Arizona Health Care Cost Containment System Implementation of Incentives and Regulatory Mandates to Increase Health Insurance Coverage

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EXECUTIVE SUMMARY

Milliman USA was retained by the Arizona Health Care Cost Containment System (AHCCCS) to prepare an overview of incentives that have been implemented by other states to increase private health coverage. We were also asked to provide commentary on the effectiveness of legislative mandates at the state level. This paper was prepared for AHCCCS as part of the Arizona State Planning Grant, which is funded by the Health Resources and Services Administration.

In particular, AHCCCS asked us to look at strategies that are targeted at the following groups:

- Consumers
- Health Plans and Insurance Companies
- Employers

For each, we were asked to summarize current approaches and best practices being used by other states and to critique the strategy in the context of the criteria developed by the Arizona Statewide Health Care Insurance Task Force. We were also asked to outline issues that may require further study.

For consumer-based initiatives, we have looked at four specific approaches: SCHIP programs; "premium sharing" and related programs; tax credits and/or deductions; and pharmacy assistance for the elderly. SCHIP programs have generally been successful in enrolling uninsured low-income children (3.3 million nationwide); however, states vary substantially in their success at enrolling targeted populations. There is also a concern that such programs may be encouraging employers and/or individuals to drop private insurance (the "crowd out" problem). Premium-sharing and similar programs targeted at low-income workers are still relatively new; some states have had success in enrolling material numbers of people. However, the "crowd-out" problem is also a concern in those programs. Tax credits and deductions have not been effectively implemented by any state as a means of reducing uninsurance. Pharmacy assistance plans have recently emerged in about half the states, either offering insurance or discounts to low-income elderly for their prescription drug expenses.

For health plan initiatives, we have looked at efforts to reform the small employer marketplace, the individual health insurance marketplace, and efforts at improving coverage in rural areas.

Small employer market reform has created a more stable insurance market and made health insurance available to employers willing and able to pay for it. However, it has not addressed the affordability problem, and some studies in fact suggest may have contributed to it. Individual health insurance market reform has, by and large, not been successful in any state. We were unable to identify any rural initiatives focusing on private health insurance that have been fully implemented.

For employer mandates, we have looked at the requirements on employers to provide coverage to all employees if they provide insurance to any, as required under HIPAA and the states small group reform laws. We have also examined the employer mandate in Hawaii, where all employers are required to provide health insurance to full-time employees. While Hawaii does boast the lowest rate of uninsureds in the nation, its approach may not transfer easily to other states.

This report provides summary information only; a more detailed analysis of this subject was beyond the scope of this paper. It assumes that the reader is familiar with health insurance and the health care system in the United States. It should only be reviewed in its entirety.

I. INTRODUCTION

Milliman USA was retained by AHCCCS to prepare an overview of incentives that have been implemented by other states to increase private health coverage. We were also asked to provide commentary on the effectiveness of legislative mandates at the state level.

Scope of Work

In particular, AHCCCS asked us to look at strategies that are targeted at the following groups:

- Consumers
- Health Plans and Insurance Companies
- Employers

For each, we were asked to summarize current approaches and best practices being used by other states and to critique the strategy in the context of the criteria developed by the Arizona Statewide Health Care Insurance Task Force. (Those criteria were provided to us by AHCCCS and are attached to this report as Appendix A). Finally, we were asked to address issues that need to be considered in adopting these approaches and any further analysis that would need to be conducted.

Specifically excluded from the scope of our paper are the following:

- Approaches being used in Arizona today
- Healthcare purchasing cooperatives (being addressed in a separate paper)
- High risk health insurance pools (being addressed in a separate paper)
- Federal initiatives (however this paper does make reference to such initiatives where appropriate)
- International approaches (being addressed in a separate paper).

In addition, we have focused exclusively on state mandates and initiatives aimed at reducing the number of people who are uninsured. As such, this paper does not address state mandated benefits which expand the scope of health insurance coverage for those who already have health insurance (e.g., mandated coverage for mental illnesses or chiropractic services).

Caveats

This paper was developed for AHCCCS as part of the Arizona State Planning Grant, which is funded by the Health Resources and Services Administration. It provides summary information about State incentives and mandates to increase health insurance coverage. A more detailed analysis of this subject was beyond the scope of this paper. It assumes that the reader is familiar with health insurance and the health care system in the United States. It should only be reviewed in its entirety.

II. CONSUMER-BASED INITIATIVES

In this section we discuss initiatives undertaken by states to encourage consumers to purchase health insurance or aid consumers in the purchasing of health care services. In particular we will address four specific approaches:

- Expanded health care coverage for poor children ineligible for Medicaid (SCHIP programs)
- Expanded health care coverage for "working poor" adults ineligible for Medicaid ("premium sharing" programs)
- Tax credits and/or deductions
- Pharmacy assistance for the elderly

SCHIP Programs

Overview and Summary

State Children's Health Insurance Programs (SCHIP) were first implemented in late 1997 and now include all 50 states, the District of Columbia, and other U.S. territories. As of September 30, 2000, 3.3 million children were enrolled in SCHIP programs nationwide; this is an increase from 2.0 million enrollees the previous year.

