

Options for Covering the Uninsured

A Report to the Maryland General Assembly

Prepared by the Maryland Department of Health and Mental Hygiene and the Maryland Health Care Commission under the auspices of a Health Resources and Services Administration State Planning Grant

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OVERVIEW OF THE PROBLEM

The State Planning Grant

On July 1, 2002, Maryland was one of twelve states to receive a 3rd-round State Planning Grant (SPG) from the Department of Health and Human Services' Health Resources and Services Administration (HRSA). This grant allows Maryland to build on its longstanding commitment to developing innovative private- and public-sector programs that make health insurance coverage more accessible and affordable for Marylanders. The grant was awarded to the Department of Health and Mental Hygiene, in partnership with the Maryland Health Care Commission and the Johns Hopkins University Bloomberg School of Public Health.

The grant has funded activities to help policy makers better understand the scope, nature, and dimensions of the problem of Marylanders who lack any form of health insurance coverage:

- One research activity analyzed the demographics of the uninsured in Maryland.
- Two focus groups studies were conducted. One brought together small businesses and health insurance brokers to provide information and insights about the barriers to insurance coverage in the small group market. The second brought together families who applied for the Maryland Children's Health Program Premium program to help us understand the obstacles with collecting premiums for public programs.
- Another major study produced estimates of the costs resulting from lack of insurance coverage. The study used data from public and private sources to quantify the costs of uninsured Marylanders to the federal and state government, private payers, and to the uninsured individuals themselves.

Summaries of the results of these research activities are presented in this report.

A major focus of grant activities has been to develop and evaluate potential strategies for increasing insurance coverage. The Health Care Coverage Workgroup—which represents a broad spectrum of stakeholders, including

employers, advocates, providers, insurers and policymakers—was convened to provide feedback on the different proposals to increase insurance coverage (see **Appendix A** for Workgroup member list). The Workgroup met numerous times and reviewed research produced under the grant and discussed a range of options for expanding health insurance coverage options, including public and private options.

The overarching goal of the Maryland State Planning Grant is to enable Maryland policymakers to make informed decisions regarding options to expand insurance coverage in Maryland. Reducing the number of uninsured is a current policy goal of many of Maryland's key policy leaders—including the Governor and legislative leaders. The grant activities are intended to develop a common understanding of the problems of uninsurance in Maryland, define a series of options for expanding coverage, and evaluate the cost and impact of options.

Description of the Uninsured

Approximately 690,000 people in Maryland have neither public nor private health insurance.¹ During 2000-2002, the rate of uninsurance in Maryland rose from 11.3% of the total population to 12.8%. Among the non-elderly, the rate rose from 12.8% to 14.4%. The increase in uninsured is largely a result of an increase in the number of uninsured adults, with a two percentage point increase from the previous reporting period; the percent of uninsured children remained constant.² Although the proportion of uninsured people in Maryland is lower than for the nation as whole (14.9%), only one state, Mississippi, had a larger *increase* in uninsured citizens in the most recent year for which data are available. The growth in the number of uninsured in Maryland is attributable primarily to a reduction in the number of people with employment-based coverage.

In order to devise sensible policies to address the problem of uninsured, it is important to have a good understanding of who they are. Contrary to many people's expectations, only 12% of the uninsured live in families (including single individuals) in which there are no working adults. Since small firms are less likely than larger firms to offer coverage, it is not surprising that 29% of the working uninsured are employed by companies with fewer than 10 employees. Another 44% work for medium-sized firms, those with 10 to 499 employees. Even though nearly

¹ U.S. Census Bureau, Current Population Survey. Data presented are for Maryland's non-elderly population during 2001-2002. The Maryland Health Care Commission report *Health Insurance Coverage in Maryland Through 2002* is available at <http://www.mhcc.state.md.us>.

² 10% of children in Maryland were uninsured in 2000-2001 and 2001-2002. 14% of adults were uninsured in 2000-2001 but increased to 16% in 2001-2002.

all large firms offer health coverage, 21% of the working uninsured are employed at firms with more than 500 workers. About 6% of the working uninsured are government employees.

There are substantial numbers of uninsured people at every income level, as shown in the graph below. The largest proportion, 41%, falls into the low-income category, having a household income of less than 200% of the federal poverty level. Another 21% are families of modest means, with incomes between 201% and 300% of the poverty level. A surprising proportion of the uninsured are in families with incomes well above the median for all families (\$35,630). About 38% of all uninsured households have incomes in excess of \$43,500, and 15% have incomes that exceed \$87,000.

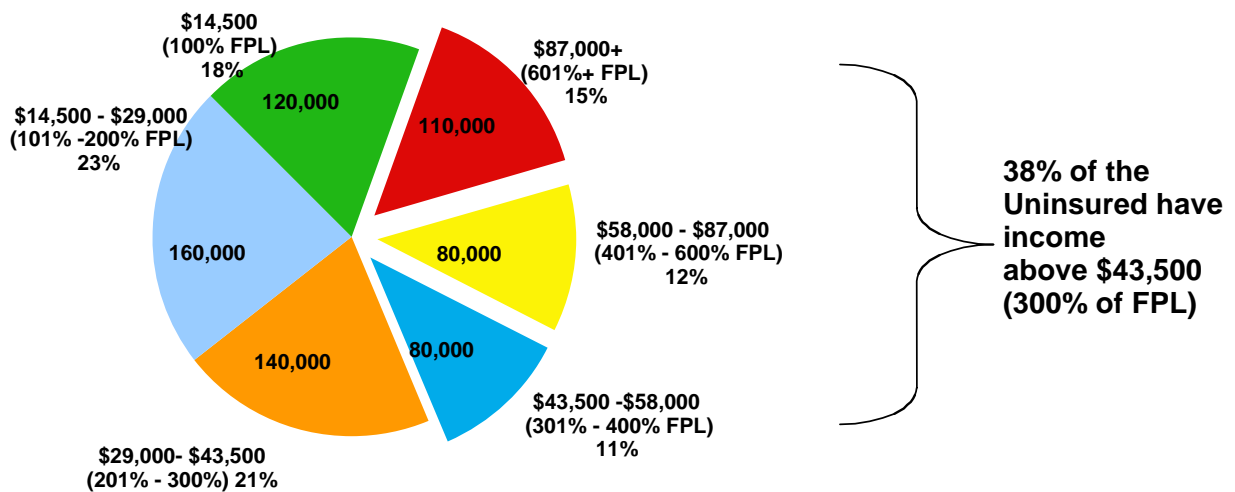


Figure 1: The Nonelderly Uninsured by Poverty Level (Family of 3), 2001-2002

While workers employed during an entire year (or full year) on a full-time basis are more likely to have health insurance, this group comprises more than two-thirds of uninsured workers. As expected, those individuals employed part-time or who are part-year workers (less than 50 weeks) are less likely to have health insurance.

Certain populations with historically high uninsured rates continue to be less likely to have health care coverage. Young adults ages 19 to 34 are less likely to have health insurance than children or older adults. Approximately 25% of young adults were without health insurance during 2001-2002; they make up 40% of all of the uninsured. Single adults are more likely to be uninsured than married adults. The uninsured rate for single female adults for 2001 and 2002 was 18%, and the uninsured rate for single male adults was 33%; this compares with 10% for married

adults. The difference in uninsured rates between single males and single females is not income related; it may be a reflection of different attitudes towards health insurance and/or job choices.

Non-U.S. citizens in Maryland are significantly less likely than citizens to have health insurance, regardless of family income. Non-U.S. citizens comprise almost 30% of Maryland's uninsured, even though they are only 9% of the non-elderly population. In addition, minority racial/ethnic groups, regardless of income, are less likely to have insurance than non-Hispanic Whites.

A person's level of education is also a predictor for having health insurance. Twenty percent of individuals with a college degree or some college education are uninsured, compared to 23% for high school graduates and 46% for those who did not complete high school. The uninsured rate among Maryland residents with only a high school diploma or no diploma was lower in 2000-2001, when it was 19 percent and 37 percent, respectively.

The growth of the uninsured population in Maryland between years 2000 and 2002 reflects a worsening social problem. The 690,000 Maryland residents who go without a stable source of health care are at greater risk of not obtaining health care services for needed care, including preventative care, and of facing financial ruin as a result of incurring large medical expenses.

Qualitative Research Findings

Under the auspices of the Maryland State Planning Grant, qualitative analyses were conducted with the expectation that the research results would be helpful in developing options for the expansion of health insurance coverage. Research with small employers and health insurance brokers was undertaken to better understand the characteristics of firms not currently participating in the State's small group market and to provide improved marketing strategies aimed at increasing take-up rates in the small group market. The research was designed to gather information about the employers' knowledge and impressions of insurance, their awareness of the small group market reforms, and reasons why they do not offer coverage and what it would take for them to do so.

In addition, focus groups with individuals who began the MCHP Premium application process but who did not ultimately enroll in the program and also those who disenrolled were conducted to better understand eligible individuals' willingness to participate in the State's S-CHIP Premium program. Additional

information on the consumer's perspective concerning Maryland's MCHP Premium would provide the State with the information necessary to reduce these drop-off and disenrollment rates and create a more consumer-friendly process. An improved process would lead to a reduction in the number of uninsured, as more individuals would be purchasing insurance through participation in MCHP Premium.

Small Employer Focus Group Project

Under the SPG, the MHCC contracted with Shugoll Research to conduct a series of focus groups with small employers and health insurance brokers in Maryland. The purposes of the research were to: (1) identify and explore the characteristics of small employers who offer and do not offer health benefits and the factors that influence small employer decision making regarding employee health benefits; and (2) learn about positive and negative experiences of health insurance brokers when selling health plans to small employers. The research results allowed insight into potential programmatic and regulatory changes that the State might consider for the small group market and to inform the development of options for expanding health coverage to Maryland's working uninsured.

A total of 12 focus groups with small employers were conducted. Initially, two pilot groups were conducted with small employers to pretest the moderator's guide and project logistics. Following the pretest, 10 focus groups were conducted with small employers that employ 2-50 full-time employees (working at least 30 hours per week) in five geographic regions of Maryland. These groups were split by size and by whether they offered health benefits. Seven groups were conducted with businesses employing 2-10 employees (two groups of businesses offering health benefits and five groups of businesses not offering health benefits). Three groups were conducted with businesses employing 11-50 employees; all of these groups offered health benefits. In addition, two focus groups were conducted with registered brokers and agents selling health insurance to small employers in Maryland.

Overall, this study found that there is a lack of detailed knowledge about health insurance among small employers in Maryland, particularly those employer groups with 2-10 employees who do not offer health benefits. For businesses with 2-10 employees, lack of affordable coverage, misperceptions about the insurance industry, and perceived administrative challenges were cited as common reasons for not offering health insurance. Small employers with 11-50 employees were more likely to offer health coverage than small employers with fewer (2-10) employees, and were also more likely to offer health benefits for specific business or philosophical reasons. Among both large and small employer groups, familiarity

with Maryland's Comprehensive Standard Health Benefit Plan (CSHBP) and small group market reforms was virtually non-existent.

Findings from the broker focus groups indicate that, when small businesses look for a health plan, they seek first and foremost a good price/value relationship. In addition, while brokers are aware of the CSHBP and small group market reforms, they have negative impressions of the plan and typically do not market it to their clients. Despite reporting that small group market reforms have increased access to health insurance, brokers believe that it also has had the negative impact of limiting the number of carriers, thus reducing competition in the small group market.

Below is a summary of notable findings from the small employer and broker focus groups, followed by suggestions that the MHCC could consider in the future for the purpose of expanding participation in the small group market.

SMALL EMPLOYER FOCUS GROUP FINDINGS

Types of Companies Not Offering Health Benefits

- **Companies in certain types of industries are more likely than other types to not offer health benefits.** Small employers in industries that have primarily low-wage and young workers, are blue collar-oriented, have a greater proportion of employees who work a trade, have high employee turnover, are severely impacted by a weak economy, or are in such industries as retail and hospitality are more likely than other types of businesses to not offer health benefits. In addition, small employers with 10 or fewer employees appear more likely than small employers with 11 or more employees not to offer health benefits.

Reasons for Not Offering Health Benefits

- **Affordability is a major reason why small employers do not offer health benefits to their employees.** Affordability is also one of the greatest concerns of small employers currently offering a health benefit plan to employees. The cost of health care benefits and the need to control this cost are major reasons why small employers either do not offer or are reducing health benefits.
- **Lack of knowledge about health insurance and misperceptions and negative attitudes toward the insurance industry contribute significantly to**

small employer reluctance to shop for health benefits. Many small employers with 2 to 10 employees who are not offering health benefits have almost no knowledge about the topic. They find that health insurance is difficult to understand, believe that offering health benefits would be too time-consuming, do not comprehend how it would benefit their business, and have a negative perception of the health insurance industry.

- **Philosophical beliefs about offering health insurance also contribute to employers' reluctance to offer health insurance.** Many small employers justify not offering health care benefits. They are concerned about employee morale if they have to reduce or cancel benefits in the future and they dislike having to deal with possible employee complaints about the benefits.

Factors Influencing Health Benefit Decision-Making

- **Employers offer health benefits for business and philosophical reasons.** Companies offering health benefits do so in large part to attract and retain good employees in competitive industries; their workers' skills are not easily replaced. Many also offer health insurance because they believe it is their social responsibility and is the "right thing to do." Additionally, small employers who offer a health benefit plan are more likely to employ the types of employees who demand or expect health benefits from an employer.

Cost-Sharing Arrangements, Preferred Delivery System Options and Benefits

- **A majority of small employers in the focus groups are amenable to paying at least 50 percent of an employee's health benefit premium.** Many of those who offer benefits currently pay 75 percent to 100 percent of the employee's premium.
- **When tested for preference of delivery system using the deductibles associated with the CSHBP, small employers chose the HMO delivery system over the PPO and POS options.** This is because of the relatively small differential in premium costs between the HMO, PPO and POS delivery system options, along with the absence of a deductible for the HMO option. The major factor that is driving a preference for the HMO option is the lack of deductible since employers emphasize that employees often complain when

deductibles are implemented to reduce premium costs. However, during the general discussion, many employers expressed concern about the “gatekeeping” aspects of HMOs.

- **Some small employers, particularly some of the larger small employers (i.e., those with 11-50 employees), prefer a non-gatekeeper delivery system option such as the PPO.** These employers want to offer two or more delivery systems to give employees the opportunity to buy up for more choice and/or to reward senior managers.
- **From a list of benefits provided to respondents, those with a significant impact on the premium were reported as “need to have” by small employers. “Need to have” benefits included hospital inpatient and outpatient services, prescription drug coverage, diagnostic x-ray and lab services, physician services, maternity care and emergency room services.** Benefits considered “nice to have” or unnecessary included home health care, mental health and substance abuse, chiropractic services, chlamydia screening and nursing home care.

Familiarity with Small Group Market Reform and the CSHBP

- **Familiarity with Small Group Market Reform and the CSHBP was poor.** Virtually none of the focus group participants were familiar with Small Group Market Reform, although some were aware of some of the protections associated with the reform. None of the participants were aware of the Standard Plan (CSHBP). However, some employers vaguely recalled their brokers presenting them with a “minimum plan” option.

Where Small Employers Find Health Benefit Information

- **Small employers rely on a variety of sources for health benefit information.** Sources include brokers, carriers, mass media, email, the Internet, colleagues, and trade associations.
- **The professional broker plays an important advisory role in the purchase process and servicing of health benefit plans.** Brokers in the focus groups often reported they advise clients to use discriminatory hiring practices or

non-standard benefit distribution practices as ways to contain costs associated with providing health benefits. Brokers have significant concerns about the high cost of servicing the small employer market and, therefore, seem less likely to want to present health benefit plans to small employers.

Small Employer Familiarity with the MCHP Premium and MCHP Premium ESI Programs

- **There is virtually no awareness of these programs.** In principle, small employers believe the Maryland Children's Health Insurance Program (MCHP) Premium programs are a good idea. However, despite their positive receptivity to the programs in theory, small employers feel that: (1) the income range qualification for the programs is too narrow, eliminating most of their employees from being able to participate; and (2) the programs would be a drain on small employers since they would have to contribute at least 30 percent of a family premium, which is above and beyond what most small employers currently contribute, since not many pick up any costs for family coverage.

Reaction to a Theoretical State-Sponsored Health Benefit Solution

- **The 5 percent "pay or play" plan might be an effective program for reducing the number of uninsured or reducing the debt associated with uncompensated care.** There is some willingness on the part of small employers not currently offering a health benefit plan to contribute 5 percent of their payroll to a fund. Others not willing to pay 5 percent may be motivated to offer an employer sponsored health plan. However, this solution might also create incentives for employers to not offer coverage, since 5 percent may be substantially lower than what some employers are now paying.

BROKER FOCUS GROUP FINDINGS

Perceptions of Maryland Small Employer Needs for Health Benefits

- **A good price/value relationship was reported as the most important feature for which small businesses are looking in a health plan.** The cost of the monthly premium largely drives plan decision-making by employers.
- **Brokers say that employers are always looking for ways to lower the cost of the premium and, in some cases, are willing to consider more innovative ways to do this.** Some brokers say a few small business clients are willing to absorb the cost of employee deductibles, if needed, in order to get a lower premium. They are willing to risk those potential costs but hope that their employees do not get sick.
- **Most brokers say that employers are reluctant to consider plans that call for a high deductible in order to obtain a lower premium even if they would like to be able to offer this type of plan.** Employees want plans with immediate “first-dollar” coverage and a low co-pay, and would not accept a high deductible plan.
- **Many brokers say that neither employers nor their employees like HMOs.** They want greater flexibility in using health care than what is offered by an HMO. Nevertheless, because they perceive that costs are so high for PPOs and other more flexible plans, companies are forced to choose HMOs to cover most of their employees.

How Brokers Service the Small Business Market

- **Brokers typically provide a number of services to their clients.** These services focus primarily on information, education, and customer service. These include researching the competition, developing presentations of alternative plan choices based on employer needs, providing general information about health insurance on an ongoing basis, and assisting with many of the administrative aspects of the plan for their clients.

