



issue brief

Limited-Benefit Policies: Public and Private-Sector Experiences

by Isabel Friedenzohn

Policymakers' interest in limited-benefit policies has resurfaced, as both health insurance premiums and the number of uninsured have continued to rise. These "bare bones" plans reduce premiums by decreasing the number of covered services in comprehensive health benefits plans or raising deductibles and other consumer costs for covered services.

The value of limited-benefit plans as a strategy to reduce the number of uninsured is a matter of debate, much of which hinges on the impact on the insurance market. Specifically, will these plans create a new coverage alternative for uninsured individuals or simply crowd-out those who previously had comprehensive health insurance?¹ The Commonwealth Fund concluded that the loss of certain benefits or substantial increases in deductibles represent both health and financial risks for consumers.² Nonetheless, interest in these plans remain.

At least 11 states have considered or enacted legislation allowing insurance carriers to sell limited-benefit plans to small groups. (See Figure 1 on p. 4.) To date, these products have not sold well, although, they have been on the market only a short time. Low-income individuals may be more willing to enroll in these policies through public programs: Several states, including Maryland, Pennsylvania, and Utah, have enrolled thousands of individuals into reduced-benefits plans, in some cases hitting their enrollment caps.

Some contend that any cost savings from these plans are illusory because policyholders trading down to bare-bones policies translate into increased uncompensated care for providers. And those who were uninsured may continue to turn to safety-net providers for care that is uninsured or falls

below a high deductible. Furthermore, beyond the essential questions pertaining to access and affordability is the underlying issue of whether people will enroll in such programs.

Background

For more than three decades, states have mandated that private carriers cover certain benefits or the services of specific types of providers. While mandated services vary from state to state, the most common are mammography and diabetes supplies. A 2003 GAO report found that seven states each had 30 or more benefit mandates, while five states each had fewer than 10.³ Most large employers already offer coverage that includes most mandates. Likewise, many, if not most, offer ERISA plans, and therefore are not subject to state-level mandates.⁴ Thus, state mandates principally affect the small group and individual markets—which states have increasingly targeted in their strategies to make health insurance more affordable. To encourage small employers to offer coverage, and individuals to take it up, many states have enacted legislation allowing insurers to offer plans with no or only some state-mandated benefits.⁵

The low demand for limited benefits to date in states that have authorized these plans exposes an important disconnect: Many



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employers believe that benefit exclusions are an acceptable way to achieve affordable health insurance coverage, but most would not want such limited coverage for themselves. In addition, when asked to specify the services they would want covered in a basic plan, employers produced lists that looked very similar, if not identical, to the comprehensive plans that they say they cannot afford.⁶

States are also exploring offering limited benefits in their Medicaid programs, as well as other state-only programs, as a way to expand coverage in tight budgetary times. These benefits are intended to provide temporary coverage for low-income beneficiaries, particularly childless adults and parents, until they can afford private insurance.

Private Market Experiences

At least three states—Maryland, Texas, and Washington—have passed minimum benefit legislation in 2004. However, in states where insurers have filed and begun to sell scaled-back benefit products, take-up rates have been remarkably low.

Arkansas

In 2001, Arkansas passed legislation allowing carriers to offer mandate-free policies. To date, at least two carriers have filed to sell such policies, but no information on the number of enrollees in these plans is available. According to Jim Bailey, regional executive for Arkansas Blue Cross Blue Shield, one of the carriers offering a mandate-free plan, the plan costs approximately 4 to 9 percent less than the usual package. However, “it does not create enough of an incentive for employers to change the plan they offer to employees, and is not cheap enough for those not offering any coverage currently,” says Bailey. Research findings by the Texas Department of Insurance reached the same conclusion about the financial impact of mandates on the cost of health insurance.⁷

Florida

Florida is hoping to take advantage of county resources to offer its Health Flex plan, a limited benefit program.⁸ The Health Flex program was established in 2002 to encourage development of “alternative approaches to traditional health insurance, emphasizing coverage for basic and preventive health care services.” Sponsors of Health Flex plans are not subject to include mandated health care benefits.⁹

As of June 2004, the state has approved four Health Flex plan applications. Of those, three are private organizations—a physician group and two licensed HMOs based in Dade and Broward counties—which do not receive any public money to fund the program. Enrollment in the Dade and Broward county programs began in May and September 2003, respectively, enrolling just 146 members—far below expectations. The most recent approved HMO plan (May 2004), the Jackson Memorial Hospital Plan, is planning to transfer all the enrollees currently in TrustCare, an indigent health benefit program, into their Health Flex plan.

