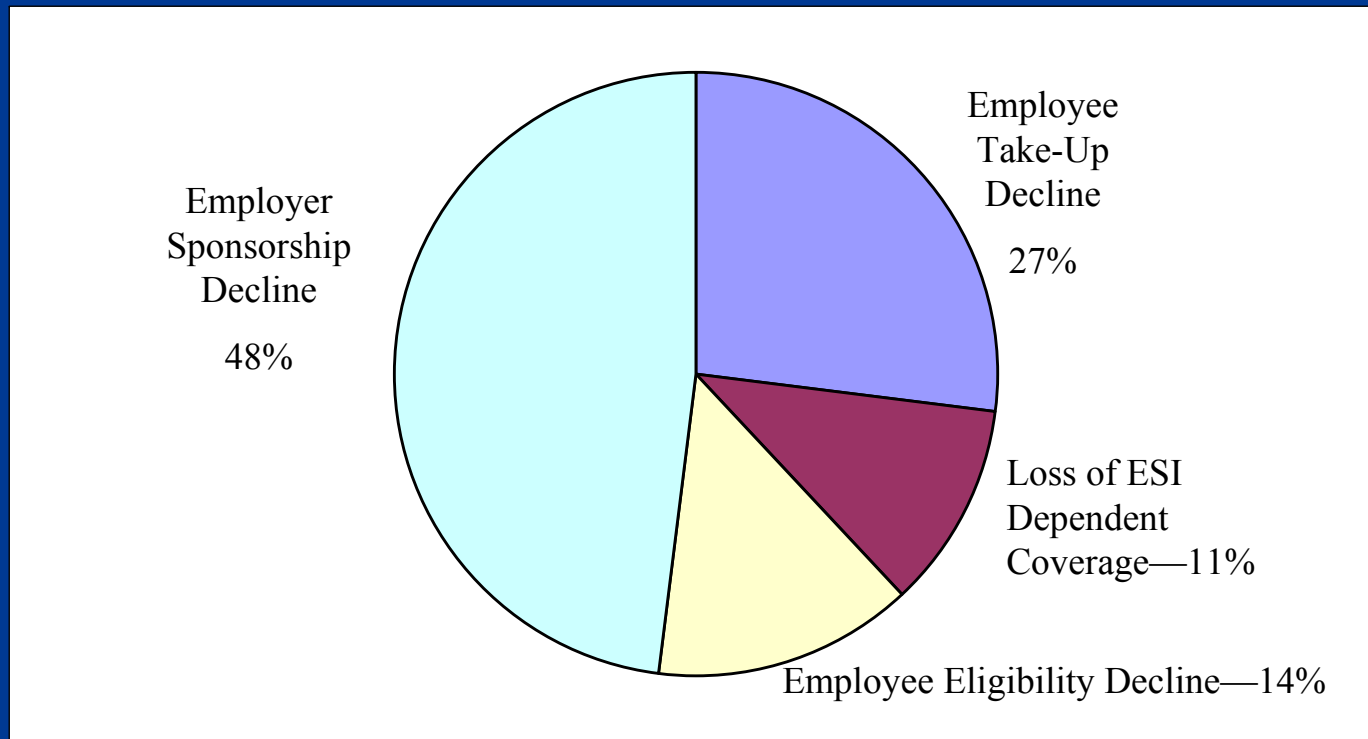
Data: KFF/HRET Survey of Employer-Sponsored Health Benefits: 1999-2006.

Health Insurance Coverage of the Non-Elderly Population, 2001-2005



Source; "Health Insurance Coverage in America: 2002 Data Update," The Kaiser Commission on Medicaid and the Uninsured, December 2003, KCMU/Urban Institute. "The Uninsured: A Primer," The Kaiser Commission on Medicaid and the Uninsured, October 2006.