Broker Familiarity with Small Group Market Reform and the CSHBP

- **Brokers are aware of Small Group Market Reform.** While brokers believe that Small Group Market Reform has improved access to health insurance, they also reported that it has had a negative impact on the insurance industry over the long term because they have perceived it to have limited the number of carriers and reduced competition in the market.
- **Brokers are aware of the CSHBP, but they have a very negative impression of the plan.** Most brokers find the plan to have deductibles that are higher than employers want and do not sell it to their clients. They report that employers have little incentive to choose the CSHBP because the cost differential between the Standard Plan and enhanced plans with lower deductibles and copays is negligible.

Broker Familiarity with the MCHP Premium ESI Program

- **None of the brokers were aware of this program.** While they were aware of MCHP, the brokers did not have knowledge of the MCHP Premium ESI Program and were confused about how it works.

CONSIDERATIONS

Targeting Efforts to Increase Coverage at Small Employers Who Do Not Offer Health Benefits

- The MHCC should review existing quantitative research to validate study hypotheses regarding the types of small employers who are less likely to provide health benefits.
- Specifically, the MHCC may want to focus on small employers: (1) with 10 or fewer employees; (2) in industries with high employee turnover; and (3) that are blue collar-oriented who have a greater proportion of employees who work a “trade” or are in industries such as retail and hospitality.

Affordability of Health Benefits

- The MHCC, in conjunction with health care analysts, legislators, insurance carriers, professional brokers and representatives from the small business community, should try to identify alternative cost containment strategies that could be implemented by small employers to reduce and/or slow the rising cost of health care benefit plans.

Some possible strategies might include providing: (1) guidelines or “best practices” for employer-employee premium sharing arrangements; (2) guidelines or “best practices” for co-pay and deductible arrangements; and (3) guidelines for employers who choose higher deductible plans to control premium costs and who want to cover those employee deductibles in order to minimize employee complaints about reduced benefits (i.e., increased deductibles)

Once such alternative strategies are developed, the MHCC should promote them on its website and communicate them to employers, brokers and local business groups/associations that represent industries with a higher proportion of companies not offering health benefits.

Lack of Knowledge and Misperception

- The MHCC should determine the feasibility of launching an employer education program to educate small employers about health benefits. This includes providing consumer-friendly educational material on its website since small employers and brokers use the Internet to gather information on health benefits. Further research is needed to determine the viability of providing marketing information through the MHCC’s website.
- Broader distribution of Maryland’s CSHBP brochure for small business is needed. The MHCC should evaluate the feasibility of mailing the brochure to small employers, possibly along with other State forms, and should make it available through local Chambers of Commerce, other local business associations and brokers.

Motivating Small Employers to Offer Health Benefits

- The MHCC should launch an employee education program in conjunction with an employer education program to increase current and potential employees' knowledge about health benefits so as to encourage them to be active participants in the health insurance system.
- Once the MHCC re-evaluates the benefits in the CSHBP, it should work with brokers to gain their cooperation in presenting and promoting the standard plan to small employers. The State should also inform brokers about some of its other programs (e.g., MCHP Premium Program), since brokers are a major source of information for small employers.
- If possible, the MHCC should work with brokers and carriers to address their concerns about the high cost of servicing the small employer market since this issue is likely to drive more and more brokers away from presenting health benefit plans to small employers.

Cost Sharing Guidelines

- The MHCC might suggest cost sharing guidelines in its education materials. For example, a guideline that small employers consider 50 percent as a starting point or "minimum" for premium cost sharing as many small employers seem amenable to paying at least 50 percent of an employee's health benefit premium.

Benefit Preferences

- The MHCC might re-evaluate the level of benefits it provides in the CSHBP for the services deemed by employers as "nice to have" or unnecessary (NOTE: All benefits that were supported as "need to have" have a significant impact on premium).

Awareness of Small Group Market Reform, CSHBP and MCHP Premium Programs

- In order to value the benefits of Small Group Market Reform, small employers must be made aware of the protections provided by the legislation, such as guaranteed issue, guaranteed renewal and the prohibition of pre-existing condition limitations. In addition, small employers need to be made aware of CSHBP, MCHP Premium and the MCHP Premium Employer Sponsored Insurance (ESI) Option Employee Buy-In, so they have the opportunity to assess the appropriateness of these programs for their companies Programs (NOTE: Budget legislation enacted during the 2003 Maryland legislative session eliminated the MCHP Premium ESI Program as of July 1, 2003).

Carrier Competition

- The MHCC should communicate to brokers, employers and policymakers that a lack of competition among insurance carriers in the Maryland small group market is a national problem and is not specifically associated with Maryland's Small Group Market Reform.

Assessment of What the MHCC Can Do to Improve Health Coverage Among Very Small Employers

- The State may be able to design a voluntary program that addresses one specific issue or barrier faced by these very small employers. However, the State will probably never be able to address multiple barriers simultaneously using voluntary incentives in order to increase employer offer rates or employee take-up rates for this group of employers.

Therefore, the State may need to consider government regulation and significant premium support if it wants to see a substantial increase in the number of very small employers offering health benefits.

MCHP Premium Focus Group Project

DHMH also contracted with Shugoll Research to conduct a series of focus groups with parents and caregivers of Maryland Children's Health Program (MCHP) Premium applicants and disenrollees. The purpose of the research was twofold: (1) to assist the Department in understanding why a significant number of MCHP Premium program applicants terminate the application process and, hence, do not enroll in the program; and (2) to help the Department better understand why some children are disenrolled from the program, usually for non-payment of premium.

The MCHP Premium Program is part of Maryland's State Children's Health Insurance Program (S-CHIP). It is funded through a combination of federal and state dollars under Title XXI of the Social Security Act. For a monthly premium of \$40 or \$50 per family, depending on family income, MCHP Premium provides health care coverage to children through HealthChoice, the State's Medicaid Managed Care Program. A premium of \$40 per family is required of participating children living in families with incomes between 200% and 250% of the federal poverty level. Children living in families with incomes between 250% and 300% of poverty pay a \$50 monthly premium per family. Maryland's MCHP Premium program was implemented on July 1, 2001. As of July 2002, roughly twice as many parents and caregivers had contacted the MCHP Premium program to initiate the application process as were actually enrolled. A much smaller proportion (approximately 5%) of enrollees was disenrolled from the MCHP Premium program.

Due to budget constraints, the 2003 Maryland General Assembly voted to discontinue enrollment in MCHP Premium and imposed a monthly premium of \$37 per family for those children living in families with incomes between 185% and 200% of poverty. Prior to the changes in the program, the research was to be used to determine modifications and adjustments that the Department might make to improve the program, as well as assisting the Department in modifying or changing its enrollment processes in order to retain more applicants and enrollees. In addition, the research would have assisted the Department in exploring different premium and co-pay structures that might make the MCHP Premium more appealing to applicants.

A total of eight mini-focus groups were conducted with two segments of dropped applicants: four with those from whom there was no initial contact after 60 days, and four with those who rejected premium payment at the outset. Additionally, an in-depth telephone interview was conducted with 10 individuals representing a mix of

those who were disenrolled by MCHP due to nonpayment of premium, as well as those who disenrolled for unidentified reasons.

The findings of the qualitative research with parents and caregivers of MCHP Premium applicants and disenrollees are presented below.

MCHP PREMIUM FOCUS GROUP FINDINGS

Attitudes toward Health Care Coverage for Children

Parents Understand the Importance of Health Care Coverage for their Children

- Most parents have had health care coverage for their children in the past:
 - Assists with maintaining children's health
 - Look for comprehensive coverage:
 - Preventive Care
 - Hospitalization/Inpatient and Outpatient Hospital Services
 - Prescription Plan
 - Dental
 - Vision
 - Are amenable to making financial concessions to obtain

Factors Influencing Health Plan Selection for Children's Coverage

Relative Value of a Health Plan is Determined Based on Amount of Coverage Provided for the Cost

- Parents consider the range of benefits provided, including the availability of "rich" vision and dental benefits afforded for the cost.

Aspects of a Health Plan's Physician Network will Influence Selection Decision

- Aspects of a health plan's physician network that are most important to parents, include:
 - Whether or not their child's pediatrician is a participating provider
 - Quality of medical care/quality of physicians who participate in plan
 - Size of physician network and accessibility of physician practices

Cost is often the Determining Factor

- Parents evaluate all aspects and issues related to cost:
 - Monthly premium
 - Any co-pays and amount of co-pays
 - Any deductibles and amount of deductibles
 - Costs associated with going out-of-network
 - Whether or not employer is contributing

Reasons for Applying to MCHP Premium for Health Care Coverage

Catastrophic Events Triggering the Need for a Quick Solution

- A major life or job related event affecting their child's health care coverage is what leads many parents to apply to the Maryland Children's Health Program for health care coverage. Parents turn to MCHP for a fast solution to a significant problem, ensuring their child has health care coverage during a period of transition:
 - Death of a spouse
 - Loss of employment
 - Unexpected major financial obligation that depleted family's resources and made payment of health care premium impossible
 - Termination of Social Services benefits
 - Change of job/no health care coverage during probationary period

Why Dropped Applicants do not Continue with MCHP Premium Application Process

MCHP Application Form is Easy to Complete, but Process is Confusing

- Applicants, because they are applying to MCHP/MCHP Premium for a "quick solution," expect to have their application processed within a few weeks.
- Also, applicants are told an MCHP representative will contact them to complete the enrollment process; however, for several applicants this did not happen. Instead, they received a follow-up letter from MCHP indicating their application had been denied because of lack of follow through.

Financial Hardship Prevents Payment of Premium

- There are some parents, particularly those who currently do not have health care coverage for their children, who simply cannot afford the \$40 to \$50 premium for MCHP Premium coverage. These parents anticipate being able to qualify for the free MCHP program, and when denied, drop out of the application process.

Availability of Insurance through Employer

- Most "premium rejecters" answer "No" to Q.6 on the MCHP application form because they already have health care coverage through an employer. They are applying for MCHP coverage for their children to:
 - Compare costs
 - Ensure their child is covered while being added to employer's plan
 - Obtain "supplemental coverage"
- Nonetheless, there appears to be a small segment of premium rejecters who answer "No" because of financial hardship; they cannot afford to pay the \$40 to \$50 monthly premium on a consistent basis.

Why Parents Disenroll from the MCHP Premium Program

Financial Hardship

- Non-payment of premium is why parents are cancelled from MCHP Premium.
- There is a segment of disenrollees who, because of continued financial problems, cannot pay the premium for MCHP Premium coverage.
- However, parents are reluctant to contact MCHP about their financial problems out of embarrassment, because they believe nothing can be done, or because they hope that the adverse financial situation will reverse itself in time.

Increase in Family Income

- Several parents indicate they had experienced a considerable increase in family income during their MCHP Premium tenure, and as a result, had become ineligible for health care coverage through the plan.
- However, some parents express displeasure with their current private health coverage, describing it as a poor value for the money. They indicate interest in returning to MCHP Premium for health care coverage because of the “richness” of benefits, but need a family plan.

Impressions of MCHP Premium Health Plan

Lack of Familiarity among Applicants

- Parents are not familiar with the specific benefits of MCHP Premium when they initially apply. Most admit their goal is simply to obtain health care coverage for their child, preferably retaining their child’s pediatrician in the process.
- However, upon reviewing a brief summary of MCHP Premium coverage, parents state that it is much “richer” than anticipated. There is considerable interest in:
 - Preventive Care
 - Prescription Plan
 - Emergency Room Services/Care
 - Inpatient and Outpatient Hospital Services/Care

Mixed Impressions among Enrollees

- Enrollees have mixed impressions of MCHP Premium, influenced greatly by the specific MCO in which their children were enrolled.
- Experiences with the size of the physician network, accessibility of participating providers, as well as perceived quality of care, influence enrollees’ impressions of MCHP Premium.

Enrollees are Dissatisfied with Dental Plan

- The current MCHP Premium dental plan is not meeting enrollees’ needs or expectations:

- Clients are dissatisfied with the limited number of area dentists who participate in HealthChoice.
- There is a perception among enrollees that dental benefits are limited.
- Enrollees criticize HealthChoice dental practices for rude, unresponsive and impersonal service; treating MCHP Premium patients as inferior to private patients.

Attitudes Toward and Expectations Regarding Health Plan Pricing

Preferred Pricing Structure Greatly Influenced by Personal Financial and Family Situation

- The number of children, their perceived relative health, as well as estimations about number of physician visits and required prescription refills per year all influence parents' selection of a preferred premium pricing structure.
- Current monthly premium pricing structure appeals to parents who have more than one child, those whose children require numerous doctor visits, or who use prescribed medications on a prolonged basis
- Regardless of family size, many parents say they like the current monthly premium pricing structure because it is a known expense that can be incorporated into the family budget. The range of medical benefits provided for the monthly premium makes MCHP Premium a good value for the money.
- A monthly premium plus co-payment pricing structure is negatively received, considered to be "cost prohibitive" because of uncontrolled costs

Coupon Book is the Preferred Premium Payment Option, with Pay-by-Phone as an Expected Back-up Method

- A coupon book with stubs that can be mailed each month is the preferred premium payment option among parents.
- It is rated highly, both in terms of overall appeal and the likelihood that parents would enroll their children in MCHP Premium if it was an available premium payment option
- Coupon book is a familiar payment method. Several already have established such a routine for other payments.
- Perceived to have more control over when the payment is made.
- Because of continued concerns about family finances, parents like the flexibility of being able to pay the premium on the day it is due. This is the appeal of the Pay-by-Phone premium payment option.

Preliminary Observations

In considering policy options to expand coverage to the uninsured in Maryland, it is useful to categorize the uninsured into populations based on certain demographic characteristics. These populations are not necessarily mutually exclusive groups:

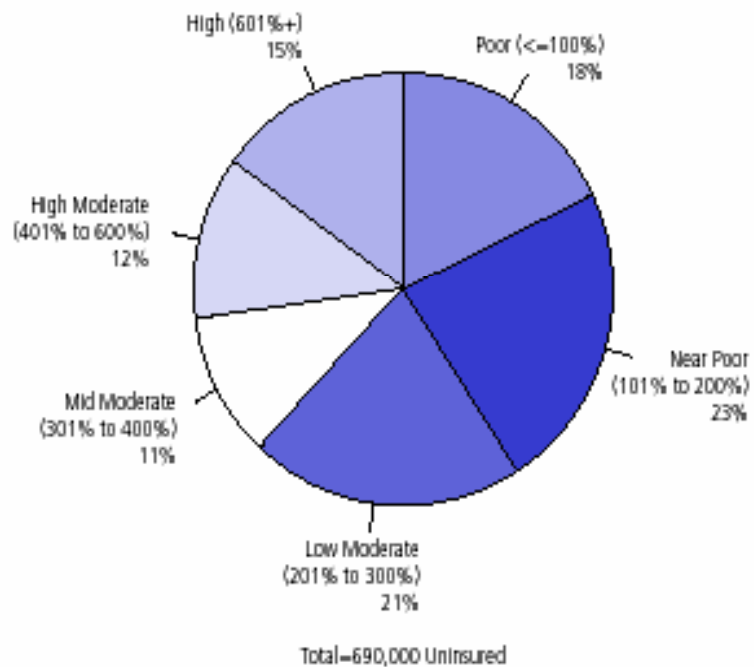
1. People who could afford to buy coverage but choose not to do so

2. People who are eligible for existing subsidy programs but do not enroll in them
3. People who cannot afford average price coverage without subsidies
4. People who might buy insurance but their employer does not offer it
5. Young adults
6. Non-US Citizens

Categorizing the uninsured in this way is useful because the policies that may be effective in expanding coverage for one category might not be helpful in expanding coverage for another.

Figure 2

The Nonelderly Uninsured by Poverty Level, 2001–2002



Before turning to policies appropriate for each group, it is instructive to recall how the uninsured in Maryland are distributed by income level, as shown in Figure 2 above (Federal Poverty Level is estimated for a Family of 3).

- Beginning with higher-income people, 27% of the uninsured in Maryland have incomes in excess of 400% of the federal poverty level (which was about \$58,000 for a family of three in 2001-2002). It seems reasonable to conclude that most of these people fall into the first category—those who can afford to buy coverage but for one reason or another do not do so. The exceptions may include very high-risk people who face prohibitively expensive premiums.
- About 41% of Maryland’s uninsured are people with incomes below 200% of the poverty level. Probably most of these people fall into the third category—people who cannot afford coverage without substantial subsidies. But some fall into the second category; they are eligible for subsidy programs but do not enroll.
- The 32% of the uninsured population who have incomes between 200% and 400% of the poverty level fall into a middle ground: many people at this income level elect to buy coverage on their own. Yet, many of the uninsured at this income level may simply have concluded that they have so little discretionary income that they cannot afford to spend a large portion of it to buy the kind of health coverage that is available to them.

The following are some general policy approaches available for covering people in each of the groups:

For those who can afford coverage but fail to buy it, one approach is to compel them to get coverage. For example, the State could mandate that all households with income in excess of \$60,000 per year buy coverage or face some kind of penalty—for example, being prohibited from taking advantage of the personal tax exemption under the State’s income tax law. Another possible approach would be to make the existing coverage options more attractive to this group. Some have suggested that high-deductible benefit plans and medical savings accounts might appeal to higher-income people who can afford to pay for routine care out of pocket but who still need financial protection against the possibility of a catastrophic medical episode. Others have suggested that a limited benefit plan for lower-income families would be more appropriate to encourage the purchase of health insurance.

For people who are eligible for subsidies but do not enroll, the options are fairly straightforward: improve outreach efforts, and reduce any stigma that may be associated with the enrollment in public programs. Specifically, the enrollment process might be simplified, made less onerous, and tailored to diverse cultural and ethnic groups; and steps could be taken to disassociate the subsidized health program from “welfare” programs.

For the third group, *low-income people who cannot afford market-price coverage*, the general approach is clear: they will require significant subsidies, either in the form of an income supplement such as a refundable tax credit to make private coverage affordable or through enrollment in a publicly subsidized special program for lower-income people.

