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

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

Percentage of children under age 18 without health insurance coverage

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

Percentage of people age 19-65 years without health insurance coverage

How can we get there?
Coverage strategies for states
States can employ a number of strategies targeted at different groups to expand coverage.

<table>
<thead>
<tr>
<th>Policy</th>
<th>Target population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand Medicaid and/or SCHIP</td>
<td>Low-income</td>
</tr>
<tr>
<td>Establish a reinsurance program</td>
<td>High-risk / High-cost</td>
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<tr>
<td>Create a high-risk pool</td>
<td></td>
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<tr>
<td>Establish limited-benefit plans</td>
<td>Individuals and small groups</td>
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<tr>
<td>Develop group purchasing arrangements</td>
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<tr>
<td>Impose a mandate or fee on employers</td>
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<tr>
<td>Create new insurance products/programs</td>
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</table>
The New England states have pursued a combination of both traditional strategies and new initiatives.

<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid &amp; SCHIP waivers</th>
<th>Reinsurance programs</th>
<th>High-risk pools</th>
<th>Employer mandates or fees</th>
<th>New insurance programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td></td>
<td>X</td>
<td>X</td>
<td>Fee proposed</td>
<td></td>
</tr>
<tr>
<td>ME</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>DirigoChoice</td>
</tr>
<tr>
<td>MA</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Fee passed</td>
<td>Commonwealth Care</td>
</tr>
<tr>
<td>NH</td>
<td></td>
<td>X</td>
<td>X</td>
<td>Mandate proposed</td>
<td></td>
</tr>
<tr>
<td>RI</td>
<td>X</td>
<td>Passed but not funded</td>
<td>Pursuing funding</td>
<td>Mandate proposed</td>
<td>SelectCare</td>
</tr>
<tr>
<td>VT</td>
<td>X</td>
<td></td>
<td></td>
<td>Fee passed</td>
<td>Catamount Health</td>
</tr>
</tbody>
</table>

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.

Income eligibility (including waivers)

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.

<table>
<thead>
<tr>
<th>State</th>
<th>Bill</th>
<th>Coverage</th>
<th>Mandate/Fee</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td>SB 462</td>
<td>Employers with 1,500 or more employees that do not offer health insurance</td>
<td>Spend 8% of total payroll on health care or pay the state the difference or a fine of $250,000</td>
<td>Did not pass out of committee during regular session</td>
</tr>
<tr>
<td>MA</td>
<td>HB 4850</td>
<td>Retailers with 5,000 or more employees that do not offer health insurance</td>
<td>$2.50 per hour (not to exceed 40 hours per week) per employee</td>
<td>Did not pass out of committee during regular session</td>
</tr>
<tr>
<td>NH</td>
<td>HB 1704</td>
<td>Employers with 1,000 or more employees that do not offer health insurance</td>
<td>$295 per employee per year</td>
<td>Passed 4/12/06 Vetoed by governor Overturned by legislature</td>
</tr>
<tr>
<td>RI</td>
<td>HB 6917</td>
<td>Employers with 8 or more full-time equivalent employees who do not offer health insurance</td>
<td>$365 per year per full-time employee</td>
<td>Signed into law May 2006</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Program</th>
<th>Enrollment Date</th>
<th>Coverage</th>
<th>Current (Expected) Enrollment</th>
<th>Premiums</th>
<th>Subsidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>DirigoChoice</td>
<td>2005</td>
<td>Small businesses, sole proprietors, individuals</td>
<td>11,131</td>
<td>As of 2006 Q4: $364 for one adult $1,094 for family of four</td>
<td>Sliding scale up to 300% FPL</td>
</tr>
<tr>
<td>Commonwealth Health Insurance Connector</td>
<td>July 2007</td>
<td>Small businesses, individuals</td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Commonwealth Care</td>
<td>Oct. 2006 - Jan. 2007</td>
<td>Individuals ineligible for MassHealth</td>
<td>(200,000)</td>
<td>Avg. monthly premium of $300 per individual</td>
<td>Sliding scale up to 300% FPL</td>
</tr>
<tr>
<td>SelectCare</td>
<td>May 2007</td>
<td>Small businesses, individuals</td>
<td>(27,000)</td>
<td>Avg. monthly premium of roughly $314 per individual</td>
<td>TBD</td>
</tr>
<tr>
<td>Catamount Health</td>
<td>Oct. 2007</td>
<td>Uninsured for 1 year and does not qualify for Medicaid</td>
<td>(25,000)</td>
<td>TBD</td>
<td>Sliding scale up to 300% FPL</td>
</tr>
</tbody>
</table>
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

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

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