

Extending Health Care Coverage in New England

Alicia Sasser

New England Public Policy Center
Federal Reserve Bank of Boston

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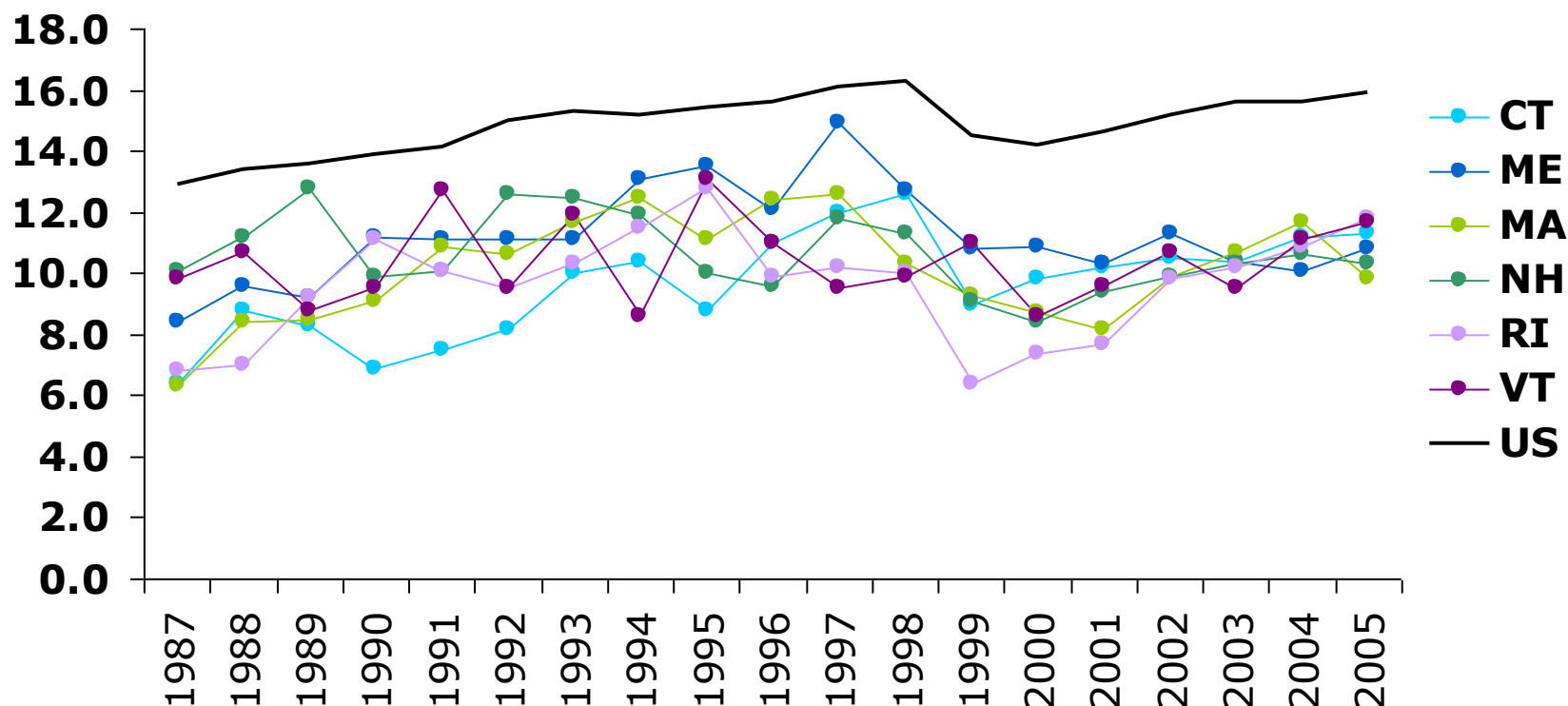
Roadmap

- How far do we have to go? Health insurance coverage rates by state
- How can we get there? Alternative coverage strategies for states
- What works and what doesn't? Evaluations of alternative coverage strategies
- Will we reach our goal? A few caveats on expanding coverage

How far do we have to go? Health insurance coverage rates by state

The rate of uninsured in New England is lower than the U.S., but has been increasing since 2000

