Options for Expanding Access to Health Care for the Uninsured

Report by
Mathematica Policy Research, Inc.

For

Office of Performance Evaluations
Idaho Legislature
July 2007

Report 07-08

Created in 1994, the Legislative Office of Performance Evaluations operates under the authority of Idaho Code § 67-457 through 67-464. Its mission is to promote confidence and accountability in state government through professional and independent assessment of state agencies and activities, consistent with legislative intent.

The eight-member, bipartisan Joint Legislative Oversight Committee approves evaluation topics and receives completed reports. Evaluations are conducted by Office of Performance Evaluations staff. The findings, conclusions, and recommendations in the reports do not necessarily reflect the views of the committee or its individual members.

Joint Legislative Oversight Committee

Senate

Shawn Keough, *Co-chair*
John McGee
Edgar J. Malepeai
Elliot Werk

House of Representatives

Margaret Henbest, *Co-chair*
Maxine T. Bell
Clifford R. Bayer
Donna Boe

Rakesh Mohan, Director
Office of Performance Evaluations

Agreement Date: 02/05/07
MPR Reference No.: 6338-004

MATHEMATICA
Policy Research, Inc.

Options for Expanding Access to Health Care for the Uninsured

A Review of State and Community Approaches

Final Report

July 18, 2007

Lynn Taylor
Cheryl Fahlman
Elizabeth Seif

Submitted to:

Rakesh Mohan, Director
Office of Performance Evaluations
Idaho Legislature
700 W. State Street
Boise, Idaho 83702
Telephone: (208) 334-3880
Website: www.idaho.gov/ope

Submitted by:

Ms. Lynn Taylor, Principal Investigator
Mathematica Policy Research, Inc.
600 Maryland Ave., S.W., Suite 550
Washington, DC 20024-2512
Telephone: (202) 484-9220
Facsimile: (202) 863-1763

This page has been intentionally left blank for double-sided copying.

ACKNOWLEDGEMENTS

Lynn Taylor is the primary author of this report. She would like to thank the considerable contributions of many people. The report could not have been completed without the generous sharing of expertise and data from many entities around the state, including the Idaho Department of Health and Welfare, the Idaho Division of Welfare, the Idaho Department of Insurance, Idaho Department of Commerce and Labor, the Idaho Association of Counties, Idaho Hospital Association, Blue Cross of Idaho, Regence BlueShield of Idaho, the Idaho Association of Counties, North Idaho Health Network, J. Robinson Enterprises and representatives from the Terry Reilly Health Services and Family Health Services health centers. Ned Parrish of the Idaho Office of Performance Evaluations (OPE) provided significant assistance putting us in touch with these important contributors. In addition to the significant contribution of co-authors Cheryl Fahlman and Elizabeth Seif, research assistance was provided by Stephanie Peterson of Mathematica Policy Research, Inc (MPR). Margo Rosenbach and Debra Lipson of MPR, Ned Parrish and Carrie Parrish (OPE), and Dr. Tedd McDonald (Boise State University) and Bob Thomas (Robert C. Thomas & Associates) reviewed the report.

This page has been intentionally left blank for double-sided copying.

CONTENTS

Chapter		Page
	EXECUTIVE SUMMARY	xi
I	**INTRODUCTION**	1
	THE UNINSURED IN IDAHO	2
	FRAMEWORK FOR EXAMINING COVERAGE APPROACHES	3
	Typology of Coverage Approaches	3
	Identification of the Target Population	7
	Selection of Financing Approach	7
	OVERVIEW OF IDAHO'S EXISTING COVERAGE INITIATIVES	8
	ASSESSING THE EFFECTIVENESS OF ALTERNATIVE APPROACHES	10
	ORGANIZATION OF THIS REPORT	10
II	**APPROACHES THAT MODIFY THE MARKET IN WHICH COVERAGE IS OFFERED**	11
	LIMITED-BENEFIT PLANS	11
	SMALL EMPLOYER PURCHASING POOLS	13
	EXPANSION OF DEFINITION OF DEPENDENCY	14
	CONTINUATION OF COVERAGE	14

Chapter **Page**

II *(continued)*

RATING REFORMS AND GUARANTEED ISSUE........15

"BUY-IN" TO STATE-NEGOTIATED HEALTH PLANS........16

INSURANCE EXCHANGE OR CONNECTOR........16

CONCLUDING REMARKS........17

III **APPROACHES THAT SUBSIDIZE MARKET-BASED HEALTH COVERAGE**........19

DIRECT PREMIUM ASSISTANCE PROGRAMS........20

Premium Assistance through Medicaid and SCHIP Programs........20
Premium Assistance Using State-Only Funds........22
Premium Assistance Using the Three-Share Model........22

INDIRECT PREMIUM ASSISTANCE THROUGH REINSURANCE SUBSIDIES........23

PREMIUM SUBSIDIES FOR STATE-SPONSORED HIGH-RISK POOLS........23

CONCLUDING REMARKS........24

IV **PROGRAMS THAT EXPAND DIRECT PUBLIC COVERAGE**........25

APPROACHES THAT EXPAND ELIGIBILITY FOR PUBLIC COVERAGE........25

Coverage of Low-Income Parents and Childless Adults........25
Universal Coverage of Children........26
Medically Needy/Spend Down Program........26

STRENGTHENING OUTREACH TO THOSE WHO ARE ELIGIBLE BUT NOT ENROLLED........27

CONCLUDING REMARKS........27

Chapter		Page
V	**APPROACHES THAT DEVELOP NEW MECHANISMS FOR ACCESSING CARE**	29
	APPROACHES TO STRENGTHEN SAFETY-NET CAPACITY	29
	Managed Care Safety-Net Programs	30
	Discounted or Donated Care Programs	30
	APPROACHES TO PROVIDE ASSISTANCE WITH MEDICAL BILLS	31
	CONCLUDING REMARKS	32
VI	**COMPREHENSIVE COVERAGE INITIATIVES THAT COMBINE APPROACHES**	33
	USE OF COVERAGE MANDATES	34
	Individual Mandates	35
	Employer Mandates	35
	CONCLUDING REMARKS	36
VII	**OPTIONS FOR FUNDING STATE COVERAGE APPROACHES**	37
	SOURCES OF FEDERAL FUNDING	37
	Medicaid/SCHIP Funds	37
	Disproportionate Share Hospital Funds	38
	Hisk-Risk Pool Funding	39
	Other Sources of Federal Funds	39
	SOURCES OF STATE FUNDING	39
	Tobacco Settlement Funds and Taxes	39
	Assessments on Insurers	39
	State General Revenues/Tax Expenditures	40
	PROVIDER DISCOUNTS/DONATED CARE	40
	CONCLUDING REMARKS	41

Chapter		Page
VIII	IMPLICATIONS FOR IDAHO	43
	REFERENCES	47

EXHIBITS

Exhibit **Page**

1 SELECTED COVERAGE APPROACHES IN STATES AND COMMUNITIES, BY TYPE OF APPROACH 4

2 OVERVIEW OF IDAHO COVERAGE INITIATIVES.......... 8

3 STATES THAT ENACTED OR PROPOSED COMPREHENSIVE COVERAGE INITIATIVES.......... 33

4 POSSIBLE OPTIONS TO EXPAND HEALTH INSURANCE COVERAGE IN IDAHO 44

This page has been intentionally left blank for double-sided copying.

EXECUTIVE SUMMARY

About one in six nonelderly people in Idaho was uninsured in 2005. Like many other states, Idaho is considering approaches to expand health insurance coverage and improve health care services for the uninsured. States have become a "laboratory" for health care reform and there is growing recognition that many lessons can be learned from other states' experiences. In February 2006, the Idaho Health Care Task Force recommended that the state undertake a study to identify ways to expand access to health care for the uninsured. In response to a request from the Joint Legislative Oversight Committee, the Idaho Office of Performance Evaluations contracted with Mathematica Policy Research, Inc. to prepare two reports that compile information for the Health Care Task Force on (1) the characteristics of the uninsured in Idaho, and (2) possible approaches for expanding coverage among subgroups of the uninsured. This report provides a compendium of coverage approaches used by other states and local communities.

TYPOLOGY OF COVERAGE APPROACHES

We grouped the wide range of coverage initiatives into four general approaches: (1) approaches that modify the market in which coverage is offered (such as changing insurance regulations), (2) approaches that subsidize market-based coverage (such as direct subsidies through premium assistance or indirect subsidies through reinsurance), (3) approaches that provide direct public coverage (such as expanding eligibility for Medicaid or the State Children's Health Insurance Program [SCHIP]), and (4) approaches that develop new mechanisms for accessing care (such as expanding the capacity of safety-net providers or helping the uninsured pay for care through loans or by negotiating discounted rates with providers). Some states have created comprehensive initiatives that combine several different approaches to address the needs of a diverse mix of uninsured subgroups.

As the Health Care Task Force considers options for improving coverage for the uninsured, it is important to keep in mind initiatives that have already been put into place in the state or that are in the process of being implemented (Exhibit A). Two key points are evident: (1) Idaho has undertaken a variety of coverage expansion initiatives already, spanning all four types of approaches; and (2) enrollment in some of these initiatives tends to be low (based on data that are currently available). As policymakers consider options for future initiatives, an important consideration will be to assess whether additional efforts

Exhibit A. Overview of Idaho Coverage Initiatives

Type of Initiative	Description	Enrollment (if known)
Approaches that Modify the Market in Which Coverage is Offered		
Small Employer Health Reinsurance Pool	This mechanism is intended to reduce premium volatility by offering reinsurance for individuals, dependents, and small groups. All carriers participating in the health insurance market in Idaho are assessed a fee to cover losses incurred by the pool.	115
Definition of Dependency	Effective July 2007, Idaho law has increased to 25 the age to which unmarried dependents may remain on their parents' health insurance policies for full-time students, and to 21 for other children.	Not yet implemented
Approaches that Subsidize Market-Based Health Coverage		
Health Insurance Premium Payment	Pays for private health insurance premiums, when it is deemed cost effective, for Medicaid-eligible individuals.	403
Idaho Access Card Program	Gives SCHIP-eligible children the option of direct public coverage or premium assistance for private coverage. To be eligible, children must be income-eligible for SCHIP and uninsured.	208
Access to Health Insurance Program	Subsidizes premiums for uninsured adults who are ineligible for Medicaid, who have income under 185% FPL, and who are working for an eligible employer. The employer must be a non-offering, small firm, and must agree to contribute 50 percent or more to the premium.	269 (capped at 1,000 participants)
Individual High-Risk Reinsurance Pool	The state operates a pool that reinsures five guaranteed-issue products and sets premiums for the products. The premiums are between 125 and 150 percent of the rates for standard risks. The pool is funded through several sources, including individual premiums, a portion of the state premium tax, and an assessment on insurers if necessary.	1,400
Approaches that Provide Direct Public Coverage		
SCHIP Eligibility Expansion	Expanded SCHIP eligibility from 150 to 185 percent of the FPL (July 2004).	3,400

Exhibit A *(continued)*

Type of Initiative	Description	Enrollment (if known)
Approaches That Develop New Mechanisms For Accessing Care		
School-based Health Service Initiative	Uses SCHIP administrative funds to provide grants to school districts to assist with salary expenses for registered nurses working in schools. Services will include health counseling and education, health screenings and preventive care, health coordination and health care referrals, and application assistance for uninsured children who are potentially eligible for Medicaid or SCHIP.	No data available
County Indigent and State Catastrophic Programs	Helps residents pay for hospital and medical bills exceeding certain standards. Residents can apply to this program after emergency hospital services have been incurred. Combined state and county spending exceeds $40 million. The program receives funding from property taxes and a line item in the state's general appropriations.	1,063 cases approved 7/05-6/06
Community Health Centers	In its 2007 session, the Idaho legislature created the Community Health Center Grant Fund to improve access to health care services for Idahoans. This law provides a mechanism for the state to fund these centers, but no funding was included for the current year.	Not funded

could be made to improve participation in current programs, such as through increased outreach and marketing, refinement of eligibility requirements, or increased subsidies to make coverage more affordable.

LESSONS LEARNED FROM OTHER STATES' EXPERIENCES

It is difficult to generalize the effectiveness of state coverage initiatives from one state to another. The likelihood of a program's success may vary from state to state, depending on the unique attributes in a given state, such as the characteristics of the uninsured, population density, health care and employer markets, available funding, and political realities. In addition, programs may be conceived with different coverage goals and philosophies in mind. Nevertheless, several lessons may be drawn from state experiences to inform future discussions by the Idaho Health Care Task Force. The lessons are summarized here. Further details about state coverage initiatives are provided in the body of the report.

APPROACHES THAT MODIFY THE MARKET IN WHICH COVERAGE IS OFFERED

- ***Limited Benefit Plans.*** Also known as bare-bones plans, these plans are designed to lower the cost of coverage and are generally targeted to small businesses or the individual market. Experience suggests that carriers are reluctant to offer these products and, when they are offered, employer participation typically is low. State officials have reported that these products are neither much less expensive than conventional coverage nor very appealing to business owners, who prefer comprehensive coverage for themselves.

- ***Small Employer Purchasing Pools.*** While these pools have been successful in offering small groups both administrative convenience and a choice of plans, there is no evidence that they reduce premiums. As a result, most researchers have concluded that purchasing pools alone do not expand coverage. There is some evidence, however, that participation is higher when a premium subsidy is offered to reduce the employer's and/or employee's share of the premium.

- ***Expansion of the Definition of Dependency.*** To address high rates of uninsurance among young adults, several states (including Idaho) have instituted a requirement that stipulates the age of dependency for coverage on a parent's group health insurance policy. To qualify, dependents usually are required to be single and childless, and the maximum age for dependency may vary according to student status.

- ***Continuation of Coverage.*** The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires firms of 20 or more employees that sponsor coverage for their workers to offer continuation coverage to enrolled workers (and their dependents) who leave their jobs. Forty states (but not Idaho) have extended COBRA-like protections to workers in smaller businesses, often called mini-COBRA.

- ***Rating Reforms and Guaranteed Issue.*** Rating reforms are designed to reduce the spread in premium rates offered to individuals and groups that is attributable to variation in their health status. Guarantee issue requirements ensure that residents are not denied coverage altogether due to their health status. The impact of such reforms is generally mixed. They can increase the availability and affordability of coverage for those with high health care needs but raise the cost for those who are relatively healthy.

- ***Buy-In to State-Negotiated Health Plans.*** A few states are leveraging the administrative services and purchasing power of the state employee's health plan to provide coverage options for small employers. To date, only modest premium savings (if any) have been realized, leading to correspondingly modest enrollment.

- ***Insurance Exchange or Connector.*** An insurance exchange, also known as a connector, centralizes health insurance purchasing transactions by administering enrollment, coverage selection, and payment processing (including subsidies). Massachusetts has recently implemented a connector as part of its comprehensive universal coverage initiative. Although there is widespread national interest in this approach, there is no evidence yet about its effectiveness in making the system more seamless.