States vary widely in their success at enrolling eligible children into SCHIP programs. New York has the largest program at 769,000 enrollees, while California is second with 478,000 children enrolled. When measuring the percentage of children who are Medicaid- or SCHIP-eligible who remain uninsured, states range from over 30% (e.g., Texas, Nevada, Louisiana) to under 10% (Minnesota, Vermont, Tennessee).

While some of these differences may be attributable to enrollment requirements for the various programs, they are more likely due to more effective implementation of SCHIP programs in certain states as opposed to others. Such initiatives include:

- Advertising in appropriate media and language
- Working with employers to facilitate SCHIP enrollment for low income workers with children

- Effective and efficient screening tactics to identify potential eligible families

- Streamlined application and enrollment process

Another area where states vary in their SCHIP programs is in their handling of the potential "crowd out" issue. "Crowd out" is defined as the substitution of public programs for private ones and can occur for two reasons: (1) individuals forego private coverage to enroll in public coverage and (2) employers reduce or eliminate premium contributions because families are able to obtain subsidies. Experts are divided as to whether substitution is even a problem in SCHIP programs; it is difficult to isolate the impact of new public programs such as SCHIP from other secular trends in coverage. Most tend to agree that the more important question is how much crowd-out is acceptable in a public program; a judgment must be made balancing increasing coverage for the uninsured, but not reducing coverage that people already have in the employer-based system.

States have used the following mechanisms to address either individual-based or employer-based substitution:

- Setting premiums and copayments that are low enough to encourage participation yet high enough to limit substitutions.

- Setting eligibility rules based on access to employer coverage, periods of uninsurance, and employer contributions.

- Using subsidies to help pay for employer sponsored coverage.

- Limiting the scope of benefits.

- Using health insurance purchasing cooperatives to make the provision of insurance more affordable for small businesses.

- Allowing employers to buy directly into state programs at a reasonable cost.

- Assisting certain employers with the cost of health insurance.

Pros and Cons

Pros and cons of SCHIP programs in light of the Statewide Health Care Insurance Task force criteria are:

Pros:

- Basic benefits are made available and are well-defined.
- Healthcare is made available and accessible, particularly in states which have done a good job of encouraging enrollment.
- Costs for children are relatively low; therefore, members can generally afford their share of the premium. In addition, enhanced Federal subsidies ease affordability for the states.
- The program picks up where Medicaid stops, and hence is seamless in that respect.
- The approach is widely accepted among providers and insurers; in many states it is a private/public partnership with commercial carriers bearing some or much of the risk.

Cons:

- Some states haven't done a great job of getting children into the program.
- Possible "crowd out" issue may contribute to the decline in employer- provided health insurance.
- Program is not seamless in that it often covers children but not adults. Children lose coverage as they reach maturity; families are split with children having insurance and adults uninsured. (There is evidence to suggest that adults are more likely to seek care for their children if the adults themselves have health insurance coverage). However, a number of states are now covering families through SCHIP, as described below.

Issues to be Considered

The two key issues that need to be considered in implementing SCHIP programs are:

- Techniques to maximize enrollment of eligible children.

- Techniques to minimize and discourage "crowd out".

Coverage for "Working Poor" Families

Overview and Summary

Certain states have also sought ways to expand coverage for low-income adults not traditionally eligible for Medicaid. States have implemented these programs through their existing Medicaid programs (expanding eligibility requirements) or through their SCHIP programs, or through some combination of the two. Given that the majority (56%) of uninsured non-elderly Americans are in families with incomes below 200% of the federal poverty level (FPL), this approach makes sense. Currently, in 32 states uninsured working parents are ineligible for Medicaid if they work full time at the minimum wage; additionally, low-income childless adults are never eligible for Medicaid unless they qualify as disabled.

States have taken a variety of approaches in their attempts to increase health insurance for the working poor. States that are seen as having innovative programs include:

Iowa: The Iowa Health Insurance Premium Prepayment (HIPP) program subsidizes enrollment in employer-sponsored private health insurance plans for Medicaid-eligible individuals and families. To qualify, a person must be eligible for Medicaid or live in the household of a Medicaid-eligible family member and have access to employer coverage. In addition, the subsidy must meet cost-effective criteria.

Massachusetts: The MassHealth Family Assistance Program covers families with incomes up to 200% of the FPL through a combination of programs funded through Medicaid, SCHIP, private funds, and state funds. Through the SCHIP program, premium assistance is provided for families with children who are eligible for SCHIP. The state's Medicaid program provides full subsidies to families with incomes below 150% of FPL for the cost of their health insurance premium; families between 150% and 200% receive partial assistance and must pay a portion of their premium.

Additionally, Massachusetts makes incentive payments to small employers that provide insurance benefits to their low-income employees. The business must employ 50 or fewer full-time workers, offer comprehensive health insurance, and pay at least half the premium.

Finally, Massachusetts also has the Children's Medical Security Plan, for any children under the age of 19 who is currently uninsured and not eligible for coverage under

MassHealth. The cost of coverage is a sliding scale based on family income level. This program is funded entirely through state funds.