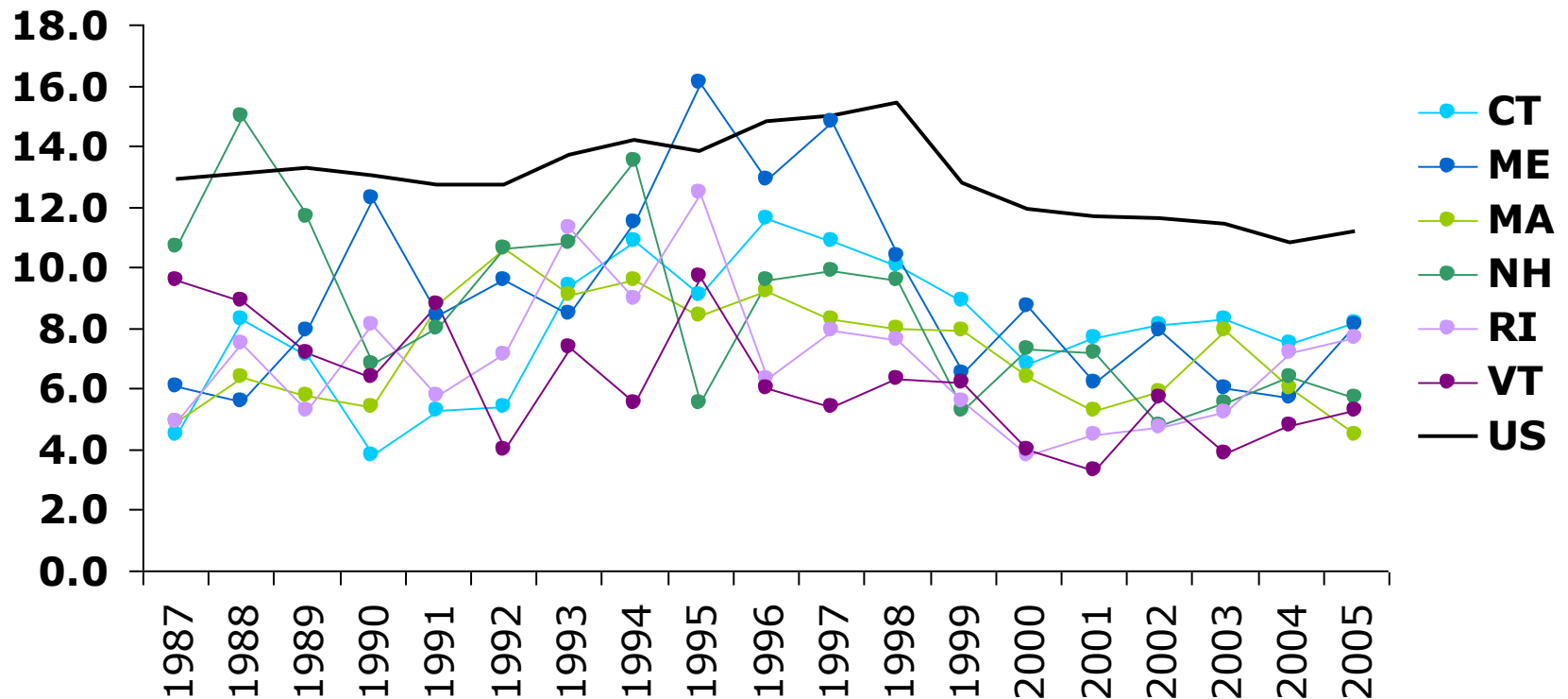
Percentage of People Without Health Insurance Coverage



Source: U.S. Census Bureau, Current Population Survey, Historical Health Insurance Tables.

Although we've done a better job of covering children in recent years...

