

Options for Expanding Health Insurance Coverage to Michigan's Uninsured

- 1 Vouchers to Low-Income Households
- 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 for Families with Incomes Beyond the Current Percent of Poverty – Without An 1115 Waiver Modification
- 6 Extending Coverage to Parents in Low-Income Families – With a SCHIP 1115 Waiver
- 7 Extending Coverage to Parents, Childless Couples and Single Adults – With a HIFA Waiver
- 8 Three-Share or Subsidized Employer-Based Coverage Programs
- 9 Limited Benefit Coverage Programs
- 10 Individual Insurance Reforms —A High-Risk Pool
- 11 Unsubsidized Health Insurance Purchasing Cooperatives for Small Employers
- 12 Purchasing Cooperatives offering Subsidized Health Insurance for Low-Wage Small Firms
- 13 “Bare Bones” Insurance — Catastrophic Coverage
- 14 “Bare Bones” Insurance — Primary Care

- 15 Mandate that Individuals Have Coverage
- 16 Coverage for People in Transition
- 17 Extending Coverage for Young Adults (ages 19-24)
- 18 Employer “Play or Pay” Mandate
- 19 The “Single-Payer” or Social Insurance Approach
- 20 The Multi-Payer Single State Pool Approach

Options for Expanding Coverage to the Uninsured in Michigan

Before considering policy options to cover the uninsured, it is useful to consider the different categories of uninsured people. People without health coverage fall into four categories:

- Those who could afford reasonably priced coverage but who have to pay premiums much higher than average because they have characteristics that place them at high risk for incurring medical expenses.
- Those whose ability to pay is so limited that they could not afford to buy even reasonably priced coverage. (Many of these people will not purchase coverage unless the price is substantially subsidized.)
- Those who could afford to purchase coverage but fail to do so, either because they feel the insurance protection is not worth the cost or because they simply don't get around to purchasing coverage.
- Those who are eligible for subsidized programs but do not sign up for them, either because they are unaware that they are eligible or because they do not want to be associated with a subsidized program for one reason or another.

There is a second useful way of categorizing the uninsured—according to their employment status:

- Those that are *employed* and are *offered* coverage but *decline* it.
- Those that are *employed* but are *not offered coverage* and thus whose only option is to buy coverage in the individual market.
- Those that are *not employed* and thus have only the option of buying coverage in the individual market.

In looking at the range of options available for providing coverage to the uninsured, it is useful to keep these categories in mind since not all options will address the needs of all categories of uninsured people. We will need to decide which categories of people we will target and which policies will be suitable for meeting each group's needs—that is, ultimately we will want to choose policies for the boxes (perhaps not all) in the matrix below.

Categories of Uninsured	Employed and offered coverage but decline	Employed but not offered coverage	Not employed
Could afford normally priced coverage but only-high cost coverage is available			
Could not afford without large subsidies			
Can afford but fail to buy			
Eligible for subsidized programs but don't sign up			

The Full Range of Possible Policy Options

The Workgroup is charged with determining one or more options that Michigan could institute to expand coverage to people who are now uninsured.

Generally speaking, there are three groups that make decisions affecting insurance coverage that the State could seek to influence: individuals, employers, and insurers. We begin by looking at individuals, that it is, the people who are not insured.

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.)

As previously noted, 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 coverage.

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, we are considering only the range of options. Later in this document, we consider advantages and disadvantages.)

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 a strong case can be made for designing credits 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. 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. Of course, this is not insurance coverage in the usual sense.
 - 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. (Michigan has recently legislated some 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.)

On the following pages, we present a series of one-page descriptions of options that represent many of the ideas outlined above. Of course, if the Work Group were interested in exploring any of these options, a more detailed analysis would be necessary. This list clearly does not exhaust the range of options. Many permutations and combinations of these options are possible.

1 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.

Pros

- 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.

Cons

- 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.¹
- 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 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.

¹ Research suggests that for people whose income is below 300% 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.

Financing

The state would have to provide sufficient revenue to cover the cost of the vouchers, probably 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.

2 TAX CREDITS FOR INDIVIDUALS TO COMPENSATE THEM FOR PURCHASING COVERAGE

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 underwrite the cost of COBRA coverage for these displaced workers. The effect of these strategies is to lower the net price of coverage.

A number of tax credit strategies have been proposed at the federal level over the past several years. For example, President Bush proposed a plan that would grant uninsured families with annual incomes of less than \$25,000 a tax credit of up to \$3,000 to assist them in purchasing private health coverage. Individuals would be eligible for smaller credits.

