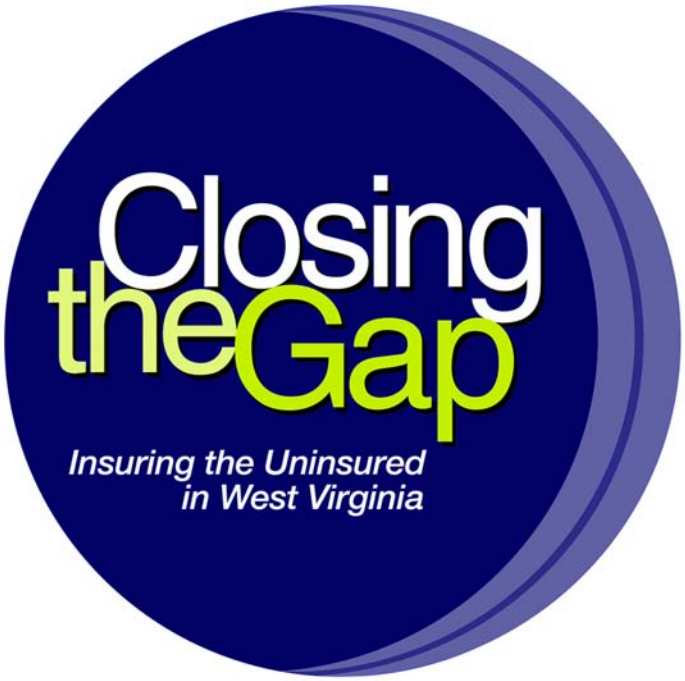

Literature Review on State Activities Related to Individual Health Insurance

Prepared by Alfreda Dempkowski
for the WV State Planning Grant
April 2003

Table of Contents

Introduction

For the last decade, state governments have undertaken a variety of activities to support increased levels of health insurance in their states. While many of these efforts have been directed at employer-sponsored insurance (ESI), attention has also focused on the individual market which includes persons not eligible for group coverage who must buy coverage on their own.

Typically, only a small proportion of persons with private insurance (about 8 percent nationally) purchase coverage in the individual market. However, large proportions of those who are uninsured appear not to have access to employer-based coverage and are part of the individual market. (See discussion below).

The individual market typically has higher premiums than employer-sponsored coverage. Administrative costs associated with insuring many persons as individuals are higher than the costs for insuring these persons collectively through a group. In addition, the individual market is more prone to adverse selection. Among persons who have to buy coverage on their own, a less healthy person is more likely to purchase coverage than one who is in good health, and this tends to drive up claim costs in this market.

Persons in the individual market include unemployed workers, students, persons working for employers who do not provide coverage, disabled persons, homemakers and dependents not eligible for a worker's ESI, and self-employed individuals, if they are not eligible to buy group coverage. Medicare beneficiaries who buy supplemental coverage on their own may also be considered part of this market.[1] The individual market thus represents a significant and disparate population with varying insurance needs.

A review of the literature was undertaken to identify activities of other state governments related to individual insurance in order to identify possible models for West Virginia as it develops its comprehensive strategy for increasing the levels of health insurance coverage in the State. The following strategies were identified and are discussed in this report:

- Full cost buy-in programs
- High-risk pools
- Tax-related incentives
- State-sponsored coverage programs
- Managed charity care
- Other approaches

Reform of the individual health insurance market is also a viable strategy for increasing health insurance levels and has been used by a number of states. Market reform measures include regulations relating to guaranteed issue, pre-existing conditions (maximum "look back" and exclusion periods) and permissible rating structures. Since the prospect for individual market reform in West Virginia was the subject of a previous in-depth analysis, market reform activities including issues surrounding "groups of one" are not included in this inventory.

Background: Individual Market in West Virginia

West Virginia residents wishing to purchase coverage on their own face two obstacles:

[1] While federal regulations do provide certain advantages to Medicare beneficiaries purchasing supplemental coverage, a Medicare beneficiary who fails to act during the federally mandated open enrollment period may find he/she has limited access to coverage that supplements Medicare.

- Medical underwriting is allowed and coverage may be denied based on health status.
- Premiums will reflect age and health status and as a result may be quite high.

Access to coverage, however, is guaranteed in two situations.

- Persons who are federally eligible for portability coverage through the Health Insurance Portability and Accountability Act (HIPAA) are guaranteed a choice of two products from each of the insurers doing business in the individual market. [2] While there is no waiting period for pre-existing conditions and coverage cannot be denied, premiums may be very high.

- West Virginia requires HMOs doing business in the individual market to offer an open enrollment period once a year. During this period, the HMO must accept the applicant regardless of health status and also charge the regular approved premium. At this time, however, only one HMO is insuring persons in the individual market and is licensed only in a handful of counties.

Persons who do not meet either of these criteria have no recourse if they are deemed medically uninsurable. A self-employed individual in West Virginia must purchase insurance through the individual market. In a number of states, a similar individual is eligible for coverage under small group regulations, which may make it easier to purchase coverage and at a more affordable price.

About 4-5 percent of the insured West Virginia population is currently covered through the individual market. At the same time, substantial proportions of uninsured adults in West Virginia are potential participants in this market. Table 1 shows the employment status of uninsured adults ages 19 through 64 and suggests the size of the population without access to group coverage.

Table 1
Uninsured Adults by Employment Status: West Virginia 2001

Employment Status	#	Uninsured Rate	% of Total Uninsured Adults
All uninsured Adults	219,258	19.9	100.0
Employed	101,955	15.9	46.5
Self-employed	32,012	35.6	14.6
Unemployed	30,696	55.9	14.0
Homemaker	29,161	25.6	13.3
Disabled	12,059	11.4	5.5
Student	8,332	17.4	3.8
Retired	5,043	10.1	2.3

Source: West Virginia Health Care Survey 2001

[2] HIPAA provides certain protections for persons transitioning from group to individual coverage. To be eligible for portability coverage through HIPAA, a person must have 18 months of continuous creditable coverage, without a significant break in coverage--a period of 63 or more days during which there was no coverage. At least the last day of coverage had to be under a group health plan. Any COBRA or state continuation coverage must be exhausted, if it is available. The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers with 20 or more workers to allow former employees, in certain situations, to purchase coverage at group rates for a temporary period. Some states have passed legislation to broaden COBRA rights.

Particularly prominent among those who must buy coverage on their own are self-employed persons and the unemployed who respectively account for 14.6 percent and 14.0 percent of uninsured adults. To the extent that employer-sponsored insurance is not available, even those who are employed may be considered individual market customers. Some homemakers, however, may not be in the individual market if they are married to an employed person who is potentially reachable through group insurance. Careful examination of the characteristics of the uninsured in the individual market is important for identifying effective strategies to increase insurance levels. Data from the West Virginia Health Care Survey 2001 are available for this endeavor.

Findings from the Literature

Full Cost Buy-Ins

Overview

In a full cost buy-in (FCBI), a person not eligible for a public program is given the opportunity to purchase coverage through the public program by paying the full premium. Typically, eligibility begins at an income level above the maximum for the public program, and there is no upper income limit. Persons otherwise ineligible for public programs (for example, certain immigrants) may also be eligible.

A FCBI can provide an insurance solution for middle to high-income persons in the individual market for example, the self-employed and workers without access to employer-sponsored insurance. It is less suitable for the unemployed who might not afford the premiums and for the retired and disabled whose health status might overburden the risk pool. A FCBI may also not be a solution for persons who are medically uninsurable because of their potential to adversely affect the risk pool. While persons in poor health who are financially needy can and do receive Medicaid, a state may not want to burden its public program with additional disabled persons.

A buy-in program can also be operated in tandem with a premium assistance program where premiums are charged on a sliding scale according to income.

Advantages

- FCBI's can make coverage more accessible and more affordable than the regular individual market. Lower premiums may result from administrative efficiencies, provider and vendor discounts, and larger risk pools that distribute costs over a wider population base. Broker and agent commissions are not involved, and insurer profit margins are eliminated. In addition, incremental costs are low when an existing administrative structure is used.