Minnesota: Minnesota has expanded its Medicaid program through a HCFA waiver. The state also has a publicly subsidized health insurance program (MinnesotaCare) which covers uninsured families and children with incomes up to 275% of FPL and adults with incomes up to 175%. Individuals are ineligible for MinnesotaCare if they have access to 50% employer-subsidized coverage. The program is funded through enrollee premiums, taxes on healthcare providers, and federal matching funds. There are also provisions to ease movement between the state's healthcare programs or as families leave the program due to higher income levels.

Oregon: The Family Health Insurance Assistance Program is a state-funded program that provides direct subsidies to families with incomes below 200% of the FPL to help them buy health insurance through their employer or the individual market. To ensure coverage of children, adults are not eligible for FHIAP unless all children are covered under a health benefit plan or Medicaid. The program is funded solely by state funds.

Washington: Expanded coverage is available for low-income workers via Medicaid waiver expansion (income and asset based) and the Basic Health Plan. The BHP provides subsidized health insurance for any state resident with an income below 200% of the FPL. Enrollee premiums are on a sliding scale based on income, age, and family size. The BHP integrates with the state's Medicaid program and eligibility is determined jointly between the two programs.

West Virginia: The state will reimburse former TANF recipients (and/or their spouses) up to $125 per month per month for the purchase of private health insurance. Eligibility is at 185% of FPL and requires that a child and working adult be present in the home. If the $125 is insufficient to meet the cost of insurance, the enrollee must make up the difference. The program is for the adults only; uninsured children are encouraged to be enrolled in Medicaid or SCHIP.

Wisconsin: BadgerCare ensures access to health care for uninsured children and parents with incomes at or below 185% of FPL (they may remain in the program until family income exceeds 200%). There is also a waiver to expand Medicaid coverage for adults and SCHIP funds are used for children. A monthly premium is charged for families with incomes in excess of 150% of FPL. BadgerCare purchases coverage for families when employer coverage is available; employers must pay at least 60% of the cost.

In addition to these state programs, two community-based programs are seen as models for extending coverage to the working poor:

> *Access Health:* This is a program of the Muskegon Community Health Project in Muskegon County, Michigan. It is a health insurance product for the working uninsured targeted to small and medium-sized businesses (up to 150 eligible employers). The business cannot have provided insurance for the past 12 months and must have a median wage of eligible employees of $10 per hour or less. The cost of premiums is shared three ways: employees (30%), employers (30%), and community match (40%). The community match is derived from local and federal dollars as well as community and foundation funds.
>
> *FOCUS:* This program, "Financially Obtainable Coverage for Uninsured San Diegans" is provided by Sharp Health Plan, and is a premium assistance program for small employers and low to moderate income employees. Small business not providing coverage for 12 months are eligible, as are full-time employees with incomes up to 300% of the FPL (all eligible dependents must also enroll). The program is funded by private grant money, fixed employer contributions, and a sliding fee scale for employees.

The same concerns about "crowd out", described above for SCHIP programs, exist for working poor programs as well. In fact, some experts have made the argument that covering parents creates a stronger incentive for crowd out than covering children only. Most employers view health care coverage as a benefit for workers, and typically contribute more towards the cost of care for employees than for dependents. Also, low-income working parents may have strong incentives to seek employment with higher wages and no health benefits, given the availability of inexpensive health insurance coverage from a public program.

States are taking different approaches to address this potential problem. Massachusetts, for example, will study the issue to determine if crowd out is occurring; if so, the state will consider a three-month waiting period before persons are eligible for coverage. Oregon requires that the entire family be uninsured for six months prior to application. Minnesota denies eligibility for MinnesotaCare if an applicant has been eligible for employer-sponsored insurance (where the employer paid at least 50% of the premium) within the past 18 months; this is true even if the employer dropped coverage for all employees. Wisconsin has a similar provision, but the employer requirement is set at 80% (making eligibility easier), and eligibility is not denied if the employer dropped coverage.

Pros and Cons

Pros and cons of working poor programs in light of the Statewide Health Care Insurance Task force criteria are:

Pros:

- Basic benefits are made available to the defined populations. However, a program that makes use of employer coverage provides a full set of basic benefits only if the employer's program does. Since many private health plans (especially indemnity insurance plans) exclude coverage for such things as preventive care, this may limit the degree to which the 'basic benefit' goal is met.

- Some states (as noted above, e.g., Minnesota) have made an extra effort to streamline administration to ease portability of benefits.

- Health care is available and accessible. Integration with employer health plans tends to "mainstream" low income workers into the providers which predominantly serve commercially insured populations.

- Healthcare is made affordable for low-income families via sliding scale premiums and/or cost-sharing provisions. Health insurance carriers can charge an adequate premium, assuming that the low-income workers do not have materially higher claim costs than other workers.

- The innovative programs cited above are seamless in the sense that they serve as a bridge between public and private insurance.

- The programs are collaborative in the sense that necessary funding comes from state and federal government, employers, and the enrollees themselves.

- Commercial carriers are involved, significantly.

Cons:

- Integration with employer plans means the state loses some control over benefit plan design.

- The programs have the potential to be very expensive for the states. Expansion of Medicaid eligibility and premium subsidies for employer plans require new expenditures of funds.

- There is a potential "crowd out" problem, if not managed, that may result in a decline in private health insurance.