Reasons Why 3.4 Million Employees Lost Insurance Between 2001 and 2005

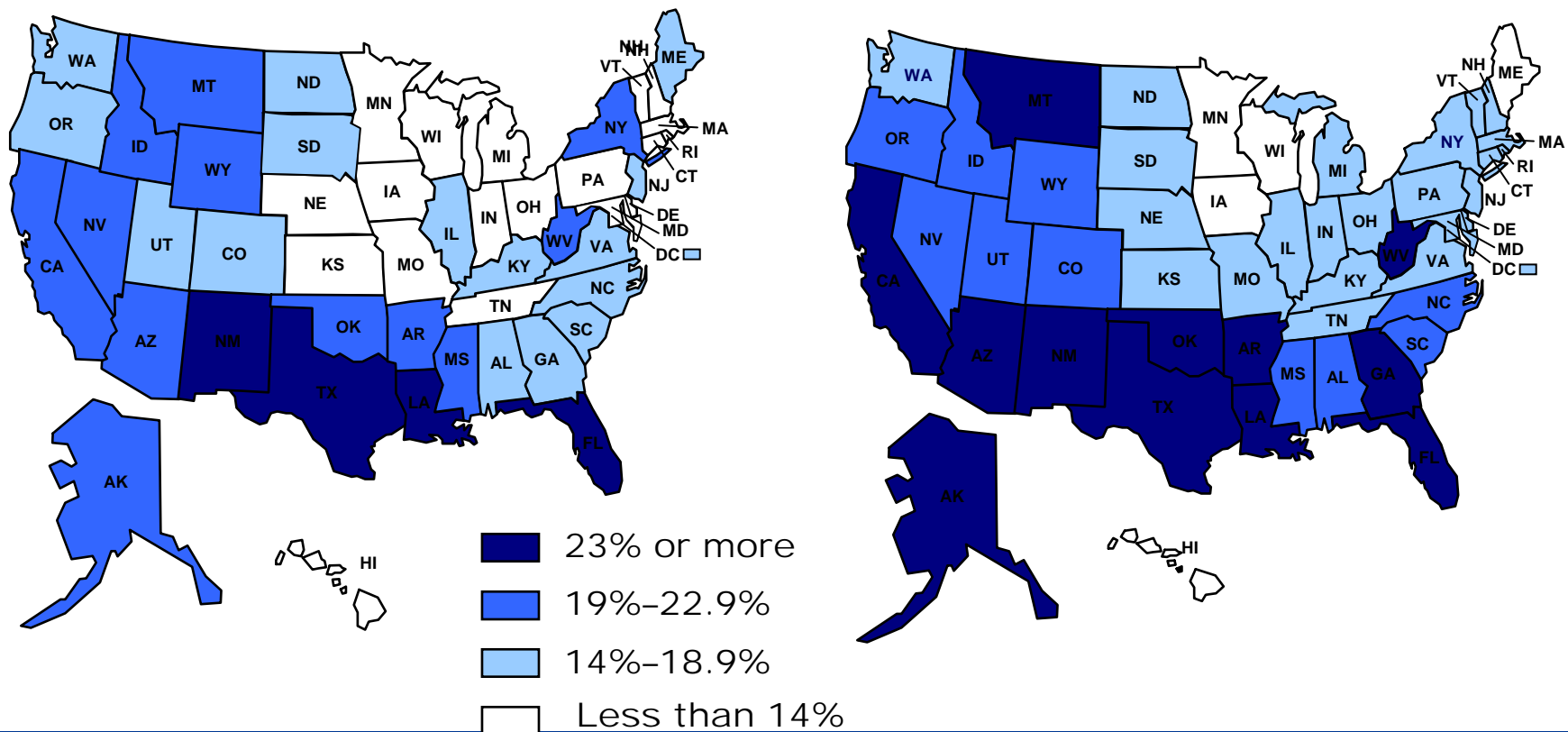


Note: Data taken from “Changes in Employees’ Health Insurance Coverage, 2001-2005”, Kaiser Commission on Medicaid and the Uninsured, October 2006.