- Unless there is a subsidy for lower-income people, the program is self-financing and requires no outlay by the state. Administrative costs, if any, are low and can be built-in to the premiums.

- FCBI's may afford an opportunity for all family members to be enrolled in the same coverage. For example, if a child is eligible for the public State Children's health Insurance (SCHIP) program[3], the otherwise ineligible parent might be able to buy into SCHIP for his/her own coverage. Having all family members in the same plan may facilitate appropriate use of services.

[3] In West Virginia, the SCHIP program is known as the Children's Health Insurance Program or CHIP.

- FCBI's also provide an option for those losing public coverage to retain the same health plan when employer-based insurance is not available, thus easing the transition from public to private insurance.

Difficulties

Erosion of the Individual Market. FCBI's can undermine the functioning of the individual market if they draw insured persons away from that market. A "look back", which requires a certain period of uninsurance for eligibility, can be imposed if there is concern that the regular market will experience undesirable leakage as a result of the buy-in program. On the other hand, if there are problems in the regular market and reform is not on the agenda, a short or no "look back" period might be desirable.

*Contamination of the Risk Pool***.** If the self-paying population is in the same rating pool as the public program participants, they could adversely affect the experience of the public program, if they are less healthy. This can be avoided by isolating the FCBI members into a separate rating pool, which would then give up some of the advantages to be gained from participating in a large risk pool.

A FCBI program can protect itself against adverse selection in much the same way as the regular market does—through medical underwriting and exclusions or waiting periods for pre-existing conditions. Benefit packages can also be limited to reduce claim costs. For example, MinnesotaCare caps its inpatient benefit for adults in both the subsidized public program and the FCBI component at $10,000. This serves to discourage someone who expects to use a great deal of inpatient care from enrolling in the FCBI. While Connecticut offers a rich supplemental coverage to children in its subsidized HUSKY program, it does not make this available to the FCBI component. The FCBI program available through Washington's Basic Health Plan, on the other hand, offered very rich coverage relative to the commercial market--maternity, mental health and prescription drugs--and experienced high utilization.

In addition, cost sharing can be set at levels similar to commercial insurance rather than the low limits allowed by SCHIP and Medicaid. This can also deter adverse selection.

Programs in Other States

Four states—Connecticut, Florida, New York and North Carolina--offer a full cost buy-in for children with family incomes above the limits for their SCHIP programs. Except for North Carolina, these full cost buy-ins had been attached to a state-sponsored children's insurance program before the advent of SCHIP. While a FCBI limited to children does not provide a solution for uninsured parents or childless adults, it can be helpful in situations where only the working parent gets employer-sponsored coverage or where the family income is simply inadequate to pay for coverage for everyone.

Limiting coverage to children has the advantage of not requiring changes to the benefit package or a re-rating of the benefit package for another demographic group. Since insurers do not typically offer products only for children, a children's FCBI has less impact on the regular market.

In New York, the self-paying children are in the same risk pool as the subsidized children and receive the same benefits with the same cost-sharing structure. They pay the same premium that the health plans charge the State for the subsidized children. Self-pay children comprise about 2 percent of the total participants. Despite the fact that there is no "look back"—the only requirement is that the child be uninsured—the state has not experienced any significant "crowd out"; that is, the situation where families substitute the FCBI for commercial insurance.

Minnesota and Washington had offered FCBI's to both adults and children, but these programs have been discontinued. The Washington program experienced very high utilization from persons who enrolled for

short periods of time to take advantage of the maternity and inpatient benefits. Washington also experienced an influx of persons from its high-risk pool into the FCBI. (High-risk pools are discussed below). The premium for the FCBI was originally capped at 105 percent of the public program; however, the cap was removed when the insurers began experiencing losses. Minnesota's program was closed in 1998 due to "crowd out" concerns and the lack of support from insurers. Minnesota subsequently applied for an 1115 waiver which would allow families to buy-into Medicaid and SCHIP.

Except for Washington where 20 percent of the enrollment was paying full premium, FCBI enrollment is typically less than 3 percent of total program enrollment. Most programs are small (well under 10,000). Most, but not all, of the FCBI's are attached to programs that utilize managed care plans as carriers.

Rhode Island operates a limited buy-in program targeted at home-based child care providers and their children. This group is eligible to buy into RIte Care, the state Medicaid program. Enrollment was 300 at the start of 2002. Delaware is reportedly considering allowing low-income workers to buy into the state employees plan at below the full premium cost, which would in effect combine the buy-in concept with a premium assistance program. As envisioned, low-income workers would have the same benefits and same choice of plans as state employees. Financing would be through an increased appropriation to the state employees' plan.

The State Planning Grant (SPG) projects in several states included a FCBI in their recommendations. Texas did considerable actuarial work and recommended that parents be permitted to buy into SCHIP. Other states recommending buy-ins to public programs included South Dakota and Vermont. Table 2 below provides highlights of selected FCBI programs.

Considerations and Conclusions

FCBI's offer states a low-cost solution for delivering coverage to uninsured persons who can afford to pay full premium. The programs appear to be especially attractive for reaching uninsured children in families that do not receive dependent coverage from an employer or that cannot afford coverage for the entire family. While attractive from a cost point of view, at least the following issues need to be considered before a state undertakes such a program:

- *Availability of individual coverage in the regular market*
- *Cost of comparable benefits in that market*
- *Financial impact on the state of offering a buy-in*
- *Intended target population (s)—children, parents, childless adults*
- *Financial impact on the target population*
- *Likelihood of participation and estimated number of participants*
- *Anticipated impact on the regular market*
- *Need for a "look back" period*
- *Role for agents and brokers, if any*
- *Delivery system options*
- *Administrative and legal issues involved in the use of a managed care delivery system (for example, the applicability of the existing contracts)*
- *Need for changes in the benefit package and cost-sharing structure (for affordability, to avoid high utilization and/or to make it more appropriate for the target population)*
- *Cost of revised benefit package based on expected utilization by the target groups*
- *Need for separate rating pool*

Sources for Full Cost Buy-Ins including Table 2: Birnbaum 2001, Hart 2002, Hawaii Uninsured Project 2002, and State Coverage Initiatives Undated A.

Table 2

Full Cost Buy-Ins: Selected Programs

State	Program Name	Start Date	Eligible Population	Public Program	Starting Income	Peak FCBI Enrollment (as of 2001)
Connecticut	HUSKY	1998	Children	SCHIP; originally state only	300% FPL	200 3% of program total
Florida	Kid Care (AKA Healthy Kids)	1992	Children 5+,	SCHIP; originally state only	200% FPL	5000 3% of program total
Minnesota	MinnesotaCare	1992 (repealed in 1998)	Adults and children	Medicaid (1115 waiver)	275% for children and parents; 175% for other adults	1000 2% of program total
New York	Child Health Plus	1991	Children	SCHIP; originally state only	250% FPL	9000 2% of program total
North Carolina	NC Health Choice for Children	1998	Previously enrolled children whose economic circumstances improve.		200% FPL	FCBI enrollment data not available. One-year enrollment limit.
Tennessee	TennCare	1993	Adults and children	Medicaid and SCHIP	over 400% FPL	FCBI enrollment data not available.
Washington	Basic Health Plan	1996 (discontinued in 2000)	Adults and children	State only	200% FPL	25000 20% of program total

High-risk Pools

Overview

High-risk pools are vehicles used by many states to make heath insurance available to persons who would otherwise be uninsurable. Despite an interest in buying coverage, many persons in the individual market are denied insurance because of their health status. Although some of these persons may be offered coverage in the regular market, it may be at an exorbitant price or the coverage may be limited. Thus a risk pool serves as a safety net for people who cannot be served in the regular market. Without a high-risk pool, these persons would remain part of the uninsured population.