APPROACHES THAT SUBSIDIZE MARKET-BASED COVERAGE

- ***Direct Premium Assistance Programs.*** Subsidy programs that target non-offering firms generally have realized low levels of employer participation. In contrast, programs that subsidize coverage for employees or their dependents who are already eligible for their employer's offer (but have declined the offer) have experienced somewhat greater levels of enrollment. However, when premium subsidies are delivered retrospectively after proof of payment is provided, experience has shown that this mechanism can create cash flow problems for low-income recipients and can be difficult for states to administer well. A popular approach is known as the "three-share" model, which subsidizes both the employee and employer premium shares. In addition, these programs pay the subsidy directly to the plan. This funding arrangement helps employers and employees understand their own costs, and it eliminates the cash flow problems that some participants might experience with a retrospective subsidy payment.

- ***Subsidies for Reinsurance.*** Indirectly subsidizing coverage through a reinsurance subsidy can lower the premium quoted by commercial carriers. Such products can be marketed to both individuals and small groups. Healthy New York has employed this coverage strategy and realized significant enrollment among uninsured individuals and sole-proprietors. Small firms also participate in the coverage at a somewhat lower level.

- ***Subsidies for State-Sponsored High-Risk Pools.*** A few states have explored premium subsides to help lower-income residents afford the premiums charged by the state's high-risk pool. Such programs can effectively target coverage to those who are at high risk of high medical expenses or who are uninsurable in the commercial market. Enrollment in these options tends to be relatively low, reflecting a small target population.

APPROACHES THAT PROVIDE DIRECT PUBLIC COVERAGE

- ***Strengthening Outreach to Those Who are Eligible but Not Enrolled.*** To boost enrollment among those who are eligible for current public programs, states have engaged in a wide variety of outreach efforts. In general, states have learned that the most effective efforts combine statewide media campaigns to

raise awareness of the program and intensive community-based efforts to provide one-on-one application assistance.

- ***Expansion of Eligibility for Medicaid and SCHIP for Children.*** Recent expansions of Medicaid and SCHIP programs around the country are generally credited with lowering rates of uninsurance for children to about half that of adults. Several states have used this approach to insure children at incomes up to 200 percent of poverty or higher. Favorable provider reimbursement rates and the availability of federal matching funds defray the direct cost to the state. In Idaho, the state pays 20 to 30 cents of each dollar spent on SCHIP and Medicaid (respectively) with the federal government paying the rest.

- ***Direct Coverage for Adults.*** In contrast to low take-up among premium subsidy programs targeting employers, programs that offer subsidized coverage directly to adults, even with limited benefits, typically have achieved strong enrollment. Moreover, in a few cases, states have garnered federal matching funds to help defray the direct cost to the state.

- ***Medically Needy/Spend-down Program.*** Thirty-five states and the District of Columbia (excluding Idaho) currently have a medically needy program through Medicaid. Medically needy programs provide Medicaid coverage to individuals who have extensive health care expenses but who are not otherwise eligible for Medicaid because their incomes exceed traditional Medicaid guidelines. The "spend down" is similar to a deductible where, before qualifying for Medicaid, applicants must incur medical expenses equal to the amount that their monthly income exceeds Medicaid income levels.

APPROACHES THAT DEVELOP NEW MECHANISMS FOR ACCESSING CARE

States and local communities realize that even aggressive approaches to increasing coverage may still leave some residents uninsured. For this reason, safety-net providers will continue to play a role in providing care to some residents. Strategies that facilitate access to such care include strengthening the health care safety net (such as increased funding of community health centers), introducing programs that better coordinate care delivered in these settings and helping the uninsured manage high medical debt (such as through loan programs). Additionally, some states have negotiated rates with providers to ensure that uninsured people do not pay more for their care than the federal or state governments pay through Medicare and Medicaid. While these are important strategies to shore up the financing and delivery of health care services at the local level, they are not coverage options *per se*.

POLICY OPTIONS FOR FUTURE CONSIDERATION IN IDAHO

To narrow future initiatives in Idaho, it is important to understand whom should be targeted because of high uninsured rates. The populations with the highest uninsured rates are young adults, people who work part-time or are unemployed, and people who are low

income. Employees with the lowest likelihood of being offered coverage are those in small firms, although many of them obtain coverage from another source (such as a spouse's employer). In addition, the uninsured rate in rural counties is higher than in urban counties. Regardless of an employee's income level, cost is the biggest barrier to obtaining coverage. Some groups face additional barriers during transition periods, for example, when they lose or change jobs or when they graduate from school. Indeed, the most common reason for experiencing uninsurance in a given year is a job loss or job change.

Based on the review of coverage initiatives in other states, we identified several options that the Idaho Health Care Task Force may want to consider as it assesses future coverage options (Exhibit B). These options were selected for three reasons: (1) they address the needs of groups with high rates of uninsurance in Idaho; (2) they build on existing coverage initiatives, where possible (such as the Access to Health Insurance program and SCHIP); and (3) they represent options that are promising based on experience in other states. However, a significant caveat should be recognized: options that were successful in other states may not necessarily be successful in Idaho, and conversely, options that were not successful in other states could be successful in Idaho if the environment is more supportive or if the design is tailored to the Idaho market. Nevertheless, these options represent a suggested "first cut" at options for the task force to consider.

It should be noted that we do not include options that are designed solely to increase access without also increasing coverage. While the expansion of safety net capacity—especially in rural areas—may ameliorate provider shortages, we believe this strategy does not take the place of making health insurance coverage more readily available and affordable. Having an insurance card improves access to care. There is considerable evidence, based on self-reported data, that those without coverage are more likely than the insured to skip a recommended medical test or treatment, not fill a prescription, postpone needed medical care, and not receive care for a serious condition.

As many states and communities have learned, careful attention to the design of the coverage program can help avoid unintended consequences such as low enrollment, unexpected state costs, contractions of provider supply, or reductions of private coverage availability. To build a foundation for tracking the effects of its coverage initiatives, we recommend that Idaho conduct a baseline survey of health insurance among employers and households, with sufficient sample sizes to support estimates within subgroups of particular policy interest. This will position the state for determining how well its initiatives are addressing the needs of the uninsured.

Exhibit B. Possible Options to Expand Health Insurance Coverage in Idaho

Uninsured Population	Possible Coverage Options
Low-income children	• Raise SCHIP eligibility threshold from 185 to 200 percent of the FPL • Target outreach to children who are eligible for but not enrolled in Medicaid or SCHIP
Young adults	• Implement and raise awareness of expanded definition of dependency for young adults who are dependents
Unemployed adults	• Enact mini-COBRA law that would provide continuation of coverage for those in small businesses that are exempt from COBRA provisions
Low-income workers with access to employer-sponsored coverage	• Continue to expand coverage through Idaho's Access Card and Access to Health Insurance programs; refine program design as necessary (such as eligibility criteria, marketing strategies, application procedures, subsidy amount); if necessary, conduct focus groups with employers and employees to better understand reasons for low participation and address barriers to the extent possible. This approach may be coordinated with the proposed pool option below. • Explore the potential for the "three-share" program, based on the model in Muskegon, Michigan. This approach may be coordinated with the proposed pool option below.
Low-income workers and sole proprietors without access to employer-sponsored coverage	• Create a purchasing pool for small businesses making subsidies available for non-offering employers and low-income workers. Explore the feasibility of federal match and of bringing in uninsured sole proprietors • The Insure Montana pool could provide a model
Residents of rural areas	• Examine options for strengthening safety-net capacity in rural areas
Cross-cutting strategies	• Assess the feasibility and viability of establishing an Insurance Connector, as in Massachusetts, to increase portability of coverage, facilitate pooling of employer contributions from more than one employer, and administer subsidies • Augment current household and employer surveys in the state to provide rigorous estimates of important subgroups • Monitor and strengthen safety-net capacity in the state. Explore coordinated care programs such as Health Advantage in Indiana.

CHAPTER I

INTRODUCTION

About one in six nonelderly people in Idaho was uninsured in 2005—a rate similar to the national average. Like many other states, Idaho is considering approaches to expand health insurance coverage and improve health care services for the uninsured. States have become a "laboratory" for health care reform and there is growing recognition that many lessons can be learned from other states' experiences. Indeed, states have considered or implemented a wide variety of approaches, ranging from modest, narrowly targeted subsidies of health care premiums to comprehensive overhauls of the financing and delivery of health care.

In February 2006, the Idaho Health Care Task Force recommended that the state undertake a study to identify ways to expand access to health care for the uninsured. Idaho's Joint Legislative Oversight Committee directed the Office of Performance Evaluations to commission several reports. Mathematica Policy Research, Inc. (MPR) has prepared this report on approaches used in other states to expanding coverage among subgroups of the uninsured. A companion report by MPR profiles the uninsured in Idaho. The State Health Access Data Assistance Center (SHADAC) is producing separate reports on the current levels of public and private health care spending in the state.

This compendium contains information about state coverage approaches that is current as of April 2007. Because many states are continuing to refine their approaches, this information is subject to change. Nevertheless, this report provides Idaho policymakers with a framework for understanding available options that could be targeted to subgroups of the uninsured population in Idaho.

The remainder of this chapter provides background information to place other states' initiatives in the context of Idaho's health care environment. The next section presents a brief profile of the uninsured in Idaho, drawing on findings from our companion study. Then we present a framework that can be used to examine other states' coverage initiatives. The final section summarizes the coverage approaches that have been implemented in Idaho to place other states' initiatives within a local context.

THE UNINSURED IN IDAHO

Understanding the characteristics of the uninsured in Idaho is an essential first step in determining the salience of alternative coverage approaches. As reported in MPR's companion report, *Health Insurance Coverage in Idaho: A Profile of the Uninsured and Those with Coverage,* about 16 to 18 percent of nonelderly residents were uninsured in 2005. The uninsured are a diverse group, as reflected by their demographic characteristics and reasons for uninsurance. Nonelderly adults were uninsured at a rate twice that of children (22 percent versus 10 percent). The availability of public coverage through Medicaid and the State Children's Health Insurance Program (SCHIP) may account for the lower uninsurance rates among children.

Among nonelderly adults, disproportionately high uninsurance rates were observed among young adults ages 18 to 24 (38 percent), adults with annual incomes below $25,000 (43 to 49 percent), and the unemployed (51 percent). Reflecting patterns of employment and income levels, uninsured rates were higher in rural than in urban counties (23 percent versus 15 percent). The most common reason for being uninsured is being unable to afford the premiums. This factor was important regardless of income. Among unemployed adults, the most frequent reason for being uninsured was "lost job or changed employers," while young adults most frequently reported other reasons, including "ineligible because of age or left school." The majority of uninsured adults (70 percent) have been uninsured for more than one year, with low-income adults having the longest duration of uninsurance; about half have been without coverage for at least five years. Recent increases in average premium costs far outstripped average wage growth (142 percent and 20 percent, respectively, from 1998 to 2004).

Data for Idaho suggest that the biggest gaps in coverage currently are among Idaho employees whose employers do not currently offer coverage, many of whom are in small firms and earning low wages. We estimated that 128,000 private sector employees in Idaho worked for an employer that did not offer any type of health insurance coverage. About one-third obtained coverage through a spouse or another source. The remaining two-thirds were estimated to be uninsured, the majority of whom are below 200 percent of the federal poverty level (FPL). As Chapter III demonstrates, programs that target non-offering employers often experience low rates of participation. Programs that target adults directly (by-passing non-offering employers) often experience greater rates of success.

In addition, we estimated that about 184,000 Idaho employees may have declined an employer's offer of coverage, but 86 percent are insured elsewhere. Hence, approximately 26,000 Idaho workers may have declined an offer of coverage for which they are eligible. Difficulty affording the employee's share of the premium is often cited as the reason for declining coverage in such cases. It can be cost effective for states to provide premium subsidies to such workers so that the employer's contribution is leveraged.

Another successful mechanism for increasing insurance coverage is by providing direct coverage through public programs. The effectiveness of these mechanisms depends on enrolling a high percentage of those who are eligible. We estimated that the majority of eligible children appear to be enrolled in Medicaid (more than 80 percent), while a lower

proportion of the eligible population appears to be enrolled in SCHIP (about 30 percent). Moreover, we estimated that if SCHIP eligibility were extended to children ages 0 to 19 with incomes between 185 and 200 percent of the FPL, another 4,000 children might become newly eligible for coverage. The state does not currently have public coverage programs for childless adults and eligibility thresholds for parents are very low.

Faced with this diversity of uninsured residents, most states use a variety of approaches to target several well-defined (and often small) subgroups of the uninsured population, such as low-income, uninsured workers in non-offering firms or uninsured children eligible for federal matching funds.

FRAMEWORK FOR EXAMINING COVERAGE APPROACHES

When states or communities investigate new approaches to covering the uninsured, they usually wrestle with three questions: (1) which coverage approach to use, (2) who to target for coverage, and (3) how to fund the program. Because the answers to these questions are related and interdependent, decision makers usually need to consider all three questions simultaneously. These questions provide a framework for reviewing the options in this report, and considering their implications for Idaho.

Typology of Coverage Approaches

We have grouped the wide range of coverage initiatives into four general approaches.[1] These approaches can be thought of as building blocks because they can be combined in various ways to achieve the state's coverage goals. The four general coverage approaches include:

1. *Approaches that Modify the Market in Which Coverage is Offered.* These approaches use low- or no-cost techniques to modify how coverage is offered in the market. Examples include regulations that facilitate the formation of purchasing pools; rate regulations limiting the amount of premium variation, especially in the small group or individual market; changes in regulations permitting the sale of lower-cost, limited benefit plans; and mandating that coverage be offered to certain groups, such as dependents of a certain age. In some cases, these strategies may be combined with premium subsidies, but often they are "standalone" options.

2. *Approaches that Subsidize Market-based Health Coverage.* These approaches encompass a variety of subsidy methods in an effort to increase take-up.

[1]Some initiatives that may alleviate the consequences of being uninsured are considered to be outside of the scope of this compendium, including initiatives that solely address underlying cost (like Certificate of Need) and initiatives that support a narrow scope of services (like pharmacy assistance). We also restrict the compendium to public sector initiatives and exclude those that result from the efforts of private or commercial entities (such as Caring Programs, sponsored by Blue Cross/Blue Shield plans, that provide limited coverage to low-income children).

Subsidies can take the form of direct assistance or vouchers; indirect reinsurance subsidies; or tax credits. A premium subsidy program might target employers, individuals, or both.

3. *Approaches that Provide Direct Public Coverage.* These approaches expand access to coverage offered directly by the state or community. In addition to expanding eligibility criteria for public programs, some states focus on reaching those who are eligible but not enrolled by increasing outreach efforts and simplifying enrollment procedures. Often these coverage programs leverage federal matching funds through Medicaid or the State Children's Health Insurance Program (SCHIP), but some are solely state-funded.

4. *Approaches that Develop New Mechanisms for Accessing Care.* Some communities have opted to develop new mechanisms to facilitate access to traditional safety-net care. These initiatives recognize that, despite initiatives to cover the uninsured, some subgroups of the population may experience periods of uninsurance during periods of employments transition. In addition to expanding the capacity of safety-net providers, some programs seek to improve the delivery of such care to give uninsured patients a medical "home." Some states work with providers to ensure that the uninsured are charged discounted rates.

Exhibit 1 provides an overview of the coverage approaches discussed in this report, arrayed according to the four types of coverage approaches listed above.