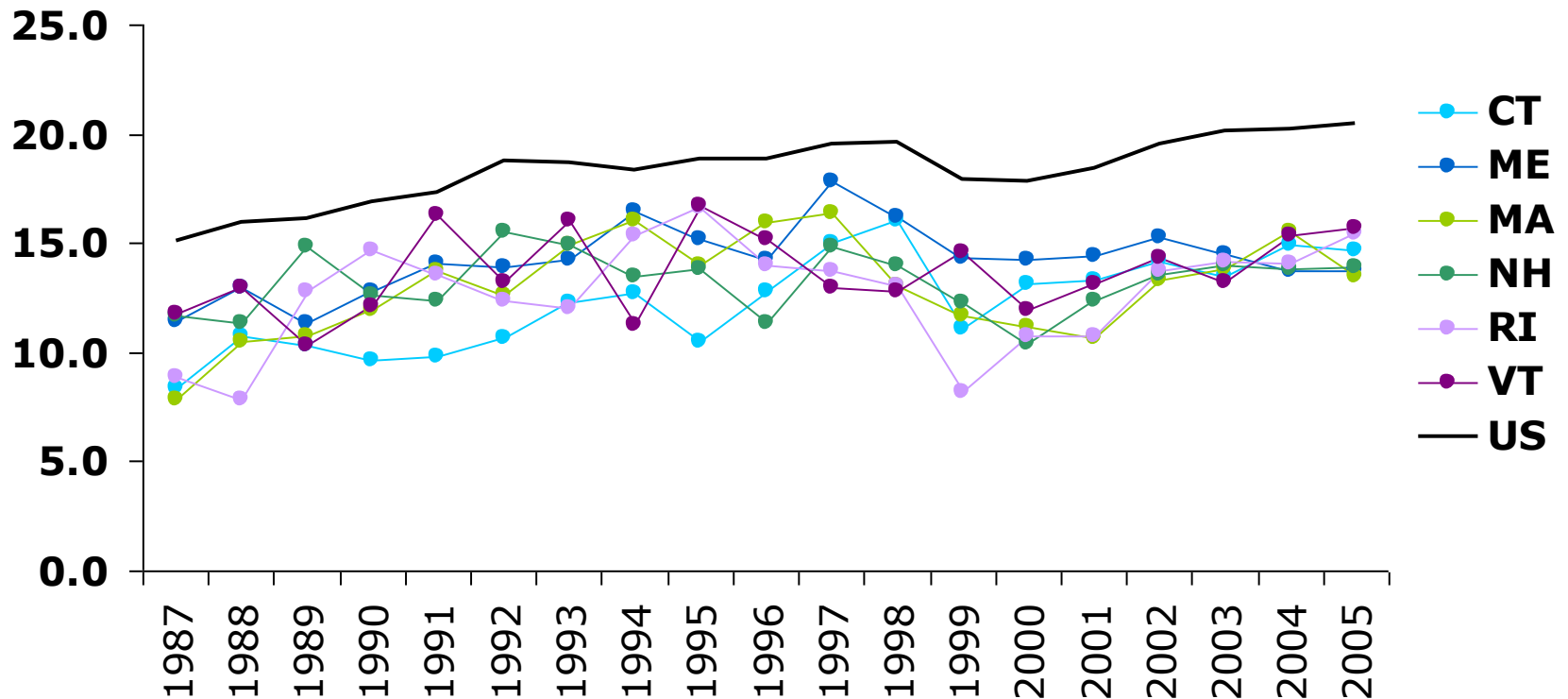
Percentage of Children Under Age 18 Without Health Insurance Coverage



Source: U.S. Census Bureau, Current Population Survey, Historical Health Insurance Tables.

...we haven't done such a good job covering the working-age population.

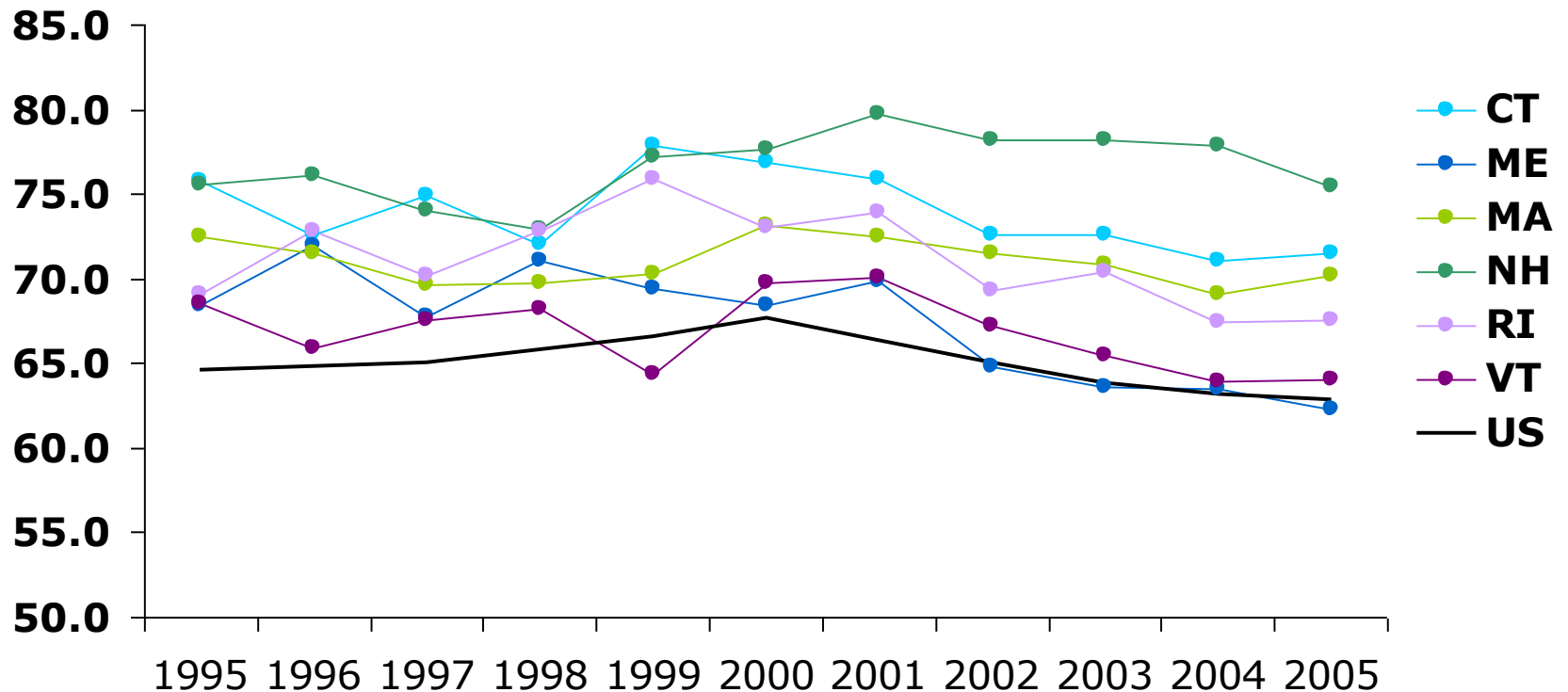
Percentage of People Age 19-65 Years Without Health Insurance Coverage