Some states also use risk pools to provide access for persons eligible for portability coverage through HIPAA. A few states open their pools to Medicare beneficiaries in need of supplemental coverage.

Since its main purpose is to provide insurance to persons who would otherwise be uninsurable, the risk pool contains a concentration of high-risk individuals who, in the aggregate, are expected to have high claim costs. As a result, risk pools charge premiums above regular market rates. Even so, premiums cover only about 50 percent of the costs of the high-risk pool, and the State needs to provide financing to cover the shortfall.

States typically operate risk pools as non-profit associations under the oversight of a board of directors composed of consumers, the insurance industry and medical professionals. The board engages a health insurer or third party administrator (TPA) to operate the program.

Advantages

- The main advantage of a high-risk pool is that it makes coverage accessible to someone who could otherwise not qualify for coverage.
- Because the extremely high-risks are isolated, states with high-risk pools tend to have healthier individual markets with lower rates and more competition among insurers.
- Certain states, those that did not have a high-risk pool as of August 6, 2002, are eligible to apply to the federal government for up to $1 million dollars toward the cost of development and initial operation of a risk pool. In announcing this initiative, the Secretary of the Department of Health and Human Services remarked, "These pools have proven to be an effective mechanism to provide comprehensive coverage to individuals who are unable to get health insurance in the private market because of poor health." The program is authorized by the Trade Adjustment Assistance Reform Act of 2002 ("Trade Act"), which, among other things, sought to assist workers displaced by trade with health insurance coverage. The high-risk pools are, however, not limited to these workers but must be open to all HIPAA eligibles.

Difficulties

High Premiums. Since coverage is typically expensive, a high-risk pool is not a solution for someone with a low-income unless there is also a subsidy. Recognizing this, six states provide subsidies for lower-income persons enrolling in their high-risk pools. The subsidies take the form of premium and/or deductible discounts; however, the remaining cost is usually still high for someone with a limited income.

*Financing***.** Because the insured population is at higher risk, pool premiums are 125-200 percent higher than those for comparable products in the regular market. Nonetheless, the risk level of the pool inevitably results in claim costs in excess of premiums, and a state sponsoring a pool must arrange for supplemental financing. On average, premiums cover about half of the cost, but this varies by state.

To avoid waiting lists and possible closure of the pool, supplemental funding must be stable and reliable. Certain sources, for example, state general revenues require annual appropriation as part of the budget process and may be less desirable. In financing the uncovered costs, states would ideally like to distribute the burden as widely as possible through society. They are somewhat limited in this effort, however, since they cannot directly assess self-insured employers who are protected from state regulation by the Employee Retirement Income Security Act (ERISA). If a state, for example, assesses insurers to support the pool, the burden falls disproportionately on the insurers and employers in the commercial market while the self-insured market is exempt. Some states allow insurers to take the assessments as an offset against taxes, in effect transferring the financial burden back to the state. One state caps the aggregate credit amount and several states allow only partial offsets.

Some states have devised mechanisms to spread the costs more broadly. These include hospital/provider surcharges, which affect both insured and self-insured plans and assessments on organizations that do business with self-insured plans including reinsurers and TPAs. Other financing sources include state general revenues and such special assessments as tobacco and alcohol taxes.

Limited Impact on Health Insurance Levels. A major drawback of a risk pool is its limited enrollment potential. While several states have large pools, most pools are quite small and enroll fewer than 5,000 persons with many having enrollments under 2,000. Risk pool enrollment typically represents only a small proportion of the individual market enrollment in the State.

Relationship to Wider Individual Market. High-risk pools appear to work best in tandem with a regulated insurance environment. In addition to a high-risk pool, a state can utilize market reform strategies to make health insurance available and affordable to its citizens. For example, guaranteed issue and open enrollment requirements may be used to assure accessibility for those with health problems. To increase affordability, a state may impose rating restrictions limiting the allowable variance for health or other rating factors.

The issue of what can be accomplished through a risk pool appears to be closely tied to the level of reform in the individual market. If the market is unregulated, insurers may dump all questionable risks in the pool and costs for the risk pool will quickly exceed available financing. At the same time, extreme market reform can backfire. For example, guaranteed issue requirements in Kentucky and Washington led all insurers to quit the market. Now both states are again allowing underwriting in the individual market and are relying on risk pools to assure availability of coverage.

The solution thus seems to be a delicate balance between market regulation and a risk pool for those not served by the market. Utah and Washington have been identified as states that exemplify this dual approach. Both use standardized underwriting criteria for eligibility for their risk pools. When a person is deemed too low a risk for the pool, the regular insurers are obliged to accept him/her. Even when there are guaranteed issue laws that are working, a high-risk pool can be used to isolate the highest risks, providing rate relief to the individual market and spreading costs more broadly through society. A pool can thus help stabilize the individual market.

Programs in Other States

Thirty states have high-risk pools. Two of these pools--Minnesota and Connecticut--have been operating since the mid-seventies. (The Idaho and Maryland pools began recently and are not reflected in the profile presented here). Nationwide, risk pools insure more than 153,000 individuals. Most pools, however, are quite small and enrollment represents only a small fraction of the individual market enrollment. Only

California and Minnesota have membership in excess of 20,000. While risk pool enrollment in Minnesota accounts for 6 percent of the individual market, in most states it represents less than 2 percent of individual market enrollment.

All states except Alabama use their pools for persons who are medically uninsurable. In 23 states, the pools provide HIPAA portability coverage, with Alabama using its pool exclusively for this purpose. Nine states open their pools to Medicare enrollees.

Connecticut, Colorado, New Mexico, Oregon, Washington and Wisconsin provide subsidies to lower-income persons joining their pools. Wisconsin uses four categories of deductible and premium subsidies for persons with incomes under $20,000. Persons with incomes between $20,000 and$25,000 receive a subsidy for the premium only. About 35 percent of Wisconsin enrollees are subsidized.

Most of the states finance their pools through assessments on carriers. Of these, about half allow the carriers to offset the assessments against taxes. About one-quarter of the states use state general revenues or special dedications from state funds. A few assess reinsurers, TPAs and/or impose provider and hospital surcharges.

Usually, a fee for service indemnity product is offered, although some pools utilize PPO's and a few, HMO's. Although there is the expectation that utilization will be high, a high-risk pool still needs to manage risk if it is going to survive on the available financing. As a result, the products available through high-risk pools typically have high deductibles, substantial cost sharing, annual and lifetime benefit limits, and waiting periods or even exclusions for pre-existing conditions.

About half of the risk pools use a lifetime benefit maximum of $1,000,000, while one pool has a lifetime maximum of $350,000 and two have no maximum. The typical deductible is $1,000 although it can be higher. There is also a wide range of out-of-pockets maximums starting at a low of $2,000 and going to "no maximum". To protect the pool from persons who would buy coverage only when they expect to use it, most pools use a waiting period of 6-months for pre-existing conditions, although some states extend the waiting period to one year. Coverage for mental health and maternity tends to be limited.

Many persons who join high-risk pools are not high service utilizers. In a study of 8 pools, 5 percent of the enrollment accounted for 64-90 percent of claims. In some states, pools are heavily used by persons ages 50 through 64. In Minnesota, 20 percent of enrollees are between 60 and 65.

Highlights of selected pools are presented in Table 3 below. High-risk pools have been a focus of State Planning Grant projects. Texas considered introducing subsidies for low-income individuals to its risk pool. They also explored the potential for improving the risk level by reducing rates for dependents not at high-risk, who now make up 10 percent of the enrollment. They also considered streamlining the benefit package to reduce premiums. The project in Washington recommended expansion of the state's risk pool.

Considerations and Conclusions

There are two options available to persons with health problems in WV who wish to buy insurance in the individual market:

> *Limited Open Enrollment.* They can buy coverage during the limited open enrollment period required for HMO's doing business in the individual market. At this time, there is only one such HMO and it is doing business only in limited counties. Thus this option is available only to a very limited population. It is also only available during a restricted time period. The cost for this insurance is over $400 a month for individual coverage.