Pros

- 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 requires no new special public program for low-income people. People buy private insurance coverage in private markets.
- This approach tends to be more acceptable to people who are wary of government bureaucracies. The tax credit is, in effect, a tax reduction, although the idea is essentially similar to giving people a voucher to use to purchase health insurance.
- This option would provide access to health insurance for those who do not have employer-based coverage.
- 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.

Cons

- 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 can 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
- The tax credits would have to be large in order to induce most of the uninsured to buy coverage. Even then, some would choose not to purchase

coverage for fear that something would “go wrong.” Further, 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 problem can be overcome by making the credits payable in advance, although this adds administrative complexity.

- 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.
- 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.
- Unless the tax credit is very large, currently uninsured people with low incomes and high health risks may remain uninsured because coverage would still not be affordable.

Financing

The state would have to provide sufficient revenue to cover the tax subsidies.

3 TAX CREDITS FOR EMPLOYERS TO ENCOURAGE THEM TO OFFER COVERAGE

The Approach

The state would extend a tax credit to employers who newly offer health coverage to employees. The expectation is that some employers, now able to subtract a portion of coverage costs from their state tax liability, would be induced to offer and pay for a portion of coverage for their employees. To make the approach cost-effective, the subsidy would need to be limited to certain employers, for example those employing low-wage workers, workers in certain industries, or employers with 10 or fewer employees. Employers would need to be required to pay some reasonable portion of the premium. To make this approach practical, it should probably include provisions to specify minimum benefits that the insurance would cover.

This approach has been proposed at the federal and state levels as an option to expand coverage.

Pros

- As contrasted with an approach that involves setting up separate subsidy programs for the uninsured, this approach builds on the employer-based insurance systems and depends on market forces, creating incentives for employer to make “mainstream” coverage available to employees.
- It uses existing administrative procedures of the tax system and does not require a separate administrative process or a specially tailored new government program government.
- For both reasons, this approach tends to be more acceptable to people who are wary of government bureaucracies.

Cons

- Many employers not now offering coverage are likely to be small, marginal firms, hiring low-wage employees. They may not generate significant profits and thus may not incur much of tax liability; so the tax credit would need to be “refundable” and quite large to create significant “take-up”.
- These employers would still have to pay a significant portion of the premium from their own funds, which may be more than marginal firms can afford. Moreover, low-wage employees might prefer to have any increased compensation in the form of higher money wages. So the approach might have little impact on covering the uninsured.
- 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; so the tax credit would probably need to be advanceable.
- 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.

- There is a possibility that some employers already providing coverage would take advantage of the tax subsidy and cut back on their contribution. (To prevent this, the credit could be limited to firms not previously providing coverage, though this creates equity problems among employers.)
- Tax credits might elicit concern about such issues as inflexible eligibility standards and complicated applications; some employers might not be willing to assume any additional administrative responsibilities.

Financing

The state would have to provide sufficient revenue to cover the tax subsidies.

4 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 administration complexity.)

A variation of this approach would be to allow certain categories of small businesses—for example, low-wage firms—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.

Pros

- 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 a 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.

Cons

- There is the potential of "crowd out." Large and small employers now providing coverage to a workforce that includes 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 cost would be lower or the benefits would be better. These problems become more severe the higher the income group eligible for subsidies, since the probability of having existing coverage increases with income. (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 rise, etc. The resistance might be less than expected, however, 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. But some advantages would be lost.)
- Assuming many of the eligible people would have children in SCHIP, the adults and children would be in separate health plans.

Financing

The state would have to appropriate sufficient funds to cover the additional cost to the state employees' insurance plan of covering the additional (subsidized) enrollees. The state would have the opportunity to calculate the effect of reducing the very substantial hospital cost-shifting attributed to hospital care to the uninsured, based on the fact that a large portion of the uninsured would now have paying coverage. This effect could be recaptured and used to offset the new direct costs to the state.

Target Population

The eligible population would be uninsured adults and children of uninsured adults with incomes below a specified level that don't qualify for current public programs. The option might also be offered to employers of low-wage workers below a specified size.