Source: U.S. Census Bureau, Current Population Survey, Historical Health Insurance Tables.

Primarily due to a decrease in employer-sponsored insurance since 2000...

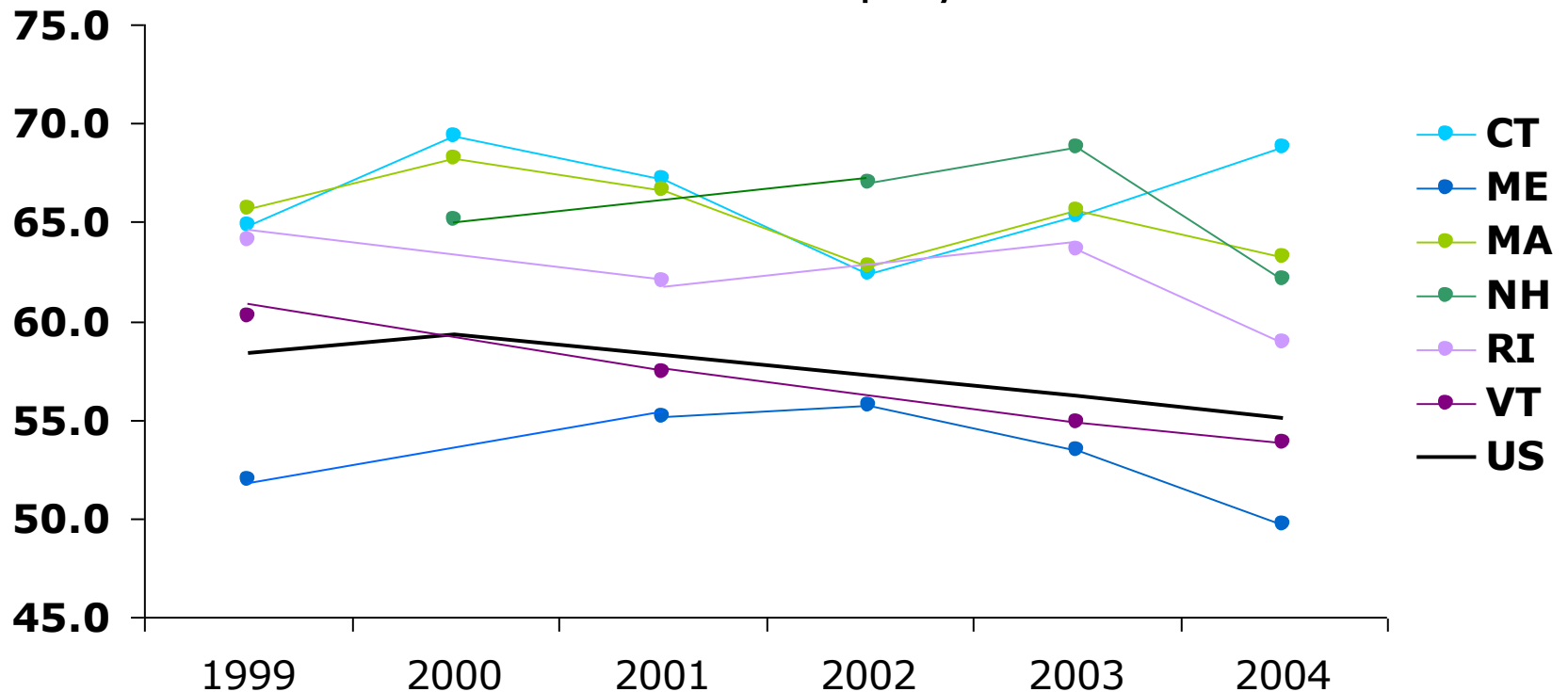
Percentage of People Under 65 Years with Employer-Sponsored Coverage