Percent of Adults Ages 18–64 Uninsured by State

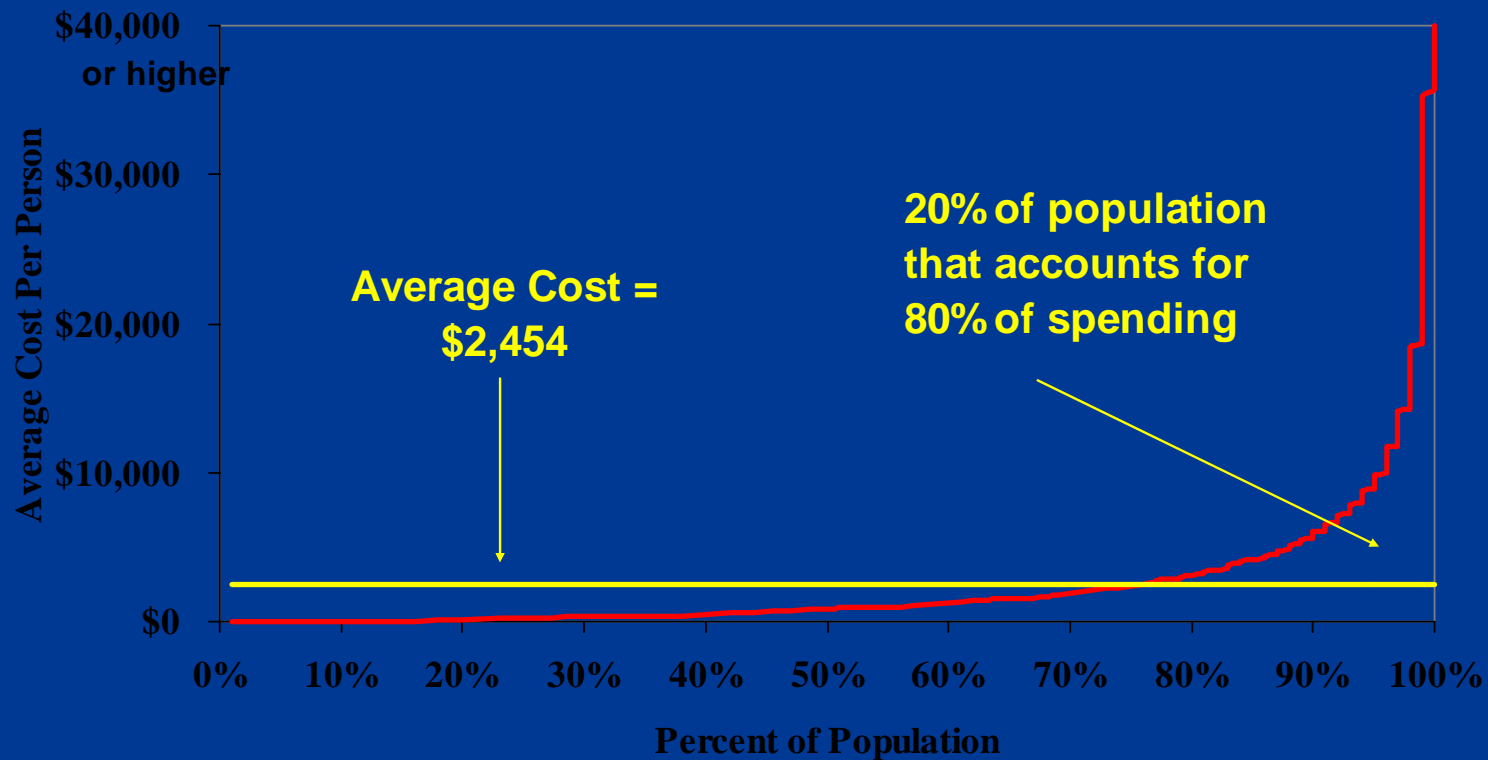
1999–2000

2004–2005



Data: Two-year averages 1999–2000 and 2004–2005 from the Census Bureau’s March 2000, 2001 and 2005, 2006 Current Population Surveys. Estimates by the Employee Benefit Research Institute.

Distribution of Health Spending Adults Ages 18-64, 2001



Source: Employee Benefit Research Institute estimates from the 2001 Medical Expenditure Panel Survey.

