Reaching the Goal: Evaluating Policy Alternatives for Expanding Coverage

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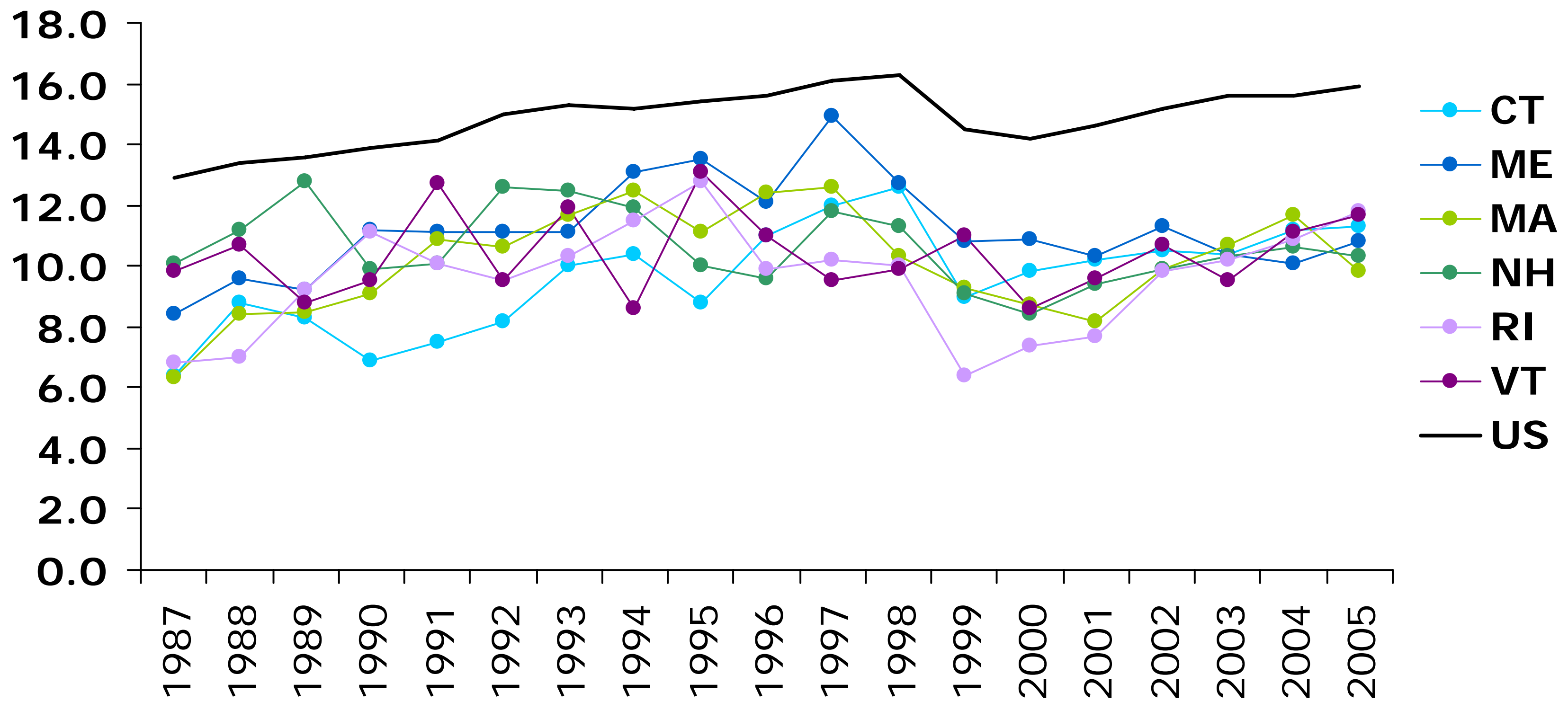
Reaching the goal

- How far do we have to go?
- How can we get there?
- Will we reach our goal?