Source: U.S. Census Bureau, Current Population Survey, Historical Health Insurance Tables.

... with fewer employers offering health insurance to their employees in most New England states

Percent of Private Sector Establishments that offer Health Insurance to Employees



Source: Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. Medical Expenditure Panel Survey - Insurance Component.

How can we get there?

Alternative coverage strategies for states

State Strategies to Expand Coverage

1. Expand Medicaid and/or SCHIP through federal waivers
2. Establish a reinsurance program
3. Create a high-risk pool
4. Establish limited-benefit plans
5. Develop group purchasing arrangements (GPAs)
6. Impose a mandate or fee on employers or individuals
7. Create new insurance programs

State Strategies to Expand Coverage in New England

	Medicaid & SCHIP Waivers	Reinsurance Programs	High-Risk Pools	Limited-Benefit Plans	GPAs	Employer Mandates or Fees	New Insurance Programs
CT		X	X			Bill still in committee	
ME	X						X
MA	X	X				X	X
NH		X	X			Bill died in committee	
RI	X					Bill still in committee	X
VT	X						X

Source: Academy Health. 2005. State coverage matrix, available at <http://www.statecoverage.net/matrix/>
 Supplemented with information from other state sources through November 2006.

Overview of Medicaid and SCHIP Eligibility Across New England (Including Waivers)

	Income Eligibility (as a percentage of Federal Poverty Line)			
	Children	Pregnant Women	Parents	Adults
CT	300%	185%	150%	-----
ME	200%	200%	200%	100%
MA	300%	200%	133%	100%
NH	300%	185%	63%	-----
RI	250%	250%	185%	-----
VT	300%	200%	185%	150%
Federal Minimum Requirements	133%	133%	42%	-----

Source: Academy Health. 2005. State coverage matrix, available at <http://www.statecoverage.net/matrix/>
Supplemented with information from other state sources through November 2006.

Reinsurance Programs Across New England

	Coverage	Year Established	Deductible	Co-insurance
CT	Small groups (50 or less)	1990	\$5,000 per covered life	None
MA	Individuals	2001	\$10,000 per covered life	10% for next \$40,000 above deductible
	Small groups (50 or less)	1992	\$5,000 per covered life	10% for next \$50,000 above deductible
NH	Small groups (50 or less)	Jan 2006	\$5,000 per covered life	None
RI	Individual and small group	July 2006	TBD	TBD

Source: Academy Health. 2005. State coverage matrix, available at <http://www.statecoverage.net/matrix/>
Supplemented with information from other state sources through November 2006.

High-Risk Pools in New England

	Eligible Population	Year Established	Premium cap	Annual/lifetime Limits
CT	Medically uninsurable, HIPAA eligibles, anyone age 19-64 with no insurance	1976	125% at initial enrollment, 150% maximum	No annual limit, \$1 million lifetime limit
NH	Medically uninsurable, HIPAA eligibles	2002	125-150% of the standard risk rate for comparable coverage	\$10,000 annual limit on drugs, \$2 million lifetime limit
RI	TBD	July 2006	TBD	TBD

Source: Academy Health. 2005. State coverage matrix, available at <http://www.statecoverage.net/matrix/>
 Supplemented with information from other state sources through November 2006.

Employer Mandates/Fees in New England

	Bill	Coverage	Mandate/Fee	Status
CT	SB 462	Retailers with 5,000 or more employees that do not provide health insurance	\$2.50 per hour (not to exceed 40 hours per week) per employee	Did not pass out of committee during regular session
MA	HB 4850	Employers with 11 or more employees that do not offer health insurance	\$295 per employee per year	Passed 4/12/06 Governor vetoed but overturned by legislature
NH	HB 1704	Employers with 1,500 or more employees that do not offer health insurance	Spend 10% of total payroll on health care or pay the state the difference (8.5% for non-profits)	Died in committee
RI	HB 6917	Employers with 1,000 or more employees that do not offer health insurance	Spend 8% of total payroll on health care or pay the state the difference or a fine of \$250,000	Did not pass out of committee during regular session
VT	H 861	Employers with 8 or more full-time equivalent employees who do not offer health insurance	\$365 per year per full-time employee	Signed into law May 2006

Source: National Conference of State Legislatures, Health insurance: 2006 Pay or Play Bills.