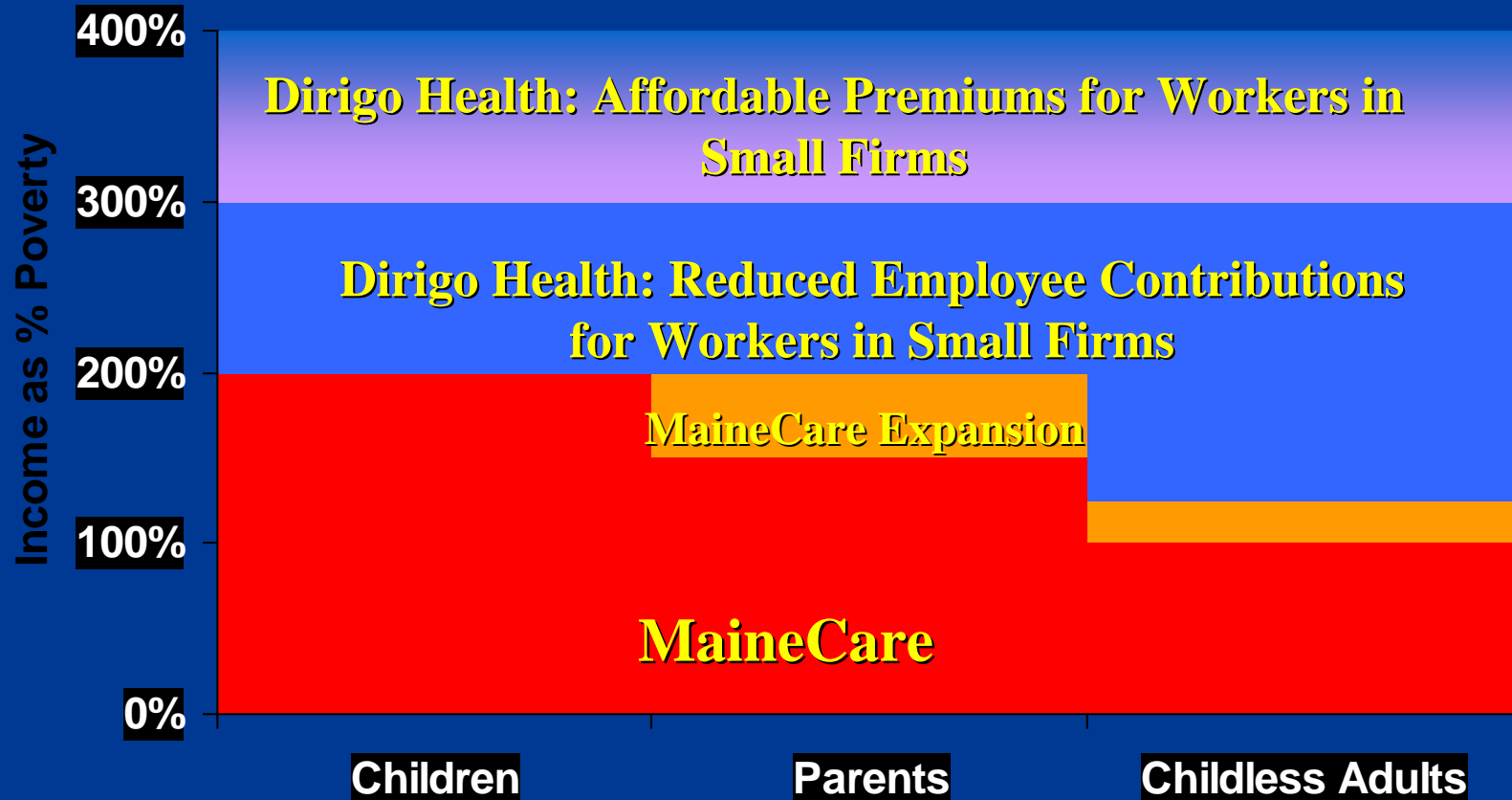
Expanding Coverage Through Innovation, Experience and Compromise

- Comprehensive approaches
 - Massachusetts, Vermont, and Maine
 - Proposed: CA, PA, NJ?, NY?, IL? OR?
- Incremental
 - Public-Private Partnerships (TN, RI, MT, UT)
 - Leveraging Medicaid to Expand Coverage to the Working Uninsured (NM, OK, AR)
 - Covering children (IL, PA, TN)

Comprehensive Efforts

Maine
Massachusetts
Vermont

Maine's Dirigo and MaineCare Eligibility



Access: DirigoChoice

- New Insurance product offered by Anthem



Maine - potential lessons

- Voluntary programs not likely to achieve universal coverage
- Financing – difficult to transfer uncompensated care dollars to premium subsidies
- Challenge of building and maintaining a consensus

Massachusetts Health Care Reform

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

Massachusetts - potential lessons

- Insurance market changes and insurance connector
- Employer Assessment & Free Rider Surcharge
- Benefit designs
- Individual mandate – key interest, but difficult for most states to address affordability

Vermont Reforms

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

Vermont – potential lessons

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

Comprehensive Proposals

California
Pennsylvania
New Jersey?
New York?
Illinois?
Oregon?

Prescription for Pennsylvania

- Cover All Kids
- Cover All Pennsylvanians
- FT students in 4 year college/university required to have health care coverage
- Governor may consider individual mandate if number of uninsured does not decline over next few years

PA: Cover All Kids

- CHIP coverage available to all* children in state
- Families $\leq 200\%$ FPL still enrolled in free CHIP/Medicaid
- Expanded program: CHIP for families between 200% – 300% FPL
- Subsidized program – average premiums range from \$38 - \$60 pmpm
- Full-cost buy-in available for families $\geq 300\%$ FPL under certain conditions

* Except children with higher household incomes who can obtain coverage through the private market at reasonable prices and undocumented children.