- The programs may not be seamless for families near the upper income limit of the program. There is a potential "gap" in coverage if families' incomes rise above the upper limit but their employer does not provide health insurance. Also, state plans tend to have less patient cost-sharing, so transition to a private plan is not seamless.

- It is unclear at this point how the inclusion of previously uninsured low-income workers will affect commercial carriers' premium rates.

Issues to be Considered and Analysis Required

The key issues and further analysis that need to be considered in implementing coverage programs for low-income workers are:

- Careful consideration must be given to administrative simplicity and streamlining. These programs for the working poor have to integrate with Medicaid (at the lower income levels) and private insurance (at the higher end).

- The programs require a healthy, functioning private insurance marketplace.

- Techniques for monitoring and managing "crowd out" need to be carefully considered.

- Because these programs have the potential to be very expensive for the states, a careful analysis of the costs of the program must be considered. Ultimately, a balance between maximizing coverage within available budgetary constraints must be struck.

- What are the advantages and disadvantages of using the Medicaid program, the SCHIP program, a completely new program, or some combination thereof?

Tax Credits and Deductions

Overview and Summary

Income tax credits or deductions for health insurance premiums have been widely discussed but rarely implemented. Most discussions have centered on federal income tax laws rather than state income tax. However, a few states have implemented some form of income tax credit program:

Colorado: For new businesses located within a defined "enterprise zone", a two year tax credit of $200 per employee is granted for businesses which pay at least 50% of the cost of health insurance for their employees. Note that this tax credit is for businesses, not individuals, and is very limited in scope.

Kansas and *Maine* have also instituted tax credit programs for small employers. Kansas allows a refundable tax credit to small employers of $35 per employee per month, while Maine allows the lower of $125 per employee with dependent coverage (per year) or 20% of dependent premiums. Like Colorado, these tax credits exits for the employers, not the employees.

North Carolina: The state grants an income tax credit for families if the families pay health insurance premiums for dependent children. The credit is $300 for families below 225% of the FPL; otherwise, the credit is $100. Note that these credits are much less than the annual cost of insurance for a family.

Missouri: The state grants an income tax credit for drug costs for low-income seniors.

Other states (13 at latest count) have granted state income tax deductions for individual health insurance. However, since most uninsureds are low-income, and marginal tax rates for these individuals are relatively low, it seems unlikely that income tax deductibility of health insurance premiums will have a material impact on the number of uninsured. State income tax rates are also much lower than federal rates and so the state income tax credit is of limited value.

Finally, a much-talked-about method to possibly reduce the number of uninsureds is the Medical Savings Account (MSA). MSAs allow individuals to accumulate savings on a tax-sheltered basis to cover out-of-pocket medical expenses and health insurance premiums. However, federal tax law does not yet fully recognize MSAs, and so implementation has been very limited to date.

Pros and Cons

Pros and cons of state income tax credits for working poor, in light of the Statewide Health Care Insurance Task force criteria are:

Pros:

- The credits encourage uninsureds to purchase health insurance, and assist in making the premiums more affordable.

- Tax deductibility of individual insurance premiums creates a level playing field with employer-based group insurance. For self-employed and other individuals who are not "working poor" but have to provide for their own health insurance via individual policies, this can be a significant advantage.

- The individual can exercise freedom of choice in choosing a health plan.

- Financial impact to the state can be readily defined and measured.

Cons:

- This may be an issue more appropriately discussed at the federal rather than state level. There is relatively little experience with this idea at the state level, and federal income tax levels are generally much higher than state tax levels, making federal deductions more valuable.

- The concept depends on a healthy, functioning health insurance marketplace (both individual and group insurance).

- Likely size of the tax credit will be small vis-à-vis the annual cost of health insurance for a family.

- Low income individuals may find it difficult to accumulate meaningful savings in an MSA, and the tax-sheltered aspect may be of little value to them, given that their marginal tax rates are relatively low (particularly for state income tax rates).

- A nonrefundable tax credit is of no use to a very low income individual or family which has little or no income tax liability.

Issues to be Considered and Analysis Required

The key issues and further analysis that need to be considered in implementing tax credits for low-income workers include:

- How much leverage do the states have to fund health insurance via tax credits? In other words, how effective is the tax credit likely to be in combating the uninsured problem?

- Can the states afford the lost revenue?

- Is refundable or nonrefundable tax credit appropriate? A refundable tax credit would be of more use to uninsured individuals with little or no tax liability, but would be more expensive for the states.

- Is the private health insurance market in the state stable and healthy?

Pharmacy Assistance for the Elderly

Overview and Summary

A number of states (at least 24) have implemented programs to help elderly individuals purchase outpatient prescription drugs, which are not covered by Medicare. While this is not strictly an uninsured issue, it does represent a significant insurance gap for a large portion of the population. One group estimates that Americans ages 65 and over pay an average of $1,200 per year on prescription drugs.

These programs typically provide discounts or insurance (with enrollee cost sharing) for seniors' prescription drug costs. Typically there is a minimum age (usually age 65) and a maximum income limit tied to some percentage of FPL, though neither of these requirements is universal.