<http://www.ncsl.org/programs/health/payorplay2006.htm>

New Insurance Programs in New England

	Program	Year Implemented	Coverage	Current/ Expected Enrollment	Premiums	Subsidy
ME	DirigoChoice	2004	Small businesses, individuals	11,131	As of 2006 Q4: \$364 for one adult \$1094 for family of four	Sliding scale up to 300% FPL
MA	Commonwealth Health Insurance Connector	July 2007	Small businesses, individuals	215,000	TBD	None
	Commonwealth Care	October 2006 - January 2007	Individuals ineligible for MassHealth	200,000	Average monthly premium is \$300 per individual	Sliding scale up to 300% FPL
RI	SelectCare	May 2007	Small businesses, individuals	27,000	Average monthly premium roughly \$314 per individual	TBD
VT	Catamount Health	October 2007	Uninsured for 1 year and does not qualify for Medicaid	25,000		Sliding scale up to 300% FPL

What works and what doesn't? Evaluations of alternative coverage strategies

Policies Targeting the Low-Income Population

- Medicaid and/or SCHIP expansions
 - Among people below the poverty level, Medicaid is unlikely to crowd-out private insurance but substitution effects increase further up the income scale
 - Medicaid beneficiaries have better access to care than the uninsured but not necessarily as good as privately insured individuals
 - Per capita spending in Medicaid is low relative to private insurance and has grown more slowly over time
 - Recent Kaiser study concluded from the body of empirical evidence that “expansion of public programs emerges as the strategy that can best target the formerly uninsured and those with the most health needs.”

Policies Targeting the High-Risk Population

- Reinsurance programs
 - Lower premiums by establishing a back-up reservoir of funds or subsidizing the expenses of high-cost enrollees
 - May provide incentive for the insurers to manage the medical care of high-cost individuals
 - Impact is greater if financed through state revenues rather than assessments on insurers
- High-risk pools
 - Coverage is expensive
 - Waiting periods for pre-existing conditions is long
 - Benefits may be limited
 - Typically have low enrollment which means limited impact on expanding coverage
 - Often operate at a loss due to need for subsidizing premiums

Policies Targeting Individuals and Small Groups

- Limited benefit plans
 - Reduction in costs is marginal (5-9% of premium costs)
 - May crowd out those who previously had comprehensive health insurance
 - Beneficiaries often access uncompensated care through safety net
 - Insurers reluctant to offer, consumers reluctant to buy
- Group purchasing arrangements
 - May reduce administrative costs and give small groups bargaining clout, thereby reducing premiums
 - Expand consumer choice but little evidence that they reduce the number of uninsured
- Employer mandates/fees
 - Employer mandates subject to ERISA requirements which have been an obstacle to implementing these types of legislation
 - Employer fees must be set so as to minimize the possibility of employers choosing to drop coverage

Components of New Insurance Programs

- Using tax policy to stimulate the purchase of private insurance
 - Can generate some increased coverage but typical levels do not have capacity to achieve significant coverage among low-income
 - Main effect is to reduce premiums for workers who already take up coverage thereby causing some disruption of group market
- Combining high deductible plans with Health Spending Accounts (HSAs)
 - Provides health insurance at lower premiums
 - Increases consumer control and responsibility
 - Firm contributions to HSAs typically much lower than the deductible amount so that enrollees face sizeable up-front out-of-pocket costs.
- Public/private partnerships
 - Remain to be seen but some indication that cooperation between states and insurers can be difficult to sustain

Will we reach our goal?

A few caveats on expanding coverage

Expanding coverage does not ensure 100% participation...

- Many who are eligible for Public health insurance are not enrolled
 - Of the 9 million children who lacked insurance in 2005, 6.6 million were in families with incomes below 200% FPL
 - Just over half of low-income adults without private insurance who qualify for public coverage are enrolled
- Participation can be hindered by a number of factors
 - Lack of knowledge about eligibility rules
 - Burden of application and enrollment procedures
 - Level of need / perceived value of assistance

Expanding coverage does not guarantee access to care...