Cover All Pennsylvanians (CAP)

- New insurance product in private market targeting:
 - Small Business (<50 employees)
 - Employer share: \$130 per employee/month
 - Employee share: \$10 - \$70 depending on income
 - Uninsured adults earning < 300% FPL
 - Full cost buy-in (\$280/month) for those > 300% FPL

CAP Financing

- A fair share assessment will be levied on all companies that do not insure their employees, That assessment will help pay for the cost of the CAP program;
- Taxes on smokeless tobacco, cigars, and an increase in the cigarette tax;
- Federal matching funds; and
- Redirecting existing health care dollars that currently fund adultBasic, uncompensated care, and the Community Reinvestment fund.

California: Governor's Health Care Initiative

- Prevention / Wellness
- Shared Responsibility/ Coverage for All
- Affordability

Prevention & Wellness

Healthier State – Long Term Affordability

- **Offer Consumers Incentives and Rewards**
 - Tied to preventive health practices
- **Diabetes prevention and treatment**
- **Reduce Medical Errors**
 - E-prescribing of all prescriptions
 - Strengthen patient safety & accountability
- **Prevent Obesity**
 - Implement comprehensive strategy to reverse obesity epidemic: public awareness & outreach, improve access to nutritious foods and physical activity
- **Tobacco Cessation Efforts**
 - Increase assistance to those seeking to quit smoking

Shared Benefit

GOVERNMENT

Healthy, productive & economically
competitive state

EMPLOYERS

Affordable
coverage

Healthy,
productive
workforce

INDIVIDUALS

Access to affordable
coverage
Healthier CA

DOCTORS & HOSPITALS

Fairly compensated

HEALTH PLANS

Expanded market
Fair compensation

Shared Responsibility

GOVERNMENT

INDIVIDUALS

- **Must secure health coverage for themselves and their children**
- **Personal responsibility for health and wellness**
- **Contribute to paying for their coverage**

EMPLOYERS

DOCTORS & HOSPITALS

HEALTH PLANS

Shared Responsibility

INDIVIDUALS

GOVERNMENT

- Expand Healthy Families/Medi-Cal for all children in families earning under \$60K
- Subsidies to families between \$20K-\$50K provided through new purchasing pool
- County responsible for access for undocumented
- Expand Medi-Cal to adults in poverty
- \$4 billion increase in Medi-Cal reimbursement rates

EMPLOYERS

DOCTORS & HOSPITALS

HEALTH PLANS

Shared Responsibility

GOVERNMENT

DOCTORS & HOSPITALS

- 2% fee on physician revenues –
4% on hospital revenues
- Participation in patient safety initiatives
- At least 85% of hospital payments spent on patient care

EMPLOYERS

INDIVIDUALS

HEALTH PLANS

Shared Responsibility

GOVERNMENT

EMPLOYERS

- Offer 125 plans to allow employees to make pre-tax contributions to coverage
- Contribute to the cost of coverage – non-offering employers with 10 or more employees will contribute 4% of payroll

< 10 employees = 80% of all CA employers

INDIVIDUALS

DOCTORS & HOSPITALS

HEALTH PLANS

Affordability: Short Term

- Reduce hidden tax
- Tax breaks for individuals & businesses tied to purchase of health insurance
- Enhance insurer & hospital efficiency by requiring 85% of premiums & hospital dollars on patient care

Affordability: Long-Term

- Health prevention & wellness
- Health IT: Paperless system w/ strong privacy protections within 10 years
- Medi-Cal rate increases tied to performance measures
- Enhance health care quality & efficiency through improved performance measurement
- Monitor & evaluate market function & costs and revise as necessary

Incremental Approaches

Children

Purchasing Pools

Limited Benefits

Reinsurance

Creative Uses of Medicaid

Safety Net

Children and AllKids: Illinois

- IL – AllKids expansion (July 2006)
 - All uninsured children eligible, sliding scale premium
 - \$45 million estimated cost - financed through savings from shift to primary care case management (PCCM)
- Builds on success and bi-partisan support for SCHIP
- Cost effective to cover children
- Improves outreach to eligible, but unenrolled
- Other states consider (PA, WA, OR, CA, NM, WI, HA, NY)
- SCHIP Reauthorization due in 2007