5 EXTENDING MEDICAID COVERAGE TO PARENTS FOR FAMILIES WITH INCOMES BEYOND THE CURRENT PERCENT OF POVERTY—WITHOUT AN 1115 WAIVER MODIFICATION

The Approach

At present, federal welfare reform legislation allows state Medicaid programs greater flexibility in treatment of the income and assets of low-income families under section 1931 of the Social Security Act in several ways:

- ***Raising the maximum income level that allows a family to qualify for Medicaid.*** States are permitted to raise the maximum income level and resource standards for Medicaid by as much as the rise in the consumer price index since July 1996, the date that welfare reform legislation was implemented.
- ***Changing the way income is counted (i.e., income disregards).*** States are given tremendous leeway in how they define and calculate income disregards. They may ignore a percentage of income, a type or source of income (e.g., tips or interest income) or an amount expressed in dollars or a percentage of the federal poverty level (FPL). For example, Pennsylvania has used this provision to disregard 50% of every Medicaid applicant's income.
- ***Changing the way assets are counted (i.e., asset disregards).*** States are permitted to ignore certain assets (e.g., a car, owned property) when determining Medicaid eligibility. For example, many states, including the District of Columbia, Pennsylvania, Massachusetts, Rhode Island and Connecticut, among others have dropped asset tests for Medicaid entirely.
- ***Redefining “unemployment” in order to cover more two-parent working families.*** Section 1931 also allows states to remove the prior “AFDC-U” restriction that permitted Medicaid coverage for low-income parents in *two-parent* families only if neither parent was working full time. Several states have been quite creative in using this provision. The District of Columbia, for example, used this provision to extend Medicaid benefits to families in which the principal wage earner earned less than 200% of the FPL after allowing for the deduction of child care expenses.

Several states have used the 1931 option to extend Medicaid eligibility for parents to the poverty level and beyond. For example, the HUSKY program in Connecticut covers parents in families with incomes under 150% of the FPL using this option. Maine has also expanded coverage to 150% of the FPL under a similar provision. However, it is important to note that the Section 1931 option cannot be used to cover single adults, childless couples, or non-custodial parents (that is, adults who are not parents of a minor child).

States have used the 1931 amendment as a stand-alone option to cover more parents in families with children, or they have used it in combination with a SCHIP 1115 waiver. However, the latter would be highly problematic, if not

impossible for Michigan, as the state has already used its entire SCHIP federal funding allotment.

Pros

- The federal government would pay 56.6% of the cost of coverage in 2006.
- Use of an existing system would eliminate the need to establish new program administration.
- The state's financial obligation could be limited. States have the flexibility to "roll-back" their 1931 disregards for new applicants or for both applicants and enrollees.
- The target population is relatively healthy. They generally are working and have fairly low health care needs (and so are less costly to cover). In addition costs are lower because Medicaid already covers women in this income range for pregnancy-related services.
- Offering coverage to parents may increase enrollment of eligible children. In addition, relevant literature indicates that children of parents with health care coverage are more likely to receive appropriate primary and preventive care than children of parents without health care coverage.
- Section 1931 eligibility adjustments are simply amendments to the state plan. They do not require a lengthy and complex approval process with the Centers for Medicare and Medicaid Services (CMS).

Cons

- To the extent that the Medicaid program retains any "welfare" stigma, the new program would similarly be stigmatized.
- Expansion of Medicaid may be viewed as politically undesirable in Michigan.
- While states can limit their financial obligations under section 1931, the Medicaid expansion rules do not allow states to impose any "crowd-out" provisions. Individuals could choose to drop private employer-based insurance. The state would have no ability to keep them from immediately enrolling in Medicaid.
- While there is no theoretical limit to the amount of income that can be "disregarded" under the provisions of Section 1931, the disregard is relative to the state's 1931 income level, a level related to its payment policies under the former AFDC program.
- At higher income levels, there is an increased likelihood that individuals will drop employer-based coverage in favor of Medicaid coverage.

Financing

The federal share of Michigan's Medicaid funding is 56.6% for 2006. The State would finance the other 43.4% share.

Target Population

This analysis assumes a decision to use the 1931 option to cover additional parents of Medicaid eligible children, namely parents living in families with incomes up to approximately 100% of FPL. But in theory the level could be higher.

Background

General background to public program approaches in Michigan: Michigan currently provides Medicaid coverage to working parents with children if their family income is less than 59% of poverty (approximately \$11,417 for a family of four in 2005). Michigan Medicaid covers non-working parents with children only

if their family income is less than 35% of poverty (approximately \$6,773 for a family of four).

Michigan Medicaid provides coverage for pregnant women and children under age 19 at higher income levels through its Healthy Kids Medicaid expansion program—up to 185% of the FPL for pregnant women and children under age one and up to 150% of the FPL for older children. The MICHild Program, Michigan's State Children's Health Insurance Program (SCHIP), provides coverage for children where Medicaid leaves off, ensuring eligibility for children up to age 19 who live in families with incomes up to 200% of the FPL (approximately \$38,700 for a family of four).