The president of American Care, Inc., the physician group serving the Miami-Dade County program, attributed the low enrollment to a lack of awareness of the program at the community and state levels, particularly among state agencies that coordinate services for the uninsured. However, according to Elfie Stamm in the Florida Bureau of Managed Care, the Bureau had forwarded extensive information to a local Medicaid office. In fact, in the first few months following the roll-out, the Health Flex Web site had more than 100,000 hits.

The biggest challenge faced by Health Flex plans is obtaining enrollment. The plans have found that the population targeted for the program also has access to safety-net programs in the state, with which they have had to compete. In fact, new research funded by the Changes in Health Care Financing and Organization (HCFO) program has found that some safety-net programs may crowd-out other coverage options, particularly for unmarried, childless adults.¹⁰

The JaxCare, Inc. Health Flex plan, based in Duval County, has significant community and local government financial support. It is targeted primarily to small businesses. Developed through a Robert Wood Johnson Foundation grant, JaxCare is funded by the city of Jacksonville, grants, corporate donations, hospital contributions, and employee and employer contributions. JaxCare, Inc., offers a more comprehensive benefit package than the other two Health Flex plans in operation. Only the outpatient component is an approved Health Flex plan. Similar to Utah’s PCN, inpatient care is offered to Health Flex members under an agreement between local hospitals and JaxCare.

Enrollment for JaxCare began in January 2004. The program has enrolled just 15 people from four small businesses to date. However, JaxCare has been working with Blue Cross Blue Shield to identify 16 larger businesses with potential enrollees.

The Florida Agency for Health Care Administration and the Florida Office of Regulation jointly submitted to Governor Bush in January 2004 a report indicating that it was premature to assess the effectiveness of the program. Florida passed legislation to extend the Health Flex program until July 2008, with the expectation that state interest in it will increase and carriers will gain more experience with it.

Minnesota

In 1999, Minnesota passed legislation to develop an alternative benefit plan pilot project for small employers, and created three new stripped-down, small employer plans. Two health carriers filed with the state but later rescinded, stating that the cost difference between the alternative plan and a comprehensive plan was not significant. According to John Gross, director of health care policy for the Minnesota Department of Commerce, the companies felt that small employers wanted comprehensive coverage for themselves and their families and therefore agents would hesitate to market plans that excluded many benefits. Because most people are accustomed to comprehensive benefits, agents feared that consumers would fail to understand that the lower premiums translated to fewer covered services.

Finally, the state found that health carriers marketing to small employers in the state also were not interested because all small-group coverage had become guaranteed issue, as required by the Health Insurance Portability and Accountability Act. Consequently, these plans could encourage adverse selection: Employers that purchased reduced benefit plans could obtain more comprehensive coverage only as they needed it—a behavior that could force up premiums and ultimately ruin the market for more comprehensive products.

Montana

With less than a year’s experience on the market, only one carrier, New West Health Services, has tested Montana’s limited coverage individual health benefit plan. The state legislature passed a

statute in 2003 allowing plans to offer a limited coverage individual health benefit plan via a renewable 12-month demonstration project for a maximum of five years. New West's Bridge Plan has an enrollment cap of 1,000, and has no deductible or restrictions for pre-existing conditions. Members have a co-payment and deductible based on household income. The plan provides unlimited office-based care, lab and x-ray services, generic prescription medications, and outpatient therapies including mental health visits.

The state received more than 400 requests for applications, but has enrolled only 53 people. "After individuals reviewed the plan, they realized that the package didn't cover enough to be of value to them," says Colleen Senterfitt, director of health care access at New West.

Based on state legislation, carriers could only sell the plan in the individual market, as legislators feared that, if it were available more broadly, employers would drop their existing coverage in favor of the lower-cost, limited coverage plan. After discussing the issue with small employers, Senterfitt suspects that enrollment might have been much higher had employers not previously offering coverage been allowed to participate.