Exhibit 1. Selected Coverage Approaches in States and Communities, by Type of Approach

State	Program (Date Begun)	Enrollment (Lives)	Target Population	Financing (Other than Employer and Individual)
		Approaches that Modify the Market[a]		
AZ	HealthCare Group (1985)	26,000	Small, non-offering firms and sole proprietors	Uses Medicaid reimbursement rates
WV	Small Business Plan (2005)	1,200	Small, non-offering firms	Below market provider rates
NM	Small Employer Insurance Program (2006)	<500 projected for 2007	Small firms	None needed
CT	Municipal Employee Health Insurance Program (2003)[b]	250	Small firms and sole proprietors	None needed
CO	Multiple Employer Welfare Arrangements (2003)	1 MEWA	Small firms	None needed
MT	Limited Benefit Plan (2003)	53	Uninsured residents	None needed
OR	Alternative Group Plan (2005)	< 50	Non-offering small firms	None needed
UT	Limited Benefit Plan (2002)	NA	Uninsured residents	None needed

Exhibit 1 ***(continued)***

State	Program (Date Begun)	Enrollment (Lives)	Target Population	Financing (Other than Employer and Individual)
		Approaches that Subsidize Market-Based Health Coverage		
NY	Healthy New York (2001)	130,000	Uninsured, low-income residents, sole proprietors and workers at small, non-offering firms	State; Tobacco settlement; Cigarette tax
WA	Basic Health Plan (1993)	100,000 (capped)	Uninsured, low-income residents[c]	State general fund
OR	Family Health Insurance Assistance Program (1997)	15,000	Uninsured, low-income residents[c]	State; Federal match
NM	State Coverage Insurance (2005)	6,000	Uninsured, low-income workers at small firms and low-income sole proprietors[d]	State; Federal match; SCHIP
RI	RIte Share (2002)	6,000	Low-income parent workers	State; Federal Medicaid match
CO	CoverColorado (1991)	5,000	Low-income residents participating in high risk pool	Assessments on insurers; state general fund
MT	Insure Montana – purchasing pool (2005)	5,000	Uninsured workers at small, non-offering firms	Cigarette tax
TN	CoverTN (2007)	3,000	Uninsured, low-income workers at small, non-offering firms and low-income sole proprietors[f]	State
NM	New Mexico Medical Insurance Pool (1988) – Low Income Premium Program	2,300	Low-income residents participating in high risk pool	Assessments on insurers; Federal grant
MI	Access Health (1999)	1,500	Low-wage workers in non-offering Muskegon country firms	DSH funds; Provider donated care
MT	Montana Comprehensive Health Insurance Association - premium assistance program (2002)	200	Low-income residents participating in high-risk pool	Federal grant
AR	Arkansas Safety Net Benefits Program (2007)	175	Low-income workers at non-offering firms and low-income sole proprietors[d]	Tobacco settlement; State; Medicaid and SCIHP
NV	Nevada Check Up Plus (2006)	NA	Low-income parent workers at small, offering firms	State; Federal SCHIP match
UT	Utah Premium Partnership (2003)[e]	NA	Uninsured, low-income workers in offering firm	State; Federal SCHIP match
		Approaches that Expand Direct Public Coverage		
PA	adultBasic (2001)	49,000 (capped)	Uninsured, low-income residents	Tobacco Settlement
ME	MaineCare (2002)	20,000 (capped)	Low-income residents	DSH money via HIFA waiver

Exhibit 1 *(continued)*

State	Program (Date Begun)	Enrollment (Lives)	Target Population	Financing (Other than Employer and Individual)
UT	Primary Care Network (2002)	16,000 (capped)	Uninsured, low-income residents	State; Federal Medicaid match
		Approaches that Expand Direct Public Coverage		
IL	All Kids – Illinois (2006)	NA[f]	Uninsured or low-income child residents	State; Medicaid and SCHIP funds
		Approaches that Offer New Mechanisms to Access Care		
IN	Health Advantage (1997)	52,000	Uninsured, low-income county residents	County property taxes
FL	Hillsborough County Health Care Plan (1991)	30,000	Uninsured, low-income county residents	Sales and property tax from county
MI	Ingham Health Plans (1998)	17,000	Uninsured, low-income county residents	DSH; County; State medical indigent funds
IN	Project Health - Indianapolis Medical Society (2004)	450	Uninsured, low-income county residents	Donated provider care; Grants

Sources (in alphabetical order by state):

AR	Arkansas Safety Net Benefits Program	Communication from NovaSys Health, LLC (March 19, 2007).
AZ	HealthCare Group	State Coverage Initiatives Program, *Profiles in Coverage: Arizona Healthcare Group* (May 2007).
CO	Multiple Employer Welfare Arrangements	Amy Fletcher, “Small-Biz Health Coverage Bill Advances, Denver Business Journal (Marh 24, 2005).
CO	CoverColorado	State Coverage Initiatives Program, Coverage Profile: Colorado (Accessed: May 8, 2007).
CT	Municipal Employee Health Insurance Program	Communication from CT MEHIP (May 8, 2007).
FL	Hillsborough County Health Care Plan	Taylor, E., P. Cunningham, and K. McKenzie. “Community Approaches to providing Care for the Uninsured.” *Health Affairs*, 2006.
IL	All Kids	(Associated Press 2005).
IN	Project Health	Indianapolis Medical Society, July 2005 Bulletin.
IN	Health Advantage	Taylor, E., P. Cunningham, and K. McKenzie. “Community Approaches to providing Care for the Uninsured.” *Health Affairs*, 2006.
ME	MaineCare	Lipson, et al. (forthcoming 2007).
MI	Access Health	Communication from consultant Gary Packingham (March 13, 2007).
MI	Ingham Health Plan	Taylor, E., P. Cunningham, and K. McKenzie. “Community Approaches to providing Care for the Uninsured.” *Health Affairs*, 2006.
MT	Limited Benefit Plan	Spencer, et al. *Health Insurance Access Programs and Policies in Montana and Other Frontier States*, January 2006.
MT	Insure Montana	Communication from Insure Montana (May 9, 2007).
MT	Montana Comprehensive Health Insurance Association	Spencer, et al. *Health Insurance Access Programs and Policies in Montana and Other Frontier States*, January 2006.
NM	Small Employer Insurance Program	NM Human Services Department. January 2007.
NM	State Coverage Initiative	New Mexico State Government General Information (Accessed May 4, 2007).
NM	New Mexico Medical Insurance Pool	State Coverage Initiatives Program, Coverage Profile: New Mexico (Accessed: May 8, 2007).
NV	Nevada Check Up Plus	State Coverage Initiatives Program, Coverage Profile: Nevada (Accessed: May 8, 2007).

Exhibit 1 *(continued)*

NY	Healthy New York	State Coverage Initiatives Program, Coverage Profile: New York (Accessed: May 8, 2007).
OR	Alternative Group Plan	Communication from Oregon Office of Private Health Partnerships (March 14, 2007).
OR	Family Health Insurance Assistance Program	Communication from Oregon Office of Private Health Partnerships (April 3, 2007).
PA	adultBasic	Insurance Department Commonwealth of Pennsylvania 2007.
RI	RIte Share	Connecticut's OLR Research Report on RIteShare (April 27, 2005).
TN	CoverTN	Media Release from TN Department of Finance and Administration (May 11, 2007).
UT	Limited Benefit Plan	Spencer, et al. *Health Insurance Access Programs and Policies in Montana and Other Frontier States*, January 2006.
UT	Utah Premium Partnership	State Coverage Initiatives Program, Coverage Profile: Utah (Accessed: May 8, 2007).
UT	Primary Care Network	*Utah Primary Care Network Demonstration Fact Sheet* (CMS, December 26, 2006).
WA	Basic Health Plan	State Coverage Initiatives Program, Coverage Profile: Washington (Accessed: May 8, 2007).
WV	Small Business Plan	State Coverage Initiatives Program, Coverage Profile: West Virginia (Accessed: May 8, 2007).

[a] Programs which also feature a subsidy are listed in the *Subsidized Market-Based Coverage* section.
[b] In 1998, Connecticut launched a program permitting non-profits of any size to buy into the MEHIP. Small, for-profit groups were added in 2003. Including non-profit entities, about 7,500 non-municipal lives participate.
[c] Subsidy can be applied to employers offer of coverage or non-group coverage.
[d] Higher income workers at enrolled firm can participate in plan but are not eligible for subsidy.
[e] Formerly known as Covered At Work (2003-2007).
[f] Total enrollment is unknown. In the first 4 months of operation, the program enrolled 30,000 previously ineligible children (Associated Press 2005).

Identification of the Target Population

Identifying the target population for a coverage initiative is key to understanding the extent to which an initiative is likely to close the coverage gaps in a given state. Most programs target one or more well-defined (and often small) subgroups of the uninsured population, such as uninsured workers in non-offering firms or uninsured children eligible for federal matching funds. These subgroups are defined based on a variety of considerations, such as their reasons for being uninsured, their duration of uninsurance, availability of employer coverage, variation in ability to pay, and availability of financing to cover the costs of coverage. In some cases, the selection of a specific coverage approach will determine the target population (for example, those with access to employer-based coverage). Additional eligibility criteria may include the income level or length of time without insurance coverage.

Selection of Financing Approach

Funding considerations can also influence the choice of coverage approach. Funding sources generally fall into three broad categories: federal, state, and other sources. Sources of federal funding may include Medicaid and SCHIP matching funds, disproportionate share hospital (DSH) funds, high-risk pool subsidies, and community health center (CHC) grants. Sources of state funding include state general revenues and tax expenditures, as well as tobacco settlement funds, tobacco taxes, and insurer assessments. Other sources may include provider discounts and donated care and employer contributions to the premiums of newly covered workers.

States and communities have exhibited creativity in developing new ways to combine funding sources to cover their uninsured residents. For example, some states have used private dollars to leverage public funds (such as Medicaid or SCHIP matching funds or disproportionate-share hospital funds). In addition, some states have redirected uncompensated care pool funds to subsidize private coverage for low-income workers and their families.

OVERVIEW OF IDAHO'S EXISTING COVERAGE INITIATIVES

As the Health Care Task Force considers options for improving coverage for the uninsured, it is important to keep in mind initiatives that have already been put into place in the state (or that are in the process of being implemented). This information will assist the Task Force in identifying future initiatives that can build upon the current approaches, either by strengthening current initiatives or targeting new initiatives to populations not served by existing programs.

Exhibit 2 shows the range of activities in Idaho. Interestingly, they span all four areas of the coverage typology. Two key points emerge from this table: (1) Idaho has undertaken a variety of coverage expansion initiatives already; and (2) enrollment in some of these initiatives tends to be low (based on data that are currently available). As policymakers consider options for future initiatives, an important component will be to assess whether additional efforts could be made to improve participation in current programs, such as through increased outreach and marketing, refinement of eligibility requirements, or increased subsidies to make coverage more affordable. In some cases, such assessments are already underway.

Exhibit 2. Overview of Idaho Coverage Initiatives

Type of Initiative	Description	Enrollment (if known)
Approaches that Modify the Market in Which Coverage is Offered		
Small Employer Health Reinsurance Pool	This mechanism is intended to reduce premium volatility by offering reinsurance for individuals, dependents, and small groups. All carriers participating in the health insurance market in Idaho are assessed a fee to cover any losses incurred by the pool.	115
Definition of Dependency	Effective July 2007, Idaho law has increased to 25 the age to which unmarried dependents may remain on their parents' health insurance policies for full-time students, and to 21 for other children.	Not yet implemented
Approaches that Subsidize Market-Based Health Coverage		
Health Insurance Premium Payment	Pays for private health insurance premiums, when it is deemed cost effective, for Medicaid-eligible individuals.	403

Exhibit 2 ***(continued)***

Type of Initiative	Description	Enrollment (if known)
Idaho Access Card Program	Gives SCHIP-eligible children the option of direct public coverage or premium assistance for private coverage. To be eligible, children must be income-eligible for SCHIP and uninsured.	208
Approaches that Subsidize Market-Based Health Coverage		
Access to Health Insurance Program	Subsidizes premiums for uninsured adults who are ineligible for Medicaid, who have income under 185% FPL, and who are working for an eligible employer. The employer must be a non-offering, small firm, and must agree to contribute 50 percent or more to the premium.	269 (capped at 1,000 participants)
Individual High-Risk Reinsurance Pool	The state operates a pool that reinsures five guaranteed-issue products and sets premiums for the products. The premiums are between 125 and 150 percent of the rates for standard risks. The pool is funded through several sources, including individual premiums, a portion of the state premium tax, and an assessment on insurers if necessary.	1,400
Approaches that Provide Direct Public Coverage		
SCHIP Eligibility Expansion	Expanded SCHIP eligibility from 150 to 185 percent of the FPL (July 2004).	3,400
Approaches That Develop New Mechanisms For Accessing Care		
School-based Health Service Initiative	Uses SCHIP administrative funds to provide grants to school districts to assist with salary expenses for registered nurses working in schools. Services will include health counseling and education, health screenings and preventive care, health coordination and health care referrals, and application assistance for uninsured children who are potentially eligible for Medicaid or SCHIP.	No data available
County Indigent and State Catastrophic Programs	Helps residents pay for hospital and medical bills exceeding certain standards. Residents can apply to this program after emergency hospital services have been incurred. Combined state and county spending exceeds $40 million. The program receives funding from property taxes and a line item in the state's general appropriations.	1,063 cases approved 7/05-6/06
Community Health Centers	In its 2007 session, the Idaho legislature created the Community Health Center Grant Fund to improve access to health care services for Idahoans. This law provides a mechanism for the state to fund these centers, but no funding was included for the current year.	Not funded

ASSESSING THE EFFECTIVENESS OF ALTERNATIVE APPROACHES

To the extent possible, this report assesses state experiences with alternative coverage approaches. However, relatively little is known about the effectiveness of other states' health care reform efforts. Most studies to date have involved case studies of program implementation; few have examined program outcomes related to access, quality, and cost effectiveness.[2] This is due to several factors: the cost of conducting evaluations, limitations of existing data, and the recent implementation of many programs.

The most common measure available to us is overall program enrollment. Enrollment levels, however, are difficult to interpret in the absence of a denominator representing the estimated number of people who are eligible for the program. Unfortunately, few states or communities have accurate data on the eligible population with which to derive a penetration rate. This is true not only at the state or community level, but also at the national level, where penetration rates for Medicaid and SCHIP are not readily available. Furthermore, many programs are open to both insured and uninsured residents, making it difficult to isolate the impact on the uninsured population.

It should also be noted that the factors influencing a program's success will vary from state to state, such as the characteristics of the uninsured, population density, health care and employer markets, available funding, and political realities. In addition, programs are conceived with different goals and philosophies in mind. For all these reasons, it is difficult to assess program effectiveness and more difficult still to generalize results from one state to another. Nonetheless, as the Health Care Task Force narrows its consideration of coverage approaches, a deeper review of programs in other states is indicated to inform the design of Idaho's potential coverage approach. As many states and communities have learned, careful attention to all aspects of the design of the coverage program, such as the eligibility criteria, funding sources, and product "branding," can help ensure a program's success.