Portability through HIPAA. Persons who have exhausted COBRA can invoke HIPAA portability rights and buy coverage from a carrier doing business in the individual market. WV requires these carriers to offer these persons a choice of two products with no medical underwriting and no waiting period for pre-existing conditions. These policies, however, are very expensive since there are no rating restrictions. It is also likely that the numbers that exhaust COBRA benefits are very small since most unemployed persons cannot afford COBRA premiums.

Anyone else with a health problem in West Virginia who is denied coverage has no recourse in the regular individual market. A high-risk pool might be an appropriate vehicle for insuring this group. However, it is unlikely that a risk pool could be undertaken successfully in the absence of some market reform.

West Virginia, since it did not have a high-risk pool as of August 2002, is eligible to apply for development funds through HHS. The issue is whether it would be worthwhile to undertake the development and operational effort for a risk pool that would probably not be very large. The major problem for WV, once federal start up funds are exhausted, would be to ensure ongoing financing.

Data from the West Virginia Health Care Survey 2001 indicate some 62,000 persons under age 65 are purchasing coverage directly. Based on the experience in other states, this suggests that the risk pool population in West Virginia would be 1,000-1,500 or 2 percent of the individual market enrollment. While this is low, it matches the participation level in many other state risk pools. In addition, the Trade Act does require that risk pools receiving federal support accept HIPAA-eligible persons, thus there is the potential for higher enrollment from the members of this group. The pool could also be opened to Medicare beneficiaries in need of supplemental coverage. Moreover, West Virginia does have a significant early retiree population ages 50 through 64 with an uninsured rate of 13.5 percent or about 25,000 uninsured persons. A risk pool might be a mechanism for delivering insurance to this population who are more likely to be denied coverage for medical conditions and/or find that age-rated coverage is simply too expensive. Thus while a high-risk pool may cover only a modest proportion of the uninsured population, it might be the answer for those segments of the individual market for whom there is no other solution.

At least the following issues should be considered in evaluating the prospects for a high-risk pool in West Virginia:

- *What proportion of the individual market would be denied coverage for health reasons and thus be candidates for a high-risk pool? What numbers are involved*?
- *How many of these persons could afford and would pay the premium? How many would need a subsidy?*
- *Is a high-risk pool the best approach to meeting the insurance needs of this population or might this be done better through a different strategy?*
- *What kind of market reforms would be needed to ensure the success of the risk pool?*
- *Would market reform strategies alone be more effective in making insurance more accessible to this segment of the uninsured population?*
- *What would be the cost of a pool after premiums and what are potential funding sources?*

Sources for High-Risk Pools including Table 3: Abbe 2001, Achman and Chollet 2001, Butler 2000, Chollet 2002, Centers for Medicare and Medicaid Services 2002, Communicating for Agriculture Undated, National Association of Health Underwriters 2001A, National Association of Health Underwriters Undated B, State Coverage Initiatives 2001, State Coverage Initiatives Undated B, Stearns et al. 1997, Texas DOI 2001 and Wisconsin Division of Health Care Financing.

Table 3

High-Risk Pools: Selected Programs

State/Program	Eligible Populations	Enrollment	Premium Cap (as % of Comparable Plan)	Subsidies to Low-Income Individuals	Financing
California Major Medical Insurance Program	• Medically uninsurable	• 21,000 (as of 2000) • 1% of individual market but one of the largest enrollments in country. • Closed to new members. Waiting list of about 6,000. (Blue Cross offers similar, non-subsidized product to waiting list.)	125% of the "standard average individual rate" unless a plan exceeding the average cost is selected, then premiums are 137.5%.	None	State funds from cigarette and tobacco tax ($41M per year)
Connecticut Health Reinsurance Association	• Medically uninsurable • HIPAA eligible • Any uninsured person ages 19-64	• 1,726 (as of 1999) • 1.1% of individual market.	125% at initial enrollment; 150% maximum	Yes, Special Health Care Plan. Reduces premium and deductible for persons under 200% FPL. Providers must accept discounted payments as payment in full.	Insurers assessed for losses based on share of health insurance direct claims volume in state.
Minnesota Comprehensive Health Association (MCHA)	• Medically uninsurable • HIPAA eligible • Medicare beneficiary • Persons ages 65+ not eligible for Medicare	• 26,000 (as of 2001) • 6% of individual market • Largest pool in country.	125% of weighted average of rates charged by a majority of the insurers and HMOs offering similar coverage.	None	$15M for 2001 from surplus in a special Workers Compensation fund. Insurers assessed in proportion to share of total health insurance premiums received in state during year. Has used revenues from surcharges on hospital admissions and outpatient procedures.

State/Program	Eligible Populations	Enrollment	Premium Cap (as % of Comparable Plan)	Subsidies to Low-Income Individuals	Financing
Nebraska Comprehensive Health Insurance Pool	• Medically uninsurable • HIPAA eligible	• 5,023 (as of 2000) • 3% of individual market	135% of rates as established for applicable risks	None	Special fund from the premium tax of all health and accident premiums.
Oregon Medical Insurance Pool	• Medically uninsurable • HIPAA eligible	• 5,696 (as of 1999) • 3% of individual market	125%; portability rates cannot be more than 100% of average portability rate charged by insurers	Subsidy through the Family Insurance Assistance Plan for those under 170% FPL. Subsidy is for 70-90% of premium. 25% of those in pool are subsidized.	Assessment on insurers and reinsurers.
Washington State Health Insurance Pool	• Medically uninsurable • Medicare beneficiary	• 1,897 (as of 2000) • Less than 1% of individual market.	150%; 125% for managed care	Yes. For those ages 50-64 and under 300% FPL and those in the pool 3+ years.	Assessment on insurers. Can offset against taxes.
Wisconsin Health Insurance Risk-Sharing Program (HIRSP)	• Medically uninsurable • HIPAA eligible • Medicare beneficiary	• 7,904 (as of 1999) • 2% of individual market	200% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductible level.	Yes. Persons with household incomes less than $20K may qualify for reduced premium, deductible and drug coinsurance out-of-pocket maximum. Those with household incomes less than $25K may qualify for a premium reduction. Thirty-five percent of enrollees are subsidized.	General revenues, insurer assessments, reduction in provider payments.

State Tax Incentives

Deductions and Credits

Tax deductions reduce the cost of purchasing health insurance through a reduction in the individual's tax liability. Since a deduction reduces the filer's taxable income, its value depends on the percentage of tax assessed on the payer's adjusted gross income. For example, a 100 percent deduction for a premium expenditure of $5,000 would be worth $325 in a state with an income tax of 6.5 percent. Even with a 100 percent deduction, the actual financial incentive is quite small.

A credit is a reduction in tax liability for a specific dollar amount. A credit of $500, for example, would represent real savings in taxes of that amount. When the credit is refundable, the taxpayer receives the credit as a refund even if it exceeds his/her tax liability. Thus a low-income person who owes no taxes could still benefit from a refundable credit. Usually a credit is quite small relative to the cost of insurance.

Advantages

A tax-based approach leaves the choice of coverage to the individual and builds on the existing tax and insurance systems. It requires neither program development nor a new administrative apparatus. Start-up and administrative costs are low.

A state might prefer to encourage health insurance through diminished state taxes rather than through an outlay of new funds.

Difficulties

Tax incentives, whether they are credits or deductions, do not cover a significant portion of the premium. Thus their effectiveness in spurring new insurance purchases is doubtful. A deduction in particular has limited value to a low-income person who may not owe taxes or to a self-employed person who does not show a profit. Even a refundable credit can pose a problem for a low-income person who would need to pay for the insurance up-front and would only receive the credit at the end of the tax year.