New Jersey

In March 2004, the New Jersey Individual Health Coverage (IHC) and the Small Employer Health Benefits Program (SEH) Boards submitted a report to the New Jersey governor and legislature to evaluate the effectiveness of limited benefit legislation, referred to as the "Basic and Essential Health Care Services Plan" or the "B&E Plan." Based on six months of data on the IHC program, the evaluation concluded that the B&E plan was modestly effective in increasing enrollment and reducing the number of uninsured in the state.¹¹

B&E's enrollment of 503 people was covered by primarily two carriers. The report observed that younger enrollees benefited most from B&E. However, the plan was not financially attractive to them because of the benefit design; rather, it was appealing because carriers were using modified community rating to set premiums—which favors younger, healthier individuals. All other products available in New Jersey's market are pure community-rated.

According to Wardell Sanders, executive director of the IHC and SEH boards, carriers were generally reluctant to sell these plans due to the potential for consumer confusion. Brokers were afraid that they could face lawsuits if consumers needed a benefit that was found in New Jersey's standardized health benefits plan, but not covered in B&E.

North Dakota

In 2001, North Dakota passed legislation allowing insurers to sell plans with fewer mandates in the individual and group markets. The state's largest carrier, Blue Cross Blue Shield (BCBS) of North Dakota, has chosen not to sell the product, believing that optional benefits such as prescription drugs, mental health services, and alcohol/chemical dependency benefits, would encourage adverse selection. In other words, only the individuals needing those services would buy the optional coverage, leading to financial losses and spiraling premiums.

"Consumers simply do not want products with limited benefits, especially those that don't offer prescription drug coverage," says Rod St. Aubyn, director of government relations for BCBS of North Dakota.

Utah

Utah's experience is unique because the state's passage of their minimum benefit legislation dove-tailed with the creation of the Primary Care Network (PCN), a first-of-its-kind Medicaid waiver program offering primary and preventive care services to parents and childless adults. The legislation, which passed in 2002, allowed insurance carriers to offer uninsured small employers and individuals the same limited-benefit plan that the waiver created. (PCN benefits are described more on p. 5.)

In designing the limited-benefit approach, state officials had hoped that it could provide a stepping stone to employers who had not offered coverage in the past. They were also optimistic that the availability of this package in the private market would stimulate the insurance industry to offer a wider range of choices to employers, such as a catastrophic benefit to supplement the package. To date, however, no insurance companies have filed to sell the primary care package.

According to Suzette Green Wright, director of the Utah Department of Insurance, insurers had no interest in competing with the public PCN plan. The PCN relies on hospitals to donate inpatient and specialty care; private carriers could not request hospitals to do the same for their enrollees.

Public Program Experiences

Traditionally, states' experiences with designing benefits packages have fallen on either end of a spectrum of covered services: They have offered packages that are either very rich or very targeted. Medicaid and State Children's Health Insurance Programs tend to be comprehensive compared to private-market plans; federal regulation sets standards for the services that states must provide, and in general presume that even modest cost sharing would pose a barrier to seeking care and further erode beneficiaries' access to providers by generating bad debt.

These concerns have driven the majority of state Medicaid programs also to cover many services that are considered "optional" under federal standards. However, other state safety-net programs may offer focused coverage on specific types of services (e.g., dental care or mental health services) that may be absent or limited even in private insurance coverage.

Recently, some states have started to develop streamlined coverage packages that fall in the middle of the benefits spectrum. (See Figure 2 on p. 4.) In some cases, these programs have been conceived as temporary programs that are designed to provide some protection until beneficiaries are in a better position to access more complete coverage. These packages work particularly well for childless adults and parents, who often earn too much to be eligible for public programs, but not enough to afford private insurance.

Maryland

Maryland offers a primary care program for chronically ill adults who are not eligible for Medicaid, are below 116 percent of the federal poverty level (FPL), and are enrolled in the state's pharmacy assistance program. Called Maryland PrimaryCare, the program provides basic physician and clinic services through a network of clinics. In recent years, enrollment in the program has been capped at 8,000 individuals. However, the state intends to expand primary care coverage to an additional 25,000 individuals under an amendment to its existing 1115 waiver.