Disabled and aged individuals are covered at 100% of FPL. Single, non-pregnant adults and childless couples may qualify for very limited coverage if family income is less than 35% of poverty.

6 EXTENDING COVERAGE TO PARENTS IN LOW-INCOME FAMILIES—WITH A SCHIP 1115 WAIVER

The Approach

A number of states, including New Jersey, California, Rhode Island and Wisconsin, among others, have used SCHIP Waivers to expand coverage to parents of Medicaid and SCHIP enrolled children.

The Centers for Medicare and Medicaid Services (CMS) requires that states applying for waivers to cover parents using SCHIP funds comply with the following requirements:

- Coverage must meet benchmark levels. The result is that the state is likely to use the same benefits as it uses for SCHIP for children.
- Cost sharing must remain within allowable limits.
- Higher-income individuals may not be covered before lower-income individuals.

In addition there are general requirements that a State's current SCHIP program must meet before a waiver request will be considered:

- At least one year of experience providing health care assistance under SCHIP.
- Submission of all required evaluations and reports.
- Coverage of children (and pregnant women) must be at an equal or higher percentage of the FPL than the proposed level for parents. (If the SCHIP 1115 waiver is not a HIFA waiver, CMS requires that children must be covered to 200% of the federal poverty level, a condition that is met in Michigan.)
- Statewide operation.
- Open enrollment (no waiting lists).

There are also requirements for extensive public input in developing the waiver plan. The state must also demonstrate that it has made an effort to enroll eligible children in its SCHIP program.

Michigan meets most of these requirements. However the Health Kids, MICHild and Adult Benefits Waiver programs currently uses all of Michigan's SCHIP funds.

Pros

- The federal government would pay 69.6% of the cost of coverage if the state were able to access un-spent allotments from other states (Michigan has used all of its own SCHIP allocation)
- Use of an existing system would eliminate the need to establish new program administration.
- Under an SCHIP 1115 waiver the state's financial obligation can be limited. States can "close enrollment" for optional expansion groups at any time and re-open enrollment when the number of enrollees drops through attrition.

Cons

- States (such as Wisconsin) with SCHIP 1115 waivers are able to cover parents of Medicaid and SCHIP children under employer-sponsored options using both Medicaid and SCHIP funds.
- Michigan is among a handful of states whose SCHIP programs have been successful enough to exhaust their SCHIP funding allocations. Michigan has no unused SCHIP funds with which to cover parents of SCHIP children. The state risks the possibility of having to cover this population with 100% state funds if unable to access other state's unspent allotments.
- To the extent that Michigan's MICHild program retains any "welfare" stigma, the new program would similarly be stigmatized.
- Expansion of SCHIP may be viewed as politically undesirable within Michigan.
- Coverage under an SCHIP 1115 waiver would require that the state impose "crowd-out" provisions.
- Even with crowd-out provisions, the availability of heavily subsidized family coverage to significant numbers of full-time working parents and children might create greater incentives (than child-only coverage) for employers and workers to drop existing private coverage (depending on what income levels are chosen and what the state does to coordinate coverage with employers).

Financing

Without significant changes in the current federal regulations, it is unlikely that this option is a viable one for Michigan at present. The federal share of Michigan's SCHIP funding in 2006 will be 69.6% with the state covering the remaining 30.4%. However, under current federal rules, obtaining this federal matching rate would be difficult, if not impossible. Since Michigan has exhausted its SCHIP funding allotment, federal matching funds *would not* be available to cover SCHIP parents unless Congress re-directs significant sums from other states' un-spent allotments to states like Michigan.

Target Population

To the extent that parents in families with incomes below 100% of the federal poverty were covered under Option 5, the target population for this option is parents in families with incomes between roughly 100% and 200% of the federal poverty level.

7 EXTENDING COVERAGE TO PARENTS, CHILDLESS COUPLES AND SINGLE ADULTS—WITH A MEDICAID HIFA WAIVER

The Approach

The Health Insurance Flexibility and Accountability and Flexibility Demonstration Initiative (HIFA) builds on Section 1115 of the Social Security Act by giving states further flexibility to streamline benefits packages, increase cost-sharing for Medicaid and SCHIP optional and expansion populations and create public-private partnerships for the provision of health insurance coverage, all in exchange for expanding coverage to previously uncovered groups.