Examples of programs in various states include:

> *California:* The Discount Prescription Medication Program requires Medi-Cal pharmacies (i.e., pharmacies that have contracts with the state Medicaid program) to provide prescription drugs to any Medicare enrollee at the Medi-Cal price (plus a very small handling fee of $0.15 per script). There is no income limit for this program and no expenditure of funds by the state.
>
> *Connecticut:* Connecticut Pharmaceutical Assistance pays part of the cost of drugs for Social Security recipients (over 65 or disabled) with annual incomes below a certain level ($15,100 for single, $18,100 for couples). There is a $25 annual registration fee and a copay of $12 per prescription.

Florida: Florida has a program very similar to California's. In addition, Florida has added a second layer, providing assistance to dually-eligible Medicaid-Medicare enrollees. This program requires a 10% copay and has a monthly maximum benefit of $80 per month.

Kansas: The Senior Pharmacy Assistance Program has a minimum age of 67 and an upper income limit of 150% of FPL. Drugs are covered with a 30% enrollee copay.

Maine: Maine residents age 62 and over with incomes below 185% of the FPL are eligible for the Low Cost Drugs for the Elderly Program. This is a two-tier program providing the following benefits:

- Basic benefits: 80% coverage for all generic drugs, and drugs associated with certain conditions such as arthritis and high blood pressure

- Catastrophic benefits; 80% coverage for all other drugs, but only after the individual has spent over $1000 on drugs in a given year.

Pros and Cons

Pros and cons of prescription drug programs for low-income elderly, in light of the Statewide Health Care Insurance Task force criteria, are:

Pros:

- Insurance programs provide affordable prescription drugs to low-income seniors.

- Discount programs provide some relief in the cost of drugs to seniors.

- Discount programs likely have no cost to the state.

Cons:

- Only prescription drugs are covered (though Basic Benefits are provided to some extent by Medicare; however, Medicare does not typically cover preventive services).

- Discount programs (e.g., California and Florida) may be limited to Medicaid participating pharmacies only.

- Stand-alone programs for prescription drugs may not be seamless with Medicare and Medicaid.

- Generally available only to seniors; non-elderly population is excluded.

- Discount programs may adversely impact pharmacies, and may discourage pharmacies from participating. (Note that insurance programs will likely incorporate discounts as well and hence will have the same effect).

- Insurance programs require state funding and have the potential to be expensive (and, typically, no federal matching funds are available).

Issues to be Considered and Analysis Required

The key issues and further analysis that need to be considered in implementing prescription drug programs for low-income seniors include:

- Is an insurance plan or discount plan appropriate? An insurance plan provides more assistance to low-income seniors, but will be more expensive to the states. A discount plan may cost the state little or nothing.

- Will a discount plan be acceptable to pharmacies?

- Will a discount plan make a meaningful difference to seniors?

- Does the state have the funding available to pay for an insurance program?

III. HEALTH PLAN INITIATIVES AND MANDATES

In this section we focus on initiatives and mandates that have been imposed on health insurance companies and health plans. The vast majority of these reforms have focused on the small employer health insurance marketplace, and, to a lesser extent, on the individual insurance market. Very few reforms have affected large employers, be they insured or self-funded.

By and large the reforms to the small group and individual insurance marketplaces have centered on availability of coverage. Common provisions adopted in most states (as included in HIPAA and the NAIC Small Group Model Law) include guaranteed renewability, guaranteed issue, limitations on pre-existing condition waiting periods, restrictions on marketing practices, and restrictions on rating practices.

A few states, such as New York, Kentucky, and Washington, had enacted considerably broader reforms, particularly in the individual insurance marketplace. These reforms have often led to considerable disruptions in the health insurance markets in those states.

In addition to these market reforms, we will also examine efforts to improve access to health insurance in rural markets.

Small Employer Group Health Insurance Market Reforms

Overview and Summary

Small group health insurance market reform started in the early 1990s with the first NAIC model law on rating practices, which was followed by a second model law which included a provision for guaranteed issue. In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA) which, among other requirements, included provisions to make it easier for an individual to transfer coverage from one source to another (hence "portability"). Taken together, HIPAA plus the state laws which were enacted in response to the NAIC models mean that some form of small group market reform has been enacted in all 50 states.

Typical provisions of small group reform include:

- *Guaranteed Issue:* A health insurance carrier cannot decline to cover a small employer. This may apply to all plans or only a certain set of plans the carrier offers (varies by state). This provision is included in both HIPAA and state reform laws.

- *Guaranteed Renewability:* A health insurance carrier cannot decline to renew coverage for an existing small employer group (except for reasons such as fraud or nonpayment of premiums). This provision is included in both HIPAA and state reform laws.

- *Limitations on Pre-Existing Condition Exclusions:* Under HIPAA, an individual is not subject to a carrier's pre-existing condition exclusion if he had "prior creditable coverage" just before enrolling in the new plan.

- *Rating restrictions:* The NAIC model laws included limitations on how carriers can determine premium rates for small employer groups. HIPAA included no such provision, and the degree to which states have implemented these restrictions varies. Generally, carriers are limited (by a complicated formula) in the degree to which they can take into consideration an employer group's claims experience and/or health status when setting rates. Some states went further and required pure "community rating", i.e., one rate charged for all employers. Note that none of these provisions restrict the absolute premium rate level a health insurance carrier can charge, but rather restrict the premium rate for any one employer group *relative to* the premium rates the carrier charges other employer groups.