For the fourth group, *people who might buy insurance but whose employer does not offer health insurance benefits*, there are several options. First, it may be that some of these individuals could buy a medically-underwritten product in the non-group (individual) market (presuming they could pass underwriting standards) but, because of the additional effort needed to gather information about this option, they are simply choosing not to purchase it. However, because non-group coverage must be purchased using post-tax dollars and there is no employer contribution, some of these individuals may not be able to afford such a policy, in which case they would be similar to the third group described above. Finally, there could be policies instituted to encourage or require employers to provide a mechanism for allowing an employee to purchase health insurance on a pre-tax basis. This encouragement/requirement could include or exclude an additional requirement that the employer pay some portion of the premium.

For the fifth group, *young adults*, especially dependent adult children, the focus needs to be on avoiding loss of existing coverage. Many young people who become uninsured are not yet in the work force on a full-time basis and are thus not eligible for employer-sponsored coverage. For them, the logical option is to find ways to have them continue on their parents' policies beyond the usual time when they "age-out," or, for those previously on Medicaid, to somehow continue publicly subsidized coverage.

The sixth group, *non-citizens*, may require multiple strategies to address the barriers to health care coverage. Under federal law, only certain qualified non-citizens are eligible for Medicaid. Therefore, addressing the problem of very low-income non-citizens who lack insurance coverage may rely exclusively on state and locally funded programs. Non-citizens of all income levels are more likely to be uninsured than citizens, suggesting that multiple strategies to expand coverage may need to be explored. These may include addressing any cultural or language barriers that may exist.

Incremental efforts that are relatively inexpensive to implement are likely to have only marginal effects on the problem, mainly because small reductions in the cost of coverage are not likely to induce very many people to buy health insurance. The Center for Studying Health System Change issued a report in December 2001 indicating that even very large premium reductions would produce only small

increases in the number of small-firm workers who would be covered.³ According to this analysis of firms with fewer than 50 workers, a 30% reduction in premium costs—which is significantly more than many proposed policy approaches would produce—would induce only 15% of currently uninsured small employers to offer coverage.⁴ The proportion of newly insured *workers* would be even less, for two reasons. First, a large portion of the workers in uninsured small firms, 59% nationally, already have access to health coverage from some other source (e.g., through spousal coverage) and presumably have already made a decision to either buy or not buy coverage. Second, a significant number of those who have no coverage would decline their employer's offer—about 20%, according to this study. If we assume these findings would apply to Maryland, a 30% reduction in premiums for small-group employers would result in about a 5% reduction in the number of uninsured workers in previously uninsured small firms (15% newly insured employers x 41% of employees not previously offered coverage x 80% of employees who would accept coverage = 4.92%). Of course, some of the uninsured workers in firms that already offered coverage—55% of all small firms in Maryland—would elect to purchase coverage because of the now-lower premium. Therefore, the net positive effect would be somewhat larger.

Other studies have come to similar conclusions. Even though these studies are discouraging, one should not draw the conclusion that incremental approaches are useless. Substantial numbers of people can be helped, and the target groups of incremental policies are often those most in need (e.g., children, the uninsured, and high-risk individuals). Nevertheless, it is important to understand that the problem of the uninsured cannot be solved without a substantial commitment of new money.

Rising Costs of Health Care

The level of health insurance premiums determines the affordability of health coverage. But changes in premiums mirror changes in health care costs over the long run. If health care costs rise rapidly, so will insurance premiums. In the short run, however, health care costs and health insurance premiums may not change in concert. Premium trends can differ from cost trends if coverage becomes more or less comprehensive, if consumer cost sharing rises or falls, or if the proportion of the

³ James D. Reschovsky and Jack Hadley, "Employer Health Insurance Premium Subsidies Unlikely to Enhance Coverage Significantly," Issue Brief: Findings from HSC, No. 46, Center for Studying Health Systems Change, December 2001.

⁴ In technical terms, the research concluded that the premium elasticity of demand of small establishments is 0.54. Price sensitivity is greater for the smallest small firms. For a more detailed exploration of small firms' price sensitivity see the same authors' technical article, "Small Firms' Demand For Health Insurance: The Decision To Offer Insurance," to be published in *Inquiry* in 2002.

premium allocated to administrative expenses and profits changes. Health insurance has long experienced what has come to be called the “premium cycle.” At the beginning of the six- or seven-year cycle, premiums rise less rapidly than underlying medical expense trends, and then, about halfway through the cycle, premiums start to rise more rapidly than the medical cost trend. (In the last three or four years, we have been in the second half of the cycle.) The usual explanation is competition among insurers: Initially, insurers compete vigorously to gain market share by cutting premiums which, after a time, causes losses. To make up for the losses, insurers then increase premiums to levels that are more than sufficient to cover current medical expenses, including additional revenue to compensate for past losses. After a time of revenues exceeding costs, the process starts over again.

Despite short-run disparities, long-run increases in health insurance premiums reflect long-run increases in medical costs. Premium levels cannot be reduced unless health care cost escalation is curbed. Therefore, it is important to understand what is happening to medical costs in Maryland.

The latest year for which health care expenditures estimates are available is 2001.⁵ In that year, total health care spending was \$21.0 billion in Maryland, an increase of 11.8% from the previous year. Over the last several years, rates of growth have been increasing: total spending grew by 5% in 1999, 8% in 2000, and 12% in 2001. Per capita spending was \$3,908 in 2001, an increase of 10.5% from 2000. The lower rate of per capita spending, of course, reflects an increase in the population between 2000 and 2001. The tables below show how the various components of spending increased between these two years.

⁵ The MHCC recently released an updated State Health Care Expenditures Report which uses data for 2002. See www.mhcc.state.md.us/health_care_expenditures/shear02/shear2002.pdf.

Table 2: Total Expenditures and Rate of Growth by Type of Service, 2000-2001 (\$ millions)

EXPENDITURE COMPONENTS	2000	2001	PERCENT CHANGE
Total Health Expenditures	\$18,786.6	\$21,008.8	11.8%
Hospital Services			
Inpatient	4,666.5	5,119.6	9.7
Outpatient	1,747.8	2,055.8	17.6
Physician Services	4,591.7	5,028.7	9.5
Other Professional Services	1,849.6	2,131.4	15.2
Prescription Drugs	2,072.0	2,354.2	13.6
Nursing Home Care	1,364.1	1,551.1	13.7
Home Health Care	621.5	697.8	12.3
Other Services	457.6	521.1	13.9
Administration and Net Cost of Insurance	1,415.7	1,549.1	9.4

Table 3: Per Capita Expenditures and Rate of Growth by Type of Service, 2000-2001

EXPENDITURE COMPONENTS	2000	2001	PERCENT CHANGE
Total Per Capita Expenditures	\$3,537	\$3,908	10.5%
Hospital Services			
Inpatient	879	953	8.4
Outpatient	329	382	16.2
Physician Services	865	936	8.2
Other Professional Services	348	397	13.9
Prescription Drugs	390	438	12.3
Nursing Home Care	257	289	12.3
Home Health Care	117	130	10.9
Other Services	86	97	12.5
Administration and Net Cost of Insurance	267	288	8.1

Source: Maryland Health Care Commission, *State Health Care Expenditures: Experience from 2001*, January 2003.

Inpatient hospital services, physician services, and administrative costs rose at a slower rate than the rate of total health expenditures. In contrast, outpatient hospital costs far outpaced the growth of any other expenditure component. Prescription drugs, nursing home care, and other professional services also grew at rates greater than the rate of overall expenditures.

To help understand the causes of cost escalation, it is useful to look at data that separate out the effects of price increases from increased utilization of services. Maryland-specific data is available for physicians and other health care practitioners for the care of privately insured Maryland residents under age 65. As shown in the table below, for the period 1999 to 2001, total expenditures for non-HMO plans increased by 28%. None of the increase was due to increased payment rates to professional providers; in fact, payment rates fell slightly. Increases in the number of people using services accounted for 17% of the total, and increases in services per

user and in the intensity of service each accounted for 5%. At least for this sector of the health economy, cost escalation is a result of more people using services, using them more often, and using services of greater intensity; it is not a result of increased payment rates to professional providers.

Table ES-1: Estimated Sources of Spending Growth for Non-HMO Plans

Sources of Spending Growth	Growth 1999- 2000	Growth 2000-2001	Cumulative 1999-2001
Increase in Payment Rates	0%	-1%	-1%
Increase in Reported Persons Using Services	8	8	17
Increase in Services per Reported User	0	5	5
Increase in Intensity per Service	2	3	5
Total Expenditure Increase	10	16	28

Source: Maryland Health Care Commission, "Practitioner Utilization: Trends Within Privately Insured Patients," 2000 to 2001, March 2003.

The cost increases of recent years are not an anomaly. Trend data for Maryland and the United States show that health care costs consistently grew more rapidly than the economy as whole. Since wage increases have not kept pace with health care cost increases, it is not surprising that many people who have to pay for health insurance from their own resources find that coverage is unaffordable.

It is not an easy task to disentangle the underlying causes of cost escalation. Most observers of the health care system believe that recent increases have been fueled by the retreat from managed care.⁶ In the mid-1990s—when many large employers were turning to managed care as a way of reducing their costs—the rate of increase of health care costs and insurance premiums fell well below previous levels. However, as consumers and physicians expressed increasing dissatisfaction with the attempts of managed care to constrain utilization of medical services and, as employers were forced to compete vigorously for scarce labor resources at the peak of the economic boom, employers began to turn away from the more stringent forms of managed care to placate their employees. The result was that utilization rates increased and premiums rose.

Several years ago, prescription drug costs were also rising much more rapidly than overall health care costs. There is evidence that this was in part a consequence of pharmaceutical companies' aggressive advertising campaigns directed to consumers. But, the development of new, more effective, but also more expensive, drugs played a part as well. In the last couple of years, drug costs have been advancing less

⁶ Cara S. Lesser and Paul B. Ginsburg, "Health Care Costs and Access Problems Intensity," Center for Studying Health System Change, Issue Brief No. 36, May 2003.

rapidly, perhaps partly in response to efforts by insurers to impose sophisticated forms of consumer cost sharing to discourage use of high-cost brand-name drugs.

Almost everyone agrees that the ever-more-rapid pace of technological change in medicine is responsible for a large portion of health care cost escalation. As a general rule, new technologies are more expensive than the ones they supplant, and technologies that were originally developed for certain limited purposes often become used on a more-or-less routine basis to diagnose or treat less critical medical conditions. While the result may be improved health status, less intrusive kinds of medical intervention, and more comfort and convenience for patients, costs rise as a result. There is no reason to expect the pace of technological change to diminish, and as long as the health care financing system gives well-insured people almost unlimited access to these new technologies, the cost-escalating consequences will be reflected in higher insurance premiums. No obvious solution is in sight.

Many careful students of the health care delivery system believe that there is one source of high costs that can be addressed—namely, the waste and inefficiencies that are by-products of failing to deliver quality care. There is well-documented evidence that accepted standards for best medical practice are often not met. What needs to be done is often not done, and what is done is too often not necessary. The fact that often-repeated studies show that people in different areas of the country and even within different areas in a state receive very different treatment for identical medical conditions is strong evidence of the problem. Not all the changes to improve quality would reduce costs, because some people receiving treatment do not get services that they need. However, quality improvements in many instances would involve less expensive treatments and, in other instances, would make treatment for later expensive episodes of illness unnecessary.

The Cost of Non-insurance

Having large numbers of people uninsured is costly. People without health insurance are more likely to postpone seeking care when they first become sick or need preventive services. As a result, they are more likely to develop serious conditions that are more costly to treat and are a threat to their long-term well-being. These consequences are not trivial. The Institute of Medicine (IOM) estimated that nearly 18,000 people die each year in the United States because they lack health insurance. The IOM also concluded that people who lack health coverage get poorer care when they do enter the medical system.

Clearly, not having health insurance imposes burdens on the uninsured in terms of reduced health status and increased likelihood of death. But, the lack of insurance coverage has financial consequences as well. Although the uninsured themselves pay a significant portion of the health care bill when they seek services, a larger portion of the costs are passed on to the rest of society. Some are absorbed by health care providers as charity care when they offer services without being fully compensated. Others are passed on in the form of higher bills to health care users who are insured, the so-called cost shifting phenomenon. Many costs are picked up by various state and county programs.

Understanding the magnitude of the costs associated with the uninsured can help in assessing the cost of policies to expand insurance coverage. Assume a policy were put in place to provide universal coverage. What would be the cost of extending coverage to everyone? As noted above, many of the costs of medical services that would be consumed by this newly insured population are already paid either by the uninsured themselves or by others. Some costs now incurred by the uninsured would be avoided because people would receive more timely care. Even so, evidence shows that if the uninsured were to have coverage, their net consumption of medical services would increase. Thus, total health care spending would rise, but the net increase would be substantially less than the total cost of the medical services consumed by the newly insured.⁷ Furthermore, some of the costs that would otherwise be paid by other payers are recoverable and could be used to finance the cost of the policy that expands coverage. For example, some of the dollars now spent by the public safety net system to cover the costs of services consumed by the uninsured could be diverted to pay for their insurance coverage.

Through the HRSA grant, the state of Maryland commissioned a study to estimate the costs of non-insurance in the State. Hugh Waters, Ph.D., of the Johns Hopkins University Bloomberg School of Public Health, directed the study, which made estimates for the following components of costs related to lack of insurance coverage for the fiscal year July 2001 to June 2002:

- ☐ uncompensated hospital care
- ☐ other public subsidies for the uninsured
- ☐ physician ambulatory services
- ☐ philanthropic spending

⁷ A recent estimate of the increase in health spending that would result from achieving universal coverage for the United States as a whole indicated that spending on the uninsured would increase within a range of about 53% to 100%, depending on whether the form of coverage was similar to average public coverage or average private coverage, respectively. However, this increase results in only about a 3-6% increase in total health care spending. See Jack Hadley and John Holahan, "Covering The Uninsured: How Much Would It Cost?" *Health Affairs*, web exclusive, June 4, 2003.

- ☐ uninsured individuals' costs
- ☐ lost health status
- ☐ added risk

The total cost associated with the people who lack insurance coverage in Maryland is estimated to be between \$2.4 billion and \$3.7 billion per year. The cost per full-year uninsured resident is between \$3,502 and \$5,365. These figures include the costs borne by the uninsured individuals themselves.

Table 4 below summarizes the study findings.

Table 4. Total Expenditures and Costs Related to Non-Insurance, by Component

Component	Value FY 2002 (\$ millions)		% of Total (Low Estimate)
	Low Estimate	High Estimate	
1. Hospital Care	\$253.9	\$370.3	10.5%
2. Other Public Subsidies :			
Statewide programs	\$408.6	\$408.6	16.9%
County-level	\$42.9	\$42.9	1.8%
FQHCs	\$10.0	\$10.0	0.4%
School-based health	\$0.5	\$0.5	0.0%
3. Physician Services	\$210.7	\$210.7	8.7%
4. Philanthropic Spending	\$12.1	\$25.4	0.5%
5. Individuals' Out of Pocket	\$317.7	\$317.7	13.1%
6. Health Status Losses	\$1,137.5	\$2,268.1	47.0%
7. Losses from Risk	\$28.0	\$56.0	1.2%
Total	\$2,422	\$3,710	100%

Table 5 below summarizes the estimates of costs *exclusive of those borne by individuals*. Maryland government is the single largest contributor to direct expenditures for the uninsured. The State paid \$311 million for services for uninsured individuals through public health programs in FY 2002. Additionally, the State contributed between \$20 and \$29 million to spending on uninsured hospital patients and also paid funds to FQHCs and school-based health programs.

Table 5. Total Expenditures and Costs Related to Non-Insurance, by Component and Source – Excluding Individual Payments and Losses

Component	Value FY 2002 (\$ millions) - by Source							Total	
	Federal Government		State Government		Local Gov't	Private Payers			
	Low	High	Low	High		Low	High	Low	High
1. Uncompensated Hospital Care	\$139	\$203	\$20	\$29		\$95	\$139	\$254	\$370
2. Other Public:									
State programs	\$98	\$98	\$311	\$311				\$409	\$409
County-level FQHCs	\$33.5	\$33.5			\$9.4			\$42.9	\$42.9
School health	\$6.8	\$6.8	\$3.2	\$3.2				\$10.0	\$10.0
	\$0.1	\$0.1	\$0.2	\$0.2	\$0.1			\$0.5	\$0.5
3. Physicians						\$211	\$211	\$211	\$211
4. Philanthropy						\$12	\$25	\$12	\$25
Total	\$277	\$341	\$334	\$343	\$10	\$318	\$375	\$939	\$1,068

The fact that the payers other than uninsured individuals are incurring costs of about \$1 billion per year for the uninsured does not mean that it is possible to “capture” savings of that amount to pay for a program to provide everyone with coverage. If all Maryland residents had coverage, some current costs would be eliminated; that is, these costs are recoverable—for example, state, federal, and local government spending for various state and county programs, for school health programs, and for safety net providers. However, some of the savings would be retained by other payers. Physician incomes would rise, hospital uncompensated care would decrease for all payers, philanthropic spending would decrease, and previously uninsured people would spend less out of pocket. These savings would not be available to finance the subsidies that may be necessary to achieve universal coverage.

INTRODUCTION TO OPTIONS

The sections that follow outline a range of options for extending coverage to people without health insurance in Maryland. This is not a list of recommendations. Rather, it is a list of the range of options that are available. The options are grouped into four categories: publicly subsidized coverage programs (Medicaid and SCHIP expansions); reforms to improve coverage for small employers; options aimed at people buying coverage as individuals; and mixed options, which have both public and private elements. Each option is described, the advantages of the option are discussed, and issues and potential problems are outlined.

Although options are listed separately, no single expansion option will solve the problem of the uninsured. In all probability, to make substantial progress toward achieving coverage for all Maryland residents, a variety of policy changes will be necessary. It is certainly possible to combine policies to create a logical and comprehensive program to move toward universal coverage.

Activities of the Health Care Coverage Workgroup

At several meetings of the Workgroup, policy options for extending coverage to the uninsured were discussed. At the initial meeting where options were discussed, a list of principles to guide the selection and prioritization of the options was provided and debated (see **Appendix B**) and then staff presented an overview of a number of potential options (see **Appendix C**).