More specifically, HIFA allows states to:

- ***Impose enrollment limits on either an expenditure or per-capita basis.***
- ***Re-design the benefits package for expansion and optional populations.*** For *optional* populations (i.e., parents of children enrolled in Medicaid or in SCHIP (MICHild in Michigan) with incomes above the TANF level), states are permitted to offer (1) the commercial benefits package of the largest insurer in the state, (2) the federal employees (FEHBP) benefits package, (3) the state employees benefits package, (4) or a benefit package approved by the federal government. For *expansion* populations (individuals that can be covered by Medicaid or SCHIP only with a waiver, i.e., single adults, and childless couples), CMS requires that the benefits design be at least a basic primary care package (note, this does not have to include an inpatient component). (Michigan has submitted a waiver under this provision to modify the benefits for Medicaid parents.)
- ***More easily expand coverage to single adults and couples.*** HIFA allows coverage of these populations, although not at higher income levels than that provided by the state for children, pregnant women, or parents. Additionally, some states (including Michigan) have used HIFA waivers to leverage existing state-only coverage for these populations into federal matching funds and more comprehensive benefits packages for these groups.
- ***Initiate increased cost-sharing requirements, particularly for optional and expansion populations.*** Cost-sharing requirements for optional children are not permitted to exceed five percent of family income, however.
- ***Pursue broad-based, statewide public-private partnerships with Employer Sponsored Insurance (ESI).*** Under HIFA, states are strongly encouraged to explore and experiment with the design and execution of ESI programs.

To date, Arizona, California, Illinois, Maine, Michigan, and New Mexico have received HIFA waivers to expand coverage to additional children, single adults, childless couples, and/or parents of SCHIP and Medicaid children.

It is important to note that all of these states, with the exception of Maine, have financed these expansions with unspent SCHIP monies. Maine has financed their expansion through the use of previously unused Medicaid Disproportionate Share Hospital (DSH) Funding.

Pros

- Increases the likelihood that Michigan can remain within its federal budget neutrality cap and still expand coverage. To the extent that Michigan's most recent HIFA waiver proposal (submitted on June 1, 2005) generates savings, coverage of additional "expansion" individuals would be possible without exceeding federal budget neutrality.
- Use of an existing system would eliminate the need to establish new program administration.
- Allows Michigan considerable latitude in controlling state spending on health care services. With a HIFA waiver, the state's financial obligation can be limited through a number of different vehicles, namely: cost sharing, closing enrollment, and limiting benefits/services.
- Affords Michigan greater opportunity to use federal dollars to cover single adults and couples. States such as Arizona have successfully leveraged existing state-only programs for these groups into federal matching funds and a more comprehensive benefits package for these groups than the state was providing previously under a state-only funded program.
- Simplified forms and a rapid application approval process relative to other waivers.
- Relative to other expansion options, it may create fewer incentives for crowd-out, as benefits packages may be more similar to (that is, not more comprehensive than) those in the commercial sector.

Cons

- To the extent that HIFA waivers have been used to expand coverage, they have been employed only by states with unused SCHIP or DSH funding. Michigan's previous implementation of a HIFA waiver has exhausted its SCHIP allocation and the state does not have unallocated DSH funding. These options are not available for Michigan unless the state is able to access other state's unspent allotments, redirects its current DSH funding, or garners savings from its current HIFA Medicaid waiver proposal.
- In Michigan, in order to meet HIFA Medicaid budget neutrality requirements, further expanding coverage under a HIFA waiver would almost certainly require the use of cost-sharing provisions and/or a revised benefits package for certain populations for whom this had not previously been the case.
- Expansions involving revised benefits packages and cost-sharing may be viewed as politically undesirable within Michigan.
- Research indicates that cost-sharing provisions can deter low-income, sicker populations from seeking needed health care.
- Michigan's current experience with ESI indicates that such initiatives are administratively complex. Encouraging both business and worker participation and generating significant enrollment in these programs is difficult.

- To the extent that MICHild (SCHIP) and Medicaid retain any “welfare” stigma, the new program would similarly be stigmatized.
- Research indicates that cost sharing can have a significant impact on take-up rates, particularly among those with lower incomes.
- Even with crowd-out provisions and a benefits package similar to private coverage, the availability of heavily subsidized family coverage for significant numbers of full-time working single adults, couples, and working parents and children might create greater incentives for employers and workers to drop existing private coverage (depending on what income levels are chosen and what the state does to coordinate coverage with employers).
- Administering different benefits packages and cost-sharing provisions adds to administrative complexity and cost.
- Those whose income levels fluctuate between those of the “mandatory” and “optional” populations may perceive the state’s public coverage as complicated and unfair.