ORGANIZATION OF THIS REPORT

This compendium of coverage options contains seven additional chapters. The next four chapters correspond to the four types of approaches: (1) approaches that modify the market in which coverage is offered, (2) approaches that subsidize market-based health coverage, (3) approaches that provide direct public coverage, and (4) approaches that develop new mechanisms for accessing care. We then describe several initiatives that have taken a comprehensive approach to achieving universal coverage by combining multiple approaches. This is followed by a discussion of funding options for state health reform initiatives. The final chapter discusses the implications for the Idaho Health Care Task Force, to help narrow the options for future consideration.

---

[2] Recognizing the need for rigorous evaluation of state health reform efforts, the Robert Wood Johnson Foundation recently launched the State Health Access Reform Evaluation (SHARE) program. The program expects to award $7 million over four years to "provide evidence to state policy makers on the specific mechanisms that contribute to successful state health reform efforts."

CHAPTER II

APPROACHES THAT MODIFY THE MARKET IN WHICH COVERAGE IS OFFERED

Many states have explored or implemented approaches that target the purchasing environment for commercial coverage. For example, such approaches might use insurance regulations to modify the way in which risk is pooled in the market, or to affect the design of the coverage offered. These approaches are intended to present low or no-cost techniques for modifying access to market-based coverage. By design, these approaches target residents at income levels that typically could afford to make some contribution to a health insurance premium.

LIMITED-BENEFIT PLANS

At least 10 states have enacted legislation to allow the sale of "limited-benefit" plans to certain target populations, such as small groups or uninsured individuals. Also known as "bare bones" plans, they exclude some or all mandated benefits for employer-sponsored health insurance, thereby lowering the cost of coverage by a modest amount.[1] Large, self-insured employers are not subject to state-level mandates.[2] Hence, these programs principally affect purchasers in the small group and/or individual markets.

These plans present an implicit trade-off. Although the premiums are intended to be more affordable, these plans provide fewer benefits, potentially exposing enrollees to higher out-of-pocket expenses for uncovered services. In addition, the exclusion of certain benefits that are typically mandated—such as mammography and diabetes supplies—may raise concerns that some people may forego needed care. Alternatively, some suggest that those

---

[1] Idaho has fewer benefit mandates than any other state (6), while Maryland has the most (46).

[2] States are limited in their ability to regulate employer-sponsored health plans directly due to the federal Employee Retirement Income Security Act of 1974 (ERISA). Hence, states influence plan design through regulations on commercial insurers. Self-insured employers do not use these fully insured products and hence they are not subject to benefit mandates. Courts have ruled that ERISA supersedes some state health care proposals, such as employer insurance mandates, if they have a substantial impact on the health plans (Butler 2000).

with limited-benefit plans may rely on the uncompensated care pool to obtain needed services that are not covered by their plan.

Experience to date suggests that carriers are reluctant to offer these products; moreover, when they are offered, employer participation typically is low. State officials have reported that these products are neither much less expensive than conventional coverage nor very appealing to business owners, who prefer comprehensive coverage for themselves (Friedenzohn 2004).

A few states have authorized extremely limited plans that go beyond the removal of benefit mandates (for example, excluding coverage of inpatient care). The examples below show that states vary in the way they have structured such plans. While Arkansas' experience is too recent to evaluate, elsewhere the take-up appears to be low, regardless of whether the small group or individual population is targeted.

- In 2007, Arkansas began offering a limited-benefit health insurance plan for businesses. Firms with fewer than 500 employees that have not provided health coverage for at least one year are eligible to purchase this safety net plan, as long as all eligible uninsured workers participate. The plan covers six physician visits, seven days of inpatient hospital care, and two outpatient hospital procedures or emergency department visits each year, as well as two prescriptions per month. Employers are required to contribute monthly premiums of $15 for workers with annual incomes up to 200 percent of the Federal Poverty Level (FPL) and $100 for higher-income workers. The program is being funded with $18 million from the 1998 national tobacco settlement, as well as federal Medicaid and SCHIP contributions via a Health Insurance Flexibility and Affordability (HIFA) waiver (NovaSys Health LLC 2007). After three months of operation, 60 firms have purchased the coverage with an average of three plan members per firm.

- In 2003, Montana authorized a small demonstration of limited-benefit plans available to those who purchase health insurance in the individual market. Applicants must be notified which services are not covered and they must have been uninsured for 90 days or more at the time they entered the demonstration. A number of services either are not covered or are limited (for example, coverage for inpatient services and for newborns). Only one insurer elected to offer this limited-benefit product. The demonstration project is capped at 1,000 enrollees, but only 53 have enrolled to date (Spencer et al. 2006).[3]

- Oregon's *Alternative Group Plan* is a limited-benefit product available only to small employers who previously did not offer coverage. It covers only adults and offers a very lean set of benefits intended to be about 30 percent less

[3] Montana legislators were concerned that if it were available more broadly, employers would drop their existing coverage in favor of the cheaper, non-group product (Friedenzohn 2004).

expensive than standard $1,000-deductible commercial plans available in the market. Fewer than 100 lives have enrolled in the plan since it was launched in January 2005 and the program is expected to close at the end of 2007.[4]

- In 2002, Utah enacted legislation permitting insurance carriers to offer coverage that is limited to primary care (excluding inpatient hospital care). No insurers had come forward to market this option as of 2005 (Spencer et al. 2006).

SMALL EMPLOYER PURCHASING POOLS

Some states have encouraged or initiated the development of small-employer purchasing pools to increase access to coverage.[5] While these pools have been successful in offering small groups both administrative convenience and a choice of plans, there is no evidence that they reduce premiums. As a result, most researchers have concluded that purchasing pools alone do not expand coverage (Long and Marquis 2001).[6] There is some evidence, however, that participation is higher when a premium subsidy is offered to reduce the employer's and/or employee's share of the premium.

- In Montana, the *Insure Montana Purchasing Pool* allows non-offering small businesses of 2 to 9 employees, all of whom earn less than $75,000 per year, to purchase coverage through the pool. Coverage through the pool not only qualifies small employers for premium incentives, but also provides premium assistance to qualified employees to help them cover their share of the premium. The program has been quite successful in attracting participating firms. Approximately 5,000 employees work for firms participating in the pool and the program has had to freeze enrollment due to limits on available funding. Insure Montana operates a parallel program featuring a tax credit for offering small businesses that are struggling to pay premiums. Approximately 4,000 employees work for firms that qualify for the tax credit (Insure Montana 2007).

[4] Oregon also developed a more comprehensive small-group plan to cover children—the Children's Group Plan. Employers may offer the Children's Group Plan by itself or together with the adult plan. The separate offering was intended to give firms the opportunity to provide comprehensive coverage for their workers' children, even if they cannot afford to cover their employees. The Oregon Office of Private Health Partnerships is not aware of any cases where employers offered the children's plan without also offering the adult plan, and overall participation is low.

[5] Idaho does not have a small employer purchasing pool *per se*, but does maintain several pools that currently serve public employees in the state. For example, the Idaho School District Council, a cooperative service agency, makes medical and dental coverage available through an Administrative and Surplus Premium Agreement. Blue Cross of Idaho carries the contract. Approximately 124 districts and 29,875 individuals participate in the Statewide Schools Plan.

[6] Some states have observed that their own regulations present obstacles to negotiating reduced premiums. In Florida, for example, state insurance rules prohibited the cooperatives from negotiating with insurers based on price, except for administrative costs.

- In Arizona, the Healthcare Group offers community-rated, guaranteed issue coverage to non-offering small firms (50 or fewer employees) and uninsured sole proprietors. To be eligible, employees must be working at least 20 hours per week. Healthcare Group was established in 1985 with support from the Robert Wood Johnson Foundation. In the early years, this program received state subsidies, but it has operated without subsidies since July 2005. Hospitals are paid Medicaid reimbursement rates and HMO carriers' losses are limited by stop-loss reinsurance financed from member premiums. As of May 2007, enrollment exceeded 26,000 lives (State Coverage Initiatives 2007).

- In Colorado, a pilot program was launched in 2003 that allows small employers to form self-funded multiple employer welfare arrangements (MEWAs) to bargain more effectively with health plans. By 2005, however, only one MEWA had been formed under this program.

EXPANSION OF DEFINITION OF DEPENDENCY

To address high rates of uninsurance among young adults, several states have instituted a requirement that stipulates the age of dependency for coverage on a parent's group health insurance policy. To qualify, dependents usually are required to be single and childless, and the maximum age for dependency may vary according to student status. As with most regulations directed at insurers, these provisions do not apply to young adults whose parents receive health insurance through a self-insured employer.

- Effective July 2007, Idaho law has increased to 25 the age to which unmarried dependents who are full-time students may remain on their parents' health insurance policies, and to 21 for other children. Utah, New Mexico, and Colorado have similar laws; Utah's law has been in place since 1994.

- In 2006, New Jersey increased the age of dependency for health insurance to age 30—the highest in the country. Under the new law, unmarried adults younger than 30 who do not have dependents and live in New Jersey can receive health insurance through their parents, regardless of whether they are students or reside with their parents. The law's sponsor estimated that the legislation might benefit as many as 200,000 young adults in the state. Insurers can charge a separate premium for the extended dependent coverage.

CONTINUATION OF COVERAGE

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 provides a vehicle for expanding coverage among those who experience interruptions of employer-based coverage due to job loss or job change. COBRA requires firms of 20 or more employees that sponsor coverage for their workers to offer continuation coverage to

enrolled workers (and their dependents) who leave their jobs.[7] In most circumstances, eligible individuals can purchase this coverage for 102 percent of the premium paid for active employees for up to 18 months, but there is no employer contribution. Because group coverage without an employer contribution is costly, only a small fraction of those eligible for COBRA actually enroll. Overall, an estimated 35 to 45 percent of the unemployed are eligible for COBRA, and approximately 19 percent purchase the coverage (Neuschler and Taylor 2002).

Forty states have extended COBRA-like protections to workers in smaller businesses, often called mini-COBRA (Cobrahealth.com 2004).[8] However, the duration of coverage varies. For example, South Dakota's mini-COBRA law offers temporary group health coverage for up to 18 months or, in some cases, 36 months. Utah allows continuation coverage for six months following termination of employment.

RATING REFORMS AND GUARANTEED ISSUE

Rating reforms try to limit premium variation by modifying the factors that can be used to develop premium rates.[9] Absent such reforms, the spread in premium rates will vary greatly between the young and healthy and the old and unhealthy. States also may require that insurers "guarantee issue" coverage for certain groups of purchasers. Without such provisions, purchasers in the individual market can be excluded from coverage because of pre-existing conditions. These reforms vary in terms of target population; some are aimed at the self-employed or sole proprietors, while others are directed to the small group market.

- Idaho offers five guaranteed issue products for individuals meeting the eligibility requirements for the high-risk pool (which has about 1,400 enrollees). The state also limits the overall annual growth in premiums and imposes health status rating bands. For a given type of coverage and class of purchaser, the premium quoted cannot vary 50 percent more or less from an index rate due to health status.

- In 2004, Washington State passed legislation redefining the small group market; the group size range is now 2 to 50, a change from 1 to 50. Sole proprietors (also known as "groups-of-one") are now subject to the rating rules in the non-group (individual) market instead of the small group market. The legislation also

[7] Nationally, job loss is the primary reason why most adults were uninsured at some point during the year (Garret 2001). Unemployed adults are uninsured at rates twice that of all adults (37 percent vs. 18 percent), yet even those who go from one job to the next, without unemployment, are at risk of being uninsured if they are not immediately eligible for coverage with their next employer.

[8] Idaho does not extend COBRA-like protections to workers in businesses with fewer than 20 workers except that it requires extension of health benefits up to 12 months for individuals who are pregnant or disabled.

[9] Federal law requires all plans sold to small groups to be guaranteed issue. This federal requirement does not exist for non-group coverage.

streamlined some administrative costs and put in place protections for the portability of policies.

- In Colorado, small group insurance companies must guarantee issue of a choice of either a standard or basic health plan to the self-employed (groups-of-one) during the 31-day open enrollment period each year.

"Buy-in" to State-Negotiated Health Plans

A few states have explored ways to leverage the administrative services and purchasing power of the state employee's health plan to provide additional, more attractive coverage options for small employers. In the approaches described below, the risk associated with small-employer enrollment is pooled separately from the public employee group, so there is no particular advantage with respect to the medical cost of the plan. Limited experience to date suggests that these plans help some small employers access coverage.

- In Connecticut, companies with 1 to 50 employees, as well as nonprofit organizations that do business with the state, may join the *Municipal Employee Health Insurance Program* (*MEHIP*), a state-administered insurance program for municipal employees (Kaminski 2005). Currently, there are 92 small groups (251 lives) and 228 nonprofit organizations (7,933 lives) insured through this program.

- Started in June 2006, the *Small Employer Insurance Program* (*SEIP*) in New Mexico helps small businesses and nonprofit organizations to buy into a comprehensive health insurance program currently offered to state employees. SEIP is self-funded (with commercial stop loss), administered by the state, and direct-marketed (New Mexico 2007). A maximum of 500 employees are projected to enroll in 2007 (New Mexico 2007).

- In 2005, West Virginia launched the *Small Business Plan* for businesses with 2 to 50 employees that do not offer health insurance. This program technically does not offer the state employee health coverage. However, the coverage costs reflect below-market provider payment rates negotiated by the state Public Employees Insurance Agency. Costs are further reduced by a high deductible and reduced administrative fees. Approximately 300 firms have enrolled.

Insurance Exchange or Connector

An insurance exchange, also known as a connector, is a concept closely related to that of a purchasing pool. Similar to a pool, the exchange centralizes health insurance purchasing transactions by administering enrollment, coverage selection, and payment processing (including subsidies). The insurance exchange may go beyond these roles to facilitate portability of coverage and to pool employer contributions when an employee has more than one job that offers health insurance benefits or when both a husband and wife receive benefits.

The *Commonwealth Connector*, which Massachusetts has implemented as part of its comprehensive universal coverage initiative, contains the following key attributes:

- It is open to all state residents.

- Employers are required to permit employees to designate the exchange as their employer group plan, although other coverage options may be offered as well. They are not required to make a premium contribution to coverage offered through the *Connector*. The Massachusetts reform laws also require employers to establish a Section 125 plan, enabling their employees to pay for coverage on a pre-tax basis and with the convenience of a payroll deduction. (An employer contribution is not required to achieve this favorable tax treatment).

- It is intended that coverage can become portable among employers within the state, and that the employee can retain it during periods of unemployment, part-time employment, or self-employment. Employees who obtain coverage through the *Connector* and lose their employer's coverage can keep it as individuals or with another employer in the *Connector*.[10]

- The exchange will serve as the mechanism for administering government subsidies for low-income persons. The Commonwealth Care plan—a subsidized plan for those who earn below 300 percent of the FPL—will be offered through the *Connector*.

According to recent estimates, more than 79,000 people have enrolled in subsidized health coverage through the *Connector* as of June 1, 2007. Although there is widespread national interest in the concept of a "connector," there is no evidence yet about its effectiveness in making the system more seamless.