The Full Range of Possible Policy Options

The following is information that was provided to the Workgroup to help it understand the options that were provided for discussion.

Generally speaking, there are three groups that make decisions affecting insurance coverage that the State could seek to influence: individuals, employers, and insurers.

It is obvious even from casual observation that, for many of the uninsured, the price of coverage is the major barrier that prevents them from purchasing coverage. Conceptually, policies that lower prices sufficiently can have the effect of ensuring

that virtually everyone buys coverage. Therefore, when considering policy options to extend coverage, it is useful to think in terms of the way various groups of uninsured would respond to price changes. (The relevant price for this analysis is the *net* price that the uninsured would pay out of pocket.)

Some uninsured individuals face unusually high prices because they represent high risks to insurers due to some present or recent medical condition or personal characteristic that is thought to be a good predictor of higher-than-average future medical expenses. For most of these people, a policy that lowered the net price to that paid by people of *average* risk would induce them to voluntarily purchase coverage.

For those uninsured people who have such low incomes that they cannot afford even reasonably priced coverage, the net price would have to be reduced very substantially to induce them to voluntarily purchase coverage.

Some uninsured people can afford coverage at its current market price but choose not to purchase it because they do not perceive the benefits as justifying the expense. There may even be some people who would fail to voluntarily purchase coverage even if the net price to them were close to zero. Ultimately, however, even these people would respond to falling prices, although for those at the extreme, the price might have to be negative; that is, they would have to be *paid* to get them to acquire covered.

In essence, all policy options short of mandating coverage can be thought of as reducing the net price of acquiring coverage. Every decrease in price will cause some additional individuals to purchase coverage, because people have different threshold price points where they will decide to buy coverage. But there are some classes of uninsured people—probably large numbers of them—that will make the decision to seek coverage only if their net price is reduced very substantially.

There are, of course, a variety of ways to reduce the net price of coverage. Some involve policies to influence individuals' decisions, others affect employers, and still others are designed to change the way insurers do business. The outline below spells out the policy options for lowering the net price of coverage. (At this point, only the range of options is being considered. Later in this document, advantages and disadvantages are considered.)

Policies to Reduce Net Price

- 1) Reduce the price of coverage that can be purchased through normal private markets.
 - a) Provide people who cannot afford the full market price of coverage with *vouchers* that they can use to purchase standard coverage. This is a very direct subsidy.
 - b) Provide *tax credits or deductions* to lower the after-tax cost of providing coverage. This is more indirect because it occurs after the purchase is made, although credits can be designed to be payable in advance, which makes them similar to vouchers.
 - i) Credits or deductions to *individuals* lower the net cost of coverage by making their after-tax income higher than it otherwise would be.
 - ii) Credits or deductions to *employers* lower the cost to individuals indirectly; the employer pays more of the premium and thus employees pay less; a portion of the employer's cost is then subsidized in the form of a lessened tax burden and higher after-tax income.
 - c) Permit individuals (and perhaps small groups as well) to *buy into an existing private plan*, such as the state employees plan. Individuals and small groups may realize some cost reduction because the scale of the system makes some economies possible, primarily because administrative costs are spread over a large group. In addition, higher-risk individuals would get lower-priced coverage because their higher-risk is being spread over a large group, and the rest of the group would be indirectly "subsidizing" their cost. It would also be possible to make coverage available at a premium that is below the actual cost of providing coverage, that is, at an explicitly subsidized rate. But someone would have to make up the shortfall.
- 2) Authorize the establishment or designation of private purchasing organizations that would offer subsidized coverage to target populations, such as low-wage and uninsured small firms.
- 3) Develop special public coverage programs for individuals who cannot afford private coverage. The net price is substantially below actual cost because government subsidizes the cost. In some cases, the cost to the individual is nearly zero. Examples include the following:
 - a) Medicaid expansion
 - b) CHIP expansion
 - c) High-risk pools (where the premium is below cost).
 - d) Some new program designed especially for the currently uninsured.

- e) Allow uninsured to go to public clinics and other providers established especially to provide care at a price below-cost (perhaps paying on a sliding-scale basis related to income)—the “safety net provider” approach.
 - f) The so-called “single-payer” or social insurance model. Under this variant of the subsidized public program, coverage is available to everybody, regardless of need, as a matter of “right” and with very little cost to the covered person (the Medicare [Part A hospital coverage] model).
- 4) Reduce the net price to *higher-risk* groups and individuals.
- a) Extend the size of the risk pool.
 - i) Pass small-group and individual market reforms that limit the range of rate variation between high-risk and low-risk people; mandate that insurers not deny coverage; and limit exclusion of coverage for prior conditions. (Maryland has already legislated many of these provisions in the small-group market.)
 - ii) Establish health insurance purchasing cooperatives for small employers. (Similar objectives as above but also to allow individual employees to have a choice of plans.).
 - iii) Require all insurers to share in the risk through some kind of risk pooling across all insurers (e.g., require all insurers to share losses in the individual market).
 - b) Regulate premium prices by requiring approval of price increases.
- 5) Reduce the *cost* (as contrasted with the price) of coverage.
- a) Induce insurers to offer policies that provide less comprehensive coverage—that is, change the insurance product.
 - i) Eliminate some or all mandated benefits.
 - ii) Define a benefit plan that covers only “catastrophic” expenses or other “bare bones” coverage.
 - iii) Define a benefit package that covers just primary and preventive care (on the assumption that safety-net providers will cover the cost of a catastrophic expense, or require all insurers to contribute to a pool to cover such “uncompensated” care).
 - b) Find ways to make existing coverage more efficient so that it can be sold at a lower price.
 - i) Purchasing pools (e.g., health purchasing cooperatives) to reduce administrative costs.

Mandated Purchase

There is another class of public policies that are not aimed at lowering the price but instead involve some kind of mandates to either provide or purchase coverage. To make such mandates workable from a practical standpoint, they would normally need to be accompanied by some sort of subsidies for some people.

- 1) Employer mandates.
 - a) Require employers to offer coverage to employees and/or to pay for a portion of coverage.
 - b) Implement a “play or pay” mandate: employers either provide coverage or pay some kind of tax to finance other coverage.
- 2) Individual mandates.
 - a) Require individuals to purchase coverage.
 - b) Mandate “play or pay” for individuals (above a certain income level): e.g., impose a tax that is forgiven if the individual purchases coverage or is covered by employer coverage. (Tax revenues would then go to pay for uncompensated care. Note that this policy is essentially the obverse of a tax credit.)

Discussion by the Health Care Coverage Workgroup

The Workgroup was asked to narrow the options which it had been presented in order to provide guidance about which options should have further consideration especially in view of the desire to have some econometric modeling performed to determine the effect of the option. There was disagreement among Workgroup members about which options should be eliminated from consideration and substantial debate about the rationale for either eliminating or maintaining a particular option.⁸ While there was some progress made in terms of narrowing the options to carry forward for further discussion, reaching consensus to narrow the choices to only four or five was not possible. As such, most of the options presented to the Workgroup are contained in this report. Some options became subsumed into other options (e.g., extending Medicaid coverage to parents became part of the public coverage option; the limited benefit option became part of the small group market options). It later became apparent to staff that performing econometric modeling for many of the options enumerated as private sector options was beyond the technical capabilities of the grant given its timeframes. Some public sector modeling is still in process but is not available for this report.

⁸ For additional details of the Workgroup’s discussion of the various options, see the minutes of the March 3, April 11 and June 5, 2003 meetings of the Workgroup available at <http://www.dhmd.state.md.us/hrsa>

All the policy options described below were considered by the Health Care Coverage Workgroup and, in many instances, the discussion reflects issues raised by the Workgroup. The inclusion of an option, however, does not imply endorsement by the Health Care Coverage Workgroup. In fact, in some instances, the discussion of the Workgroup suggests that the policy may not be particularly attractive or appropriate for Maryland at this time. There was little or no consensus about many of these options.

PUBLIC COVERAGE

Maryland's existing publicly funded health care programs can be divided into two major categories: (1) comprehensive health insurance coverage programs – Medicaid and Maryland Children's Health Program (MCHP); and (2) safety net and gap-filling programs.

Medicaid and Maryland Children's Health Program (MCHP)

The Medicaid program provides medical and long-term care coverage to low income Maryland residents in the following three main groups: (1) Children and their parents, including pregnant women; (2) Individuals with disabilities; and (3) Elderly individuals. Through Medical Assistance, Maryland provides comprehensive health insurance to approximately 570,000 people – about one in ten Marylanders.

Under the Maryland Children's Health Program (MCHP), children in families with incomes up to 300% of the federal poverty level (about \$43,500 for a family of three) are eligible for Medicaid coverage. Children in families with incomes between 200% and 300% of the federal poverty level (MCHP Premium Program) pay a monthly premium. During FY 2004, the MCHP Premium program was frozen to new enrollments for children in families with incomes above 200% of the federal poverty level (about \$29,000 for a family of three). Only one state has a higher income eligibility standard for children. Despite Maryland's generous coverage of children, the Maryland Medicaid program has one of the most restrictive income eligibility criteria for adults. Low-income parents must have incomes below 40% of the federal poverty level. For a family of three the income limit is \$5,200 annually. Childless adults must be aged, blind or disabled as well as meeting federal Supplemental Security Income standards. In recent years, a number of targeted programs have been implemented that serve individuals with disabilities and elderly individuals. Pregnant women with incomes up to 250% of poverty are covered under Medicaid.

About 80% of Medicaid beneficiaries receive service through HealthChoice, a statewide managed care program. Those not enrolled in HealthChoice are Medicare beneficiaries, are in institutions, are receiving limited Medicaid services, or are

enrolled for a limited period of time. Children account for about 65% of Medicaid enrollment, but less than 22% of expenditures (FY2002).

Safety Net and Gap-Filling Programs

In addition to Medicaid and MCHP, there are a number of other publicly funded programs that fill in the gaps in existing health insurance coverage and provide medical services for specific groups or specific services. Income eligibility guidelines for these programs vary from program to program, and generally these programs have disease-specific eligibility criteria. These programs include:

- Breast and Cervical Cancer Screening Program
- Breast and Cervical Cancer Diagnosis and Treatment Program
- Maryland Primary Care
- Children's Medical Services
- Alcohol and Drug Abuse Treatment Services
- Public Mental Health System
- Kidney Disease Program
- Medbank
- Maryland AIDS Drug Assistance Program
- Maryland AIDS Insurance Assistance Program
- Ryan White
- Cigarette Restitution Fund Cancer Prevention, Education and Screening Program
- Tobacco Use Prevention and Cessation
- WIC

Overview


Federal law allows states the option to cover parents in low-income families under Medicaid or through Medicaid or State Children's Health Insurance Plan waivers. Many states have used these mechanisms to expand Medicaid coverage for parents. Additionally, states have used waivers to expand coverage for childless adults.

Some states have drawn on unused CHIP allotments or disproportionate share funding to expand coverage for parents or childless adults. Neither of these funding sources is available for Maryland. Maryland has used all of its CHIP allotment and has relied on redistributions from other states to finance the MCHP program. In addition, Maryland is a low Disproportionate Share Hospital (DSH) Program state and has no DSH funds that it could redirect to finance an expansion to parents or childless adults. More recently, states have used Medicaid waivers to provide a limited benefit package to adults.

In September 2003, Secretary Sabatini proposed an amendment to Maryland's existing 1115 waiver to provide primary care coverage to low-income adults up to 116% of the federal poverty level. This proposed waiver amendment expands the benefits available to individuals currently enrolled in the Maryland Pharmacy Program.

Maryland could expand comprehensive Medicaid coverage to low-income parents or, using a waiver, could expand Medicaid coverage to low-income parents and childless adults.

Advantages

- *Maximizes use of federal funds:* Half of the costs of a Medicaid expansion would be paid for with federal matching funds. Maryland receives a higher federal match under the MCHP program (65% federal funds), but, because Maryland has exhausted its allotment, the higher match would not be available.
- *Existing infrastructure:* The Medicaid program already has an existing infrastructure to provide coverage to 570,000 Marylanders. About 80% of Medicaid enrollees receive services through the HealthChoice program. Under HealthChoice, individuals enroll in one of 7 private Managed Care Organizations.
- *By offering coverage to parents, more children are likely to enroll and use services.* Evidence suggests that offering coverage to parents will result in more children enrolling in programs. In addition, by providing the family with the same comprehensive insurance coverage, individuals are more likely to use needed health care services. 

Issues

- *Crowd-out.* Some individuals who currently have private health insurance coverage will become eligible for free comprehensive insurance coverage under a Medicaid expansion. Some of these individuals may choose to drop private

coverage. A program would need to be carefully designed to minimize the incentives for currently insured individuals to drop private coverage.

- *Welfare stigma.* Most state experience suggests that some individuals who are eligible to receive public coverage choose not to. One of the reasons people may not enroll in Medicaid is the concern that it is a welfare related program. The program design would need to take this concern into consideration when developing the enrollment process and outreach activities.
- *Cost.* Any expansion of the Medicaid program would necessitate the use of additional State general funds, even with a federal match for the program.

Questions to be addressed

1. What income requirements should be established for adults under for the expanded Medicaid program?
2. Should adults have access to all of Medicaid's comprehensive benefits?
3. Should adults enrolled in the Medicaid program be required to contribute to the cost of their care through premiums, co-payments, or deductibles?
4. Would the Medicaid physician fee schedule have to be increased significantly to support a large expansion to the Medicaid program?

SMALL GROUP MARKET OPTIONS

Maryland Health Insurance Reform Act of 1993

In 1993, the Maryland General Assembly enacted House Bill 1359, which, among other duties, charged the Maryland Health Care Commission (the Health Care Access and Cost Commission at the time) with implementing reforms in the small group health insurance market. At that time, the small group market (employers with under 51 employees) was in disarray. Premiums were increasing rapidly for many employers. Insurance carriers were dropping coverage for an entire employer group when just one employee had increased claims experience. Medical underwriting was excluding coverage for those very diseases and conditions that were in need of coverage. In addition, small employers were the most likely to not have human resources personnel to analyze competing benefit plans, thereby making it difficult for them to comparison-shop across carriers.

House Bill 1359 and subsequent improvements have stabilized the small group market. Current protections in this market include guaranteed issue and renewal, a preexisting condition limitation prohibition, and adjusted community rating (based only on age and geography). In addition, the Comprehensive Standard Health Benefit Plan (CSHBP) was devised to provide a standardized set of benefits and copayments to allow employers to make accurate comparisons of premiums across plans offered by different carriers. Recent legislation altered the premium cap, or ceiling, of the standard plan, so that the cost may not exceed 10% of the state's average annual wage. Carriers pool the risk of all small groups they insure: the rate charged to any particular employer group cannot vary by more than $\pm 40\%$ from the average rate.

While the success of the State's small group market reform effort, now in its tenth year, has increased access to employer-based coverage for residents, it has not solved the problem of the uninsured among small group employers: 44% of uninsured

workers ages 19-64 in Maryland work for companies with 25 or fewer employees.⁹ The annual average cost of the CSHBP per employee in 2002 was \$3,813 (or \$4,885 with riders).¹⁰ This premium represents a blended figure of the premium of employee-only and family plans. In 2002, the number of covered lives in the small group market decreased by 1.7% from 2001, while the number of employer groups increased by almost 1%.

States generally define a small employer as a firm employing 50 or fewer workers, and every state has passed reforms affecting the provision of health insurance in the small group market. Forty-eight states have enacted legislation prohibiting insurers from denying coverage to small employers (guaranteed issue); HIPAA regulations guarantee the renewal of health plans for small employers in all states; all 50 states have limits on preexisting condition exclusion clauses (although not all states have prohibited limitations entirely); and 47 states maintain premium rate restrictions.¹¹ Every state, with the exception of Maryland, offers more than one health plan option to small employers. Although one standard plan must be offered by all carriers selling in the small group market in Maryland, that plan can be enhanced by riders that add benefits to enrich the coverage available in the CSHBP or that lower deductibles and copayments. These options can lead to numerous variations on the standard plan. Ninety-nine percent of employers are buying riders, at a higher premium, to enhance the Standard Plan.

This paper provides an overview of four options that have been suggested as ways to expand affordable health insurance coverage in the small group market in Maryland, as well as the major benefits and drawbacks associated with each proposal.¹² The four options include:

1. Basic Health Coverage Plan
2. Voluntary Purchasing Pool
3. Reinsurance
4. Tax Credits for Small Employers

⁹ Current Population Survey (CPS). Data for 2001 – 2002.

¹⁰ *Maryland's Small Group Health Insurance Market, Summary of Carrier Experience for CY2002*, MHCC 6/19/2003.

¹¹ National Conference of State Legislatures. *Major Health Care Policies: 50 State Profiles*. 1997.

¹² See Appendix D for public comments solicited by the Maryland Health Care Commission on these options.

Basic Health Coverage Plan

Allow health insurance carriers to offer a basic plan with limited benefits to small employers, in addition to the Comprehensive Standard Health Benefit Plan (CSHBP).

Overview

The MHCC is currently charged with designing the Comprehensive Standard Health Benefit Plan (CSHBP), which is the minimum plan that carriers in the small group market must sell to small employers. The design of the CSHBP includes the benefits that must be covered and specifies cost-sharing arrangements. The current minimum benefits of the plan must be the actuarial equivalent of the minimum benefits required to be offered by a federally qualified HMO. The cost of the CSHBP may not exceed 10% of the State's average annual wage.¹³

Legislation was introduced this year that would have required the Maryland Health Care Commission (MHCC) to develop a basic health benefit plan for employers with 2 to 50 employees and self-employed individuals.¹⁴ The cross-filed bills, which did not specify a minimum set of benefits, stated that the premium of a basic plan could not exceed a certain percentage of the State's average annual wage (House bill proposed 6% and Senate bill proposed 8%). While both House and Senate versions of this legislation did not pass, legislation enacted during this year's session requires MHCC to study the feasibility of offering a basic plan in the small group market.