- *Marketing restrictions:* Both the NAIC models and HIPAA forbid marketing practices by insurance carriers that might be deemed to circumvent the other restrictions (e.g., a carrier cannot pay an agent a higher commission for writing coverage on healthier employer groups).

The impact of these reforms has had a positive effect on the small group health insurance marketplace in the sense that coverage is more stable, more readily available, and cost increases more predictable, than it was in the days prior to reform. Today, most small employer groups that wish to purchase health insurance for their employees can usually do so, if they can afford the premiums.

The effect of small group market reform on the number of uninsureds, however, has been nil, and possibly negative. Studies vary and sometimes contradict in their results, possibly due to differences in methods. However, most studies seem to indicate that small group market reforms have served to discourage employer coverage, probably because insurers respond to reforms by raising insurance prices and employers then increase employee contributions. At the same time, however, it is very difficult to isolate the impact of small group market reforms from other market factors (such as the increased penetration of managed care plans in most markets).

One state that has demonstrated success through small-group reforms is Maryland. In 1994, Maryland instituted guaranteed issue, renewability, limitations on pre-existing condition exclusions, standardized benefits, and restrictions on experience rating. Between 1995 and 1998, there was a 24 percent increase in the number of small employers providing health insurance and a 20% increase in the number of employees covered.

New York implemented considerably more stringent restrictions in its reform of the small group market. In addition to the guaranteed issue and similar provisions common in other states, New York required carriers to rate groups using pure community rating – i.e., the same rate charged for all employers, regardless of the age of its employees. Because of the heavy cross-subsidizations that this rating practice requires, considerable adverse selection occurred in the New York marketplace, and health insurance premium rates rose considerably. As a consequence, the percentage of small-group employees with private health insurance declined about 10% in the four years following reform. (New York's reforms in its individual insurance market are discussed later in this section).

Similarly, Kentucky also implemented community rating along with other reforms in the mid-1990s, and experienced considerable upheaval in its small employer market, with most carriers withdrawing from the state, premium rates rising sharply, and fewer individuals insured.

Pros and Cons

Pros and cons of small employer group health insurance market reform, in light of the Statewide Health Care Insurance Task force criteria are:

Pros:

- Basic health insurance benefits are made available to all employers who wish to purchase them.

- Portability is significantly enhanced via guaranteed issue and pre-existing condition exclusion limitations.

- Incidents of extreme rate shocks and loss of coverage have been significantly reduced, resulting in a more stable marketplace.

- One study has indicated that by stabilizing the small employer markets, carriers are more likely to participate.

- Reform preserves the private market structure of employer-based health insurance.

Cons:

- Affordability has not been addressed; many employers still do not offer coverage because they cannot (or do not wish to) pay for it. As a result, small group reform by itself has done little to help the uninsured problem.

- Rating restrictions may have caused rates to rise and result in fewer employers offering health insurance.

- Over ambitious reform can cause significant market distortions and result in exacerbations of the uninsured problem. In extreme cases, market distortion has resulted in a significant contraction of the market, with many carriers exiting, thereby reducing competition.

Issues to be Considered and Analysis Required

The key issues and further analysis that need to be considered in implementing small employer group market reform include:

- How to address the affordability issue to encourage more employers to offer coverage.

- How much experience rating is appropriate? What is the right balance between the need for rate stratification to produce an actuarially sound health insurance marketplace, and social goals of not unduly burdening groups with higher than average costs?

Individual Insurance Market Reforms

Overview and Summary

Many of the same reforms enacted in the small group insurance marketplace hold for the individual health insurance market as well. HIPAA requires health plans to guarantee issue coverage with no pre-existing condition exclusion period for individuals leaving group health plans, if those individuals meets certain criteria. HIPAA also requires health plans to guarantee renewal of individual coverage for all individuals (except in cases of fraud or nonpayment of premium, or if a carrier decides to withdraw from the market). In addition, many states have

adopted individual insurance market reforms, ranging from sweeping changes as part of a comprehensive reform program, to more targeted and narrow changes.

It is important to understand that the individual insurance market is fundamentally different from the employer market. Purchasers of individual insurance policies may be self-employed, retired, unable to work, but the majority are workers whose employers do not offer coverage. Individual health insurance purchasers are on average significantly older than workers and their dependents with employer-based coverage. Marketing and administrative costs are higher than for group products, and in most markets, unmanaged fee-for-service products are more predominant than individual HMO policies. As a result, premiums in the individual market are typically higher than those in group insurance. In addition, the income tax subsidies for health insurance in the group market do not exist in the individual market. Consequently, individual health insurance is unaffordable to many people.

In addition, the potential for adverse selection is greater in the individual market than it is in the group market. Thus, the impact of reforms such as guaranteed issue has the potential to increase premium rates by a greater amount than in the group insurance markets.

Perhaps as a consequence, it is difficult to point to any states with success stories in reforming the individual health insurance marketplace. Uniformly, reforms have been followed by decreases in the rate of coverage in the individual insurance market and an increase in the number of uninsured. Although some critics suggest that these results are a function of the reforms themselves, it is possible that (at least in some cases where more modest reforms were enacted) they are attributable to broader secular trends in health insurance coverage. Regardless, it is fair to say that individual market reforms have not met their goals of increasing coverage.