Figure 1: Minimum Benefit Legislation

State	Eligible Populations	Carriers Selling?	Enrollees	Key Points of Legislation
Arkansas <i>The Health Insurance Consumer Choice Act</i> (2001)	Individual and small group markets <100	Yes	Data not available; no HIPGs established.	Consumers must state in writing that they are aware of their rejection of a full coverage plan (modified in 2003). Also allows employers with up to 100 workers to join a health insurance purchasing group (HIPG).
Colorado HB 1164 (2003)	Small groups (businesses with 2–50 employees)	Yes	No enrollment data available until 3/05	Allows small employers to purchase “basic health benefit plans,” which do not cover some state-mandated services.
Florida SB 46E (2002)	64 years; < 200 % FPL, uninsured for last 6 months; not eligible for public coverage, lives in county specified by agency.	Yes	146 (as of 1/04)	Made available “health flex plan” to be sold by insurers, HMOs, PSOs, and public or private community-based organizations. Plan can limit/exclude benefits required by law, cap the total amount of claims paid per year, limit enrollment, or take any combination of these actions. Plans are free from all statutorily required health care benefit mandates.
Maryland SB 570 (2004)	Small group market (small employers whose employees earn 75% of average annual wage in state, and employers that have not offered the standard plan for past year)	Not yet as new legislation	n/a	Legislation requires carriers who insure 10% of covered lives in the small group market to offer the limited plan. Other carriers may offer it if they choose. The actuarial value of the limited plan cannot exceed 70% of the actuarial value of the comprehensive standard health benefit plan.
Minnesota SF 84 (1999)	Small groups	No	n/a	Benefit plans may alter or eliminate coverage that is required by law, other than the requirement that care provided for covered services such as osteopaths, optometrists, and chiropractors be reimbursed on a nondiscriminatory basis.
Montana HB 384 (2003)	Individual market (As long as insurers indicate which services are limited or not covered, they may provide these plans to residents who have remained uninsured for >90 days.)	Yes	53	Inpatient services are not covered in these plans. Insurers may also limit coverage for newborns, severe mental illness, emergency services, certain basic health services, and services provided by a certain category of licensed health care practitioners. Demonstrations may be renewed for additional 12-month periods for up to five years, effective until 2009.
New Jersey SB 13 (2002)	Individual and small group	Yes	503	Every carrier that writes individual health benefits plans shall offer a plan in the individual market that includes only certain benefits.
North Dakota HB 1226 (2001)	Individual and small group	No	n/a	Allows insurers to sell plans without any or all of the state mandates.
Texas SB 10 (2004)	Individual and small group	Yes	Unknown	Legislation requires: 1) that carriers offer at least one plan offering all the mandated benefits required by law, 2) that insurers disseminate written disclosures listing the mandated benefits absent from the health plan.
Utah HB 122 (2002)	Individual and small group	No	n/a	Permits an insurance carrier to offer coverage similar to what is offered under the states’ 1115 Medicaid waiver (Utah Primary Care Network).
Washington HB 2460 (2004)	Small group	Not yet as new legislation	n/a	Allows the purchase of a “value plan.” The bill removes single-person “groups,” lowers costs of claims, streamlines some administrative costs, protects portability of policies, and implements new rating factors for health insurance plans.

Pennsylvania

Pennsylvania’s adultBasic was started in 2002 in collaboration with the state’s Blues plans. Subsidized with the 30 percent of the annual receipts from the state’s tobacco settlement funds, the program offers basic health insurance coverage for adults aged 19 to 64 who have family incomes below 200 percent FPL. The benefits are less than those typically provided under Medicaid; however, they include inpatient care, unlike some other scaled-back programs. The adultBasic program requires a monthly premium of \$30 and imposes modest co-pays for some benefits. As of May 2004, average monthly enrollment was approximately 40,000 individuals and the waiting list exceeds 90,000. According to Deputy Commissioner Patricia Stromberg, such an overwhelming response sends a clear message regarding the need for such a program.

Utah

In March 2002, Utah received a Medicaid 1115 waiver to implement its Primary Care Network (PCN), which provides primary care and preventive services to low-income adults who would otherwise lack health insurance. The intent of the PCN was to establish a framework for providing preventive care to people in the safety net system and to address gaps in their access to specialty care. It covers services similar to those provided at community and rural health centers. The program does not cover inpatient care, but beneficiaries can use hospital and specialty care donated to the program. PCN began accepting applications in July 2002, and has hit its enrollment cap of 19,000 people.

Early evaluation results from January 2004 suggest that the program is hitting its objectives. In a disenrollment survey, 51 percent of

respondents indicated that they did not re-enroll because they no longer met the program’s eligibility criteria (e.g., their income was too high, or they had other coverage available).