Catastrophic Coverage: One possible design for a basic plan is catastrophic coverage. Without a change to current law, catastrophic coverage would have to include the benefits that are required to be offered by a federally qualified health maintenance organization (FQHMO). Catastrophic plans generally cover major hospital and medical expenses and include relatively high deductibles that must be met before the carrier pays for expenses. A catastrophic plan does not provide first-dollar coverage for routine visits to doctors or prescription drugs, requiring the enrollee to pay for these services out-of-pocket until the deductible is met. Commission action at its October 30 public meeting created a high-deductible PPO plan within the CSHBP benefit design structure. Deductibles in the CSHBP can now be as high as \$2,500 for an individual and \$5,000 for a family. However, once deductibles are met, coverage is comprehensive.

¹³ Senate Bill 477 (2003), *Small Business Health Insurance Affordability Act*, reduced the cap from 12% to 10%.

¹⁴ House Bill 627/Senate Bill 382 (2003), *Health Insurance – Small Group Market – Basic Health Benefit Plan*.

Limited Benefit Coverage: Another type of health insurance plan that a growing number of employers are offering to low-income employees is a limited benefit plan. Under this type of plan, employees, for example, could pay a lower premium for coverage primarily for everyday medical care, such as doctor visits. A much lower deductible is usually required to be met before benefits are paid by the insurer. These plans may limit a carrier's annual exposure in medical expenses; under some limited benefit plans, hospitalization and other major medical expenses are limited in reimbursement, if covered at all.¹⁵

Programs with Minimum Ambulatory Services: Communities in several states are developing or have implemented programs of minimum ambulatory services (no acute care) targeted to low-income individuals. An example of a program for this population is the Ingham Health Plan (IHP) in Ingham County (Lansing) Michigan. The IHP provides primary and preventive care for over 12,000 county residents with incomes less than 250% of the FPL. Members have nominal co-payment amounts. Covered services include primary care (which is capitated), specialty care (which is prior authorized), laboratory and radiology (contracted with local hospitals), and prescription drugs. The formulary includes primarily generics and is restrictive. This model assumes that these are the services low-income individuals are most likely to "do without." They will seek and receive emergency and urgent care from the "safety net" system, often as charity care of a hospital system. Limiting the scope of benefits reduces "crowd out" – the chance that this program will lead individuals eligible for employer-sponsored coverage to forego that option and instead choose the limited benefit program.¹⁶

Advantage

- *Increased Affordability and Access:* The average cost of a basic health benefit plan may be lower than the CSHBP because of its more limited coverage. Employees who currently cannot afford to obtain and maintain health insurance coverage through the Standard Plan for themselves and their dependents may be able to purchase a basic benefit plan. This increased access to health care could, in turn, help to improve the quality of health of these individuals.

¹⁵ Terhune C. "Fast-growing health plan has a catch: \$1,000-a-year cap." *Wall Street Journal*. 14 May 2003.

¹⁶ In each of the communities using this model, special Medicaid financing strategies are used to draw federal funds to enhance the available local funds.

Issues

Several issues need to be considered in deciding whether the MHCC should create a plan with fewer benefits.

- *Risk-Segmentation:* The availability of a basic health benefit plan in the small group market could encourage risk segmentation in that market. A plan offering fewer benefits and greater cost-sharing arrangements for employees is likely to be marketed to and chosen primarily by employers who have relatively healthy or young employees. Less healthy or older employees will need and choose the CSHBP (or a plan which is even more enhanced) because it has more comprehensive benefits and lower out-of-pocket costs. As a result of this segregation of low-risk employees from higher-risk employees, the healthier employees would no longer be part of the shared-risk pool and would no longer help to subsidize less healthy or older employees; this could cause the small group market to deteriorate. Any limited benefit plan may need to offer substantially fewer benefits than the Standard Plan to discourage this potential adverse selection.

If this risk segmentation occurred, premiums in the CSHBP would have to increase in order to cover the claims of the smaller, less-healthy, and older pool. Increasing premiums for those with the greatest health and financial needs for insurance will lead to a portion of these individuals opting to go without health coverage or employers dropping coverage—perhaps causing an adverse selection “death spiral.” On the other hand, information from carriers stating that almost all employers who are currently buying the CSHBP are also purchasing enhancements to the plan shows that currently-insured employers seem to want an enhanced plan rather than a more limited one. Thus, the potential for adverse selection may be overstated.

- *Effects of Benefits under a High-Deductible Catastrophic Plan:* A basic plan that is essentially a catastrophic plan would likely cover only major hospital and medical expenses and include high deductibles. The enrollee would pay out-of-pocket for doctor’s office visits and other preventive care benefits, including prescription drugs. For lower-income employees and their families, the need to pay for covered benefits (before the deductible has been met) and those benefits not included in a basic plan could be prohibitively expensive. Research has shown that even with minimal cost-sharing, low-income consumers might forego needed primary and preventive care. Benefit plan design with some first-dollar preventative care could mitigate this problem.

- *Effects of Benefits under a Limited Benefit Plan:* Individuals enrolled in a limited benefit plan may not be able to obtain needed health care services if the plan does not provide coverage or adequate coverage for a particular condition or they exceed coverage limits. This could lead to poorer health outcomes among these individuals than if they had comprehensive coverage. Allowing the sale of such coverage starts what many would see as a bad precedent by allowing the sale of coverage that provides inadequate protection against the kinds of expensive events that are the real purpose of insurance. However, if the individuals opting for a limited benefit plan would otherwise be uninsured, then some benefits are arguably better than no benefits, especially if certain preventative benefits were covered.
- *Past Experience Shows Basic Benefit Plans are Unpopular:* Basic plans, especially catastrophic plans, typically have not been popular, as small employers seem to want to offer comprehensive benefits similar to large employers. However, limited benefit plans are currently the fastest-growing health insurance offerings in the workplace, due in large part to the economic downturn and increasing health care expenses.¹⁷
- *Employees Lose Choice of More Comprehensive Plan:* If employers selected only a basic health plan for cost reasons, then their employees would be subject to that decision unless they bought a more comprehensive plan on their own without the benefit of pretax dollars.

Questions to Be Addressed

A number of questions are generated when considering the issue of a basic health plan in the small group market:

1. Who is the target audience for the basic health plan? And how will that affect what should be the benefit structure of the basic plan? For example, for small employers, it is more likely that a catastrophic plan would be appealing to those whose employees have high average income, while a limited benefit plan with first dollar coverage or at least lower deductibles may be more attractive to those at the low-wage end of the scale.
2. What services should be included in or excluded from the basic plan (i.e., preventative care, comprehensive primary care, urgent and emergent hospital and surgical care, mental health integration, etc.)?

¹⁷ Terhune C. "Fast-growing health plan has a catch: \$1,000-a-year cap." *Wall Street Journal*. 14 May 2003.

3. Should riders be prohibited? If employers were allowed to buy riders for additional services to bring the basic health plan to just under the CSHBP, what would be the point of having the CSHBP? One option is to allow riders to decrease the copays and deductibles but not allow riders to increase the services in the plan.
4. Should a basic benefit plan be available only to those employers who had not offered coverage during a certain defined past (i.e., no benefits offered during the past 24 months) to discourage employers who offer more comprehensive coverage to drop that coverage?
5. Should the basic benefit plan be designed with a floor and a ceiling so that carriers can be creative within those parameters (e.g., a floor that requires a minimum of 10 days of inpatient hospital coverage and a ceiling that allows a maximum of 30 days inpatient hospital coverage)?
6. Should the same protections that apply to the CSHBP apply to the basic plan? These protections include guaranteed issue and renewal and no medical underwriting. Should insurers be allowed to rate for pre-existing conditions for a limited period for newly enrolled groups without previous coverage?
7. Should there be a restriction on the type of delivery systems available (e.g., HMO and PPO only)?

Voluntary Purchasing Pool

Overview

Several states have sponsored health purchasing cooperatives or similar arrangements for pooled purchasing so that small employers, and perhaps individuals and large groups as well, can collectively purchase health insurance. A purchasing pool offers the advantage of allowing the pooling of purchasing power from multiple sources, which may give buyers greater purchasing clout in negotiating with health plans and providers. Such pooling arrangements also have the advantage of giving employees and individuals, including individual employees, a choice among several health plans. A pool also provides a mechanism for simplified enrollment and administrative efficiency for employers who would like to offer health care coverage but do not have the resources to spare for benefit management. These economies of scale may produce some savings for the buyers.

Pooling arrangements are often viewed as being particularly appropriate for very small employers, who are less likely than other employers to offer insurance.

Advantages

- *Continuity of Care:* The prototype purchasing pool allows individual participants to choose any of the health plans participating in the pool. Thus if the individual's source of coverage changes—say, because of a job change—but, whoever sponsors the new coverage also participates in the purchasing pool, the individual can maintain a relationship with a particular health plan and the associated providers, which helps to facilitate continuity of care. If public payers also allow subsidized individuals to get coverage through the pool, participants can maintain continuity as changes in family earnings over time affect eligibility and cause people to move among different state, federal and private sources of insurance coverage.
- *Mechanism to Combine Premium Sources:* The purchasing pool could provide a mechanism to combine multiple public and private financing sources—including tax credits, state subsidies, contributions from multiple employers (in the case of part-time workers with more than one job), and contributions from small employers who are willing to provide some level of contribution but not enough to ensure that carrier minimum participation requirements for group coverage would be met.

- *Administrative Issues:* A purchasing pool seems like a particularly appropriate mechanism to make public subsidy dollars go further when they are used to subsidize small employers and individuals. Costs of coverage in the individual and small employer market are high, in part, because of the diseconomies of small scale. The pool could reduce employer administrative costs and burdens by playing such purchaser/sponsor roles as negotiating and contracting with health plans, offering workers a choice of competing plans, and resolving coverage problems. The pool might also assume some of the administrative functions that insurers typically perform, thereby reducing their costs. Rules that regulate the conduct of carriers offering coverage through the pool could also be tailored to promote greater cost-effectiveness and quality. They could, for example, be required to adopt disease management programs and to use consumer cost sharing mechanisms that would create incentives for patients to select cost-effective care. Under present circumstances, cost-sharing arrangements put into place in the small group Standard Plan to encourage appropriate utilization of services are often bought away by the employer via riders.
- *Employer Requirement for Payroll Deduction:* Some have suggested that employers should be required to offer, but not necessarily pay for, health coverage and also withhold premiums from the employee's wages and pass that on to insurers. The reasoning is that coverage rates would rise because employees would then have a ready source of coverage and would not have to go out and find it on their own. One objection to imposing such a requirement is that it would place an administrative burden on employers, forcing them to go out and find a source of coverage for their employees. However, a purchasing pool could provide a ready source of coverage for such employers so that the administrative burden would be minimal. An added benefit would be that individual employees would have a choice among all of the health plans participating in the pool. It appears that requiring employers to facilitate employee premium deduction, whether they contributed to the cost of coverage or not, would allow employees to take advantage of the pre-tax exclusion of premiums. (As a result of a number of recent tax changes, employers can establish various mechanisms to allow both the employer and the employee portion of health premiums to be excluded from the employee's taxable income.)
- *Achieving Critical-Mass Size and Maintaining Pool Stability:* Experience shows that purchasing pools must be large to succeed in the long term. If the pool is not relatively large, it cannot achieve economies of scale or negotiate favorable terms for its participants. Moreover, if the pool does not have at least the potential to account for a significant market share, the more prestigious insurers will be reluctant to participate. The potential new business will not be sufficient to offset

the administrative costs of selling through the new entity, especially since all of the participating insurers will be competing on a head-to-head basis. The insurers must also be persuaded that they will not become victims of adverse selection. The inclusion of a large, stable average-risk population to “jump start” the pool would help to achieve economies of scale and to encourage carriers to participate.

- *Cost Savings:* To date, the research shows that purchasing pools that operate on a guaranteed-issue basis are not able to offer premiums at rates significantly lower than those available outside the pool. The hoped-for savings from administrative economies and purchasing power have not been realized, at least at the scale at which existing purchasing pools operate. Of course, if the pool is selective and excludes higher-risk applicants, the pool premiums are likely to be lower. The consequence of this risk segmentation is, however, that others in the small group market must bear the burden of higher premiums. Allowing the purchasing pool to operate under a different set of rules than the general market leads to adverse selection in other purchasing pools and the small group market as a whole.
- *Market Rules and Adverse Selection:* The market rules that govern the sale of health coverage need to be the same inside and outside the pool. Allowing a pool to operate under different rules produces one of two results: If the pool operates under more lenient risk-rating rules, it will initially be offering lower premiums to higher-risk people than they can get outside the pool. As a result, it will attract a disproportionate number of such people, which will cause rates to rise and deter normal-risk people from participating. Over time, it will become a high-risk pool. At the other end of the spectrum, if the pool can effectively exclude higher-risk individuals, through creative benefit design or by pricing premiums based on health status, prior medical experience, or other risk-related characteristics, those left in the general market will experience higher premiums because of adverse selection. Pools that attract a disproportionate number of sicker people cannot succeed over the long term without some kind of financial compensation to offset the poor health experience of their members. On the other hand, providing a guarantee to offset the costs of adverse selection may make subsidies unnecessary because that guarantee will ensure that the premium rates can be kept sufficiently low to attract normal-risk people to the pool. Subsidies for high-risk people are one form of such guarantees. Another is reinsurance, discussed below.

The current rules that address risk selection in the small group market include guaranteed issue and renewal, adjusted community rating, and the prohibition

of preexisting condition limitations. If different rules were allowed, some mechanism would be needed to mitigate the likely adverse selection.

In addition, some mechanism would likely be needed to address the potential problem that some healthy individuals will choose to remain uninsured until they anticipate needing medical care, so that only the less healthy join the pool. For example, a rule could be established that would permit insurers to vary rates depending on the length of time an individual has been uninsured (i.e., it would permit an insurer to “rate-up” an applicant by a certain percentage for a certain period of time if the applicant had not been continuously enrolled prior to application). This would discourage employers from waiting until an employee is sick to buy health insurance.

- *Reinsurance:* One way to protect the purchasing pool and its participating insurers against the possibility that the pool will attract primarily high-cost individuals or groups is to establish a reinsurance fund that reduces the amount of risk assumed by any one insurer. Insurers are more likely to participate if they know that their financial exposure is limited; furthermore, the pool premiums can be reduced because a major portion of the cost of the most expensive episodes of care are passed on to the reinsurance mechanism. In Arizona, for example, insurers are responsible for claims up to \$20,000. The State self-insures for claims between \$20,000 and \$100,000 and maintains a catastrophic insurance policy for claims exceeding \$100,000.¹⁸ The Healthy New York program also utilizes a reinsurance pool to alleviate the potential risk to any one carrier and to assist in reducing premiums by shifting some of the risk from the participating carriers to the State.
- *Role for Brokers/Agents:* The experience from past attempts to establish purchasing pools shows that it is essential to avoid alienating agents and brokers, which requires preserving a role for them. Small employers depend heavily on agents and brokers for advice about health coverage; if agents and brokers are hostile to the pool, it will likely have a hard time attracting employers. In some states, brokers and agents are guaranteed a certain level of commission.
- *Solvency:* Insolvency among self-insured group purchasing pools has recently increased.¹⁹ In some states, the solvency and reserve requirements are less strict for the pools than for insurers. This has led to insolvency, with thousands of consumers nationwide having to pay millions of dollars in unpaid medical claims.²⁰ The solvency and reserve requirements for this type of purchasing pool

¹⁸ Mila Kofman, “Group Purchasing Arrangements: Issues for States,” State Coverage Initiatives, Issue Brief, Vol. IV, No. 3, April 2003.

¹⁹ *Ibid.*

²⁰ *Ibid.*

should be stringent enough to ensure that the risk of insolvency is small. A state's guaranty association may not cover consumers' claims should a pool become insolvent. A public-private partnership could enable the state to establish solvency and reserve requirements that would significantly lessen the risk of a future insolvency.

- *Implementation Issues:* A purchasing pool consisting of small and large employers, State employees, the self-employed, individuals and/or local government employees may need to be implemented incrementally. The viability of such a pool could be tested through a pilot or demonstration project involving very small employers groups (under 10) and one large group such as the State employees.

Questions to be Addressed

1. Should a purchasing pool begin by targeting certain hard-to-reach groups (e.g., very small employers) and then phase in other populations (larger groups, individuals, etc.)?
2. Should there be a requirement that carriers participate? Should there be a limit to how many plans can participate? What should the role of the pool administrators in qualifying carriers to participate?
3. Should employers below a certain size be required to purchase coverage *only* through the pool if they choose to purchase coverage at all?

Reinsurance

Provide an alternative reinsurance mechanism for insurers offering coverage in the small group market.

Overview

"The inability to predict a person's medical costs constitutes the largest source of risk for carriers."²¹ Reinsurance is an alternative mechanism for spreading risk among insurers that does not involve screening out high-risk applicants and referring them to a distinct pool.²² The essence of this approach is that either the state or a mandatory pooling of carriers would take on most of the risk (cost) of paying for the most expensive cases, making it possible for insurers to offer coverage at lower rates,²³ which should induce more employers to offer coverage. The reinsurance approach limits a given insurer's losses on any individual enrollee or aggregate losses on all enrollees because part of the insurance risk is transferred to another insurer or insurers (or the state).^{24,25} Reducing the risk of very high costs for carriers might also create an environment where there are more incentives to participate in the market and reduce the occurrence of insurers employing mechanisms that either (1) rate enrollees based on their perceived risk (although Maryland's small group market laws already limit carriers' ability to do this)²⁶, or (2) avoid covering certain populations (e.g., very small employers with 2-10 employees and the self-employed). Even with reinsurance, carriers would retain an incentive to manage every enrollee's care and costs²⁷ since they would still bear the responsibility for most medical expenses (but not for most catastrophic expenses associated with serious accidents or life-threatening illnesses). And, of course, the reinsurance mechanism could be structured to require the insurers to bear a portion of the catastrophic costs as well.

Several states have implemented reinsurance mechanisms in their small group and/or individual health insurance markets. Examples of state reinsurance programs are described below.

²¹ Swartz K. *Healthy New York: Making Insurance More Affordable for Low-Income Workers*. The Commonwealth Fund. November 2001.

²² Merlis M. "Public Subsidies and Private Markets: Coverage Expansions in the Current Insurance Environment." Kaiser Project on Incremental Health Reform. October 1999.