CONCLUDING REMARKS

This chapter has identified various approaches that could be used to modify the market in which health coverage is offered, with the intent that coverage would increase (and uninsurance decrease) as a result of market reforms. One of these options, the expansion of the definition of dependency, has already been enacted in Idaho and is now being implemented. COBRA coverage, of course, is available nationally, but take-up is very low. Other options would require new initiatives, most of which are no or low cost, but experience generally has shown that they have little effect on expanding coverage. One option that holds considerable promise for the future is the insurance connector option recently implemented in Massachusetts. It addresses many key issues related to portability of

[10] This design theoretically offers other benefits. For example, a two-income couple will be able to combine contributions from their employers to buy and keep the plan they want, instead of being forced to choose one employer's plan while forgoing the subsidy offered by the other employer. Similarly, a worker with two part-time jobs will be able to combine both employers' contributions (if available) to purchase coverage.

coverage, pooling of employer contributions in low-income families, and administration of subsidies for low-income people. This innovative mechanism is worthy of closer consideration by Idaho's Health Care Task Force.

Chapter III

Approaches that Subsidize Market-Based Health Coverage

The most common reason cited by individuals and non-offering employers for not taking up or offering coverage is the cost of premiums (Kaiser/HRET 2006; GAO 2003). In response, many coverage expansion programs subsidize the cost of coverage. Subsidy-based programs that seek to retain or expand employer-based coverage typically target one of two types of employers (and their workers): (1) small employers that do not offer coverage to any workers, and (2) employers of any size that offer coverage where the employee is eligible but decides not to enroll. These types of workers constitute a large number of the uninsured nonelderly adults in Idaho. We estimated that about 128,000 uninsured workers were in firms that did not offer coverage, of whom, 33 percent obtained coverage elsewhere. Another 184,000 workers received an offer of coverage that they declined, of whom, 86 percent obtained coverage elsewhere. Thus, when subsidies are targeted to employers and employees, it is important to recognize that many workers in these firms may have already obtained coverage elsewhere (such as through a spouse) in the absence of a subsidy. A concern for these programs is whether or not the subsidies will go to workers who have coverage from another source.

This chapter discusses several types of subsidy programs: (1) those that offer direct premium assistance, (2) those that offer indirect assistance through reinsurance subsidies, and (3) those that subsidize high-risk pools. Direct premium assistance and reinsurance subsidies are generally targeted to the group market. It is less common for premium subsidy programs to subsidize market-based coverage for individuals.

DIRECT PREMIUM ASSISTANCE PROGRAMS

States consider several options in structuring their premium assistance programs: to whom the subsidy is targeted (employer, employee, or both);[1] the size of firm eligible to participate (when the subsidy is targeted to the employer); how it is financed (federal, state, other sources, or a combination of sources); and how the subsidy is paid (prospectively or retrospectively). Programs that subsidize the employer's portion of the premium typically limit the size of firms eligible to participate—often to firms with 50 or fewer employees—but sometimes the subsidy is limited to much smaller firms. In Idaho, as in other states, the vast majority of firms that do not offer coverage are very small (fewer than 10 employees). Consequently, such firms tend to be the dominant participants in these programs, and the upper end of eligible firm sizes usually is not a limiting factor.

Subsidy programs that target non-offering firms generally have realized low levels of enrollment, even though they can be cost-effective to operate and may support other policy goals (McLaughlin et al. 1992; Kronick et al. 2004). Programs that subsidize coverage for employees (or their children) who already are eligible for their employer's offer (but have declined the offer) have experienced somewhat greater levels of enrollment. Research seems to indicate that the former approach requires overcoming both employer and employee reasons for not purchasing coverage, whereas, in the latter case, employers have already demonstrated that they are willing to offer coverage. Premium subsidies can be delivered prospectively or (more commonly) retrospectively after proof of payment has been provided. The latter can create cash flow problems for low-income recipients and can be difficult to administer.[2]

Premium Assistance through Medicaid and SCHIP Programs

Under current law, states can use several approaches to apply the federal Medicaid and SCHIP match to employee subsidies for group coverage. Like Idaho's *Access Card* and *Access to Health Insurance* programs, these programs benefit from federal match as well as an employer contribution. However, these programs target only a subset of low-income

---

[1] In addition to the *Insure Montana* tax credit for small employers that offer coverage, we are aware of only two programs that have offered employers a premium subsidy without an accompanying employee subsidy: the Kansas Small Employer Tax Credit and the Maine Small Employer Tax Credit (for dependents). Both programs have realized low take-up.

[2] Subsidies also can take the form of a tax credit. Tax credits are less commonly used at the state level than at the federal level, because feasibility at the state level would depend on the state income tax structure and the filing habits of the target population. Furthermore, tax credits could not be used in conjunction with a Medicaid- or SCHIP-based premium assistance program. Most proponents of this subsidy mechanism agree that tax incentives should take the form of advanceable, refundable credits, as opposed to a deduction. An analysis of the Health Coverage Tax Credits enacted as part of the Trade Act of 2002 found that many eligible workers could not afford to prepay the full premiums while waiting for the tax credit (Dorn et al. 2005).

workers (or their children) who are Medicaid- or SCHIP-eligible.[3] Two different terms are used to refer to these programs, reflecting the underlying funding arrangements. Health Insurance Premium Programs (HIPP) pay the employee's share of premiums for Medicaid-eligible individuals when it is cost-effective to do so.[4] Similar programs authorized under SCHIP[5] or through a federal Section 1115 Health Insurance Flexibility and Accountability (HIFA) waiver[6] are referred to as "premium assistance programs."

- Rhode Island's *RIte Share* has enrolled approximately 6,000 Medicaid-eligible parents and children. This program requires applicants to enroll in employer coverage if it is available to them. Participating families at the upper end of income eligibility must pay a fixed share of the premium; lower-income families are not required to pay. Although the premium assistance program has relatively low enrollment (compared with total Medicaid enrollment), state officials consider this program an important component of their continuum of coverage options for low-income families.

- Oregon's *Family Health Insurance Assistance Program* provides a premium subsidy on a sliding scale to uninsured individuals – including adults without children – with incomes below 185 percent of the FPL. Applicants are required to enroll in their employer's group insurance if available; otherwise, they enroll in an individual plan in the private market. The premium assistance ranges from 50 to 95 percent of the premium, depending on family income. Approximately 5,000 individuals participate under group coverage, and 10,000 purchase individual coverage.

- Utah's *Premium Partnership for Health Insurance* began in January 2007. Uninsured low-income workers and their families can receive up to $150 per adult and $100 per child on a monthly basis to help defray the cost of employer-sponsored insurance premiums, if these premiums represent more than 5 percent of their annual income.

---

[3] Massachusetts, however, has created a seamless program, from the perspective of the applicants, that blends coverage for workers and dependents who are eligible for federal match together with those who are ineligible.

[4] Federal regulations permit the option of subsidizing the purchase of private group health plans for Medicaid beneficiaries when it is cost-effective to do so. States also can pay premiums for non-Medicaid eligible family members when cost-effective, and may make enrollment in a group health plan a requirement of Medicaid eligibility. In its HIPP program, Idaho has had several parents who received coverage because it was cost-effective to enroll their Medicaid-eligible child in employer-sponsored family coverage.

[5] Federal regulations require that "(t)he State's cost for coverage for children under premium assistance programs must not be greater than the cost of other SCHIP coverage for these children." States also must provide wraparound coverage for benefits and limit cost sharing for families enrolled in SCHIP-funded premium assistance programs if there is no federal waiver.

[6] Under waivers, the federal government has permitted some states to enroll beneficiaries in premium assistance programs without providing wraparound coverage for benefits or limitations on cost sharing.

- In December 2006, Nevada began offering a subsidy program called *Nevada Check Up Plus* for eligible parents of children enrolled in Medicaid or SCHIP with access to employer-sponsored health coverage and incomes under 200 percent of the FPL; to be eligible, they also must work for employers with only 2 to 50 employees. The subsidy is worth up to $100 per month per parent.

Premium Assistance Using State-Only Funds

Although many states with premium assistance programs utilize Medicaid or SCHIP funds to support the subsidy, at least one state relies on state funds only. Washington operates a long running program called the *Basic Health Plan* targeted to individuals who do not qualify for Medicaid, Medicare, or other public programs and who have an income of less than 185 percent of the FPL. Monthly premiums are based on age, income, family size, and health plan chosen, with an annual deductible and coinsurance on some services. The subsidies can be used for individual or employer coverage but most enrollees apply the subsidies to individual coverage. This popular program serves 100,000 residents and has capped new enrollment due to funding constraints.

Premium Assistance Using The Three-Share Model

Three-share programs subsidize both the employee and employer premium shares. In addition, these programs pay the subsidy directly to the plan. This funding arrangement can make it easier for employers and employees to understand their own costs and eliminates the cash flow problems that some participants might experience with a retrospective subsidy payment.

- In *Access Health* (Muskegon, Michigan), the employer and the employee each pay about 30 percent of the premium, with the community paying the remainder from DSH funds (Fronstin and Lee 2005). The program covers about 1,500 low-wage employees in the county. *Access Health* offers a range of benefits, including inpatient and outpatient services, primary care and preventive services, emergency room care, and prescription drugs, but only from providers within the county.

- In New Mexico, the *State Coverage Insurance* (*SCI*) is a public-private partnership that offers coverage to uninsured adults with family incomes below 200 percent of the FPL who are not otherwise eligible for public or employer-sponsored health insurance programs. The program primarily targets non-offering employers, with the employer and employee together paying about one-third of the premium; the employee share of the premium is scaled to household income (New Mexico State Government 2007). Individuals, including self-employed workers, may enroll in the program by paying both the employer and employee shares of the premium. Approximately 6,000 are enrolled after almost two years of program operation.

- *CoverTN*, which began in April 2007, is a statewide, low-cost, limited benefit insurance plan for uninsured, low-income employees of small businesses and self-employed individuals in Tennessee. The program is available to employers with 25 or fewer employees if at least half of their employees have annual salaries of less than $41,000 a year. Like the New Mexico *SCI* program, if an employer declines to participate, an employee can enroll by paying two-thirds of the cost. The *CoverTN* plans are designed to be portable, following the enrollee from job to job or during brief periods of unemployment (CoverTN 2007). In the first two months since enrollment began, 3,000 workers enrolled.

This approach holds promise for Idaho as well. In fact, five northern Idaho counties are spearheading a study that will examine the feasibility of implementing a three-share model similar to the *Access Health* plan in Michigan. This study will include a market analysis of likely participation among small, uninsured businesses.

INDIRECT PREMIUM ASSISTANCE THROUGH REINSURANCE SUBSIDIES

Reinsurance pays all or some of the claims incurred above a certain threshold amount for commercial carriers or self-funded plans. Normally, reinsurance coverage is purchased on the market for a premium. In contrast, under the *Healthy New York* program, the state reinsures selected plans directly as a means of lowering the market cost of the coverage. All HMOs in the state are required to offer the plan. Eligible residents include uninsured, low-income workers without an employer offer of coverage and uninsured, low-income sole proprietors, as well as small, low-wage employers who do not offer coverage. This subsidy is estimated to lower the cost of health insurance coverage by about 30 percent (EP&P 2005). *Healthy New York* enrollment stands at about 130,000 members. An estimated 27,000 enrollees are workers in small firms that did not previously offer coverage.

PREMIUM SUBSIDIES FOR STATE-SPONSORED HIGH-RISK POOLS

High-risk pools can expand access in two ways: (1) by providing a coverage option for individuals who otherwise might be "uninsurable," and (2) by removing these high-risk individuals from the non-group market "pool" to make premiums more affordable for those remaining in the non-group market. While most states limit the amount by which premiums in the high-risk pool can exceed similar market-based coverage (as discussed in Chapter II), a few states subsidize this type of coverage by providing premium subsidies to low-income pool applicants.[7]

- The *Montana Comprehensive Health Insurance Association* operates a premium assistance program for its high-risk pool enrollees with incomes at or below 150 percent of the FPL. Qualifying individuals receive a subsidy worth 45 percent

[7] Idaho operates a high-risk pool (see Chapter II), but the state does not subsidize premiums for low-income applicants.

of the premium. As of June 2005, 200 people were enrolled in the program (Spencer et al. 2006).

- The *New Mexico Medical Insurance Pool* (*NMMIP*) operates a premium assistance program that offers a 75 percent premium reduction for individuals with incomes up to 200 percent of the FPL, and a 50 percent reduction for those with incomes up to 400 percent of the FPL who are eligible for coverage in the state's high-risk pool. At the end of June 2006, more than 2,300 persons were enrolled.

- Colorado's high-risk pool, *CoverColorado*, offers premium discounts to low-income applicants. These discounts are worth approximately 20 percent of the premium. As of June 2006, just over 5,000 people were enrolled in the program.

Concluding Remarks

The options described in this chapter increase the availability and affordability of private health insurance—through group plans, individual products, or high-risk pools—particularly for low-income workers in small firms. These options generally utilize a combination of funding sources, including employer and employee contributions and state funds. Some states also have taken advantage of the flexibility available under Medicaid and/or SCHIP to obtain federal matching funds to cover all or part of the premiums, when it is cost-effective to do so. Although it is difficult to assess the effectiveness of these programs, state experiences suggest that these programs are an important component of coverage initiatives to make private coverage more available and affordable to uninsured workers and their families. States that provide direct subsidies to individuals appear to have higher enrollment, particularly when they pay for the premium up front, rather than through retrospective reimbursement. Despite sometimes modest enrollment, programs that target employer-based coverage are often viewed favorably because the presence of an employer contribution (even if below the normal market level) reduces state subsidy costs and strengthens the employer-based coverage system overall.

CHAPTER IV

PROGRAMS THAT EXPAND DIRECT PUBLIC COVERAGE

Public coverage programs typically target very low-income residents, although children are usually eligible at higher income levels than adults. Public coverage can be particularly important for low-income residents without access to employer coverage. Considerations in designing public coverage programs include (1) the income threshold at which eligibility will be set, (2) whether coverage will be targeted to children, parents, and/or childless adults, (3) whether premiums or point-of-service cost-sharing will be required (subject to federal limitations), (4) how awareness will be raised to maximize participation by those who are eligible, (5) how the benefit package will be structured, and (6) what mechanisms will be used to avoid substitution of public for existing private coverage. Financing considerations include how the state will raise funds in order to receive federal matching funds (if they are available).

APPROACHES THAT EXPAND ELIGIBILITY FOR PUBLIC COVERAGE

In addition to increasing the availability of public coverage for children, states have used the flexibility granted through HIFA waivers to expand coverage in non-traditional ways.[1] Indeed, Idaho's *Access Card for Adults* program expanded SCHIP eligibility to cover adults earning up to 185 percent of the FPL and working for a qualifying small employer. Enrollment has been modest thus far, mirroring enrollment challenges faced by other programs that target non-offering employers.

Coverage of Low-Income Parents and Childless Adults

In contrast to low take-up among premium subsidy programs targeting employers, programs that offer subsidized coverage directly to adults, even with limited benefits, have achieved strong enrollment:

---

[1] The HIFA demonstration initiative uses CMS section 1115 waivers to maximize private health insurance options and target Medicaid and SCHIP assets to populations with incomes below 200 percent of FPL.