A tax incentive cannot encourage someone to buy insurance when it is not accessible either due to medical underwriting restrictions or high premiums. Researchers, looking at the differential impact of tax incentives on the likelihood of women purchasing coverage, concluded *"low-income women would be hard-pressed to find an affordable health plan, even if they were in excellent health. In many cities, it would be hard for a women to find a plan at all."* (Collins et al. 2002, p. ix).

Programs in Other States

Eleven states provide "state only" tax deductions for individual health insurance. Eligible populations include "individual, spouse and dependents", "self-employed, spouse and dependents", "self-employed", "employee (determined by 401c 1 IRC 86), spouse and dependents" and "individual". In almost all states the deduction is 100 percent of premium expenditures. In one state the deduction ranges from 10 percent to 25 percent of premium expenditures depending on filing status and income.

North Carolina has been one of the only states to offer a refundable tax credit. A refundable credit of $300 was available to persons with incomes under 225 percent PPL and a credit of $100 to persons with incomes over 225 percent FPL. This program was repealed as of January 2001.

The SPG projects in Massachusetts and New Hampshire recommended tax incentives as part of the state's comprehensive strategy. New Hampshire recommended *"sufficiently large tax credits to assist individuals and families in buying buy health insurance, and help those who are already insured maintain coverage*." (Sacks et al. 2002).

Considerations and Conclusions

Despite the lack of reporting on program results, it is probably fair to conclude that, given the size of the incentives relative to the cost of insurance, tax incentives have had limited impact on improving the levels of health insurance coverage. Since they are overwhelmingly deductions, they have almost no value to low-income persons with no or low tax liability who need financial assistance to afford coverage. For a tax incentive to be worthwhile it needs to be sufficiently large, relative to the cost of coverage, and needs to address the tax situation of a low-income person; that is, be refundable.

Employed persons who receive health coverage through their employers receive this benefit tax-free. That is, they are not taxed on the value of their employer's contribution. Providing tax incentives for individuals who purchase coverage in the individual market helps redress the fundamental inequity that results from the tax-favored treatment of group health insurance and may be desirable regardless of the impact on health insurance levels. As such, tax incentive programs may be better viewed as instruments of tax policy rather than as strategies for increasing insurance levels.

Medical Savings Accounts

Medical Savings Accounts (MSA's) are health insurance products that combine a tax-deductible savings account with a high deductible health insurance policy. The funds put into the savings account must be used for health care expenses in order to retain the tax-deductible status. Since the costs associated with a high deductible policy are less than premiums for comprehensive first dollar coverage, an MSA product can lower the price of insurance to purchasers in the individual market. The MSA thus combines a tax incentive with a product design strategy to encourage health insurance purchases.

Existing Programs

Congress authorized a national demonstration of MSA's in 1996 that has been extended to 2003. Up to 75,000 individuals, either self-employed or in firms under 50, are eligible to receive tax advantages for certain kinds of MSA's. The MSA's must be linked to insurance plans with specified deductibles and specified out of pocket maximums with these values indexed to inflation. An individual can contribute up to 65 percent of the deductible and families up to 75 percent into the MSA on a tax-deductible basis. Participation in this program has been very low.

Thirty-three states including West Virginia have enacted state medical savings account laws that provide either a tax exemption or tax deduction to individuals for MSA contributions used for medical expenses. Allowable maximum contributions made to the account are usually 60 percent of the deductible for individuals and 75 percent for families, although actual dollar amounts are sometimes specified. Policy deductible ranges and out of pocket limits vary among states.

West Virginia allows any resident to establish a medical savings account to serve as self-insurance for the payment of qualifying medical expenses. The deposits to the account when used for medical expenses are exempt from state taxes. They are excluded from state income tax through a decreasing modification to the taxpayer's federal adjusted gross income, which provides the starting point for the WV income tax assessment. The annual contribution maximum is limited to 65 percent of the annual deductible for individuals and 75 percent of the annual deductibles for families. Policy deductible range is $1500 to

$2250 for individuals and $3000 to $4500 for families. Non-medical withdrawals before age 59 ½ are subject to taxation and a 20 percent penalty. The tax benefit in dollars is the contribution multiplied by the marginal tax rate. At a tax rate of 6.5 percent, a contribution of $2000 is worth $130.

The SPG project in Massachusetts recommended the sale of catastrophic policies with high deductibles in the individual market in combination with MSA's.

Considerations and Conclusions
Similar to other tax incentives, the break provided by an MSA is a small proportion of the funds that are expended on health insurance.

A person can only utilize an MSA if he/she is otherwise eligible for coverage in the individual market. Persons who are denied coverage based on health status do not have this option. Indeed, a major criticism of MSA's is that they are most attractive to healthy individuals who do not expect to need coverage up to the high deductible levels. If correct, MSA's would serve to siphon the best risks out of the individual market.

Sources for State Tax Incentives: National Association of Health Underwriters 2001B, National Association of Health Underwriters 2001C, National Association of Health Underwriters Undated A and West Virginia Tax Commission 1998.

State-Funded Coverage Programs

Several states use "state-only" funding to provide health insurance coverage to persons in the individual market. The coverage programs make a specific benefit package available at no or low cost or may help a low-income person buy coverage in the regular individual market.

Financing for these programs comes from a variety of sources. While some programs include all low-income persons, many focus on a specific segment of the uninsured, individual market. Most of these programs have been successful in enrolling their target populations and have thus contributed to improved health insurance levels in their states.

Three SPG projects (Minnesota, South Dakota and Washington) recommended broad premium assistance programs to help low-income people buy private individual coverage. The SPG project in Iowa recommended short-term coverage for the unemployed, and the Washington project also endorsed subsidies or COBRA reforms for unemployed workers in need of transitional assistance.

A sampling of state-funded programs follows. They were selected to illustrate the diversity of target populations and funding sources tapped by the states.

adultBasic (Pennsylvania)

Target Population:	**Uninsured low-income adults**
Eligibility:	Adults ages 19 through 64 with family incomes below 200% FPL. Persons must be uninsured for 90 days unless they have been laid off a job.
Enrollment:	45,676 persons (as of 1/03). A waiting list is now in effect due to funding limits.
Cost-Sharing/ Benefit Package:	A basic benefit package is offered including preventive care, physician services, diagnosis and treatment of illness or injury, inpatient hospitalization, outpatient hospital services and emergency care. All participants pay a monthly premium of $30 and certain copays are required. Coverage is provided through private insurance companies.
Funding:	"State only" from tobacco settlement funds.

Basic Health Plan (Washington)

Target Population:	**Uninsured low-income adults and children**
Eligibility:	BHP covers uninsured parents and childless adults with family incomes between 92% and 200%. FPL. Children not eligible for other public programs may also enroll and comprise about 10% of the enrollment. Persons with incomes over 200% FPL may obtain coverage but are unsubsidized.
Enrollment:	Subsidized enrollment reached a peak in February 2001 with 133,360 participants. This put enrollment at capacity due to funding limitations. Non-subsidized enrollment totaled 476 as of June 2002. (Only certain current members are eligible for this form of participation.) Because of funding restrictions, BHP is budgeted for an enrollment of 81,000 during the period 2003-2005.
Cost-Sharing/ Benefit Package:	Adult premiums are based on income. Adults with incomes below 100% FPL pay $10 monthly; those between 100% and 200% FPL pay between $10 and $65. Children below 200% FPL pay $0. Children over 200% FPL pay $42 monthly. Premiums for adults above 200% FPL range from $95 to $196 monthly. The program offers managed care plans. An effort is underway to develop a less costly benefit that will be medically sound and affordable to low-income families. The redesign will allow additional enrollment in the program.
Funding:	State funds for the program come from the Health Care Subsidy Fund, which draws on a tobacco tax, an alcohol tax, and a hospital provider tax.