Financing

The states that have received HIFA waivers have financed their coverage expansion through the use of unspent SCHIP or DSH monies. Neither of these options is currently open to Michigan. Thus the state would have to finance any coverage expansion through a reallocation of existing Medicaid and SCHIP dollars. To remain within the state’s budget neutrality cap, Michigan would have to generate savings through benefits package revision and cost-sharing provisions among existing expansion and optional populations. However, Michigan would receive a 69.6% federal match on all SCHIP enrollees and a 56.6% match on Medicaid enrollees.

Target Population

The target populations are low-income single adults, low-income childless couples and Medicaid and SCHIP parents.

8 THREE-SHARE OR SUBSIDIZED EMPLOYER-BASED COVERAGE PROGRAMS

The Approach

Communities in Michigan and 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, as they leverage funding from employers, employees and government sources to create insurance coverage that is affordable for small businesses (perhaps those with fewer than 20 workers) and their low-income workers.

Typically, a local non-profit entity administers the coverage program. Qualifying businesses are those that have not offered health care benefits in the past and are based in the county. The benefits package is often comprehensive, covering primary care, specialty care, inpatient, emergency room, mental health and generic drugs. Co-pays are typically \$5-\$20. These programs have no deductibles. In some cases, covered services are provided exclusively by in-county providers and hospitals. In other programs the benefits are limited through features such as annual ceilings on payments for inpatient care.

Programs are funded by a one-third share or contribution from the employer and the employee respectively (usually about \$50-\$60 for each), with the remaining one-third (or more) coming from the non-profit entity. The funds for the non-profit come from a variety of sources. In Michigan they represent a combination of county government funds and federal Medicaid funds obtained through a Medicaid Disproportionate Share Hospital payment (DSH) to a local hospital.

There are a number of 3-share programs in Michigan, the largest of which are Health Choice in Wayne County and Access Health in Muskegon County. The Health Choice and Access Health programs are relatively comprehensive but do not include all of the benefits required under Michigan's insurance laws. Some of the programs subsidize licensed insurance products.

The difference between the 3-share model and the individual tax credit approach is that this subsidizes low-wage businesses rather than focusing on low-income individuals, and it leverages funds from employers that are not currently contributing to health coverage for their employees.

In each of the Michigan communities using this model, special financing strategies using DSH payments draw federal funds to enhance the available local funds. Since these programs do not depend upon Medicaid payments to government-owned health care providers they are not adversely impacted by recent federal regulations.

Pros

- 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.
- 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.
- Michigan's Medicaid DSH capacity has been fully committed in recent years.

Cons

Financing

As noted above, Michigan may not have any unused Medicaid DSH capacity available for this purpose. In addition, generating the matching funds may be difficult. This strategy is currently based on local matching funds rather than any statewide approaches.

Target Population

The target populations are generally small businesses that have a low-income workforce and do not currently offer health insurance to their workers.

9 LIMITED BENEFIT COVERAGE PROGRAMS

The Approach

Communities in Michigan and several other states have implemented programs of minimum ambulatory services (no acute care) targeted to low-income individuals between the ages of 19 and 64. An example of a program for this population is the Ingham Health Plan (IHP) in Ingham County (Lansing). The IHP provides primary and preventive care for 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.

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

Pros

- Low-income individuals have new access to affordable prescriptions and primary and preventive care, which presumably improves their health status.
- More individuals can receive access to basic services if the benefit package is limited.
- If special Medicaid financing is used, federal funds pay 50% or more of the costs.
- Safety-net providers are no “worse off” and may be better off, since some services that would otherwise be uncompensated care are now covered services.

Cons

- Approach fosters continuation of a fragmented safety-net approach to health care.
- A new administrative structure is required.

Financing

It may be possible to fully fund the subsidy program from existing state and local funds in combination with federal Medicaid funds since about 50 of Michigan’s 83 counties already have such a program.

Target Population

The nature of the target population depends on the other options selected. If programs were to cover adults with children eligible for Medicaid or SCHIP, this option would still be a way to provide limited coverage to low-income individuals that are not part of a family with dependent children under age 18.

A key question is the percentage of poverty to be used to determine the cut-off for eligibility. If an option such as subsidized buy-in to the state employer plan is selected in addition to this option, it would be critical to design the program so that it does not create crowd-out for the employer-based option. The income limit

for this option should probably not be any higher than 200% of the FPL. Researchers do not fully agree on the income level at which crowd-out should be a concern. It is most likely somewhere between 150% and 200% of FPL. Therefore this option should probably not go beyond 200% of FPL and it might be desirable to limit it to 150% of FPL.