- In July 2002, Utah received a Section 1115 waiver to implement the *Primary Care Network (PCN)* for low-income, uninsured adults. This coverage contains a limited benefit that includes primary and preventive care but excludes inpatient and specialty care. There is a yearly enrollment fee for participants of $15 to $50, depending on income; the program also features low co-pays. Despite a very limited benefit, this program reached its enrollment cap after a little over one year. Currently, 16,000 adults participate.

- Pennsylvania created *adultBasic,* which uses state tobacco settlement funds to provide health insurance for uninsured adults with incomes up to 200 percent of the FPL. It offers a somewhat limited benefit package that excludes prescription drugs and mental health; it costs the enrollee $33.50 per month. As of April 2007, *adultBasic* had 49,000 individuals enrolled, with almost 90,000 people on the waiting list (Insurance Department Commonwealth of Pennsylvania 2007).

- *MaineCare for Childless Adults* uses a portion of the state's Federal DSH contribution to provide health insurance coverage for childless adults earning up to 100 percent of the FPL. The program expected 11,500 to enroll and actually had 20,000 enroll in the first 14 months of operation (Lipson et al., Alteras and Silow-Carroll 2004).

Universal Coverage of Children

In 2005, Illinois became the first state in the nation to establish a state health insurance program that was designed to cover all children in the state. The "All Kids" program combines low-income and higher-income children. Starting at family incomes of 150 percent of the FPL, parents pay a per child premium that slides with income. Families earning more than 400 percent of the FPL can participate but they pay full premium costs. The state received federal match for children under 200 percent of the FPL and uses state funds to cover higher income children and recent immigrant children who are not covered by Medicaid or SCHIP. Almost 30,000 newly eligible children (with incomes of 185 percent of FPL and above) enrolled during the program's first four months of operation.

Medically Needy/Spend Down Program

Thirty-five states and the District of Columbia (excluding Idaho) currently have a medically needy program through Medicaid.[2] Medically needy programs provide Medicaid coverage to individuals who have extensive health care expenses but who are not otherwise eligible for Medicaid because their incomes exceed traditional Medicaid guidelines. The

[2] In the early 1990s, the Idaho legislature passed authorization to implement a Medically Needy Program, but repealed their action the following year because of concerns about implementing an entitlement program without appropriate cost controls.

"spend down" is similar to a deductible where, before qualifying for Medicaid, applicants must incur medical expenses equal to the amount that their monthly income exceeds Medicaid income levels.

STRENGTHENING OUTREACH TO THOSE WHO ARE ELIGIBLE BUT NOT ENROLLED

Many states enroll only a fraction of residents who are eligible for public programs. To boost enrollment among those who are eligible, states have engaged in a wide variety of outreach efforts (Williams and Rosenbach 2007). In general, states have learned that the most effective efforts combine statewide media campaigns to raise awareness of the program and intensive community-based efforts to provide one-on-one application assistance. Here we highlight just a few examples that illustrate states' outreach techniques (see Rosenbach and Williams [2007] for a systematic review of the evolution of state outreach efforts).

- Virginia worked with the local schools to provide information for families with uninsured children. In Fairfax County, the local schools helped to identify uninsured children, referred them for coverage, and followed up to ensure they enrolled (Howell et al. 2006).

- New Jersey targeted outreach to its SCHIP-eligible population through many avenues, including a back-to-school media blitz, parties for adolescents at the local YMCA, development of classroom materials about health insurance, and an information package for businesses that were closing down (Trenholm et al. 2006).

- Arkansas engaged in extensive media outreach when the state implemented its SCHIP program. Like many other states, Arkansas re-branded its SCHIP program as "health insurance" rather than Medicaid. This helped to remove the stigma attached to applying for "welfare" (Walls et al. 2006).

CONCLUDING REMARKS

Expansion of public coverage—coupled with enhanced outreach to those who are eligible but not enrolled—augments strategies that subsidize private coverage. Well-designed programs have a proven ability to enroll low-income residents—particularly adults—who face high rates of uninsurance when they do not have access to an employer offer of coverage. The availability of federal matching funds for some populations can be attractive, because the state pays only 20 cents (SCHIP) or 30 cents (Medicaid) of every dollar spent on coverage. However, other considerations may affect the willingness of states to expand public coverage options, particularly concerns about creating an ongoing public commitment and the potential substitution of public for private coverage.

This page has been intentionally left blank for double-sided copying.

CHAPTER V

APPROACHES THAT DEVELOP NEW MECHANISMS FOR ACCESSING CARE

The approaches discussed in previous chapters are designed to expand coverage that protects enrollees from the risk of unexpectedly high medical expenses.[1] States and local communities realize that even aggressive approaches to increasing coverage may still leave some residents uninsured. For this reason, safety-net providers will continue to play a role in providing care to the low-income, uninsured population. Currently in Idaho, community health centers (CHCs)—one component of the safety net—serve about 18 percent of the uninsured population in the state (NACHC 2006). Several communities have explored new mechanisms that facilitate access to such care, including strategies to strengthen the health care safety net, improve the coordination of safety-net care and negotiate lower hospital rates for self-pay patients. In addition, a few states have programs to help the uninsured repay their medical debt.

APPROACHES TO STRENGTHEN SAFETY-NET CAPACITY

Traditionally, uninsured individuals have sought care at CHCs, free clinics, and emergency departments (Taylor et al. 2006). A common approach to increasing safety-net capacity has been to expand the availability of and funding for these providers. Going beyond this approach, some communities have created models that involve a more systematic and coordinated approach to care in these settings, such as managed care safety-net programs and discounted or donated care programs.[2] Idaho passed legislation in 2007

[1] This distinction includes many grey areas. In some cases, the benefit limits may be so severe that the product does not offer meaningful coverage. In other cases, the product may be designated as something other than an insurance product for reasons of program operation. For example, a unique Michigan law permits local governments to organize "systems of care" that can bear the risk associated with health coverage without being licensed by the state. As a result, programs like *Access Health* are not licensed insurance products and are not subject to the state's benefit mandates and other insurance rules.

[2] An interesting model for strengthening CHCs is the *Washington Community Health Plan*. This plan was formed by the community health centers in Washington State and operates as a fully regulated HMO available to *Basic Health* plan members. There are even limited cases of the plan "sponsoring" the individual's share of

establishing the framework for a state grant program for CHCs, although no funding was included for the first year.

Managed Care Safety-Net Programs

Several communities have developed innovative programs to organize and coordinate the care delivered by safety-net providers using managed care principles. In the two examples cited below, local tax dollars have been allocated to develop systems of care for uninsured, low-income residents. Although not providing coverage *per se*, these programs provide a medical home and coordinate care in a manner similar to traditional managed care.

- Established in 1997, *Health Advantage* is a managed-care program for the indigent, established by Marion County, Indiana and modeled after the Indiana Medicaid program. The primary source of funding comes from local property taxes. This program serves 52,000 low-income, uninsured residents—half of the uninsured in Marion County (Mays et al. 2005; Taylor et al. 2006).

- The *Hillsborough County Health Care Plan* is a comprehensive managed care plan for indigent residents with incomes up to 100 percent of the FPL who do not qualify for other coverage. The plan features a network of 600 primary care physicians, 12 clinics, and 5 hospitals. The program receives funding from a 1/4-cent sales tax and property taxes from the county. Approximately 30,000 county residents are served by the program (Taylor et al. 2006).

Discounted or Donated Care Programs

Another strategy used by some communities is to organize "systems" of discounted or donated care. Such programs are sometimes characterized as "brokered access to care." Participating providers, primarily physicians, agree to accept a limited number of patients pro bono or at a deeply reduced rate.

- *Ingham Health Plan* in Ingham County, Michigan offers access to discounted services at the plan's primary care locations, as well as for service at other sites if authorized by the providers. However, program funds must be available at the time of service otherwise care is limited (Ingham Health Plan 2007). Copayments of $2 to $10 are charged, and inpatient care is not offered. This care is available to uninsured county residents earning less than 250 percent of the FPL. Approximately 17,000 county residents are members, an estimated 50 percent of all uninsured people in Ingham County. The program is funded

(*continued*)
the premium for certain uninsured residents. Similarly, safety-net providers in Massachusetts have formed a health plan that will be offered through the connector.

through a combination of DSH funds, state medically indigent care funds, and county funds (Katz et al. 2005; Taylor et al. 2006).

- In 2002, the Indianapolis Medical Society created *Project Health*. This program supplements the primary care provided by *Health Advantage* with a system of donated specialist care. The program uses case management to maximize the effective utilization of existing community resources and increase coordination among service providers. In 2005, this program served 450 patients (Mays et al. 2005; Indianapolis Medical Society 2005).

APPROACHES TO PROVIDE ASSISTANCE WITH MEDICAL BILLS

For uninsured individuals with catastrophic medical bills, several states provide financial assistance retrospectively. These programs are not entitlement programs like Medicaid, nor are they health insurance programs. Rather, they help pay for health care costs after they have been incurred on a case-by-case basis. The majority of funding goes to hospitals, but some specialty physicians also receive reimbursement. The programs do not pay for preventive or primary care.

- Idaho created the *County Indigent and State Catastrophic Programs* to help residents pay hospital and medical bills exceeding certain standards. The program receives funding from property taxes and a line item in the state's general appropriations.

- New Mexico's *County Indigent Fund* was established in 1978 to provide reimbursement for residents in 30 of the state's 33 counties. The funds come from a variety of sources, including the sale of property, property taxes, investment income, and grants.

- The *Colorado Indigent Care Program* provides funding for uncompensated medical bills for low-income, uninsured individuals. Established in 1983, it is funded through a budget line item in the state's general expenditures and federal funds.

In addition to covering the costs of high medical bills after they have occurred, some states have introduced laws that limit the amount that hospitals may charge lower-income, uninsured patients. These laws are in response to findings that some hospitals charge uninsured patients the "rack rate," which can be substantially higher than the rates paid by Medicare or negotiated by commercial health plans.

- In New York State, hospital charges for uninsured patients with incomes below 300 percent of the FPL cannot be higher than those charged to its highest volume payer, Medicare, or Medicaid, whichever of the three is highest. This law became effective January 1, 2007.

- California recently passed a similar law (AB 774) that requires hospitals to discount their charges for patients with incomes under 350 percent of the FPL.

- Other states have reached voluntary agreements with their hospitals. For example, in 2005, the Minnesota Attorney General's office forged an agreement with more than 50 hospitals in which the hospitals agreed to charge a fair price for care, and uninsured patients who make less than $125,000 a year receive the same discounts that insurance companies receive from the hospitals. Similarly, in Washington State, all hospitals will give a discount to uninsured people with incomes under 300 percent of the FPL.

- Other laws require hospitals to inform patients about resources available at hospitals for charity care. For example, in 2003, Connecticut passed a law to increase such disclosure requirements ("An Act Concerning Hospital Billing Practices," Public Act 03-266).

CONCLUDING REMARKS

Approaches that expand the capacity of safety-net providers are designed to improve access to and affordability of care, but they do not expand health insurance coverage. Closer proximity to health centers is associated with decreased levels of unmet need and lower likelihood of emergency department use and hospitalization for the uninsured (Hadley and Cunningham, 2004), but such access is not an adequate substitute for health insurance coverage. Considerable evidence suggests that utilization of care is more appropriate for people with health insurance coverage than for those who are uninsured. Nonetheless, until universal coverage is achieved, Idaho may want to examine strategies to strengthen care delivered in these settings.

CHAPTER VI

COMPREHENSIVE COVERAGE INITIATIVES THAT COMBINE APPROACHES

Several states have combined elements from the coverage approaches discussed in previous chapters into comprehensive programs that are designed to achieve near-universal coverage. [1] Exhibit 3 shows how the coverage approaches discussed in this report have been utilized by six states that have either enacted or proposed comprehensive initiatives.

Exhibit 3. States That Enacted or Proposed Comprehensive Coverage Initiatives

	Individual Mandate	Employer Mandate	Public Program Expansion	Subsidies for Market-Based Coverage	Insurance Market Reforms
Enacted:					
Maine (2003)			✓	✓	(a)
Massachusetts (2006)	✓	✓	✓	✓	✓
Vermont (2006)		✓	✓	✓	(a)
Proposed:					
California	✓	✓	✓	✓	✓
Minnesota (by 2011)	✓			✓	✓
Washington (by 2010)	✓		✓	✓	✓

(a) Maine and Vermont enacted a series of insurance reforms in the 1990's that served as a foundation for later reforms.

[1] Even with the mandate, Massachusetts seeks to achieve 95 percent coverage. Absent an automatic enrollment mechanism, the state believes that full compliance is not realistic. The experience with car insurance provides a useful parallel. Researchers note that about 15 percent of motorists do not have car insurance, even though it is required in every state (Scandlen 2006).

Maine. The *Dirigo Health* program was rolled out in 2003 to address costs, quality, and access to health care, with the goal of establishing near universal coverage within six years. The program features a voluntary coverage program, *DirigoChoice,* for small groups and individuals. This coverage program subsidizes the employee share of the premium and deductible for enrollees with incomes under 300 percent of the FPL. Currently, the coverage is commercially underwritten. After three years of operation, the *DirigoChoice* component of the plan covers approximate 11,000 members, including over 3,300 businesses. The reforms also included a Medicaid expansion component for childless adults (up to 100 percent of the FPL) that experienced similar enrollment and modest cost containment initiatives.

Massachusetts. During 2006, Massachusetts developed a comprehensive initiative to tackle the coverage of uninsured individuals who are ineligible for Medicaid. The strategy involves redirecting resources already in the system—principally the uncompensated care pool—to create affordable products for those who are uninsured.[2] Reforms included (1) an individual coverage mandate, (2) an employer "fair share contribution" of $295 per-employee for those companies that do not offer health insurance, (3) subsidies for low-income individuals (up to 300 percent of the FPL), (4) insurance market reforms, including the merging of non- and small-group markets, (5) the creation of a health care "connector," and finally (6) a "four-share" payment structure (federal, state, employer, and employee contributions).

Vermont. In May 2006, Vermont created *Catamount Health,* a voluntary program that features public and private insurance options with subsidies for individuals with incomes up to 300 percent of the FPL. Like the Massachusetts program, it has an employer "pay or play" assessment of $365 per FTE. Unlike the Massachusetts program, there is no individual mandate associated with *Catamount Health*. Funding includes assessments on employers who do not cover their own workers, an increase in the state's tobacco tax, and federal match for individuals enrolled in the Medicaid expansion under its waiver.

USE OF COVERAGE MANDATES

Policymakers in some states have concluded that voluntary approaches to expanding insurance coverage are unlikely to lead to large increases in coverage, even with generous subsidies. As a result, several of these states have adopted individual or employer mandates to move the state toward its coverage goals. A mandate is designed not only to increase coverage, but also to address the "free rider" problem, where some individuals opt out of coverage in favor of paying for care out-of-pocket, or relying on free clinics and uncompensated care pools.[3] However, to institute such a requirement, the state would need to ensure that affordable coverage is available to the groups subject to the mandate.

---

[2] The federal government currently puts $385 million a year into the state's uncompensated care pool.