Children's Medical Security Plan (Massachusetts)

Target Population:	**Uninsured low and middle-income children**
Eligibility:	Children under age 19 not eligible for MassHealth, the federally matched program. A child must not have coverage for primary or preventive care.
Enrollment:	21,657 children (of 3/00). 34% of enrollment under 200% FPL, 64% between 200% and 400% FPL and 2% above 400% FPL. (as of 1999) New enrollments were suspended in November 2002.
Cost-Sharing/ Benefit Package:	Coverage is limited to preventive and primary care and includes a prescription benefit with a $200 annual cap. Copayments from $1-$5 are required for certain services and are based on income and family size. For families with incomes under 200 percent FPL, there is no premium. Families with incomes between 200 percent and 400 percent FPL pay $10.50 monthly per child to a maximum of $31.50. Those with incomes over 400 percent FPL pay the full premium amount of $52.50 monthly per child.
Funding:	"State only". The appropriation for FY 2000 was $13.6 million.

Healthy NY (New York)

Target Population:	**Low-income individuals and self-employed persons.** Healthy NY is also available to small groups.
Eligibility:	Low-income workers and self-employed persons must have incomes below 250% FPL and not be insured for the last 12 months.
Enrollment:	More than 1,000 persons (includes all eligibility categories) (as of 8/00)
Cost-Sharing/ Benefit Package:	The benefit package, while comprehensive, is exempt from some mandates including mental health care, home health care, chiropractic services, and outpatient treatment for alcoholism and substance abuse. The program also relies on managed care to hold down the premiums, and only in-network services are covered. Cost sharing is higher and benefits somewhat leaner than the regular market. All HMOs licensed in the state are required to participate. Plans are required to use community rating and to rate each enrollment tier (single, husband/wife, etc.) based on the combined experience of the three participant categories (small groups, sole proprietors and individuals). This program is unique in that it is available to both the individual and small group

markets and blurs the distinctions between the markets by requiring the insurers to pool the experience of all participants into a single rating pool. Since the largest discount from regular market premiums is experienced by individuals (30-50% compared to 15-30% for small groups), this approach favors the individual market. Nonetheless, given the state subsidy, small groups still do better than they would in the regular market.

Funding: The program is partially funded through enrollee premiums. To keep premiums affordable, the State subsidizes the program by reinsuring 90 percent of an individual's claims between $30,000 and $100,000. As a result the products available to the individual market through Healthy New York have premiums 30-50% below premiums for comparable products in the regular market. Healthy NY has an allocation of $219M for the 30-month period from January 2001 through June 2003.

Medical Security Plan (Massachusetts)

Target Population: **Persons receiving unemployment compensation**

Eligibility: This plan subsidizes insurance for persons collecting unemployment compensation who meet the income criteria. Program is operated by the Division of Employment and Training for Massachusetts.

Enrollment: Not available

Cost-Sharing/ Benefit Package: Payments for COBRA are partially subsidized for families with incomes under 400 percent FPL. For families with incomes under 200 percent FPL who do not have access to ESI, the program pays for health insurance through an indemnity plan.

Funding: "State only" through the Health Insurance Trust Fund supported by an employer tax of .12% on the first $14,000 of each employee's salary levied on employers with six or more employees.

MinnesotaCare (Minnesota)

Target Population: **Low-income, uninsured persons**

Eligibility: MinnesotaCare provides health coverage to adults age 21 and over with household incomes under 175% FPL. It also covers children and parents with family incomes to 275% FPL. To be eligible, a person must not have had health insurance for the last 4 months. This requirement is waived for certain children.

Enrollment: 153,953 (as of 6/02)

Cost-Sharing/ Benefit Package: Enrollees pay a monthly premium based on income and family size. The average premium in FY 2002 was about $23 per enrollee per month. The amount paid by any enrollee ranged from $4 monthly for children in low-income households to $425 for a family of three or more with an income close to the program maximum of 275% FPL. Coverage is through prepaid health plans and includes a full range of inpatient and outpatient care including prescription drugs. Copayments are required for certain enrollees.

Funding: Health Care Access Fund which is funded by a provider tax of 1.5% of revenues. (Federal matching funds are received for enrollees who would be eligible for the Medicaid program).

TMA Plus (Michigan)

Target Population: **Low-income workers who exhaust transitional medical assistance benefits**

Eligibility: TMA Plus is available to adults with family incomes below 175% FPL. A child from the former TMA coverage must still be in the household and must meet the age requirement. The child, however, is not covered through the program.

Enrollment: NA

Cost-Sharing/ Benefit Package: Premiums depend on the number of persons covered and the length of time in the TMA Plus program, with per person costs starting at $50 monthly during the first 6 months of coverage and rising to $110 during the fourth 6-month period. After that, there are no further increases.

Funding: TMA Plus uses "state only" funds to continue coverage for persons whose eligibility for Transitional Medical Assistance (TMA) is exhausted. Federal matching funds are available for TMA for up to 12 months for persons who would otherwise lose Medicaid eligibility when they become employed. The period eligible for a federal match has been extended in some states through a waiver.

Considerations and Conclusions

Unless state-sponsored coverage is available, certain populations may not be insurable. That is, they will remain ineligible for the federally matched programs and will never afford coverage on their own. States have been creative in funding these "state only" programs through tobacco and alcohol taxes, taxes on hospitals and other health care providers, tobacco settlement funds, and employer taxes. Such programs may the only prospect for insurance for some segments of the individual, uninsured market.

Some segments of the uninsured who are in the individual market may have very special needs that can only be met through a focused program. Some of these populations may be small (persons needing continued TMA coverage) or may be in need of coverage on a temporary basis (persons collecting unemployment), which suggests that the costs of a narrowly focused program are relatively low.

Sources for State-Funded Coverage Programs: Chollet and Achman 2003, Massachusetts Department of Public Health, Massachusetts Division of Employment and Training, Massachusetts Division of Health Care Finance and Policy 2000, Michigan Department of Community Health 2001, Minnesota Department of Human Services Undated, Pennsylvania Department of Insurance Undated, State Coverage Initiatives Undated D, Summer 1998, Swartz 2001, Washington (State of) 2003, and Washington (State of) 2002.

Managed Charity Care

Managed charity care programs are set up to improve care delivery to persons who would otherwise receive uncompensated care in an uncoordinated and periodic manner. These programs bring a new dimension to the "safety net" that is the source of care for many uninsured persons. Instead paying providers for services for uninsured persons after the fact through uncompensated care funds, the program re-directs these funds to an insurance program that encourages the use of primary care and promotes continuity of services overseen by a primary care provider.

One such program, the DC Health Care Alliance provides coverage to uninsured DC residents with household incomes under 200% FPL. As of January 2003, 24,225 persons were enrolled. The Alliance represents a public private partnership between the DC Department of Health and the Greater Southeast Community Hospital Corporation. Services are received from the hospital, its subcontracting providers, and physicians contracted by the program. The Alliance is overseen by the DC Health Care Safety Net Administration.

Many such programs have been the result of local community initiatives. Some of the well-known ones include the Wishard Advantage Program in Indiana and the Ingham Health Plan in Michigan. Several SPG projects have included "safety net" programs, including managed charity care programs, in their comprehensive strategies for the individual markets to reach those populations for whom there may be no other solution. The Kansas project recommended the establishment of a health plan administered by facilities that currently serve a large population of uninsured patients. The Wisconsin project suggested that the state strengthen its partnerships with local governments and community agencies to provide basic primary care and preventive programs.

Sources for Managed Charity Care: DC Department of Health 2002, DC Health Care Safety Net Administration 2003, Felland and Lesser 2000, and Haslanger et al. 1998.

Other Approaches to the Individual Market

Product Design Strategies

Product design strategies focus on creating low-cost products to make insurance more affordable to the target population. The lower cost may result from limited benefits, major cost sharing, and/or a very

limited provider network. Typically, product design strategies are included as components of other approaches. For example, the Massachusetts Children's Health Security Program covers only outpatient services. Medical Savings Accounts are used in combination with high-deductible catastrophic policies, which are offered at lower premiums since the covered person pays out of pocket for all services up to the deductible. The Washington Basic Health Plan is seeking to streamline its benefits in order to cover more persons.