²³ If the costs of reinsurance are borne by the insurers, these costs will be passed on in some form or other to the insurers' customers and will be reflected in higher premiums.

²⁴ *Ibid.*

²⁵ NAHU. Glossary. Accessed online at www.nahu.org, 15 May 2003.

²⁶ Swartz K. "Government as reinsurer for very-high-cost persons in the non-group health insurance markets." *Health Affairs*. Suppl. W380-W382. 23 October 2002.

²⁷ *Ibid.*

Arizona. Arizona established a reinsurance fund to provide protection against future losses for insurers offering coverage to small employers through the Healthcare Group of Arizona (HCG, which was set up as a separate organization within the State's Medicaid program). In 1999, legislation appropriated \$8 million from tobacco tax revenue for FY 1999-2000 and \$8 million of the tobacco settlement funds for FY 2000-2001 and each year thereafter to constitute a reinsurance fund to cover large claims and reimburse health plans for their losses.²⁸ Funding was guaranteed through June 2001. An assessment on all health insurers to fund a reinsurance pool was considered but was widely opposed by the insurance industry and ultimately rejected.²⁹

From its inception, HCG purchased reinsurance from a commercial insurer, with participating plans contributing premiums for the reinsurance. Health plans incurred major losses with this approach. The State then opted to self-insure, using the \$8 million annual appropriation for claims between \$20,000 and \$100,000, and to buy formal reinsurance for catastrophic claims of \$100,000 and above. This approach encourages health plans to better manage low- to normal-risk enrollees and protects them against the more expensive outliers.³⁰

New Mexico. New Mexico created the New Mexico Health Insurance Alliance (NMHIA) in 1994 to improve health insurance access for small businesses, the self-employed, and individuals. In this program, risk is managed through reinsurance and shared among virtually all health insurance carriers in the state. NMHIA withholds a reinsurance premium from all premiums for small employers, amounting up to 5% in the first year of coverage and up to 10% in renewal years. The reinsurance fund pays an insurer the amount by which the incurred claims and reinsurance premiums exceed 85% of earned premiums each year. A loss subsidy takes effect if losses exceed the reinsurance fund's resources.³¹ Despite the risk-sharing mechanisms introduced in New Mexico, participating carriers have generally considered NMHIA business to be unprofitable.³²

New York. The Healthy New York program, which was created to increase health insurance coverage in small group and individual markets by making it more affordable, has a reinsurance mechanism. At the inception of this program, the State of New York acted as a reinsurer by subsidizing up to 90% of the costs of enrollees with annual claims between \$30,000 and \$100,000, implicitly subsidizing the

²⁸ Silow-Carroll S, Waldman EK, Meyer JA. *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs*. The Commonwealth Fund. February 2001.

²⁹ *Ibid.*

³⁰ *Ibid.*

³¹ *Ibid.*

³² Silow-Carroll S, Waldman EK, Meyer JA. *Expanding Employment-Based Health Coverage*.

premium by removing much of the insurers' risk of high-cost claims.³³ Carriers paid all of the costs below \$30,000 and also above \$100,000 and for 10% of costs between \$30-\$100,000. It is estimated that approximately 1% of the insured population has medical care expenses over \$30,000 per year.³⁴

In June 2003, Healthy New York revised the reinsurance mechanism by lowering the attachment points (that is, the level of medical costs at which reinsurance goes into effect).³⁵ The current range of costs that are subject to reinsurance is between \$5,000 and \$75,000. Officials at Healthy New York estimate that, by lowering these attachment points, premiums have decreased by 17%.

Maryland. During the 2003 legislative session, the *Maryland Health Insurance Reform Act- Modifications- Health Reimbursement Account Plan- Reinsurance Pool*³⁶ bill was introduced. This bill, which did not pass, proposed repealing provisions of existing law relating to the Maryland Small Employer Health Reinsurance Pool and establishing a new Maryland Small Group Reinsurance Pool requiring membership of carriers who sell in the small group market in the pool and authorizing each member to cede risk to the pool. The bill was not enacted. Carriers are not currently obligated to cede risk to the Maryland Small Employer Health Reinsurance Pool, and some carriers have indicated that they instead purchase reinsurance for all of their lines of business as a whole with a reinsurance carrier or reinsure through another one of the divisions in their own company.

Advantages

- *Effect on Premiums and Access:* Providing reinsurance can reduce premiums.³⁷ Because individual carriers would not need to purchase as much reinsurance as they currently do, their costs would be lowered so that premiums could be reduced and more uninsured people could subsequently be induced to purchase coverage.³⁸
- *Competition:* A reinsurance mechanism could serve to maintain or increase insurer participation in the small group market, thus enhancing price competition. Since insurers' risk of paying for very high costs would be reduced, smaller carriers could more easily afford to enter and stay in the market.

³³ Swartz K. *Healthy New York*.

³⁴ *Ibid.*

³⁵ Personal communication with Healthy New York program. 25 April 2003.

³⁶ House Bill 785 / Senate Bill 609, 2003.

³⁷ Swartz K. *Markets for individual health insurance: Can we make them work with incentives to purchase insurance?* The Commonwealth Fund. December 2000.

³⁸ Swartz K. "Government as reinsurer."

- *Cost Control Incentive Maintained:* Reinsurance can include incentives for carriers to restrain health care costs since carriers would still be responsible for covering a certain proportion of costs after reinsurance starts³⁹ and, if structured like Healthy New York, *all* costs that exceed the reinsurance cap. The proportion covered by a carrier could also be structured using a sliding scale that decreases as expenses increase (e.g., 50% for claims between \$30-\$50,000; 25% for claims between \$50-\$150,000; and 0% for claims above \$150,000).

Issues

- *State Subsidy:* To lower costs of coverage significantly—which is necessary to induce a substantial number of uninsured small employers to offer coverage—would require a large state subsidy, assuming the State took on the costs of reinsurance.
- *Some Carrier Risk:* In the Healthy New York program, carriers are not totally protected if claims for high-cost enrollees exceed the available reinsurance funds.⁴⁰ In addition, reinsurance does not eliminate the risk that an individual carrier may have a disproportionate share of claims above the maximum attachment point. In the event that this occurs, carriers might request higher premiums to recoup their losses.⁴¹
- *Effect on Carrier's Own Management of Reinsurance:* There is some evidence that large carriers reinsure themselves through subsidiaries of their own company so that a public pool would reduce profits in their own reinsurance line of business.
- *Limited Experience:* The results of states' experiences with reinsurance mechanisms have not been well documented, which makes it difficult to determine the optimal method for implementing this option.

Questions to be Addressed

1. Should the reinsuring entity be the State itself (or reinsurance purchased by the State), or should it be a State-chartered corporation administered and financed by health insurers (including, potentially, all carriers selling State-regulated health insurance plans writing policies for State employees and Medicaid)?
2. If the State subsidizes the pool, how much should it contribute to the pool and what should be the attachment points?

³⁹ Swartz K. Healthy New York.

⁴⁰ *Ibid.*

⁴¹ *Ibid.*

3. What are the potential savings in premiums by having insurers cede risk at certain attachment points?
4. Should reinsurance be linked with a purchasing pool? (See section on purchasing pools).

Tax Credits for Small Employers

Offer tax credits to small employers to help them provide health care coverage to their employees.

Overview

Offering tax credits to help people purchase individual health insurance is one of the key options that will be considered in the national debate over how to reduce the number of uninsured Americans.⁴² The purpose of this approach is to lower the net cost of coverage for those buying health coverage. Proponents of tax credits typically have proposed to offer the credits to individuals to assist them in purchasing health coverage. Another option is to extend a tax credit to employers in exchange for their offering health benefits to employees.

If tax credits were extended to certain employers—for example, small employers—coverage would be more affordable for both employers and employees so that more small employers would be expected to offer health insurance to their employees. To make this approach cost-effective, the subsidy would need to be limited to certain employers, such as those employing low-wage workers, operating in certain industries, newly offering health coverage, or having a certain level of firm size (e.g., 10 or fewer employees). Employers would also need to be required to pay some reasonable portion of the premium and to offer at least a specified package of minimum benefits—for example, the currently required Comprehensive Standard Health Benefit Plan or a “basic” plan currently under consideration (see section on Basic Health Coverage Plan).

Tax credits for small employers have been proposed at the federal and state levels as an option to expand coverage. In 2001 and 2002, for example, several proposals were introduced at the federal level (S.2679 and S.284). One of these options included offering a 30% to 50% tax credit (the percentage would vary with firm size, with smaller firms receiving a higher percentage).

At the state level, legislation offering tax credits to offset the cost of health insurance premiums for either small employers or individuals has recently been introduced in **Colorado, Florida, Georgia, Hawaii, Indiana, Maine, Montana, Missouri, New**

⁴² Center for Studying Health System Change. The Individual Health Insurance Market: Researchers, Policy Makers Seek Common Ground on Tax Credits for the Uninsured. Issue Brief No. 58. December 2002.

Mexico, New York, Pennsylvania and Vermont.⁴³ Vermont policymakers have recommended creating a small employer tax credit to provide subsidies directly to employers to help them offer coverage to their workers. Eligibility would be limited to firms that have not provided health coverage for at least the 12 previous months and to firms with an average payroll below the average for small firms in the state.

Another related option is to offer health coverage tax credits to low-income individuals who work for small businesses that either do not offer coverage or do not contribute to premiums. The credit would assist individuals who could otherwise not afford to buy into their employer-sponsored plan or purchase individual coverage.

It has been suggested that tax credits be linked to some sort of group purchasing pool so as to keep all those being subsidized in a single pool⁴⁴ and provide them with a ready source of cost-effective coverage. If those who accept the tax credit were required to purchase coverage only through the purchasing pool, the market share represented by the pool would likely be large enough to attract carriers. All of the issues related to the creation of a purchasing pool would still need to be addressed (see section on purchasing pools).

Advantages

- *Effect on Access:* Tax credits could expand access to health insurance in the small group market by decreasing the amount that employers or individuals would pay for health insurance, thereby enabling more people to purchase health coverage (many for the first time).^{45,46}
- *Uses Current System:* As contrasted with an approach that involves setting up separate subsidy programs for the uninsured, this approach builds on employer-based insurance systems, depends on market forces, and creates incentives for employers to make private coverage available to their employees. Nearly 60% of Maryland's uninsured are employed adults, and 77% of Maryland's non-elderly uninsured live in families with one or more full-time workers.

⁴³ National Conference of State Legislatures. Health Policy Tracking Service Issue Briefs Summary. 1 April 2003. Available online at <http://www.ncsl.org/programs/health/healthinsurance.htm>.

⁴⁴ Sally Trude and Paul B. Ginsburg, "Tax Credits and Purchasing Pools: Will this Marriage Work?" Center for Studying Health System Change. Issue Brief No. 36. April 2001.

⁴⁵ *Ibid.*

⁴⁶ Pollitz K, Sorian R. Ensuring health security: Is the individual market ready for prime time? *Health Affairs*. Suppl. W372-W376. 23 October 2002.

The development of new government programs would not be required because existing administrative procedures of the tax system could be used for tax credit initiatives.

- *Increased Participation of Low-Risk Individuals:* The anticipated increased participation of younger and healthier employees, who might be employed in low-wage businesses, in the small group market could cause premiums for all employees in this market to decrease.

Issues

- *Size of Tax Credit is Critical:* The success of a tax credit depends on the size of the credit. Many employers who do not offer coverage are small, marginal firms that hire primarily low-wage employees. Since these businesses may not generate significant profits, they may not incur much of a tax liability. These employers might not experience sufficient benefits from a tax credit and might not participate unless the tax credit was refundable and quite large. It has been estimated that even a 30% reduction in premiums would cause only 15% of small employers currently not offering health insurance to decide to offer it.⁴⁷
- *Possible Limited Impact:* Even after receiving tax credits, small employers who help subsidize their employees' coverage would still have to pay a significant portion of health insurance premiums from their own funds; this amount might be more than marginal firms can afford. Moreover, low-wage employees might prefer to have any increased compensation in the form of higher wages. Therefore, this approach might have a limited impact on improving coverage of the uninsured.
- *Refundable and Advanceable:* Credits that are available only at the time of tax filing would not make insurance coverage affordable for employers who have insufficient monthly income to pay the insurance premiums during the year. An advanceable tax credit could address this concern, but generates administrative difficulties.
- *Impact on State Budget:* Because tax credits would need to be large to be effective, this approach could have a significant budgetary impact in the form of foregone tax revenues.
- *Response of Employers Currently Providing Coverage:* There is a possibility that some employers already providing coverage would take advantage of the tax subsidy

⁴⁷ James D. Reschovsky and Jack Hadley, "Employer Health Insurance Premium Subsidies Unlikely to Enhance Coverage Significantly," Issue Brief: Findings from HSC, No. 46, Center for Studying Health Systems Change, December 2001.

and cut back on their contribution toward employee health insurance premiums. To prevent this, the credit could be limited to firms not previously providing coverage, though this creates equity problems among employers and may create gaps in insurance coverage.

- *Administrative Concerns:* Some employers might not be willing to assume any additional administrative responsibilities associated with receiving tax credits, such as potentially complicated applications and rigorous eligibility standards.
- *Does Not Address Underlying Causes of Cost Increases:* Tax credit options do not address the underlying causes of increasing small group market premiums, such as higher per person utilization of health care services, the loosening of managed care cost-control measures, and new medical technologies and higher-cost new-generation pharmaceuticals.

Questions to be Addressed

1. How large must a tax credit be to induce employers to offer and employees to buy insurance? How much in lost tax revenue can the State afford?
2. What population should be targeted for a tax credit?
3. If the tax credit were refundable and advanceable, how can administrative issues be addressed?
4. Should a tax credit be linked to an authorized purchasing pool?

INDIVIDUAL MARKET OPTIONS

Individual Tax Credits

The Approach

Individuals whose income is below a specified level would be eligible for a tax credit—that is, a subtraction from their state tax liability—equal to some portion of the amount they pay toward their health insurance premium. The credit could be used to pay for either individual coverage or for the employee portion of the premium for employer-based coverage. Tax credits could also be offered to employees who are laid off to help subsidize the cost of COBRA coverage for these displaced workers. The effect of these strategies is to lower the net price of coverage.

Advantages

- By reducing the net cost of coverage, this option would reduce the financial barriers to buying coverage for individuals who have to purchase through the individual market and for employees who have turned down employer-sponsored coverage because they cannot afford the employee portion of the premium.
- As contrasted with an approach that involves setting up separate public subsidy programs for the uninsured, this approach depends on market forces, allowing people to buy “mainstream” coverage.
- It uses existing administrative procedures of the tax system and does not require a separate administrative process or a specially tailored new government program.

Issues

- Many of the uninsured have such low incomes that their tax liability is so small that a tax credit, even if equal to the full amount of their tax liability, would not be large enough to induce them to buy coverage. This disadvantage might be

overcome by establishing “refundable” tax credits so that people whose tax liability is less than the maximum credit would receive a net *payment* from the State as a tax refund.

- Credits that are available only at the time of tax filing would not make insurance coverage affordable for people who have insufficient monthly income to pay the insurance premiums during the year. This disadvantage could be overcome by making the credits payable in advance, but this would add significant administrative complexity.
- Unless the tax credit is large, currently uninsured people with low incomes and high health risks may remain uninsured because coverage would still not be affordable.
- Because tax credits would need to be large to be effective, this approach would have a significant budgetary impact in the form of forgone tax revenues. Of course, the budgetary impact could be reduced by making the tax credit smaller or by limiting eligibility to people with very low incomes, but the consequence would be that fewer of the uninsured would be covered. The State would have to provide sufficient revenue to cover the tax subsidies.
- Some people who are already buying coverage on their own would be eligible for the subsidy. Unless the reforms prohibited subsidies to people already covered—which creates equity problems—some of the cost would go to aid people who do not need the inducement of a subsidy to buy coverage. This is the “crowd out” problem.

Reform of Individual Market Insurance Rules

Guaranteed Issue

Although a number of states require insurers to provide coverage on a guaranteed-issue basis in the individual market, this is not as common as in the small-group market. In 2001, 16 states had laws requiring some form of guaranteed issue in the individual market, although in many instances there were limits on the coverage that was available.⁴⁸ States are sometimes hesitant to require guaranteed issue in the individual market because of the peculiarities of that market. Because health insurance is expensive and because individuals can predict with some degree of accuracy when they will need expensive medical care, individuals may choose to go without coverage when they do not anticipate needing care and buy coverage only when they expect to incur large medical expenses. Such behavior is inconsistent with the insurance principle, which is based on the assumption that risk is spread over a large group of individuals, any one of whom is unlikely to incur high medical bills. Providing individual coverage on a guaranteed-issue basis when purchase of coverage is voluntary allows people to avoid paying their fair share of the insurance bill, which raises premiums for everyone who does buy coverage. Besides being unfair, the result is that some individuals drop coverage.

Whether guaranteed issue (paired with sufficiently rigorous rating restrictions) can be effective in the individual market remains to be seen. New Hampshire recently repealed its law requiring guaranteed issue in the individual market.⁴⁹

Rate Bands and Other Rate Restrictions

Guaranteed-issue laws without regulations to limit insurers' ability to vary premium rates are ineffective. If insurers can charge high-risk individuals extremely high rates, they effectively deny people the ability to buy coverage. One of the most obvious ways to make coverage more affordable for high-risk people is to limit the extent to which insurers can vary premium rates based on characteristics of the insured individuals or groups. The extreme form of rate compression regulation is pure community rating, which requires insurers to charge the same premium rates to everyone applying for a specified benefit package. A few states have required pure community rating in the individual markets, but states have generally shied

⁴⁸ Lori Achman and Deborah Chollet, *Insuring the Uninsurable: An Overview of State High-risk Health Insurance Pools*, Commonwealth Fund, August 2001, Table 11.