[3] Some suggest that an individual health insurance mandate would undermine the "right" to self-insure. There is an analogy with auto insurance. Some states require that auto insurance have provisions exempting

Individual Mandates

Beginning on July 1, 2007, Massachusetts is the first state to require that all adult residents of the state obtain health insurance if affordable coverage is available.[4] Compliance with the mandate will be confirmed on state tax returns.[5] Those who do not obtain coverage will lose their personal exemption for that tax year. Beginning in tax year 2008, residents without coverage will have to pay a penalty equal to half of the cost of a policy. Additional penalties could conceivably approach the premium an individual would pay for coverage. To facilitate compliance with the individual mandate, Massachusetts developed an insurance "connector." The key features of the connector were described in Chapter II.

Employer Mandates

Some states have adopted a "play or pay" strategy to ensure a minimal level of employer support for health insurance coverage.[6] Such a strategy imposes a tax or assessment on employers (which is not prohibited by ERISA) to fund public coverage initiatives. The state then offers a credit against the assessment on employers that provide coverage. These proposed "play or pay" initiatives vary in their details.

- Vermont's *Catamount Health Plan* requires employers to pay $365 per year for every full-time equivalent employee (FTE) not covered by the employer's health plan. There will be an initial exemption of eight FTEs when the program begins in October 2007, which will go down to six FTEs in 2009 and four in 2010 and beyond.

- Massachusetts requires a per-employee $295 "fair share contribution" from employers with 11 or more employees who do not provide health insurance for their employees or do not make a "fair and reasonable" contribution to its costs. Employers will pass the "fair and reasonable" test if at least 25 percent of their

---

(*continued*)
those who self-insure. For example, Ohio and Washington permit the use of bonds or certificates of deposit in lieu of auto insurance.

[4] While no state has previously implemented a large-scale individual mandate, several states have mandated coverage for college students, including Massachusetts, New Jersey, and Idaho.

[5] Approximately 50,000 uninsured children live in families with incomes too high to qualify for Medicaid; they will not be subject to the individual mandate.

[6] States are prohibited by the Employee Retirement Income Security Act of 1974 (ERISA) from requiring employers to offer health insurance as a benefit. Nonetheless, there is a growing consensus among state policymakers that a carefully crafted "play or pay" strategy could survive an ERISA challenge. Hawaii, which has had an employer mandate for more than 30 years, has an exemption from ERISA because it went into effect before ERISA was passed. Hawaii's mandate requires employers of all sizes to provide coverage for their workers, and requires that the worker's contribution to that coverage be limited to 1.5 percent of wages. The mandate generally is credited with achieving a much higher rate of coverage in the state than would have occurred otherwise (Kronick 2004). Nevertheless, 10 percent of Hawaiians under age 65 are uninsured because of the absence of a qualifying workforce connection.

full-time employees are enrolled in the company's group health plan and the employer contributes toward the premium. If they do not meet that criterion, they still can pass the test if they can demonstrate that they offer to pay at least 33 percent of their full-time employees' health insurance premiums.

- Maryland introduced a bill that would have required employers of 10,000 or more employees either to spend at least 8 percent of their payroll on health benefits or put the money directly into the state's Medicaid program. In January 2007, the U.S. Court of Appeals for the 4th Circuit upheld a lower court finding that struck down the law because it constricted the employers' choice in offering health insurance, thereby violating the ERISA provisions of federal law.

CONCLUDING REMARKS

Designing a comprehensive coverage strategy requires a bold—and creative—vision, as evidenced by the multifaceted strategies pursued by the states described in this chapter. These initiatives take into account the diverse characteristics of the uninsured and their reasons for not having coverage. All but one of these states (Maine) have implemented or proposed an employer or individual mandate, reflecting an emerging perspective that such a mandate may be necessary to achieve near-universal coverage of the uninsured. Otherwise, under a voluntary system, some employers or individuals may opt out of coverage, potentially resulting in adverse selection among those who choose to participate, as well as contributing to uncompensated care costs. Massachusetts is currently implementing the first individual mandate in the U.S., but it may take several years to understand how well their overall vision is working to expand and adequately finance coverage.

CHAPTER VII

OPTIONS FOR FUNDING STATE COVERAGE APPROACHES

The financing of state coverage initiatives is considered the most important—and, at the same time, the most difficult—decision involved in designing and implementing state health reform efforts. States have taken various approaches to financing their initiatives, including seeking additional federal or state dollars to fund coverage expansions, or reallocating existing uncompensated care funds to free up dollars to subsidize premiums for low-income, uninsured workers. Alternatively, some states negotiate provider discounts to make care more affordable, rather than expanding coverage *per se*. Many programs, especially the comprehensive initiatives, rely on more than one funding source to finance premium subsidies and/or direct coverage options.

Each state is unique in its financing environment. For example, some states have large uncompensated care pools or disproportionate share hospital (DSH) allocations from which to redirect resources. Other states have large, unspent federal SCHIP allocations to draw on. Some states, like Massachusetts, have previously established funding streams to pay for uncompensated care than can be redirected. While difficult, some states raise taxes to infuse new dollars into the system. This chapter illustrates the range of options available to states, based on our review of state initiatives.[1]

SOURCES OF FEDERAL FUNDING

Medicaid/SCHIP Funds

The federal Centers for Medicare & Medicaid Services (CMS) operates three systems of waivers through which states may fund coverage-expansion programs with Medicaid and/or SCHIP monies: (1) Section 1906 waivers (also called Health Insurance Premium Payment,

[1] For an excellent overview of state financing options for coverage expansions, the reader is referred to a webcast sponsored by the Kaiser Family Foundation, entitled "Elements of State Health Reform: Financing Mechanisms and Benefit Packages in Coverage Expansions," May 3, 2007. The webcast is available online at http://www.kaisernetwork.org/health_cast/hcast_index.cfm? display=detail&hc=2115.

or HIPP, waivers); (2) Section 1115 demonstration waivers; and (3) Health Insurance Flexibility and Accountability (HIFA) waivers. Each waiver includes limits on the states' ability to structure the initiative. As a result, programs may develop creative and/or complex designs to accommodate federal funding rules. In at least one instance (Maine), a state was able to leverage the employer-paid premiums as the state's share for Medicaid/SCHIP matching funds.

- Massachusetts uses Medicaid and SCHIP funding to support its *Insurance Partnership* and *Premium Assistance* programs. Subsidies to employers that do not offer coverage are eligible for the federal Medicaid match. Subsidies to all other participating employers are paid with state-only funds. Subsidies paid to workers who are covering their previously uninsured children qualify for the federal SCHIP match, and subsidies to all other workers participating in the Premium Assistance program qualify for the federal Medicaid match.

- New Mexico's *State Coverage Insurance* program uses SCHIP funding to cover childless adults as well as those with children. New Mexico is the only state to have secured SCHIP funds to support childless adults, although a few have received Medicaid waivers to do so (e.g., Maine).

Disproportionate Share Hospital Funds

Dating from the early 1980s, DSH was intended to give states a vehicle for providing extra payment to hospitals that served a disproportionate number of low-income and uninsured patients. Under the terms of the Emergency Medical Treatment and Active Labor Act (EMTALA), hospitals must care for patients without regard for their ability to pay. For hospitals that serve a disproportionate number of low-income or uninsured patients, Congress created the DSH payment.[2] States provide money to hospitals as DSH payments, and the federal government reimburses the states using a statutorily determined formula that yields matching rates that are currently between 50 and 77 percent of the payment.

Several states have leveraged Medicaid DSH funds to support their programs (Silow-Carroll and Alteras 2004). For example, through its 1115 waiver, Maine used DSH funds to raise the *MaineCare* eligibility threshold for childless adults to 100 percent of the FPL. In addition, Michigan permits counties that operate hospitals to establish local nonprofit organizations—such as the *Access Health* plan—to provide care for the uninsured. Because the premium contributions that employers make to *Access Health* are paid to the state, the contributions can be used to generate federal match under the DSH program (Fronstin and Lee 2005).

[2] This is a multipart calculation that takes into account the number of Medicare hospital (Part A) days and the number of Medicaid days (for patients with no Medicare coverage), along with the hospital size and whether the hospital is a sole community provider or rural referral center.

High-Risk Pool Funding

In 2002, the federal government passed the Trade Adjustment Assistance Act (TAAA), which contained a provision under which the federal government provides money to help subsidize the cost of state high-risk pools. States are required to apply for the money, and it may be used for a number of purposes, including: (1) as seed money to start a high-risk pool, (2) reimburse losses incurred by the state from operating a high-risk pool, or (3) to provide additional benefits to the consumer, such as a premium subsidy for low-income individuals (Fish-Parcham 2006). Colorado, Montana, and New Mexico have obtained federal funding for the operation of their high-risk pools. Idaho is in the process of applying for such funding.

Other Sources of Federal Funds

The federal government continues to support the *Consolidated Health Center Program*, making grants directly to community health centers and rural health clinics. In recent years, federal funding has increased as part of an initiative to create new access points and to expand the capacity of existing facilities. In addition, the *High Poverty Counties Initiative* was recently established to expand access in the nation's poorest counties. While these programs do not provide coverage *per se*, they may expand access for those who are uninsured or underserved.[3]

SOURCES OF STATE FUNDING

Tobacco Settlement Funds and Taxes

Tobacco settlement funds have provided seed money for several programs (for example, the Arkansas *Safety Net Benefits Program*) and some operating capital for others. Some states have introduced a "sin tax", such as a tobacco tax, to partially fund or subsidize health care expansions in the state. *Healthy New York* and Montana's *Small Business Health Insurance Program* use tobacco tax revenues for partial funding of subsidized coverage.

Assessments on Insurers

Some states have used insurer assessments to fund programs intended to expand coverage. These funds must be used with care, because if assessments result in higher premiums, private coverage in the fully insured market may be made less affordable. Self-

[3] The *Healthy Communities Access Program* (*HCAP*) was a separate federal grant program designed to help communities, health care providers, and others to develop or strengthen integrated community health care delivery systems. The funds were used to coordinate health care services for individuals who are uninsured or underinsured, and to develop or strengthen activities related to providing coordinated care for uninsured or underinsured individuals with chronic conditions. One grantee in Idaho, Family Practice Residency of Idaho, received over $900,000 from this grant program in FY 2004 (HRSA News Brief, September 3, 2004). This program was unfunded in 2006.

insured plans are not subject to premium taxes, although states can impose an alternative assessment, such as a head tax.

- Idaho has such an assessment in place to fund the state's reinsurance program for the high-risk pool. This assessment is made on all companies that have fully insured claims in Idaho, in addition to a "head tax" for all carriers participating in the health insurance market.

- Maine's *Dirigo* program is funded, in part, by a "Savings Offset Payment." This payment is based on the estimated savings to insurers and providers from a variety of cost containment measures. Health insurers were expected to negotiate with providers to extract these savings from lower provider rates, but instead, evidence suggests that they may have passed the extra costs on to customers.

State General Revenues/Tax Expenditures

Several programs are partially or completely funded from general state revenues, or as foregone revenues (called tax expenditures). The Washington *Basic Health Plan* is currently funded wholly from state general revenues, although the state is considering waivers to enable the state to receive a federal match. *Healthy New York* relies partially on state funding from general revenues. While politically difficult to enact, such use of "state-only" funds offers the maximum flexibility to the state in tailoring the program to its own economic and fiscal circumstances—compared, for example, to the use of Medicaid or SCHIP funds.

County-based programs frequently rely on county taxes—either alone or in combination with state and DSH funds—to fund their programs. For example, the Ingham county health plans, *IHP* and *IHP Kids*, use a combination of DSH, county, and state general funds for their programs. *Health Advantage* in Indianapolis uses funds raised by county taxes.

PROVIDER DISCOUNTS/DONATED CARE

Programs that operate locally have had some success in recruiting providers to accept reduced payment rates or to donate services. Building provider capacity at the local level is another way to improve access, although it is not a coverage initiative. This strategy has been especially effective if the providers believe that the program is narrowly targeted, their financial exposure is limited, and they are brought in as "partners." However, experience has shown that programs with very limited front-loaded benefits are less popular with hospital providers because they still generate a significant uncompensated care burden.

Project Health in Indianapolis and *IHP* and *IHP Kids* in Lansing, Michigan use donated physician care and hospital services to provide services. In addition, *Access Health* in Michigan reimburses providers at Medicare rates plus 10 percent. While providers consider these rates to be below average, they are nonetheless supportive of the program, and almost all of them participate. The program has a policy of prompt payment to providers and covers only care provided within the county.

CONCLUDING REMARKS

This chapter highlights the wide range of options for financing state health reform efforts. In considering these options, the first step will be to assess the level and sources of existing resources in the system. This assessment should include both public and private resources. (This effort is currently underway as part of a separate contract with the Office of Performance Evaluations.) The next step will be to examine options for additional, unspent resources (such as unspent SCHIP allotments or tobacco settlement funds) that could be used to expand coverage further. Once this information has been gathered, it can then be used to explore how funds could be pooled and potentially redirected to fill Idaho's gaps in health insurance coverage.

This page has been intentionally left blank for double-sided copying.

CHAPTER VIII

IMPLICATIONS FOR IDAHO

States have pursued many different strategies to increase health insurance coverage and access to care for the uninsured. Enrollment has often been low, however, reflecting the challenges associated with expanding the number of employers that offer coverage as well as the number of employees that take up coverage. Because the cost of coverage is a significant barrier, many initiatives concentrate on creating more affordable options and offering subsidies to encourage participation. Other states' experiences can provide important lessons for Idaho as it considers options for the future.

In recent years, Idaho has undertaken several initiatives to increase coverage, spanning all four types of approaches highlighted in this report. These approaches may serve as a foundation for developing a comprehensive strategy for the future. The challenge for the Idaho Health Care Task Force is to identify which options are most likely to be successful in closing the coverage gaps in a cost-effective manner. To assist future discussions about coverage options, this chapter synthesizes information from the profile of the uninsured and the compendium of coverage options.

To whom should future initiatives in Idaho be targeted? As presented in the profile of the uninsured, the populations with the highest uninsured rates are young adults, people who work part-time or are unemployed, and people who are low income. Employees with the lowest likelihood of being offered coverage are those in small firms, although many of them obtain coverage from another source (such as through a spouse's employer). In addition, the uninsured rate in rural counties is higher than in urban counties. Regardless of a resident's income level, cost is the biggest barrier to obtaining coverage. Some groups face additional barriers during transition periods, for example, when they lose or change jobs or when they graduate from school.