10 INDIVIDUAL INSURANCE REFORMS —A HIGH-RISK POOL

The Approach

This approach involves trying to spread risk more broadly to make coverage more affordable for individuals who have health conditions or other characteristics that make insurers view them as posing a high risk of incurring expensive medical claims.

High-risk pools are sometimes thought of as a form of last-resort coverage for people who have medical conditions or other characteristics that make them uninsurable in the eyes of insurers. In other words, insurers conclude that they could not afford to provide coverage for these individuals except at rates that are so high that coverage would be unaffordable; so they deny their application for coverage. One solution is to separate out these individuals from the rest of the insured population and put them together in a special pool that provides coverage at *subsidized* premium rates—that is, the premium revenues do not cover the costs of providing the medical services that this group uses.

A modified form of this approach would be open the high-risk pool to anyone who faces an insurance premium that is above some relatively high percentage—for example, 150%—of what a person of their age would normally pay, even if they have not been turned down for coverage.

It is important to recognize that this approach, like virtually all others that seek to reduce premiums for high-risk people, requires that the costs be spread over the normal-risk population. Since the premiums for those in the high-risk pool are subsidized, the shortfall has to be made up by collecting revenue from other than the high-risk people themselves. Typically, states have generated the revenues by assessing fees on other insurers in the state. The insurers, of course, pass on these additional costs in the form of higher premiums to the individuals and groups they insure, thereby raising premiums for this population. The consequence is likely to be that a few people who are on the margin of buying coverage decide that they no longer can afford it.

One of the problems of assessing other insurers is that federal law (ERISA) prohibits states from requiring self-insured employers to pay such fees; so the subsidies are financed from the smaller employers that are not self insured and the people who buy coverage in the individual market. Not only is this not an equitable distribution of the burden; it also places a practical limit on the amount of revenue that can be collected.

Another approach to financing the subsidies is to use more broadly based revenues. A number of states impose fees on hospitals and or other providers. This is a mechanism for spreading the risk more broadly among most of the insured population, since providers pass on that these fees in the form of higher reimbursement charges, and these are, in turn, reflected in higher premiums for both insured and self-insured groups. Even more equitable would be to finance the subsidies from state general revenues because the cost would then be spread across the whole tax-paying population.

Pros

- In a system where people who depend on the individual insurance market for coverage, other techniques for making coverage for higher-risk individuals—such as limiting insurers' ability to vary rates based on risk—are probably not viable because people can wait to buy coverage until they anticipate needing expensive medical care. So high-risk pools may be one of the few feasible methods for providing a source of coverage for high-risk individuals.
- High-risk pools tend to be favorably viewed by people who are wary of expansion of public programs.

Cons

High-risk pools, for the most part, have not produced a significant reduction in the number of uninsured. But that is not really to be expected, since they are really aimed at making the system more equitable for the relatively small portion of the population that is in the high-risk category; high-risk pools are not designed to meet the needs of the average-risk uninsured. But even when they are evaluated only in terms of their success in meeting the needs of the high-risk population, pools have experienced a number of difficulties:

- While subsidized, the rates are often still too high to be affordable for many of the people who qualify for participation. Rates tend to range from 125% to 200% of the rates for standard coverage. One recent study concluded that premiums range from 4% to 12% of median household income. The average premium was 8.1% of median household income. So subsidies would need to be sufficient to make coverage affordable, which raises the budgetary cost.
- Even though premiums are often high, coverage may not be comprehensive; the benefit structure may include high deductibles and substantial consumer cost sharing. Typically, there are limits on coverage for pre-existing conditions. So coverage would need to be sufficiently comprehensive, which raises budgetary costs.
- High-risk pools are often underfunded. As a consequence, either some people who are eligible to participate are put on waiting lists and left without coverage, or the premiums are so high that many people for whom the program is designed cannot afford the coverage. So adequate, ongoing funding is necessary.

Financing

The state would incur costs to subsidize the difference between the premiums collected from those in the pool and the amount of medical claims they generate.

Target Population

Individuals who could afford average priced coverage but not premiums that reflect their higher risks.