Health Care Purchasing Cooperatives

Historically, health care purchasing cooperatives have been directed at improving the buying power of small groups. By acting together, it was hoped that small groups would gain market clout and access to more affordable health insurance products. While it does not appear that cooperatives have been successful in delivering lower premiums, they have enhanced the choice of coverage for pool participants. (For a comprehensive review of purchasing cooperatives, the reader is referred to the "Literature Review on State Activities Related to Employer-Sponsored Insurance" prepared previously.)

At this time, most cooperatives limit their membership to groups although some include the self-employed. Purchasing pools, however, hold potential for improving access to coverage for persons buying insurance on their own. Some analysts have advocated using pools in conjunction with tax credits for persons who buy coverage in the individual market as a way to assure that coverage is available. While opening a pool to all or part of the individual market may introduce rating complications, it can have the benefit of growing pool membership such that the pool becomes a significant player in the marketplace. With governmental support, a cooperative could grow its membership and become a force to be reckoned with. For example, a state government might specify the cooperative as the source for coverage for individuals or employers that receive subsidies or tax credits. Theoretically, a successful cooperative could eventually replace an ineffective market.

The Delaware SPG project endorsed the establishment of a purchasing pool for "employees of small employers and people whose incomes are 200-300% FPL." The Washington project supported "individual or individual/small-market purchasing pools, other community-based purchasing pools, mobile-worker purchasing pools."

Any assessment of the potential for a purchasing cooperative in WV as a strategy for the small group market should also consider the benefits it could bring to the individual market.

Conclusions and Recommendations

Multi-Faceted Strategy

There is no one solution for the individual market, which is comprised of many distinct subgroups. Rather a multi-faceted strategy will be needed to reach out to the diverse populations that do not have access to group coverage.

Targeted Programs

Impact on Access and Affordability

Of the strategies examined here, only the state-sponsored coverage programs address both the access and affordability issues in the individual market. However, this is the most difficult approach to adopt given the states' budget crises. Full cost buy-ins and high-risk pools, while effective for some segments of the market, are primarily focused on access. Tax incentives, while directed at affordability, appear minimally effective. The limits of each strategy demand that no one approach be relied on as a cure-all. At the same

time, given the limited arsenal, each strategy should be assessed for what it can do for at least some segment of the individual market. Each strategy reviewed here has been recommended by one or more SPG projects as part of the comprehensive uninsured strategy for their states. Table 4 below provides a sampling of these recommendations.

Many of the strategies used by states for the individual market focus on a particular segment of the market. For example, some states have developed high-risk pools to assist the medically insurable and disabled, a strategy that might also work for retirees who otherwise face prohibitive premiums under age rating. Other states have focused programs on unemployed workers. Careful examination of the characteristics of the uninsured in the individual market is important for identifying effective strategies to increase insurance levels.

For example, almost 10 percent of uninsured adults (about 21,000 persons) in WV have incomes in excess of $40,000 per year. Presumably they can afford coverage, so planning for this group will focus on the availability of coverage, perhaps through a purchasing pool, full cost buy-in program or high-risk pool. Data from the West Virginia Health Care Survey 2001 will be helpful for identifying the most appropriate target populations for WV.

Cost Considerations

The strategies available to states for increasing the levels of health insurance in the individual market vary in their program development and ongoing administrative costs. Some involve real outlays for insurance coverage, while others do not. Table 5 summarizes the strengths and difficulties of the various strategies with a broad assessment of the costs involved.

Table 4

State Planning Grant Project Recommendations Related to Individual Health Insurance

Strategy	Recommendations
Full Cost Buy- Ins (FCBI)	• Expand current public programs. All individuals would be permitted to join the new insurance program. (CA) • Create a Medicaid buy-in for small employers and low-income people (SD) • CHIP buy-in for parents (TX) • Buy-in to VHAP: Individuals without access to employer coverage living below 300% FPL could be permitted to purchase coverage under the VHAP program by paying a premium. (VT)
High-risk Pools	• Subsidies to help high-risk people buy individual coverage. (WA)
Managed Charity Care	• Establish a health plan administered by facilities that currently serve a large proportion of uninsured patients. (KS)
Product Design Strategies	• Provide a limited benefit plan for residents ages 9-64 who are at FPL and up to 200% FPL. (DE) • Sell catastrophic policies with high deductible in the group and individual markets in combination with medical savings accounts (MSA's). (MA)
Purchasing Pool	• Establish a purchasing pool intended for employees of small employers and people whose incomes are 200-300% FPL. The state would establish an entity that would act as a purchaser of health coverage. (DE) • Individual or individual/small market purchasing pools, other community-based purchasing pools, mobile-worker purchasing pools. (WA)
Safety Net Programs	• Health Link Program, using cooperating doctors to provide free care to uninsured individuals. (NH) • Encourage access to direct services for people who do not have insurance. (VT) • Direct safety-net subsidies, including discount health cards for individuals. (WA) • Strengthening partnerships with local governments and community agencies to provide basis primary care and preventive programs. (WI)
State-Funded Coverage Programs	• Provide short-term insurance coverage to the unemployed that is modeled after a state employee benefit package; there would be no premium while the individual is unemployed. (IA) • Subsidies for low-income people to purchase private coverage (MN) • Provide a premium subsidy for qualifying low-income people below 200% FPL who do not have access to employer-sponsored coverage. (SD) • Individual/family incentives: Subsidies to help low-income people buy individual coverage and to help high-risk people buy individual coverage. (WA) • Subsidies or reforms for transitional coverage (COBRA) (WA
State Tax Incentives	• Tax incentives for all individuals/families that lack access to employer-sponsored coverage. (MA) • Sufficiently large tax credits to assist individuals and families in buying health insurance, and help those who are already insured to maintain coverage. (NH)

Source: Sacks et al. 2002

Table 5

Strengths, Difficulties and Costs of Available Strategies to Support Individual Health Insurance

Strategy	Major Strengths	Difficulties	Program Development Costs	Ongoing Administrative Costs	Ongoing Insurance Costs
Full Cost Buy-in (FCBI)	• Assures product availability • More affordable premiums due to administrative efficiencies and provider/vendor discounts	• Lower-income persons may need subsidy • Potential to increase risk level in public pool • Not widely tested	Low to Moderate	Low	No ongoing cost for insurance; those buying-in pay own way
High-risk Pools	• Accessible coverage for those otherwise uninsurable • Capped premiums • Federal funds available for development	• Requires reliable and stable funding to supplement premiums, which cover only about 50% of costs • Low potential enrollment • Lower-income persons still need subsidy • Needs to work in tandem with market reform to avoid undue risk concentration in pool	Moderate	Moderate	Moderate to high; requires financing to cover costs in excess of premiums.
Managed Charity Care	• Accessible and affordable coverage for the uninsured • Can tap uncompensated care funds • Improves quality of care by substituting regular care for episodic, uncoordinated care	• None	Moderate	Moderate	Moderate to High, but represents a re-direction of "safety net" funds.
Product design strategies	• More affordable premiums • Integral component of almost every strategy	• Lean benefits may not be attractive	Low to moderate	Low	Any ongoing cost depends on whether premium assistance is provided.