Exhibit 4 highlights several options that the Idaho Health Care Task Force may want to consider as it assesses future coverage options. These options were selected for three reasons: (1) they address the needs of groups with high rates of uninsurance in Idaho; (2) they build on existing coverage initiatives, where possible (such as the Health Insurance Access program and SCHIP); and (3) they represent options that are promising based on experience in other states. However, a significant caveat should be recognized. Options that were successful in other states may not necessarily be successful in Idaho, and conversely,

Exhibit 4. Possible Options to Expand Health Insurance Coverage in Idaho

Uninsured Population	Possible Coverage Options
Low-income children	• Raise SCHIP eligibility threshold from 185 to 200 percent of the FPL • Target outreach to children who are eligible for but not enrolled in Medicaid or SCHIP
Young adults	• Implement and raise awareness of expanded definition of dependency for young adults who are dependents
Unemployed adults	• Enact mini-COBRA law that would provide continuation of coverage for those in small businesses that are exempt from COBRA provisions
Low-income workers with access to employer-sponsored coverage	• Continue to expand coverage through Idaho's Access Card and Access to Health Insurance programs; refine program design as necessary (such as eligibility criteria, marketing strategies, application procedures, subsidy amount); if necessary, conduct focus groups with employers and employees to better understand reasons for low participation and address barriers to the extent possible; this approach may be coordinated with the proposed pool option below • Explore the potential for the "three-share" program, based on the model in Muskegon, Michigan; this approach may be coordinated with the proposed pool option below
Low-income workers and sole proprietors without access to employer-sponsored coverage	• Create a purchasing pool for small businesses making subsidies available for non-offering employers and low-income workers. Explore the feasibility of federal match and of bringing in uninsured sole proprietors • The Insure Montana pool could provide a model
Residents of rural areas	• Examine options for strengthening safety-net capacity in rural areas
Cross-cutting strategies	• Assess the feasibility and viability of establishing an Insurance Connector, as in Massachusetts, to increase portability of coverage, facilitate pooling of employer contributions from more than one employer, and administer subsidies • Augment current household and employer surveys in the state to provide rigorous estimates of important subgroups • Monitor and strengthen safety-net capacity in the state; explore coordinated care programs such as Health Advantage in Indiana

options that were not successful in other states could be successful in Idaho depending on the market context and the precise implementation strategy used. Nevertheless, the options in Exhibit 4 represent a suggested "first cut" at options for the task force to consider.

In addition, we suggest the state's development of new coverage initiatives be undertaken as part of a larger, comprehensive "state health plan." This comprehensive state health plan would include cross-cutting strategies to address health care cost escalation; new targeted surveys to measure Idaho's progress toward its coverage goals and to inform refinements to the coverage approach; and a combined safety-net/rural health strategy to ensure adequate access to providers.

While the expansion of safety net capacity—especially in rural areas—may ameliorate provider shortages, we note that this strategy does not take the place of making health insurance coverage more readily available and affordable. Having an insurance card opens doors for specialty care, in particular. There is considerable evidence, based on self-reported data, that the uninsured are more likely than the insured to skip a recommended medical test or treatment, not fill a prescription, postpone needed medical care, and not receive care for a serious condition.

As many states and communities have learned, careful attention to all aspects of the design of the coverage program, from the eligibility criteria to funding sources to product "branding," can help avoid unintended consequences. Undesirable consequences might include low enrollment, unexpected state costs, contractions of provider supply, or reductions of private coverage availability.

The Health Care Task Force and other agencies in Idaho are continuing to gather information they can use to decide on future coverage options. For example, the State Health Access Data Assistance Center (SHADAC) is examining public and private sector spending on health care. This information should shed light on the source and magnitude of resources that could be used to develop and subsidize more affordable coverage for uninsured workers and their families. In addition, the Idaho Department of Health and Welfare has commissioned an analysis of premium assistance programs in six other states, with the goal of assessing their "fit" and feasibility for Idaho. Finally, five northern Idaho counties are spearheading a study that will examine the feasibility of implementing a three-share model similar to the *Access Health* plan in Michigan. This study will include a market analysis of likely participation among small, uninsured businesses.

This page has been intentionally left blank for double-sided copying.

REFERENCES

Alteras, T., and S. Silow-Carroll. "Childless Adult Coverage in Maine: State Report." August 2004. Available online at [www.kff.org/medicaid/upload/Medicaid-and-Other-Public-Programs-for-Low-Income-Childless-Adults-Maine.pdf]. Accessed May 4, 2007.

Associated Press. "AllKids Insurance Enrollment Outpaces Targets," November 21, 2005. Available online at [Pantagraph.com]. Accessed May 4, 2007.

Butler, P. "ERISA Preemption Manual for State Health Policy Makers." Washington, DC: National Academy for State Health Policy, January 2000. Available online at [www.statecoverage.net/pdf/erisa2000.pdf]. Accessed April, 21 2007.

Chollet, Deborah. "The Role of Reinsurance in State Efforts to Expand Coverage." *State Coverage Initiatives Issue Brief,* vol. V, no. 4, October 2004. Available online at [statecoverage.net/pdf/issuebrief1004.pdf]. Accessed May 4, 2007.

"COBRA Coverage for Low-Income Unemployed Workers." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2001.

Cobrahealth.com "Statewide Directory." Available online at [www.cobrahealth.com/statelawdirectory.htm]. Accessed April, 21 2007.

Collins, S.R., C. Schoen, J.L. Kriss, M.M. Doty, and B. Mahato. "Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help." New York: The Commonwealth Fund, updated May 24, 2006.

CoverTN. "Cover Tennessee Program Overview." Available online at [www.covertn.gov/cover_tn.html]. Accessed April 24, 2007.

Dorn, S., J. Varon, and F. Pervez. "Limited Take-up of Health Coverage Tax Credits and the Design of Future Tax Credits for the Unisured." Washington, DC: Economic and Social Research Institiue, Novemeber, 2005.

EP&P Consulting Inc. 2005. Available online at [www.ins.state.ny.us/website2/hny/reports/hny2005.pdf]. Accessed April 21, 2007.

Fish-Parcham, C. "High-Risk Health Insurance Pools." Issue Brief. Washington, DC: Families USA, May 2006. Available online at [www.familiesusa.org/assets/pdfs/High-Risk-Pools-May-2006.pdf]. Accessed April 24, 2007.

Friedenzohn, Isabel. "Limited Benefit Policies: Public and Private-Sector Experiences." *State Coverage Initiatives Issue Brief*, vol. V, no. 3, July 2004.

Fronstin, Paul, and Jason Lee. "A Community Expands Access to Health Care: The Case of Access Health in Michigan." *Health Affairs*, May/June 2005.

Garrett, B., L. Nichols and E. Greenman. "Workers Without Health Insurance: Who Are They and How Can Policy Reach Them?" Battle Creek, MI: W.K. Kellogg Foundation, Community Voices, Healthcare for the Underserved, 2001.

General Services Department, The State of New Mexico. Available online at [www.state.nm.us/gsd/rmd/seip.html] Accessed April 21, 2007.

Hadley J. and C. Cunningham. "Availability of safety net providers and access to care of uninsured persons." *Health Services Research,* 2004;39:1527-1546.

Howell, Embry, Christopher Trenholm, Kathy Gifford, and Bridget Lavin. "Covering Kids and Families Evaluation. Case Study of Virginia: Exploring Medicaid and SCHIP Enrollment Trends and Their Links to Policy and Practice." Robert Wood Johnson Foundation, Princeton, NJ: July, 2006. Available online at [www.rwjf.org/files/research/CKF_VA_case_study-final%20report.pdf]. Accessed April 22, 2007.

Indianapolis Medical Society. "Project Health Overview." Available online at [www.imsonline.org/public/components/societytools/admin/viewNewmisc.asp?newsjob=ArticleID&ArticleID=3202&ArticleName=Project+Health+Overview]. Accessed April 23, 2007.

Indianapolis Medical Society. July 2005 Bulletin. Accessed April 23, 2007.

Ingham Health Plan 2007. Available online at [www.communityhealthplans.org/IHP.asp]. Accessed April 23, 2007.

Insurance Department, Commonwealth of Pennsylvania, 2007. "adultBasic: Health Insurance for Adult Pennsylvanians." Available online at [www.ins.state.pa.us/ins/cwp/view.asp?a=1336&Q=543266&PM=1&insNav=|]. Accessed May 4, 2007.

Insure Montana 2007. Available online at [www.insuremontana.org/index.asp]. Accessed April 23, 2007.

Kaiser/HRET. *Survey of Employer-Sponsored Health Benefits, 1999-2006.* Washington DC: September 26, 2006.

Kaminski, Janet. "Cost of Health Insurance for Small Employers." Connecticut General Assembly. Bulletin 2005-R-07-06, October 19, 2005. Available online at [www.cga.ct.gov/2005/rpt/2005-R-0706.htm]. Accessed November 17, 2005.

Katz, Aaron, Melanie Au, Gary Claxton, Joy M. Grossman, Robert E. Hurley, Jessica H. May. *Lansing's Calm Health Care Market Belies Increased Competition, Economic Doldrums, Community Report No. 8,* Center for Studying Health System Change, October 2005.

Kronick, Richard, Todd Gilmer, and Thomas Rice. "The Kindness of Strangers: Community Effects on the Rate of Employer Coverage. *Health Affairs* Web Exclusive. June 2, 2004.

Institute of Medicine (IOM). *Hidden Costs, Value Lost: Uninsurance in America*, Washington, DC: Institute of Medicine, 2003.

Lipson, Debra, Lynn Taylor and others. *An Evaluation of DirigoChoice after Two Years of Program Operation*. Washington, DC: Mathematica Policy Research, forthcoming 2007.

Long, Stephen H., and Susan M. Marquis. "Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?" *Health Affairs,* January/February 2001.

Mays, Glen P., Thomas Bodenheimer, Laurie E. Felland, Kelly L. McKenzie, Hoangmai H. Pham, Lydia E. Regopoulos, *Continued Hospital Expansions Raise Cost Concerns in Indianapolis, Community Report No. 2*, June 2005, Center for Studying Health System Change.

McLaughlin, C.G., and W.K. Zellers. "The Shortcomings of Voluntarism in the Small-Group Insurance Market." *Health Affairs*, Summer 1992.

National Association of Community Health Centers, Inc. (NACHC). *Health Center Fact Sheet for Idaho, 2005*. Washington, DC: NACHC, 2006.

Neuschler, Edward, Rick Curtis, Lynn Taylor, and Rafe Forland. "Using Premium Assistance to Expand Coverage Through Small Firms." Washington, DC: The Institute for Health Policy Solutions, January 2004.

New Mexico State Government, 2007. "New Mexico State Coverage Initiative: General Information." Available online at [nmsci.state.nm.us/GeneralInformation.aspx]. Accessed May 4, 2007.

NovaSys Health LLC, 2007. Available online at [www.arhealthnet.com/]. Accessed April 21, 2007.

Reschovsky, James, and Jack Hadley. "Employer Health Insurance Premium Subsidies Unlikely to Enhance Coverage Significantly." Issue Brief No. 46. Washington, DC: Center for Studying Health System Change, December 2001.

Research Triangle Institute. "Employer Subsidies for Health Insurance Premiums: Massachusetts' Unique Experiment." Research Triangle Park, NC: RTI, September 2004.

Scandlen, Greg. *Will Mandatory Health Insurance Work?* National Center for Policy Analysis, Brief Analysis #569. September 6, 2006. Available online at [http://www.ncpa.org/pub/ ba/ba569/ba569.pdf]. Accessed April, 21 2007.

Silow-Carroll, Sharon, and Tanya Alteras. *Stretching State Health Care Dollars: Innovative Uses of Uncompensated Care Funds.* New York: The Commonwealth Fund, October 2004.

Spencer, Donna, and Nitika Malik, and Lynn A. Blewett. "Health Insurance Access Programs and Policies in Montana and Other Frontier States." Minneapolis, MN: State Health Access Data Assistance Center (SHADAC). January 2006.

Swartz, Karen. "Reinsurance: How States Can Make Health Coverage More Affordable for Employers and Workers." New York: The Commonwealth Fund, July 2005.

State Coverage Initiatives, Profiles in Coverage: Healthy New York. January 2005a. Available online at [www.statecoverage.net/newyorkprofile.htm]. Accessed November 8, 2005.

State Coverage Initiatives, Profiles in Coverage: Maine Dirigo. May 2005b. Available online at [www.statecoverage.net/maineprofile2.htm]. Accessed November 8, 2005.

State Coverage Initiatives, *Profiles in Coverage: Arizona Healthcare Group*, May 2007. Available online at [http://www.statecoverage.net/arizonaprofile.pdf]. Accessed May 9, 2007.

Taylor, E., P. Cunningham, and K. McKenzie. "Community Approaches to Providing Care for the Uninsured." *Health Affairs*, vol. 25, 2006, pp. w173-w182.

Trenholm, C., B. Lavin, and J. Wooldridge. "Covering Kids and Families Evaluation. Case Study of New Jersey: Exploring Medicaid and SCHIP Enrollment Trends and Their Links to Policy and Practice." Princeton, NJ: Robert Wood Johnson Foundation,, May 2006. Available online at [www.rwjf.org/files/research/CKF_NJ_case_study-final%20report.pdf] Accessed April 22, 2007.

U.S. Government Accountability Office (GAO). "Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses." GAO-03-1133, September 30, 2003. Available online at [www.gao.gov/new.items/d031133.pdf]. Accessed May 4, 2007

Walls, J., B. Lavin, K. Gifford, and C. Trenholm. "Covering Kids and Families Evaluation. Case Study of Arkansas: Exploring Medicaid and SCHIP Enrollment Trends and Their Links to Policy and Practice." Princeton, NJ: Robert Wood Johnson Foundation, July 2006. Available online at [www.rwjf.org/files/research/AR%20case%20study.final1 (Revised%207-26-06).pdf]. Accessed April 22, 2007.

Williams, Susan R., and Margo L. Rosenbach. "Evolution of State Outreach Efforts Under SCHIP." *Health Care Financing Review*, forthcoming, summer 2007.

This page has been intentionally left blank for double-sided copying.

Office of Performance Evaluations Reports Completed 2005–Present

Publication numbers ending with "F" are follow-up reports of previous evaluations. Publication numbers ending with three letters are federal mandate reviews—the letters indicate the legislative committee that requested the report.

Pub. #	Report Title	Date Released
05-01	Public Education Technology Initiatives	January 2005
05-02	Child Welfare Caseload Management	February 2005
05-01HTD	Use of Social Security Numbers for Drivers' Licenses, Permits and Identification Cards	February 2005
05-01F	Management of Correctional Data	March 2005
05-03	Idaho School for the Deaf and the Blind	October 2005
05-04	State Substance Abuse Treatment Efforts	December 2005
06-01	Management in the Department of Health and Welfare	February 2006
06-02	Idaho Student Information Management System (ISIMS)—Lessons for Future Technology Projects	August 2006
06-01F	Public Works Contractor Licensing Function	August 2006
06-02F	Idaho Child Care Program	August 2006
06-03F	Timeliness and Funding of Air Quality Permitting Programs	August 2006
06-04F	Fiscal Accountability of Pupil Transportation	August 2006
06-05F	School District Administration and Oversight	August 2006
06-06F	Public Education Technology Initiatives	August 2006
06-07F	Higher Education Residency Requirements	August 2006
06-08F	Child Welfare Caseload Management	August 2006
07-01	Use of Average Daily Attendance in Public Education Funding	February 2007
07-02	Virtual School Operations	March 2007
07-03F	Higher Education Residency Requirements	July 2007
07-04F	State Substance Abuse Treatment Efforts	July 2007
07-05F	Idaho School for the Deaf and the Blind	July 2007
07-06F	Public Education Technology Initiatives	July 2007
07-07	Health Insurance Coverage in Idaho: A Profile of the Uninsured and Those with Coverage	July 2007
07-08	Options for Expanding Access to Health Care for the Uninsured	July 2007

Reports are available on our website at www.idaho.gov/ope/.
Office of Performance Evaluations • P.O. Box 83720 • Boise, ID 83720-0055
Phone: (208) 334-3880 • Fax: (208) 334-3871