Purchasing Pools: California PacAdvantage

- Longest running and largest health insurance purchasing alliance formed in 1993
 - Over 100,000 covered lives
- Small firms (2-50) able to enroll and offer a choice of private health plans
- Evaluations demonstrated that PacAdvantage improved choice of health plans, but was never demonstrated to have expanded coverage
- December 2006 - PacAdvantage closes due to withdrawal of participating plans

Purchasing Pools: Insure Montana

- \$10 million coverage initiative funded through tobacco tax
 - Tax Credits
 - 40% of overall funding is for tax credits for small business that provide health insurance (tax credit provided on a “first come first serve basis”)
 - Purchasing Pool –
 - 60% of overall funding is for subsidies for small businesses that were previously unable to offer coverage on a “first come first serve basis” to assist both employer and employee pay portion of health insurance premium.
- Enrollment (Fall 2006) = 7,000 lives between two programs

Lessons Learned: Purchasing Pools

- Strategy has generally not expanded coverage to the uninsured
- Has improved plan choice for small firms/employees
- Has not generated significant administrative savings or price discounts
- Unless designed carefully, pools can create adverse risk selection
- To be effective, need to combine pool with other strategies such as subsidy or individual mandate

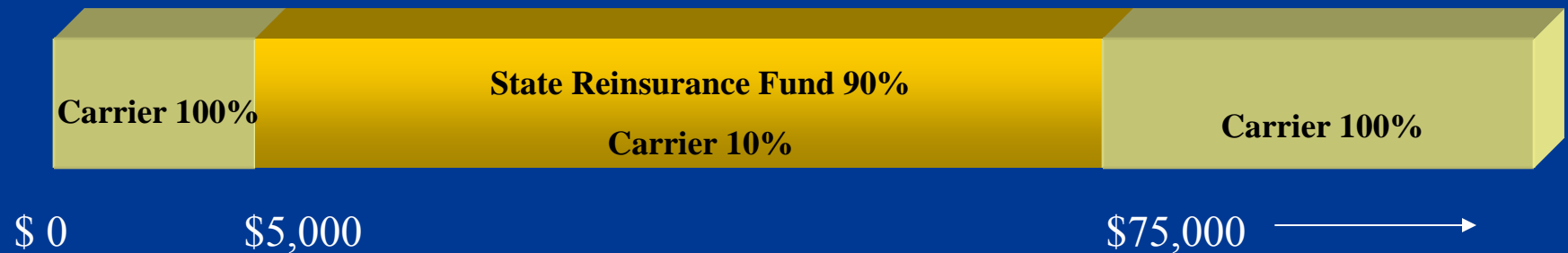
Limited Benefit Plans have had Marginal Impact

- At Least 13 states have passed limited benefit legislation, 2 states passed new legislation in 2005
- Barebones and other limited benefit plans have had low take-up rates
- May lead to currently insured to scale back benefits
- May contribute to increased uncompensated care

Reinsurance: Healthy New York

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

Healthy New York Reinsurance Subsidy



- Estimated savings of 50% for individuals
- Over 131,000 enrolled (12/06)
 - Most enrollment is non-group
- State Reinsurance Fund spent \$13.3 million in 2003, \$34.5 million in 2004, \$61.7 million in 2005

Early Lessons on Reinsurance: Healthy NY

- Requiring HMOs to offer Healthy New York product is less expensive than establishing new program
- Perceived efficiency and value of program
- Getting participation requires long-term partnership to build trust that coverage will continue to be there
- While targeting small groups, product has enrolled mainly individuals and self-employed
- Must have market oversight to assure lower premiums

Creative Uses of Medicaid

- Premium Assistance: 15 states
 - Medicaid/SCHIP pays for employee portion of existing private insurance
- Medicaid Buy-In
 - All-Kids = sliding scale subsidy subsidized by SCHIP
 - New Insurance Product with a subsidy
 - Subsidy for low income individuals, and small firms

New Medicaid Strategies Address Low Offer Rates

- 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)

Medicaid's Changing Role

- Use in expanding coverage to the uninsured
- Covering different populations, sometimes higher income groups
- Increased cost-sharing
- Changing benefit designs
- Consumer responsibility