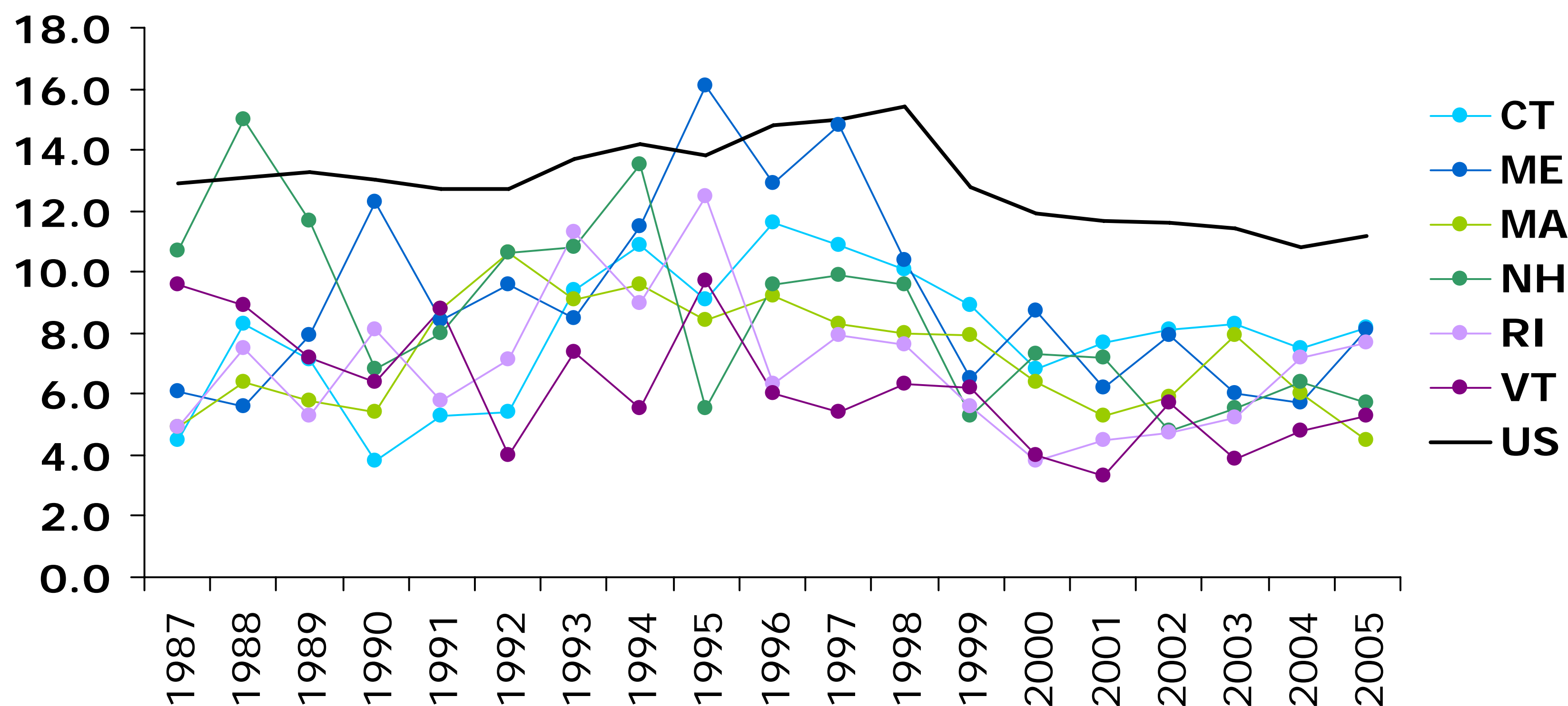
The rate of uninsured in New England is lower than in the U.S. but has been increasing since 2000



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.