Experiences in specific states include:

- The states of Kentucky, Massachusetts, and Washington implemented comprehensive individual market reforms modeled on the 1994 Clinton healthcare proposal. In all three states, individual insurance premiums increased substantially and insurers pulled out of the market. (Kentucky, in fact, had 45 carriers leave, leaving it with only one private insurance company writing health business in the state). Kentucky and Washington have since repealed portions of their reforms.

- The state of New York enacted changes in the individual insurance market that included guaranteed issue and pure community rating (i.e., same rate charged for everyone regardless of age). This resulted in substantial premium rate increases due to adverse selection, and all individual indemnity carriers exited the market.

However, individual HMO policies became more widespread and led to a stabilization in the market. As a result, some view the New York reforms as a partial success, in the sense that coverage is now readily available for high-risk individuals from a number of different carriers in the state. However, it is difficult for lower-risk individuals to find affordable coverage, and the only choices are HMO and POS plans.

- New Mexico enacted reforms including guaranteed issue, a 6-month limit on pre-existing condition exclusions, and certain premium rate restrictions which limited the degree to which a carrier could vary its rates. In the years following reform, the number of people with individual health insurance declined by more than half.

- Louisiana's reforms were much less comprehensive than those cited above. They included guaranteed renewal and certain limits on pre-existing condition exclusions. Premium rate restrictions include a variation of plus or minus 10% for an individual's health status, and unlimited variation for demographic characteristics. Following reform, the number of individuals enrolled in the individual health market declined by about one-third.

In addition to these reform efforts, nine states regulate individual health insurance premium rates via minimum loss ratio regulations (i.e., the minimum percentage of aggregate premiums that must be paid out in health care benefits to insureds). These minimum loss ratios range from 60% (Maryland) to 75% (New Jersey). Minimum loss ratio regulations are intended to ensure that insurance carriers do not overcharge for health insurance, due to high administrative and marketing costs and/or excessive profits. However, minimum loss ratio regulations do permit a carrier to charge whatever it wants for health insurance if it is justified by historical and reasonably anticipated future health care cost levels. Because these regulations do not address the overall cost of healthcare, they are ineffective at addressing the affordability issue.

Pros and Cons

Pros and cons of individual health insurance market reform, in light of the Statewide Health Care Insurance Task force criteria are:

Pros:

- Guaranteed issue and rating restrictions make health insurance available to high-risk individuals who might not have access to it otherwise.

- Guaranteed renewability provisions means individuals can be assured of keeping their coverage once they have bought it.

- Minimum loss ratio requirements ensure that carriers pay a reasonable proportion of premium revenues in health care benefits.

Cons:

- Because of the high degree of adverse selection in the individual market, over-reaching reforms can cause considerable market upheaval and, in the most extreme case, cause the market to cease to function. Competition among carriers can be reduced or even eliminated. High premiums put individual insurance out of reach for many people.

- Individual insurance, which is already more costly than group insurance, is typically made more expensive by even moderate market reforms.

- Experience has shown that reforming the individual insurance market is extremely difficult to achieve successfully.

- Minimum loss ratio regulations do not effectively address the issue of affordability.

Issues to be Considered and Analysis Required

The key issues and further analysis that need to be considered in implementing individual health insurance market reform include:

- How to meet the social goals of making health insurance available for high-risk individuals while still maintaining affordability for lower-risk persons.

- How to implement reforms in such a way that it does not cause problems in the functionality of the individual health insurance marketplace.

Rural Coverage Initiatives

Overview and Summary

Health insurance in rural areas faces its own unique set of issues and problems. First, because a higher proportion of rural residents is self-employed, the individual insurance market is more predominant than it is in urban areas. Second, managed care tends to be less prevalent in rural areas than in urban. Third, indemnity insurance can be more expensive than HMO coverage (though certainly not always so). Finally, indemnity carriers may be squeezed out of states with very high managed care penetrations in the urban areas, further reducing choice and competition in the rural market.

In addition, the delivery of healthcare in rural areas is also challenging. There may not be an adequate number of physicians and hospitals, and transportation over considerable distances can be an issue.

Most of the initiatives regarding rural healthcare that we have seen emphasize providers of healthcare (physicians and hospitals) rather than insurance coverage in rural areas. As one example of an insurance initiative, many states' Medicaid managed care programs have implemented rules for including Rural Health Centers, Federally Qualified Health Centers and/or Community Health Centers in their provider networks.

The state of Minnesota adopted a law last year to facilitate the creation of entities called Community Integrated Service Networks (CISNs). CISNs were intended to be HMO-like entities limited to fewer than 50,000 enrollees, but without all of the regulatory restrictions that HMOs must comply with. The initiative was geared towards the rural market with the hope of providing local control over health insurance and delivery in those areas. However, at the present time, there are no CISNs in Minnesota.

We are unaware of any other rural health insurance coverage initiatives in any other states.

IV. EMPLOYER MANDATES

In this section we focus on incentives and mandates to employers to provide coverage to their employees. These programs can take on a variety of forms:

- One state (Hawaii) requires employers to provide their employees with health insurance by paying some portion of the premium.