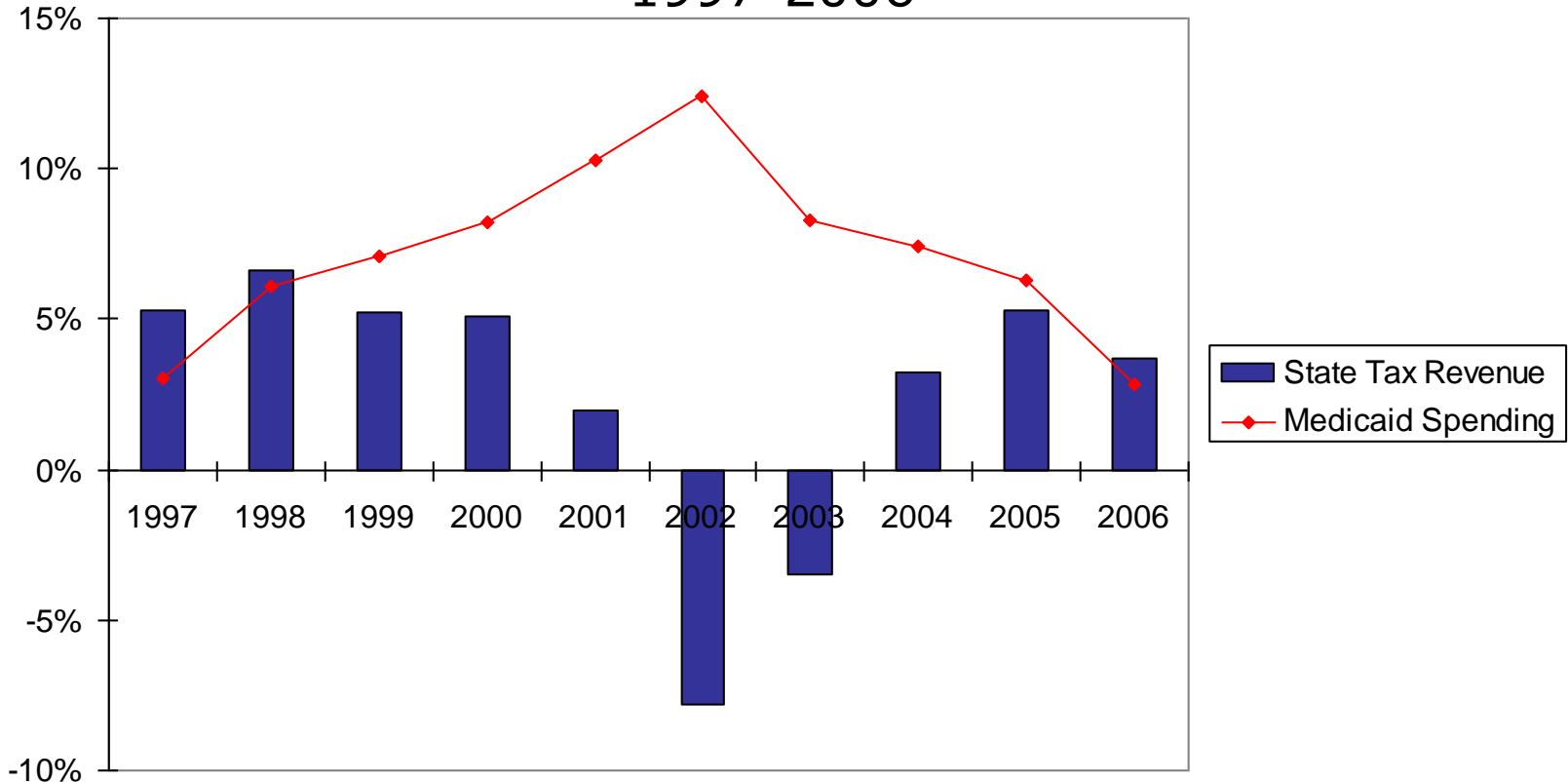
- Many low-income people cycle on and off health insurance throughout the course of a year
- Other barriers such as transportation costs, inability to navigate the health care system, language and cultural differences, and racial/ethnic disparities in care all serve to reduce access
- Low Medicaid payment rates and burdensome administrative requirements reduce the supply of providers willing to accept Medicaid patients

Expanding coverage is subject to changing budget constraints...