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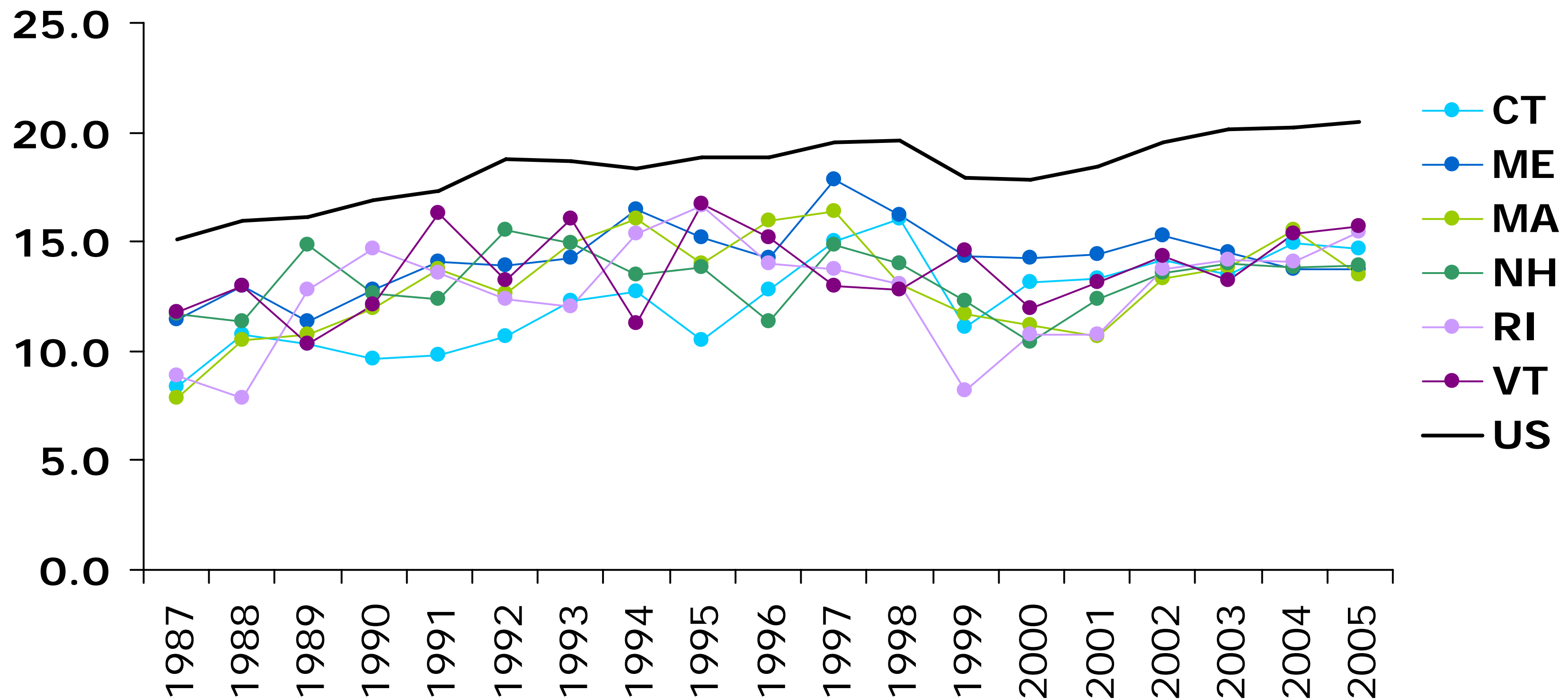
…we haven't done such a good job covering the working-age population.



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

How can we get there?
Coverage strategies for states

States can employ a number of strategies targeted at different groups to expand coverage.

Policy	Target population
Expand Medicaid and/or SCHIP	Low-income
Establish a reinsurance program Create a high-risk pool	High-risk / High-cost
Establish limited-benefit plans Develop group purchasing arrangements Impose a mandate or fee on employers Create new insurance products/programs	Individuals and small groups

The New England states have pursued a combination of both traditional strategies and new initiatives.