Strategy	Major Strengths	Difficulties	Program Development Costs	Ongoing Administrative Costs	Ongoing Insurance Costs
Purchasing cooperatives	• Make coverage available but not necessarily at lower prices • If available in group market, could be extended to individual with appropriate safeguards for risk control • Can be used in conjunction with other strategies (tax incentives or subsidies) to make coverage affordable to individual purchasers.	• Do not necessarily impact affordability	Moderate to high	Moderate	No ongoing cost for insurance
Safety Net Programs	• Provide services to uninsured persons	• Usually require some provision of free care by cooperative providers • Do not provide health insurance coverage thus insured rates are not increased	Varied	Varied	Costs are for services after the fact, not insurance
State-Funded Coverage Programs	• Make coverage accessible and affordable • Can target specific groups within individual market • May be the only recourse for certain segments of the individual market	• Can require substantial financial commitment from state	Moderate	Moderate	Varies depending on enrollment capacity and benefit package
Tax Incentives	• Make premiums more affordable • Utilize existing tax and insurance systems	• Incentives too low to stimulate new purchases/impact health insurance levels • Refundable credits needed for persons with little or no tax liability	Low to Moderate	Low	Depends on amount of incentive

Cited Sources and Other References

Abbe, B. March 2001."What is a Risk Pool? State Health Insurance Risk Pools - Funding and Operations". Testimony to Colorado House of Representatives. Communicating for Agriculture and the Self-Employed.

Achman, L. and D. Chollet. August 2001. ***Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools.*** Publication #472. The Commonwealth Fund. New York, NY.

Birnbaum, M. August 2001. "Full Cost Buy-Ins: An Overview of State Experience". State Coverage Initiatives. Issue Brief. Academy for Health Services Research and Health Policy. Washington, DC.

Butler, P. August 2000. "Issue Brief: ERISA Complicates State Efforts to Improve Access to Individual Insurance for the Medically High-Risk". State Coverage Initiatives. Washington, DC.

Centers for Medicare and Medicaid Services. 2002. "Announcement of Availability of Seed Grants to States to Create Qualified High-Risk Pools". Baltimore, MD.

Chollet, D. October 2002. "Expanding Individual Health Insurance Coverage: Are High-risk Pools the Answer?" **Health Affairs** (On-Line as Web Exclusive).

Chollet, D. and L. Achman. February 2003. ***Approaching Universal Coverage: Minnesota's Health Insurance Programs***. Publication #566. Task Force on the Future of Health Insurance. The Commonwealth Fund. New York, NY.

Collins SR, S. Berdson and D. Downey. December 2002. ***Health Insurance Tax Credits: Will They Work for Women?*** Publication #589. The Commonwealth Fund. New York, NY.

Communicating for Agriculture and the Self-Employed. Undated. "What is a Risk Pool?". Web-Site.

Conover, C.J. and H.H. Davies. February 2000. "The Role of TennCare in Health Policy for Low-Income People in Tennessee". Occasional Paper No. 33. Assessing the New Federalism. The Urban Institute. Washington, DC.

DC Department of Health. Health Care Safety Net Administration. ***2002 Annual Report***. Washington, DC.

DC Health Care Safety Administration. March 2003. "Alliance Statistics as of March 2, 2003." Web-Site.

Duchon, L. and C. Schoen. December 2001. "Experiences of Working-Age Adults in the Individual Insurance Market". Issue Brief. Publication #514. The Commonwealth Fund. New York, NY.

Felland, L. E. and C. Lesser. January 2000. "Local Innovations Provide Managed Care for the Uninsured". Issue Brief No. 25. Center for Studying Health System Change. Washington, DC.

Hart, S. Jan/Feb 2002. "Options for Expanding Health Insurance in Texas--CHIP Full Cost Buy-In". Milliman USA. Slide Presentation for the Texas State Planning Grant Conference. Houston, TX.

Haslanger, K., R. Mechanic, M.J. O'Brien and K. Thorpe. 1998. ***Taking Steps, Losing Ground: The***

Challenge of New Yorkers without Health Insurance. United Hospital Fund. New York, NY.

Hawaii Uninsured Project. January 2002. "A Plan for Action".

Health Affairs. "The Nongroup Market: a Web Symposium". (On-Line as Web Exclusive).

Lambrew, J.M. and A. Garson. January 2003. ***Small But Significant Steps to Help the Uninsured.*** Publication #585. The Commonwealth Fund. New York, NY.

Maine Bureau of Insurance. January 2001. "White Paper: Maine's Individual Health Insurance Market".

Massachusetts Department of Public Health, Bureau of Family & Community Health, Division of Maternal, Child and Family Health. "Children's Medical Security Plan". Web-Site.

Massachusetts Division of Employment and Training. "Introducing the Medical Security Plan". Web-Site.

Massachusetts Division of Health Care Finance and Policy. June 2000. ***An Evaluation of Health Care Programs for Low-income Uninsured and Underinsured Massachusetts Residents***. Chapter 1: The Children's Medical Security Plan".

Michigan Department of Community Health. April 2001."TMA Plus Extending Your Health Care Coverage". Brochure. Web-Site.

Minnesota Department of Human Services. "MinnesotaCare - Fact Sheet". Web-Site.

National Association of Health Underwriters. June 2001A. "Comparison of State-Level High-risk Pools (as of June 15, 2001)".

National Association of Health Underwriters. August 2001B."State-Level Health Insurance Reforms As of August 1, 2001".

National Association of Health Underwriters. August 2001C. "Comparison of State-Level Continuation Coverage Laws".

National Association of Health Underwriters. Undated A. "State-Level Medical Savings Account Laws".

National Association of Health Underwriters. Undated B. "Trade Adjustment Act of 2002."

Pennsylvania Department of Insurance. "Facts about adultBasic". Web-Site.

Pollitz, K., R. Sorian and K. Thomas. June 2001."How Accessible is Individual Health Insurance for People in Less-than-Perfect Health?" Kaiser Family Foundation.

Pollitz, K., S. Lewis, R. Imes, and E. Bangit. March 2001. ***A Consumer's Guide to Getting and Keeping Health Insurance in West Virginia.*** Georgetown University Institute for Health Care Research and Policy. Washington, DC.

Sacks, H., T.Kutyla and S. Silow-Carroll. November 2002. ***Toward Comprehensive Health Coverage for***

All: Summaries of 20 State Planning Grants from the U.S. Health Resources and Services Administration. Publication #577. The Commonwealth Fund. New York, NY.

Swartz, K. November 2001. ***Healthy New York: Making Insurance More Affordable for Low-Income Workers.*** Publication #484. The Commonwealth Fund. New York, NY.

State Coverage Initiatives. July 2001."High-Risk Pools Grow Despite Funding Challenges". Newsletter #5. Washington, DC.

State Coverage Initiatives. Undated A. "State Coverage Matrix. SCHIP Full Cost Buy-Ins". Washington, DC.

State Coverage Initiatives. Undated B. "State Coverage Matrix. State-Only High-risk Pools". Washington, DC.

State Coverage Initiatives. Undated C. "State Coverage Matrix. State-Only Tax Incentives." Washington, DC.

State Coverage Initiatives. Undated D. "State Coverage Matrix. State-Only Coverage Programs". Washington, DC.

Stearns, SC, R. Slifkin, K. Thorpe and T. Mroz. June 1997."The Structure and Experience of State Risk Pools: 1988-1994". **Medical Care Research and Review** pages 223-238.

Summer, L. April 1998. ***State-Subsidized Health Insurance Programs for Low-Income Residents: Program Structure, Administration, and Costs.*** The Commonwealth Fund. New York, NY.

Texas Department of Insurance. October 2001."Texas State Planning Grant Policy Options".

Trude, S. and P.B.Ginsburg. April 2001."Tax Credits and Purchasing Pools: Will This Marriage Work?" Issue Brief No. 36. Center for Studying Health System Change. Washington, DC.

Washington (State of). Governor's Communications Office. February 2003."Gov. Gary Locke Calls for Redesign of Basic Health Benefit, Allowing the Addition of 11,000 Low-Income People to Program". Olympia, WA.

Washington (State of). June 2002. ***A Study of Washington Basic Health Plan***. State of Washington, Health Care Authority.

West Virginia Tax Commission. November 1998."Individual Medical Savings Accounts". Publication TSD-403. Charleston, WV.

Wisconsin Division of Health Care Financing, Department of Health and Family Services, "Wisconsin Health Insurance Risk Sharing Plan (HIRSP)", Web-Site.