Recent DRA State Plan Amendments

- West Virginia:
 - “Secretary-approved coverage” for children and parents
 - 2 Benefit plans: Basic & Enhanced (includes Healthy Rewards)
 - Member agreement – providers monitor patient’s compliance
- Kentucky:
 - 4 Benefit plans: global choice (default), Family Choices (most kids); Optimum Choices (MRDD), Comprehensive Choices (Nursing Home Care)
 - New cost sharing and service limits
 - “Get Healthy Benefit Accounts”
- Idaho:
 - 3 Benefit plans for healthy children and working adults, individuals with disabilities and elderly
- Kansas:
 - Benchmark benefit for Working Healthy Ticket- to-Work Medicaid Buy-In:
 - State Plan Medicaid package plus personal assistance, needs assessments, independent living counseling, and assistive services
 - DRA flexibility allowed Kansas to avoid modifying its existing Home and Community-Based Services waivers while ensuring CMS’s personal assistance requirements were met

Medicaid – Looking Ahead

- Growing complexity of Medicaid
- Enrollment growth offset decline of employer sponsored insurance
- Medicaid growing for same reasons health care cost growing + enrollment
- State budget pressures – cost containment options – eligibility, utilization, reimbursement
- Medicaid important source of federal matching funds for new state initiatives

Safety Net: Access versus Insurance

- Communities with strong insurance coverage and a strong safety net presence demonstrated the highest access to care.
- Investment in insurance goes further to improve access to care versus investment in the safety-net.
- Insurance expansions and safety-net expansions should be viewed as complements.
- Without universal coverage, the safety net is important and some investment in the safety is needed. The question is how much?

Source: Cunningham and Hadley, "Expanding Care versus Expanding Coverage: How to Improve Access to Care," *Health Affairs*: July/August 2004

Challenges of Community-Based Models

- Assuring long-term, sustainable funding
- Need to address both access and insurance
 - The safety-net is a delivery system while insurance is a financing strategy
- Difficult to design a program to fill gaps in complex health system

Lessons from Implementation of New State Strategies

- Complex Design Makes Implementation Difficult
- Small Businesses are Hard to Reach
- Ramp-Up Time Needed: No Instant Success
- Balance Vision and Realistic Expectations

Common Themes and Trends

- Comprehensive state reforms build upon prior efforts and financing mechanisms.
- Reforms attempt to stem the erosion of ESI.
- Successful efforts to enact reforms often expect shared financial responsibility. Some states are beginning to recognize the need for mandatory participation.
- Expansions in coverage often rely on private insurers to deliver care.
- Medicaid benefits are being redesigned through the DRA, but to date these efforts have not included expansions in coverage.
- States addressing cost and quality in addition to health insurance coverage.

State Actions Bring Hope, Raise Expectations

- Evidence from prior state experiences suggests that reforms will take time - reducing the uninsured by enrolling them in new initiatives can be a particularly slow process.
- Ambitious goals that brought these programs to life may be their biggest challenge - creating an expectation that they will meet these lofty goals in the short term.
- New state reforms can be fairly judged only after several years, allowing a realistic length of time to work through implementation challenges.

State Actions Bring Hope, Raise Expectations (cont.)

- Expectations that state-based reforms will result in a comprehensive national solution for the uninsured should be tempered by the acknowledgment of significant variation across states—including uninsured rates, available state funds to invest in coverage, insurance market structures, and other important factors.
- It is unrealistic to expect that all states will have equal ability to carry out far-reaching comprehensive reforms without federal assistance.

Lessons From Prior Expansion Efforts

- State strategies make a difference because they help people access health care.
- Leadership, opportunity, and readiness to act are all key ingredients to making reform happen.
- There are no free solutions.
- There has been little success in addressing underlying costs of health care, but a new focus on chronic care management holds potential.

Lessons From Prior Expansion Efforts (cont.)

- Voluntary purchasing pools, as a standalone strategy, are not likely to be sufficient to expand coverage.
- It is difficult to find agreement on what services will be covered.
- Fully addressing the problem of the uninsured needs a national solution.

Concluding Thoughts

- States play critical role in moving the conversations about coverage expansions
 - Testing new ideas (politically and practically)
 - Creating momentum for national policy solution
- Catch 22: Often need ambitious goal to sell new initiatives but need to be realistic about what states can do
 - Given overall fiscal picture, how far can states go?
- Comprehensive versus Incremental
 - Sequential = incremental plus a vision
- Few states can even approach universal coverage without a federal framework and funding