- A few states (Massachusetts, Washington, and Oregon) have considered "pay or play" mandates, where an employer must provide coverage or pay a tax. However, no state successfully implemented such a program, due to political and/or economic reasons, and no "pay or play" mandates exist today. (In addition, there are questions as to whether a state can actually institute a "pay or play" mandate due to ERISA). Therefore, we will exclude it from discussion in this paper.

- There are limited examples of employer tax credits or other incentives for providing health insurance in certain circumstances. These have been previously described in other sections of this report:

  - Colorado's employer income tax credit was outlined in Section 2.
  - Massachusetts' incentive to employers to provide health insurance for certain low-income employees was also mentioned in Section 2.

- Small group reform laws generally require that if an employer provides health insurance to its employees and their dependents, it cannot exclude anyone due to poor health status or similar reasons.

The Hawaii Program

Overview and Summary

Since 1974, Hawaii has required employers to provide health insurance for all employees working over 20 hours a week. (Under a special ERISA exemption granted by Congress, Hawaii is the only state that can regulate the health insurance plans of self-insured companies). Excluded from the requirement are employees working fewer than 20 hours a week, government employees, small family businesses, and seasonal workers.

In addition, Hawaii's QUEST program covers 130,000 low income people who do not have access to private coverage.

According to the US Census Bureau, Hawaii has the lowest percentage of citizens who are uninsured of any state in the nation. About 7.5% of Hawaii's residents lack health coverage, compared to about 16% nationally.

The private health insurance market in Hawaii is very concentrated, with two carriers -- Hawaii Medical Service Association (a Blue Cross plan) and Kaiser Permenente – insuring the majority of the population. With mandated coverage and a concentrated market, one might expect that health care costs in Hawaii to be very high; however, according to the Milliman *Health Cost Guidelines*, the average health cost for a comprehensive medical benefit in Hawaii is only 4% above the national average.

Pros and Cons

Pros and cons of the Hawaii employer mandate to provide health insurance, in light of the Statewide Health Care Insurance Task force criteria, are:

Pros:

- Basic healthcare benefits are available to anyone with a full-time job.
- Coverage is provided through commercial carriers.
- Premium rates are not higher than in other states without such mandates.
- The mandate requires no outlay of state funds.
- By providing near-universal coverage, the system is relatively seamless.
- Providers in the state have readily accepted the model.
- By forcing lives into the insurance system, insurers are assured of getting enough healthy individuals insured, thus ameliorating health care costs and making health insurance more affordable.

Cons:

- Hawaii is geographically remote and isolated, and its economy is largely based on tourism and agriculture. Manufacturing is predominantly related to the processing of

food products. Consequently, the Hawaii mandate may not translate readily into mainland states.

- There is a risk that adoption of the Hawaii model in another state could cause significant economic hardship in that state, including loss of jobs as employers move to other states without such a mandate.

- Individuals in Hawaii do not have the option of choosing to forego health insurance in favor of higher wages.

- Mandates may not be acceptable politically in other states.

- Hawaii's uninsured rate, though lowest in the nation, is only slightly better than rates in Minnesota and Wisconsin, which do not have such mandates.

- While there is not evidence of cause-and-effect, the private health insurance market in Hawaii is very concentrated and hence competition may be limited.

- A mandate is not a partnership or collaboration.

- This approach requires an ERISA preemption; would Congress grant another?

Issues to be Considered and Analysis Required

The key issues and further analysis that need to be considered in implementing an employer mandate similar to Hawaii's include:

- How would such a mandate impact a state's economy? Would employers leave the state in favor of states without such a mandate?

- The model depends on a healthy, functioning private health insurance market. Could such a mandate be adopted in other states without causing significant disruptions in the marketplace? What sort of regulatory structure would be required – would premium rate regulation need to be much more strict?

Small Group Reform Mandates

Overview and Summary

The NAIC model small group reform laws do not permit an insurer from excluding specific employees or their dependents from an employer group's coverage, provided that the employee is eligible under the employer's program. Insurers are also forbidden from encouraging employers to make specific employees or dependents ineligible. HIPAA's requirement applies to employers: they are forbidden from discriminating against employees in poor health in their health insurance program.

Pros and Cons

Pros and cons of the mandate to include all otherwise eligible employees in an employer-sponsored health insurance program, in light of the Statewide Health Care Insurance Task force criteria, are:

Pros:

- The mandate makes basic benefits available to all employees and dependents regardless of health status.

- It improves the seamlessness of employer-sponsored insurance by removing the potential that employees or dependents might lose their coverage if they become ill.

- The mandate does not require an outlay of state funds.

Cons:

- The requirement may cause health insurance premiums to be higher than they would otherwise.

V. CONCLUSION

Despite nearly 15 years of unprecedented economic growth, the availability and affordability of health insurance remains a substantial problem in the United States. Upwards of 43 million Americans remain uninsured.

States have become something of a 'laboratory' in finding what works, and what doesn't work, in combating the uninsured problem. There have been successes (e.g., SCHIP, premium-sharing) and failures (e.g., individual health insurance market reform).

This report has presented a summary of they myriad of programs and initiatives the various states have implemented to decrease the number of individuals without health insurance. We have also outlined the pros and cons of each approach and highlighted areas that may warrant further study and analysis.