⁴⁹ State Coverage Initiatives, *State of the States: Bridging the Health Coverage Gap*, January 2003.

away from this policy for fear that the increase in premium rates for low-risk individuals and groups would cause too many people to drop coverage. A less extreme form of rate compression is adjusted community rating. States that use this approach, which is more common, allow insurers to vary rates somewhat, but they typically prohibit the use of certain characteristics, particularly previous medical conditions or current health status, and they place a limit (or impose “rate bands”) on the amount of variation that is permitted. Commonly, rating is permitted for age, gender, and geographic location.

Issues

Individual market reforms are designed to bring down the price of coverage for high-risk individuals. Maryland has just recently implemented a high-risk pool that is designed to offer reasonably priced coverage to exactly such individuals. Until there is more experience to determine whether this approach will be successful, it is questionable whether it is advisable to consider individual market reforms, particularly given the difficulties of implementing such reforms in a way that does not have significant undesired consequences.

MIXED OPTIONS

Coverage for People in Transition

The Approach

This strategy is designed to avoid having people who are already insured lose coverage because of some status change, such as loss of a job, change in eligibility for public programs, moving from child to adult status, movement from student to worker status, etc. The idea is to provide options to people at transition points—at the time and location where they are moving from one status to another—so that they do not experience a gap in coverage, after which it is more difficult to regain coverage. That people in transition are a particularly important target for coverage expansion approaches is shown by the fact that 50 percent of uninsured people have had coverage within the previous one or two years.⁵⁰

People who have studied the issue of providing coverage for people in transition have concluded that a program to meet their needs has to have several key elements.⁵¹ First, the coverage products offered to people have to be good products. Second, the coverage has to be affordable, which often means that it must be subsidized. Third, the program must have an effective enrollment process. This last point deserves some elaboration. If programs for people in transition are to be most effective, experience shows that the new coverage should be available *automatically* at the point of transition from their previous coverage—for example, when they start a new job, when they start unemployment benefits, at loss of spousal coverage (for example, through a divorce or death), at the point of loss of parental coverage by young adults, and at the start or loss of Medicaid or SCHIP coverage. Enrollment systems are also much more likely to have higher take-up rates if the default option when people are offered a choice is “enrollment” rather than “non-enrollment.” For example, when a person takes a new job, unless the employee takes action *not* to enroll, he or she would automatically be enrolled.

⁵⁰ Lynn Etheredge, “Health Insurance Coverage at Transitions: What Works, What Doesn’t Work,” Presentation to the Health Care Coverage Workgroup, April 11, 2003.

⁵¹ See the presentation cited by Etheredge above.

Discussed below are some specific groups in transition for which policies could be developed to promote continuity of coverage.

The Unemployed

The unemployed seem like a particularly appropriate target population because most of them will be re-employed in a relatively short period of time and once again have access to health coverage. Finding a way to keep them insured would help to avoid serious disruptions in care for people with ongoing health problems, as well as providing all who remain covered with the assurance that they need not forego needed care or have to shoulder a devastating financial burden if they require major medical services.

Most people who have health insurance when they lose their jobs are eligible for COBRA coverage, but the cost (102% of the full premium, which averages \$663/month for family coverage and \$255/month for single coverage in the U.S.) is more than many can afford at the very time they have lost a major source of income.

A variety of possibilities exist to cover the uninsured:

- ☐ Provide advanceable tax credits to subsidize purchase of COBRA coverage.
- ☐ Provide substantial, advanceable tax credits that can be used to purchase any kind of group or individual coverage.
- ☐ Require employers who offer coverage to continue providing coverage on the same terms for some period of months (e.g., 2 months) after employment termination or until the person is re-employed.
- ☐ Allow unemployed to buy into the State employees plan at a subsidized rate.
- ☐ For people who are eligible for unemployment compensation, also provide temporary subsidies to allow purchase of COBRA coverage.

Of course, each of these approaches has significant disadvantages and costs that might make them impractical. In addition to cost, one of the problems is that the people who are most likely to take advantage of such programs are those who are most likely to need expensive medical care, so they are relatively expensive to cover.

People Leaving Medicaid

Another group that deserves attention is those who are *transitioning from Medicaid*. Nationally, there is major problem of lost coverage for the children who lose Medicaid coverage because of increased family income, but who, though eligible for

CHIP, are not enrolled. This could be rectified, at least in part, by having states establish formal procedures to inform people leaving Medicaid about their eligibility for CHIP.


Another group that has problems are disabled children who lose their Medicaid coverage at age 21 if they go to work.

Yet a third group is the parents who lose coverage once their children who are enrolled in Medicaid “age out” of coverage.

Young Adults “Aging Out” of Private Family Coverage or Medicaid/CHIP Coverage

Another target group for transition coverage is adult children who “age out” of their parents’ policies. We discuss approaches to reach this group in some detail in the following paragraphs.

The Approach


This approach involves requiring insurers to offer young adults the opportunity to be covered under their parents’ health insurance policy by extending the cut-off age for eligibility—to at least age 21—or alternatively, requiring insurers to offer these young adults a separate individual policy at the same premium  with the same benefits.

Young adults, who are in the age group most at risk for being uninsured, are twice as likely as children or older adults to lack health insurance coverage. While some older children maintain coverage under their parents’ policies if they attend college on a full-time basis, many lose coverage under their parents’ employer plans before they turn 21. For those young adults who are employed, many work in entry-level, low-wage jobs, which often do not offer health insurance. Approximately three-quarters of uninsured young workers have no opportunity to enroll in an employer plan through their jobs, either because their employer does not offer a health plan or they are ineligible to participate in the plan. An additional 17% are offered coverage but decline to enroll because of the cost. While this age group is perceived to have low levels of health risks and problems, some young adults do have serious illnesses, and those who are healthy may forgo important preventive health care or wait as long as possible to access care if they do need it.

Potential approaches to address this issue include the following:

1. Extending employer/private plans’ parental coverage for dependents through the age at least 21 years and perhaps up to 25 years, for unmarried

individuals. Employers would not have to contribute, and this coverage could be structured like a rider.⁵² (Minnesota, for example, has recommended that individuals ages 18-24 be covered under parental policies, and all members of Congress and federal employees have the option to have their older children covered under their plans. In Utah, insurers must allow dependents to be included on their parents coverage through age 25.)

2. Allowing children who can no longer be considered as dependents on their parents' plans (typically because of age or school status) to have automatic eligibility for individual coverage under the same rates  and benefits as they received as a dependent on their parents' policy.
3. Extending Medicaid beyond age 19. Connecticut's HUSKY program permits children already on the program to maintain coverage beyond their 19th birthday.

Advantages

- ☐ The option of extending parental coverage would not require employers to contribute to the cost and would allow young adults who may otherwise have trouble finding affordable policies in the individual market to obtain affordable coverage as dependents under their parents' policies.
- ☐ Young adults represent relatively low actuarial risks, and thus extending parental coverage may incur only a slight increase in insurance premiums (although there is likely to be some adverse selection, since young people with existing health problems are those most likely to take up coverage). This approach could be particularly effective when the job market is weak.
- ☐ The approach of extending Medicaid/CHIP coverage beyond age 19 provides an efficient way to reduce the high rate of uninsurance in this age group, as program administration could be extended to include these individuals. It also presents a valuable option if the state has excess CHIP allotments.
- ☐ Indirect cost savings could be realized because, if young people have access to preventive care, they are likely to be healthier and more productive workers.

⁵² If a rider were utilized to allow a young adult to remain on a family policy, the rider would apply to the entire group policy, not to a particular family who was keeping their dependent on their certificate coverage and the cost would be spread to all family policies with that employer group. If the additional cost of the young adult was to only be applied to those families who wanted the additional coverage, a new type of family composition category that would account for the inclusion of the young adult could be created (i.e., a "family plus young adult " or "employee plus young adult" category).

Issues

- Extending parental policies could increase the cost of family coverage for all employees if the young adults who choose coverage have higher-than-average risk profiles, which is likely.
- Employers might oppose attempts to extend coverage to these older dependents, and the ERISA exemption prevents the State from mandating that self-insured employers do so. For example, there might be issues associated with a 20-year-old single dependent acquiring coverage at a lower rate than a 20-year-old spouse of an employee, whose rate is priced to cross-subsidize the rates of older employees (although this is already the case for older dependent children who are students). Potential legal issues associated with this would need to be explored. In Minnesota, employers have indicated that they would not allow this type of coverage extension, but might consider it if the older dependents would pay the same rate as an individual employee does. Young adults who are dropped from their parents' family policies due to age are currently able to maintain coverage through their parents' employers, under COBRA provisions for 18 months, at 102% of what a young-adult employee would pay. Since the opportunity for this type of coverage is already available, there may be no need for an additional program, especially since the Federal law affects even employers who self-fund health coverage. As noted, because of the ERISA pre-emption, these employers would be exempt from any program that Maryland established. An approach to consider is extending the COBRA benefits beyond the current allowable duration.
- Extending the age bracket of Medicaid/CHIP coverage could also increase costs to the program. However, the cost impact could be mitigated by phasing in coverage using the same formula used to phase in coverage of children, which can extend age eligibility one year at a time.
- The state costs associated with extending parental coverage would be negligible, but the cost of family coverage could increase, as well as an employer's cost, especially if they contribute to family coverage (see footnote on previous page). The state and federal government would have to provide sufficient funds to support the Medicaid/MCHIP expansion approach. If the State had excess CHIP allotments, it could use those to fund this extended coverage to young adults instead of returning the funds to the federal government for redistribution.

“Three-Share” Model

The Approach

Communities in several states are developing or have implemented programs of subsidized coverage targeted to employers of low-wage workers. These programs are commonly referred to as 3-share programs, since in most cases the subsidy covers one-third of the cost of health care services for employees and their dependents, with employers and employees each paying another third. The target populations are small businesses with fewer than 20 workers that have a low-income workforce and do not currently offer health insurance to their workers.

The largest of the 3-share programs is Health Choice in Wayne County (Detroit) Michigan. This program currently covers around 15,000 employees and their dependents in 2,000 businesses. The Michigan Health Choice coverage is relatively comprehensive but does not include all of the benefits required under Michigan’s insurance laws. Other 3-share programs include Access Health in Muskegon County, Michigan.

Qualifying businesses are those that have not offered health care benefits for some defined period. The goal of these programs has been to keep the premium low enough to make coverage attractive to employers and employees that would not buy more comprehensive coverage. Some of these programs recently implemented or currently implemented will subsidize licensed insurance products, generally through indemnity carriers.

In all of the communities using this model, special Medicaid financing strategies (typically with Disproportionate Share Hospital [DSH] Program payments) are used to draw federal funds to enhance the available local funds.

In 2003, legislation was enacted in Maryland that allows a pilot program to implement a subsidized coverage program targeting employers of low-wage workers in Western Maryland under the auspices of a federal Community Access Program grant. Under the Maryland model, coverage would involve a somewhat limited benefits plan: half would be subsidized by the employer and the other half would be paid for by the employee (two-share). Alternately, a community endowment will be set up for those employers and individuals who cannot afford the cost-sharing arrangement of the two-share plan. The program will commence July 2004. In addition, certain eligibility requirements have been set:

- Employers located in Allegany County are eligible if they do not now offer, or have not in the past year offered, their W-2 employees a health insurance plan.

Employers are eligible if they have a coverage need for uninsured employee groups such as part time workers and non-management workers or, if they have a group of employees not offered health benefits in the past 12 months.

- ☐ Enrollment in the product shall be limited to individuals not covered by other public programs such as MCHIP and Medicaid, who do not have insurance and whose income is at or below 300% of the federal poverty level.
- ☐ Individuals will not be excluded because of pre-existing conditions.
- ☐ There will be a designated open enrollment period. Sole proprietors will not be offered the product in the first year of operation. The only exception may be if a group of day care providers enroll as one.

Advantages

- ☐ Affordable health care is available to those that have not been able to afford it in the past.
- ☐ Employer funds that are not currently used for health care are leveraged.
- ☐ Employee contributions are used to purchase organized health care and protection from high medical costs rather than to pay for services out-of-pocket as funds allow.
- ☐ If special Medicaid financing is used, federal funds pay 50% or more of the subsidy costs.

Issues

- ☐ Employers may not be able to provide coverage because they have offered it in the past, or the cost is still prohibitive after the subsidy.
- ☐ The legal structure of a 3-share plan may be problematic if the coverage is more restrictive than Maryland's licensed insurance products. Typically, the programs have received statutory exclusion from the definition of "insurance product".
- ☐ Generating Medicaid financing could be problematic and complex, given Maryland's all-payer hospital rate setting system.
- ☐ Since Maryland has an all-payer hospital rate setting system, unlike other states that have used this approach, it is not feasible to use DSH payments as a funding vehicle.

Vouchers to Low-Income Households

The Approach

The state could supply vouchers to households falling below some income level, which they could apply to the cost of individual insurance or to pay the employee portion of employer-sponsored insurance. Presumably, the state would specify what minimum benefits the insurance would need to provide.

Advantages

- This is a straightforward *market-based* approach, requiring no new special public program for low-income people. People buy private insurance coverage in private markets.
- The approach would have less social stigma associated with it than special state programs for “poor” people, such as Medicaid; so the “take-up rate” might be higher; that is, more low-income individuals would voluntarily participate
- This approach directly targets the people who need subsidies rather than trying to help them indirectly, as when subsidies are made available through employers.

Issues

- To be effective in inducing many of the uninsured to buy coverage, the voucher would have to be large, which would make the budgetary cost high.⁵³
- Establishing and administering standards for determining eligibility might be difficult. For example, the state would want to make sure that no one eligible for other subsidized programs that are funded in part by the federal government got a voucher (which presumably would be funded entirely from state funds). Likewise, safeguards would be needed to ensure the employers who employ significant numbers of people who might be eligible for vouchers did not drop employer-based coverage or, more likely, substantially reduce their employer

⁵³ Research suggests that for people whose income is below 300 percent of the federal poverty level, subsidies of from one-third to one-half the premium would be necessary to induce many of them to purchase coverage. Mark Pauly and Bradley Herring, “Cutting Taxes of Insuring: Options and Effects of Tax Credits for Health Insurance,” *Using Tax Policy to Reduce the Number of Uninsured*, Council on the Economic Impact of Health System Change conference, Dec. 17, 1999, p. 26.

contribution, knowing that people could qualify for the new state-funded voucher (the so-called “crowd out” problem).

- To the extent that people use the voucher to buy insurance in the individual market, the approach sends people to the portion of the insurance market where there is much risk segmentation, where rates can vary greatly depending upon risk status, where administrative costs are high, where applicants can be denied coverage, and where it is more difficult for people to get good information to ensure that they are getting a “good deal.” To some extent, allowing people to use the voucher to buy into some state-administered health plan could ameliorate this problem.
- Eligible people might fail to apply for the voucher. Vigorous education and outreach efforts would be needed.
- The state would have to provide sufficient revenue to cover the cost of the vouchers, without any sharing of costs by the federal government. Cutting the size of the voucher reduces the budgetary cost but also reduces the take-up rate.

Subsidized Buy-In to State Employees' Plan

The Approach

The State would allow eligible, uninsured low-income working people to buy into the State employees' plan *at a price below the full premium cost*. The amount enrollees pay out of pocket for their portion of the premium would be based on their income level and, thus, their ability to pay. Since the State employees' insurance plan is self-funded, the State could simply absorb the premium shortfall, and it would be reflected in a larger appropriation to fund the enlarged State employees' plan. Low-income people enrolled would be eligible for the same covered benefits and the same choice of health plans as are offered to State employees. It would be possible to have less comprehensive coverage for this population, but that would add to administrative complexity.

A variation of this approach would be to allow certain small businesses to buy into the State employees' health plan at the full premium cost or at a subsidized rate. A buy-in without subsidies would probably not reach many of the uninsured, however.

Advantages

- Other than a system for determining eligibility and calculating the subsidy amount (which is common to virtually all approaches), this approach involves little new administrative structure and takes advantage of existing economies of scale and risk pooling.
- This approach puts uninsured people into an already existing, mainstream coverage system, thereby removing nearly the entire stigma associated with accepting subsidized coverage. Enrollees would have an insurance card just like the ones State employees have, and providers would not be able to distinguish the subsidized people from State employees. Subsidized enrollees would have no more trouble gaining access to providers than do State employees. These features should increase the take-up rate.
- Even though this is mainstream coverage, the State still has the ability to implement cost-control features and otherwise influence the nature of the system.
- The increase in volume of enrollees in the State employees' plan would enhance the State's bargaining power in negotiating with health plans.

Issues

- There is the potential for “crowd out.” Large and small employers now providing coverage to a workforce that includes a substantial number of eligible people might be tempted to drop coverage, knowing that employees could enroll in the State’s plan. A similar danger is that individuals now covered by their employer’s plan would switch to the State plan because their out-of-pocket costs would be lower or the benefits would be better. (There are ways to reduce the crowd-out effect.)
- Because the providers serving these people would be doing so on the same terms as for State employees, the budgetary cost would be higher than if the people were enrolled in a program in which providers accept Medicaid rates.
- Depending on the nature of eligibility requirements and the size of the subsidies, the State employees’ program might experience some adverse selection, which would raise the cost of the program.
- State employees might strongly object to the inclusion of this group, for fear that their inclusion would result in unfavorable changes in the State’s benefits, or that the risk profile would worsen and costs per enrollee would rise, etc. However, the resistance might be less than expected because most enrollees would be low-income *working* families that do not qualify for welfare or other typical forms of public assistance. (It would be possible to design a program that put the non-State enrollees into a separate risk pool to reduce opposition from State employees; however, some advantages would be lost.)
- Assuming many of the eligible people would have children in CHIP, the adults and children would be in separate health plans.

Single Payer Plan

The Approach

The State would guarantee that all Maryland residents are automatically covered for a defined set of health care benefits, which would be publicly financed. Similar to Part A hospital coverage under Medicare, coverage under the system is a “right” of all residents and is not dependent upon meeting any tests of eligibility based on need, family status, or other personal characteristics. No premium payments are required for the basic coverage benefits. This is the social insurance approach that prevails in many other countries.

The state of Maine’s Health Care System and Health Security Board, a stakeholder group created by the legislature in 2001, has recently released an in-depth report on a single-payer system for Maine. The Maryland Citizens’ Health Initiative released a detailed study by the Lewin Group in 2000 which analyzed both a single-payer and a multipayer approach to achieving universal health care.