In another evaluation, 60 percent of members who reenrolled reported improvement in one or more health indicators, but no significant changes in health status. Respondents also indicated that obtaining specialty care was still a problem. As more data become available, the state will be better able to determine the program’s impacts. Arkansas, New Mexico, and Maine are also pursuing expansions of eligibility for public benefits that are scaled back relative to Medicaid.

Conclusion

Experimentation in designing coverage products to reach uninsured individuals and small businesses is not a new phenomenon.

(continued on p. 6)


Figure 2: Public Program Benefits

State/Program	Eligibility	Benefits	Premiums & Cost Sharing
Maryland PrimaryCare	<ul style="list-style-type: none"> ◆ Are between the ages of 19 and 64 ◆ Have a valid Maryland Pharmacy Assistance Program (MPAP) card ◆ Have a diagnosed chronic medical condition that can be treated in a doctor’s office ◆ Have no other access to medical care through private health insurance, Workers Compensation, Medicare or Medical Assistance, or Veterans’ benefits 	<ul style="list-style-type: none"> ◆ Annual physical examination ◆ Office visits for sick and well care ◆ Limited laboratory tests, including blood tests on an annual basis ◆ Basic x-rays (does not include CT scans, MRIs, or other special x-rays) ◆ Screening for and referral to alcohol and drug addiction treatment as prescribed by physician ◆ Diabetes treatment, including annual foot and eye exam ◆ Maintenance drugs and anti-infectives under MPAP 	None
Pennsylvania adultBasic	<ul style="list-style-type: none"> ◆ Have no other health coverage (including Medicaid or Medicare) ◆ Lack coverage under other insurance plan for 90 days, except for a person (and spouse) who has been laid off ◆ Are between the ages of 19 and 64 ◆ Have family income below 200 percent FPL ◆ Have lived in Pennsylvania for at least 90 days prior to enrollment ◆ Have U.S. citizenship or a permanent legal alien status 	<ul style="list-style-type: none"> ◆ Hospitalization (unlimited days) ◆ Physician Services (primary care and specialists) ◆ Emergency Services ◆ Diagnostic Tests (e.g., x-rays, mammograms, and laboratory tests) ◆ Maternity care ◆ Rehabilitation and skilled care (in lieu of extended hospitalization) 	<p>Premium</p> <ul style="list-style-type: none"> ◆ \$30 monthly premium <p>Cost-sharing:</p> <ul style="list-style-type: none"> ◆ Doctor Visit - \$5 ◆ Emergency Room - \$25 (waived if admission occurs) ◆ Specialists - \$10
Utah Primary Care Network	<ul style="list-style-type: none"> ◆ Are between the ages of 19 and 64 ◆ Have not had health care coverage for six months or longer ◆ Have employer that pays less than 50 percent of health care benefit ◆ Have annual income less than 150 percent FPL 	<p>Primary care focus (with access to donated hospital and specialty care):</p> <ul style="list-style-type: none"> ◆ Primary care visits ◆ Flu immunizations ◆ Urgent care and Emergency Room ◆ Lab/x-ray ◆ Ambulance ◆ Durable Medical Equipment ◆ Basic dental ◆ Hearing tests and vision screening 	<p>\$50 annual enrollment fee</p> <p>\$5 co-pay</p>

For nearly two decades, private health plans have been involved in this area.^{12,13} Some efforts have been more effective than others; however, rarely has enrollment met expectations. Anecdotal evidence suggests that insurers are reluctant to sell bare-bones policies, and consumers are uninterested in buying them. Nevertheless, because these efforts are new, they may develop more successfully given time and greater agent and consumer familiarity with limited-benefit products.

As states also consider options for public coverage expansions, some are reconsidering the notion of offering comprehensive benefits to all populations that they might cover in their Medicaid programs. Because these products would be offered at low or no cost to beneficiaries, public programs do not face the same market challenges of “selling” a product.

Enrollment experience is only part of the information necessary to evaluate program performance. A full evaluation of limited benefits as a coverage-expansion mechanism would consider their impact on crowd-out,

whether they would result in adverse selection, their implications for the safety-net providers, and a comparison with more comprehensive policies if offered in the commercial market. 

About the Author

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Endnotes

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