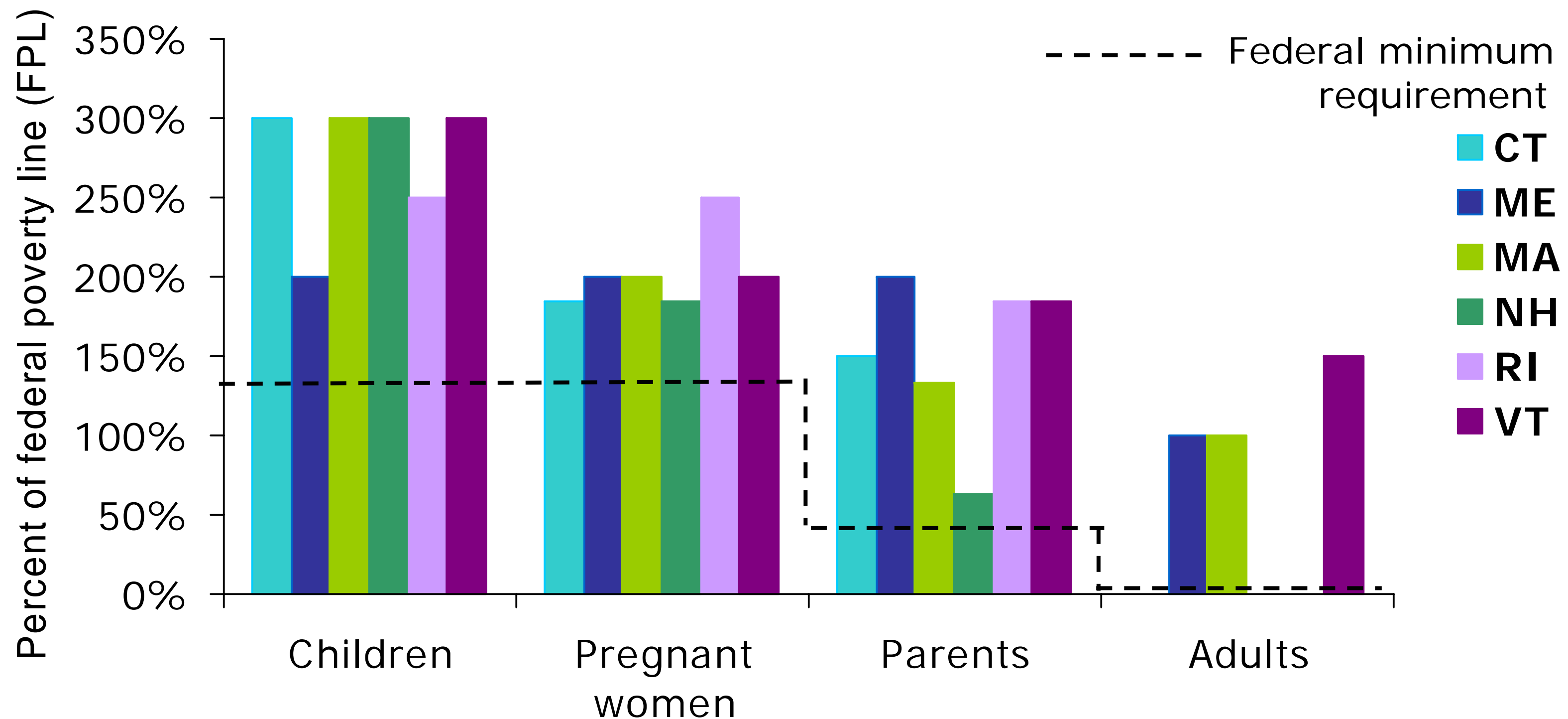
	Medicaid & SCHIP waivers	Reinsurance programs	High-risk pools	Employer mandates or fees	New insurance programs
CT		X	X	Fee proposed	
ME	X				DirigoChoice
MA	X	X		Fee passed	Commonwealth Care
NH		X	X	Mandate proposed	
RI	X	Passed but not funded	Pursuing funding	Mandate proposed	SelectCare
VT	X			Fee passed	Catamount Health

Source: Academy Health, 2005. Supplemented with information from state sources through November 2006.

Policies targeting the low-income population have been modestly successful.

- Medicaid and/or SCHIP expansions
  - Among people below the poverty level, unlikely to crowd out private insurance, but substitution effects increase further up the income scale
  - Beneficiaries have better access to care than the uninsured but not necessarily as good as privately insured individuals
  - Per capita spending is low relative to private insurance, and spending for acute care has grown more slowly over time

New England provides relatively generous coverage for low-income individuals through the Medicaid and SCHIP programs.



Source: Academy Health, 2005. Supplemented with information from state sources through November 2006.

Policies targeting the high-risk population have had mixed results.

- Reinsurance programs (CT, MA, NH)
  - Lower premiums by subsidizing the expenses of high-cost enrollees or establishing a back-up reservoir of funds
  - 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 (CT, NH)
  - Coverage is expensive
  - Benefits may be limited
  - Long waiting periods for pre-existing conditions
  - Typically have low enrollment by design; not intended as a means to expand coverage significantly
  - Often operate at a loss because the high-risk population is expensive to cover

Policies targeting individuals and small groups have had limited success to date.

- Limited benefit plans
  - Reduction in costs is marginal (5 to 9% of premium costs)
  - Beneficiaries often access uncompensated care via safety net
  - May crowd out those who previously had comprehensive health insurance
  - Not very popular with employers or consumers
- Group purchasing arrangements
  - Give small groups bargaining clout to negotiate lower premiums
  - Difficult to avoid adverse selection while broadening coverage
  - Expand consumer choice but little evidence that they reduce the number of uninsured
- Employer mandates/fees
  - Employer mandates have been found in violation of ERISA
  - Employer fees may cause some employers to drop coverage

Many New England states are considering employer mandates and fees.