- Between 2001 and 2004 states experienced severe fiscal stress as revenues fell while Medicaid spending and enrollment peaked
 - The most common containment action was to freeze or reduce provider payment rates
 - Other strategies included targeted benefit cuts and restricting eligibility

In FY 2006, state revenue growth exceeded Medicaid cost growth for the first time since the late 1990s

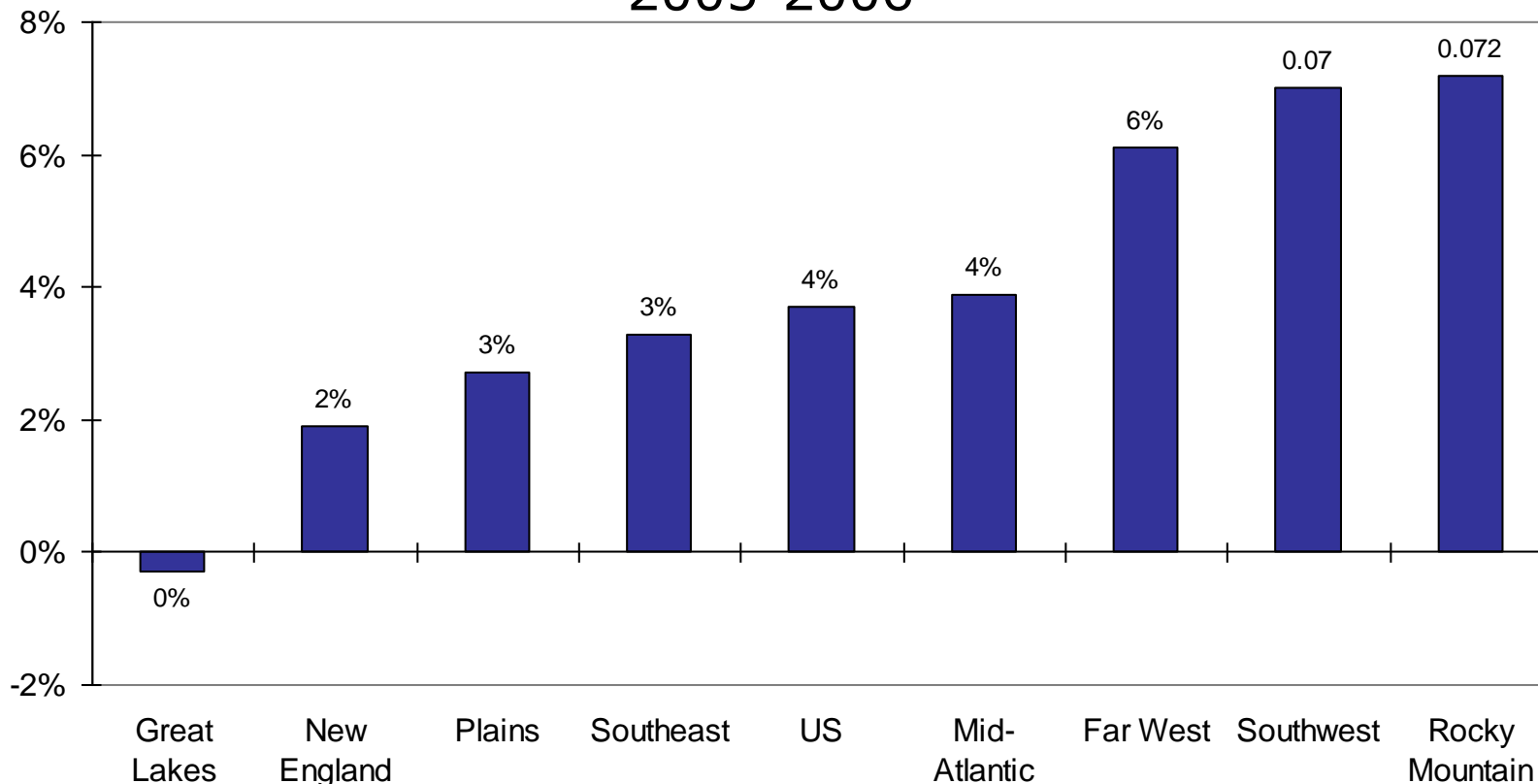
State Tax Revenue and Medicaid Spending Growth 1997-2006



Source: Kaiser Commission on Medicaid and the Uninsured. "Results from a 50-State Medicaid Budget Survey, State Fiscal Years 2006 and 2007. October 2006.

New England lags behind much of the country in terms of revenue growth...

Regional Variation in State Revenue Recovery 2005-2006



Source: Preliminary Estimates, Rockefeller Institute of Government. Data is Adjusted for inflation and Legislative changes.

Yet states continue to approach policy changes with caution...

- Improving fiscal conditions have allowed for some program investments, but many states continue to focus on controlling costs
- Changes in federal policy that affect the financing and administration of Medicaid also impose additional cost concerns
- Unclear whether current reforms will be sustainable in the long-run as fiscal conditions change