Advantages

- This approach guarantees universal coverage. There are, by definition, no uninsured; nobody “falls through the cracks.”
- The approach, at least in its pure form, is administratively much less complicated because there is a single payer, the government—no coordination of benefits, no determination of eligibility, no filing of claims by patients, etc. Administrative costs should be reduced once the new system is in place.
- There is no stigma associated with accepting subsidized coverage, since everyone is in the same system.
- There is no uncompensated care (at least for the services covered under the standard benefit package). Providers do not have to absorb the costs of unpaid bills.
- There is no need for a safety-net provider system. Everyone has access to “mainstream” providers.
- There is minimal “tiering” of care based on income or socio-economic status.

Issues

- Because the State would be paying for a very large proportion of health costs now covered by employer and employee premium contributions, the cost to state government would be very high, requiring a major increase in state revenues. (A tax could be levied on employers, who would no longer be paying premiums for health insurance.)
- It is difficult to envision how money now provided by the federal government for Medicaid and CHIP (and other smaller federally subsidized programs) could be captured, given current federal law.
- The State would face difficult administrative tasks in setting up such a system—for example, establishing mechanisms to pay providers, control costs, etc. (The Medicaid program might provide a foundation on which to build.)
- A single state establishing a system alone might face a large influx of people with serious medical problems who move to Maryland from other states to become eligible for publicly financed coverage. This could be a particular problem for Maryland, given its proximity to the population concentrations in the District of Columbia and Northern Virginia. Maryland might also have difficulty attracting or even retaining providers, depending upon the rules for reimbursing them and the amount being paid.
- Raising sufficient revenue to fund the program might put the State at a comparative disadvantage in attracting new productive people to the State if the source of revenue is tax paid by consumers and in attracting business if the tax is levied on business. Some businesses could decide to move out of the State if the tax was perceived to be too onerous.
- The State would have to increase revenues very substantially. Many options exist for the kinds of taxes that could be levied.

“Pay or Play” Employer Mandate

A high proportion of non-elderly Americans get their health-insurance coverage through the workplace. Over 90 percent of the people in Maryland who lack health insurance are members of families in which at least one person is in the work force. Given these facts, many people have concluded that an effective way to extend insurance coverage would be to build on the employer-based system.⁵⁴ This so-called “pay or play” option would allow employers to either provide coverage themselves or pay a fee, presumably to government, which would be used to finance coverage for the uninsured.

California has recently passed legislation that incorporates the pay or play model (joining Hawaii as the only other state that has an employer mandate). The California approach is to require employers with 20 or more workers to pay a fee to a government agency; the fee is waived for employers that provide coverage to their employees and pay the prescribed portion of the premium. For the largest firms, those with 200 or more employees, the provisions will go into effect beginning in 2006. The requirements would apply to employers with 50 or more workers in 2007. For employers with 20 to 49 employees, the law would apply only if the State provides a tax credit equal to 20% of the net employer cost of the fee. However, the law is under attack and may not survive an expected state referendum or several court tests that are anticipated.

Advantages

- This approach to coverage expansion does not require large increases in government spending. The cost is off budget—borne by employers instead of government—and, thus, requires no general income tax increase. However, this approach would, in essence, be a tax on those employers not currently providing health insurance to their employees.
- The approach is sometimes seen as helping to bring about greater equity between employers who already provide coverage and those who do not. Particularly in the case of employers whose employees get coverage through an employed spouse, the mandate can be seen as a way of requiring the non-offering employers to pay their fair share.

⁵⁴ Health Care for All! gave a presentation to the Workgroup about their proposal which includes some of the aspects of a pay or play employer mandate. The presentation is available at <http://www.dhmf.state.md.us/hrsa/pdf/PlanSummary.pdf>

- Compared to coverage expansion approaches that depend upon establishing a separate program for the uninsured, this approach also avoids the problem of “crowd out,” which occurs when people already covered through private sources switch to the new public program and thereby put more of the burden on government and less on the private sector.

Issues

- Apart from its substantive merits or demerits, some people find the employer mandate approach philosophically objectionable simply because it involves a degree of compulsion, requiring some employers to do what they would otherwise choose not to do.
- Requiring employers to cover the cost of coverage is equivalent to mandating a substantial wage increase, at least in the short run. Some critics contend that the result would be layoffs of workers and higher prices for the products that employers produce, which would make these products less competitive in national and international markets. Economists, however, generally agree that, in the longer run, employers will pass back the cost to employees in the form of lower wages or other reductions in compensation. The reasoning is that in deciding how much labor to hire—which involves weighing costs against benefits—employers consider the *total* compensation costs of hiring another worker and compare that to the additional revenue that the worker would bring in. Thus, when making hiring decisions, employers will pay less in money wages if they have to pay more in the form of fringe benefits. If this reasoning is correct, the long-range effect on a state’s competitive position relative to other states is likely to be little affected by an employer mandate.
- One type of employer is likely to be adversely affected—those who pay only the minimum wage; they cannot legally pass back the costs of health insurance to their employees by lowering money wages. Hence, firms paying the minimum wage that did not previously offer coverage might lay off some workers.
- Any form of employer mandate faces a major hurdle: the federal ERISA legislation that prohibits states from regulating employer benefits. States can regulate insurers and stipulate what benefits they can and cannot offer, but they cannot require employers to offer certain kinds of health insurance coverage or even to require coverage at all. States are able to regulate the kind of insurance that fully insured employers provide because they can regulate the kind of insurance that insurers can sell. But the ERISA pre-emption prevents states from mandating that self-insured employers provide coverage. Some legal experts believe that carefully crafted legislation can, *in effect*, allow states to require even

self-insured employers to provide coverage. Presumably, this explains why the California legislation requires all employers to pay a fee but returns this fee in the form of a tax credit if they provide insurance coverage to their employees. It seems certain that this approach will be tested in the courts.

Individual Mandate

One approach to achieving universal coverage would be for government to mandate that everyone have health insurance of one form or another. This may be the only way to insure that one segment of the insured population is covered: in Maryland, about 38% of the people who are uninsured have annual incomes in excess of 300% of federal poverty levels (about \$43,500 for a family of 3). It is reasonable to conclude that most of these could afford to buy coverage but choose not to do so for some reason. Yet, when these people incur some kind of catastrophic medical expense, they are likely to receive care from the safety net system, thereby passing on their costs to the rest of the population. Mandating that everyone have coverage would go far toward solving what some see as a “freeloader” problem.

No state has in place legislation that requires everyone to have coverage.

A more moderate approach would be to require households at higher income levels (for example, those above 300% of the federal poverty level) to purchase coverage, since they presumably can afford to do so. Requiring lower-income households to buy coverage would be impractical without some kind of subsidies to make purchase of such coverage affordable.

A more moderate approach could include allowing standard or itemized deductions and personal exemption credits on an income tax return only if the taxpayer (above some percent of the federal poverty level) could provide proof that health insurance had been purchased.

The Approach

The State could pass legislation requiring everyone to acquire health coverage of one kind or another. Presumably, the State would specify some minimum benefit package; this might be “bare bones” or catastrophic coverage or coverage similar to that offered in the CSHBP. Individuals who failed to acquire coverage could be required to pay an amount equal to the cost of coverage as an addition to their state tax liability. (In effect, everyone could be required to pay a tax equal to the cost of coverage, and then a credit could be given for the cost of the coverage for those who purchased coverage or were otherwise covered.) Presumably, any tax revenues generated this way would go to pay for “uncompensated” care to cover the costs of treating the people who still remain uninsured. As stated above, another approach could disallow certain tax exemptions if health insurance was not purchased.

Advantages

- This approach creates strong incentives for everyone or a limited population (for example, households whose incomes exceed 300% FPL) to acquire coverage; everyone would be covered or would contribute toward the cost of coverage.
- This approach would ensure inclusion of people who can afford coverage but who choose not to buy it.

Issues

- Imposing an individual mandate does nothing to make coverage more affordable for the large portion of uninsured people who do not have sufficient resources to afford coverage without subsidies. Their only choices would be to comply with law at great financial sacrifice by going without other needed items in their budget or to simply disobey the law. From a practical standpoint, this means that an individual mandate, if applicable to the entire population, must be accompanied by some sort of subsidy program to make coverage affordable for low-income people. It might be more feasible to implement an individual mandate for just higher-income people; for example, perhaps those with incomes above 300% or above 400% of the poverty level.
- One practical problem is how to enforce a mandate. It would be possible to determine who does or does not have health insurance by requiring all taxpayers to show proof of coverage at the time they file their annual tax returns. Of course, this approach would not be helpful in detecting noncompliance among people who do not file tax returns, as is the case for a significant number of low-income people whose income is so low that they are not required to file. It would be effective if the mandate only applied to higher incomes since they file tax returns.
- Another issue is what kind of penalties to impose on those who fail to obey the law. Some analysts have suggested that a penalty that might be effective without being unduly onerous would be to deny those who are out of compliance the right to take advantage of some tax benefit, such as the personal income tax exemption.
- The individual mandate involves a degree of compulsion that some people may find unacceptable. However, supporters of the idea point out that all states require everyone who drives an automobile to purchase automobile insurance, and most people find this acceptable.

Appendix A

Maryland Health Care Coverage Workgroup Members

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APPENDIX B

Principles to Guide the Selection and Prioritization of Viable Options to Extend Health Coverage to Maryland's Uninsured

The following list represents proposed principles to aid the Workgroup in selecting and prioritizing among the range of options available to extend health care coverage to residents of Maryland who are now uninsured. The list was developed by staff as well as additional principles suggested by the Workgroup members.

It was recognized that no approach to covering the uninsured can be optimal with respect to all of these criteria. Approaches that fair well with respect to some criteria will almost surely do less well in terms of some others.

The order in which we have listed the proposed principles *does not* reflect any judgment about their relative priority.

Other things being equal, preference should be given to policies that . . .

- can generate sufficient political support from Maryland residents, elected officials, the business community, health care providers, health plans and insurers.
- are affordable given Maryland's budget situation.
- are likely to be maintained (opposed to scaled back) over the long term.
- extend coverage to lower income people before higher income people.
- produce the highest ratio of people covered per state dollar spent.
- maximize use of federal dollars rather than state dollars.
- minimize replacement of private coverage with public coverage.
- are equitably financed such that people in equal circumstances are treated equally and any associated tax obligations for health coverage or care are progressive rather than regressive.
- build on successful existing institutions and administrative structures rather than requiring the creation of entirely new institutions and structures.
- minimize administrative complexity.
- minimize administrative costs.
- do not depend heavily on changes in federal law or federal regulations.
- do not create disincentives to work.
- minimize social stigma and maximize personal dignity.
- create incentives to economize on the use of costly medical resources.
- encourage broad risk pooling and sharing of risk.
- achieve immediate benefits rather than postponing coverage extensions to a point further in the future.

- are cost-effective in terms of maximizing positive health outcomes and improving quality of care.
- encourage utilization of primary and preventive care services.
- do not undermine existing programs that cover people who would otherwise be uninsured.
- promote equitable access to and delivery of health services and minimize barriers to access and delivery.
- respond to varying levels of needs in different parts of the state.
- promote equity of reimbursement across provider groups, both public and private.
- incorporate reimbursement policies consistent with attracting sufficient numbers of providers to provide services for target populations.

APPENDIX C

Options for Expanding Coverage to Maryland's Uninsured

1. Vouchers to Low-Income Individuals
2. Tax Credits for Individuals to Compensate Them for Purchasing Coverage
3. Tax Credits for Employers to Encourage Them to Offer Coverage
4. Subsidized Buy-in to State Employees' Plan
5. Extending Medicaid Coverage to Parents
6. Extending Coverage to Parents and Childless Adults with a 1115 or HIFA Waiver
7. Low-Income Immigrants State-Only Medicaid Program
8. Three-Share Subsidized Employer-Based Coverage Programs
9. Limited Benefit Coverage Programs
10. Individual Insurance Reforms
11. Small Group Market Reform Expansion to Include Businesses with 2-100 Employees
12. Unsubsidized Health Insurance Purchasing Cooperatives for Small Employers
13. Purchasing Cooperatives offering Subsidized Health Insurance for Low-Wage Small Firms
14. "Bare Bones" Insurance — Catastrophic Coverage
15. "Bare Bones" Insurance — Primary Care
16. Mandate that Individuals Have Coverage
17. Employer "Play or Pay" Mandate
18. The "Single-Payer" or Social Insurance Approach
19. Transitional Programs
20. Extending Coverage for Young Adults (Ages 19-24)

APPENDIX D

Public Comment Received from Interested Parties on Small Group Market Options Discussed with the Maryland Health Care Commission

In November, under the auspices of a study required by Senate Bill 477 (2003), the Maryland Health Care Commission held a public meeting of interested parties to discuss the issue of a Basic Plan in the small group market and a number of other potential options that would require statutory changes to implement. The meeting was attended by insurance carriers, brokers, employers, consumer advocates, the Maryland Association of Nonprofit Organizations, and State regulators. The following are the public comments received from interested parties.

Basic Health Plan

Carriers and some brokers present contended that the creation of a Basic Plan separate from the CSHBP was not necessary and perhaps could be harmful to the small group market. The primary comment was that the modifications that were recently adopted by the Commission to the CSHBP to be effective July 2004, essentially created a “basic” plan. The higher deductibles associated with the PPO delivery system meets the definition of a catastrophic plan as described above; therefore, any alternative basic plan to be developed would be more along the lines of the limited benefit plan. Both carriers and brokers expressed concern that the creation of a limited benefit plan in addition to the CSHBP would lead to risk segmentation in the small group market. The younger, more healthy groups would buy the limited benefit plan (because they would not see the need for the more expansive coverage) and those remaining in the CSHBP pool would see their premiums increase as there would be less healthy people with which to spread the risk. One carrier characterized this as punishing the employer groups who had played by the rules and had been providing coverage for their employees all along under the CSHBP. The overall sentiment expressed was that efforts should be made to encourage healthier groups to purchase the Standard Plan so as to increase the size of the current pool and that making a Basic Plan available would have the opposite effect.

Carriers also expressed concern about a number of issues that are addressed above: that a less comprehensive plan would be unlikely to attract customers; that federally-qualified HMOs could not market a limited benefit plan thus leading to less competition. Carriers also raised the possibility that having two plans in the small group market would actually increase administrative costs because the carrier would have to market two separate products and manage two community-rated pools. One carrier raised the issue of how a limited benefit plan would work in relation to the plan offered under the Maryland Health Insurance Plan (MHIP), the new high-risk pool that uses the same comprehensive benefit plan as required in the small group

market. The MHIP product can only be sold to individuals who failed medical underwriting, not employer groups.

The consumer advocates also voiced concern over risk segmentation and, in addition, speculated that having a limited benefit plan would lead to increased underinsurance and that employers and employees would be confused about the level of coverage that they had under the limited benefit plan. A limited benefit plan would give people a sense of health care security that they would not really have.

A lengthy discussion centered on “fixed indemnity” plans which are currently available in Maryland. A number of brokers said that they are becoming increasingly popular and are, in essence, equivalent to a limited benefit plan already. Fixed indemnity plans are a type of insurance that, for example, pays a certain dollar amount for each day a policyholder is in the hospital (i.e., \$100 per day) or for a physician office visit (e.g., \$30 per visit). Most of these policies have a limit on the number of hospital days (e.g., maximum 100 days) or the number of office visits (i.e., 5 visits per year). Fixed indemnity products are different from expense-incurred insurance policies where the benefits are related to the expenses policyholders actually incur when they receive services. Currently, fixed indemnity insurance does not fall within the definition of the health plans that are governed by the requirements of the small group market. Currently, only a very small number of fixed indemnity policies are being sold in Maryland.

Voluntary Purchasing Pool

Comments from carriers noted the potential and likely difficulties in administration especially surrounding the issue of collecting and processing the premiums and the lag time in payment from the pool. It was also noted that a purchasing pool could increase administrative costs as the operating expenses of the pool would have to be paid and currently these costs are borne by the carrier but spread out over its entire book of business. These administrative activities would still be needed by the carrier for its other products so the activities would be duplicated. Another carrier suggested that, while there could be administrative savings for employers, it would add to the carrier’s administrative costs which would then be passed back to the employer.

The general sentiment was that the small group market reforms and the current community rating requirements are equivalent to having a purchasing pool and that allowing another separate purchasing pool, the current pool would be diluted. There was a concern about adverse selection between those receiving benefits within the pool and those who remain outside the pool.

There was disagreement by the carriers that the smallest groups are not being targeted; they state that the average size of the employer group they cover is seven lives.

HealthCare for All, while they endorsed the idea of a larger risk pool, felt that health care expansion could be better accomplished through the adoption of their proposal.

Reinsurance

The carriers and a consumer group do not support reinsurance as a means of reducing the cost of health insurance. The carriers believe that private reinsurance, or reinsurance purchased directly by the carrier, is more cost-effective and creates an incentive for carriers to manage care effectively. Private reinsurance is based on a carrier's claim experience, thus encouraging the carrier to manage the care provided to their members through care and disease management programs, as well as the payments to health care providers. The carriers indicated that mandatory reinsurance pools create a disincentive that inevitably leads to less efficient care since higher risks are transferred to the pool. A consumer group commented that the State will take on much of the cost from high risk patients, thus shifting the cost from insurers to their benefit. In addition, a State-mandated reinsurance pool would require state-funding.

A business owner supports the concept of a privately-funded reinsurance pool to encourage more carriers to sell the CSHBP, thus leading to greater competition in the small group market and reduced premiums.

Tax Credits for Small Employers

The respondents support the concept of tax credits as a general incentive to small employers to offer health insurance to their employees; however, several posed concerns related to the source of funding and the level of participation. One carrier proposed that tax credits are a "way of increasing affordability and accessibility in the small group market." However, a business owner indicated that tax credits act as a subsidy and therefore, may, in fact, lead to higher health insurance charges only to exacerbate the problem of rising health insurance premiums. Consumer groups are concerned that funding for tax credits may be redirected from State programs such as Medicaid or federally qualified health centers, and that the size of a tax credit is critical to the take-up rate of small businesses.