	Bill	Coverage	Mandate/Fee	Status
CT	SB 462	Retailers with 5,000 or more employees that do not offer 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 Vetoed by governor 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	HB 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

Four of the New England states have passed or implemented new insurance programs.

	Program	Enrollment Date	Coverage	Current (Expected) Enrollment	Premiums	Subsidy
ME	DirigoChoice	2005	Small businesses, sole proprietors, individuals	11,131	As of 2006 Q4: $364 for one adult $1,094 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	Oct. 2006 - Jan. 2007	Individuals ineligible for MassHealth	(200,000)	Avg. monthly premium of $300 per individual	Sliding scale up to 300% FPL
RI	SelectCare	May 2007	Small businesses, individuals	(27,000)	Avg. monthly premium of roughly $314 per individual	TBD
VT	Catamount Health	Oct. 2007	Uninsured for 1 year and does not qualify for Medicaid	(25,000)	TBD	Sliding scale up to 300% FPL

Rhode Island aims to reduce premiums costs for businesses by 25% through the SelectCare Program.

- Enrollment will begin in May 2007
- Plan will cover roughly 27,000 of the uninsured through individual and small group plans
- Average monthly premium target of $314 per individual
- Funding primarily based on a $100 million fund from securitized tobacco payments

The Catamount Health program endeavors to insure 96% of all Vermont residents within 5 years.

- Enrollment will begin in October 2007
- Eligibility restricted to those who have been uninsured for 12 months and do not qualify for Medicaid or other state programs – roughly 25,000 individuals
- Premiums subsidized on a sliding scale up to 300% FPL
- Plan characteristics include a family deductible of $500 with coinsurance of 20% and a cap of $1,600 for out-of-pocket costs
- Funding will be through a combination of individual contributions for premiums, a $365 employer assessment, an increase in the state's tobacco tax, and matching federal dollars.

Maine seeks to achieve universal access to health care coverage under DirigoChoice.

- Enrollment began in January 2005 and covered 11,131 people as of September 2006
- Available to small businesses, sole proprietors, and eligible individuals without access to employer-sponsored insurance
- Offers discounts on monthly premiums and reductions in deductibles and out-of-pocket costs on a sliding scale up to 300% FPL.
- Plan characteristics include a deductible of either $1,250 or $1,750, 100% coverage for preventive visits, and $20 co-pays for other office visits
- Funding comes through a combination of employer and employee contributions, Medicaid dollars, and an assessment on insurers' gross premium revenues (Savings Offset Payment).

To date, only the DirigoChoice Program has been fully implemented…

- Characteristics of enrollees
  - Approximately 40% previously uninsured; 23% underinsured
  - Even distribution across individuals, sole proprietors, and small groups
  - Most (65%) fall into discount groups between 100% and 200% FPL
  - Nearly half of individual enrollees were unemployed
- Utilization and costs of the program
  - Average costs for those submitting a claim was $2,700
  - Top 1% of claimants drove 30% of plan costs
  - Roughly 8% of members identified as high risk
  - For CY2005, total costs were $348 PMPM, half of which was subsidized
- Characteristics of disenrollees
  - Primarily young adults age 18-24 years
  - Of those surveyed, about 40% disenrolled involuntarily
  - Voluntary disenrollees cited costs and inadequate benefits
  - After disenrolling, 60% had private coverage and 30% were uninsured

Sources: Harrington, Karynlee and Will Kilbreth. 2006. "Dirigo Health Agency. A Snapshot of the Program 2005 & 2006." Characteristics of disenrollees from recent survey by Muskie School of Public Service.

Components of new insurance programs pose difficult design issues that are critical for success…

- Subsidizing premiums on a sliding scale
  - Can generate some increased coverage and ease burdens on currently insured low-income individuals and families
  - May cause some disruption of group market
  - Funding may not be sufficient to cover all who are eligible
- Developing insurance exchanges
  - Payment of premiums by individuals can be on a pre-tax basis
  - Coverage can be portable as individual changes employers.
  - Typically combine high-deductible plans with health savings accounts to keep premiums low
- Creating public/private partnerships for financing
  - Cooperation between states and insurers can be difficult to sustain

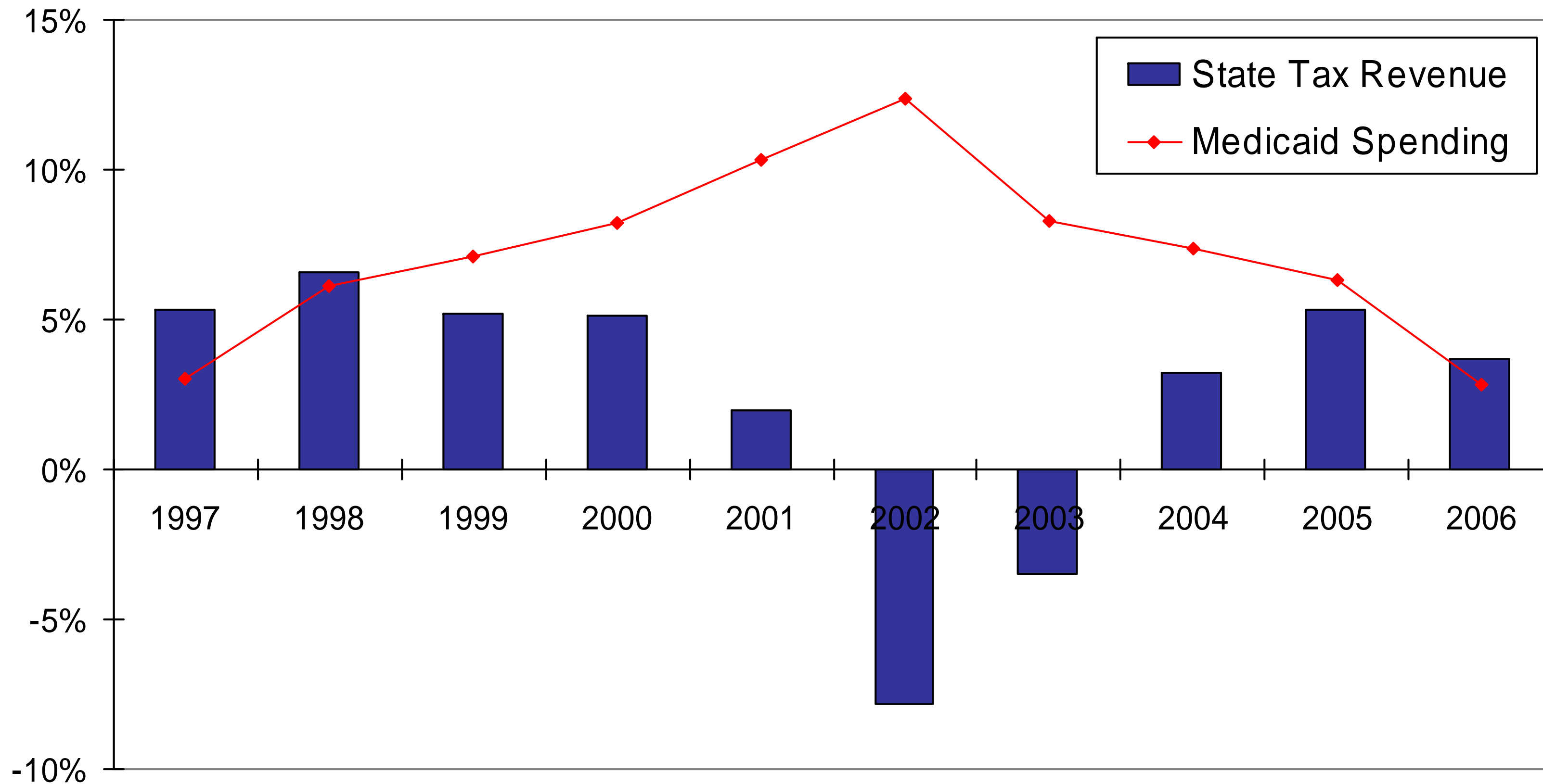
Will we reach our goal?
A few caveats on expanding coverage

Even with the best program design, there are additional obstacles to overcome.

- Expanding coverage does not ensure 100% participation.
- Participation does not guarantee access to care.
- Coverage expansions are continually subject to budget constraints

The good news: In FY 2006, state revenue growth exceeded Medicaid cost growth

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.

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Yet there are additional constraints that will affect the ability of states to expand coverage.

- Changing economic and fiscal conditions
- Rising health care costs and changing demographics
- Shifting federal policy affecting both Medicaid and SCHIP