11 UNSUBSIDIZED HEALTH INSURANCE PURCHASING COOPERATIVES FOR SMALL EMPLOYERS

The Approach

Several states have sponsored efforts to form health purchasing pools or health-purchasing cooperatives (HPCs) so that small employers can pool their purchasing power and collectively purchase health coverage. The cooperative signs contracts with health plans that agree to offer a few standardized products to any small employer that chooses to buy through the HPC. The expectation is that with the purchasing clout of many small employers purchasing collectively, the HPC will be able to do what large employers do: bargain for better premiums and realize administrative savings, thus making coverage more affordable. (HPCs generally cannot produce lower costs by pooling risk; risk pooling depends on state laws restricting premium variation. If HPCs adopt more lenient rules in accepting applicants than is done in the outside market, they will attract a disproportionate share of higher-risk enrollees. That will raise costs and premiums, which will, in turn, cause lower-risk enrollees to leave, since they will be able to get a better deal in the outside market.)

Pros

- Though states (or municipalities, such as New York) normally provide start-up money, the cost is relatively small.
- This approach tends to be politically palatable to people of different philosophical perspectives, though insurers and insurance agents may oppose it.
- HPCs make it possible for an employer to allow *individual* employees to choose different health plans rather than forcing everyone to enroll in a single plan chosen by the employer. Hence, HPCs are an appropriate vehicle for offering subsidized coverage.

Cons

- The evidence is that few HPCs are able to offer products at prices significantly lower than those generally available already, at least in part because most cooperatives have not been able to capture a large market share and become large enough to have clout or realize administrative economies of scale.
- Even if they were *very successful*, cooperatives could not produce price reductions sufficient to attract large numbers of the uninsured, many of whom would still need subsidies.
- It has been difficult to persuade health plans to continue to participate in HPCs, since they don't see them as a significant source of profits when they aren't large.
- Insurance agents and brokers may see HPCs as a threat, but success depends on their willingness to sell the HPC products.
- Coops can't be more permissive in accepting high-risk groups or in pooling risks in setting premiums than the market is generally; if they do, they will become victims of adverse selection—that is, they will end up with all the high risk and thus have to charge very high premiums.

Financing

A few cooperatives have been started without any government money, but most have depended upon government for start-up funds (usually \$1 million to \$4 million) and then support themselves from fees added to the premium once they become fully operational. But lack of money for marketing has hurt HPCs' attempts to capture a large market share.

12 PURCHASING COOPERATIVES OFFERING SUBSIDIZED HEALTH INSURANCE FOR LOW-WAGE SMALL FIRMS

The Approach

A health insurance purchasing pool could coordinate public subsidies and private contributions to cover low-wage uninsured small firms and their workers. For example, it could provide heavily subsidized coverage to low-wage workers and their dependents while relying on employer and employee contributions to cover higher wage co-workers.

Pros

- By providing coverage through the workplace, the pool could reinforce rather than undermine employer-based coverage.
- By providing a single coverage venue that harnesses various contribution sources, the cooperative could provide a stable source of coverage (facilitating continuity of care) as changes in family earnings over time affect eligibility and cause people to move among different state, federal and private sources of coverage.
- The cooperative could reduce employer administrative costs and burdens by playing such purchaser/sponsor roles as negotiating and contracting with health plans, offering worker choice of competing plans, and resolving problems. That is, it could be an efficient way to provide subsidized coverage for small low-wage employers.
- The pool could be structured to facilitate the combination of multiple financing sources, tax subsidies, state and private dollars in a seamless manner that allows affordable single-source coverage for working families of small firms.

Cons

- The subsidy must be large enough to attract participation of significant numbers of uninsured small employers and employees. Otherwise, the pool cannot significantly reduce the number of uninsured, and will not have sufficient enrollment to attract the participation of the health plans on terms needed to make the pool a success. (To be attractive to health plans, the pool needs to offer them access to new enrollees who cannot be reached in traditional ways.) Large subsidies require significant state funding.
- Some important interests may oppose the creation of such a purchasing pool, favoring subsidies that are used to buy into existing private coverage sources.
- If the subsidy is targeted at individuals who work for small firms, not all the uninsured will be reached. (Although many uninsured individuals are small-firm workers or their dependents, many others work for larger firms or have no stable attachment to the work place.)

Target Population

The target population for this approach is people who are not eligible for other subsidy programs, who are currently uninsured, and who work for small employers, both those that currently offer coverage and those that do not. We assume that these people are primarily included among the uninsured with incomes over 200% and 300% of poverty, which is 108,500 people (1999-2000

data). However, it is unclear what portion of this population works for small businesses.

13 “BARE BONES” INSURANCE — CATASTROPHIC COVERAGE

The Approach

The legislature could permit insurers to sell a “bare bones” insurance package in both the individual and small-group markets that would cover only expenses past some relatively high level—perhaps \$2,500 for an individual and \$5,000 for a family. The hope would be that the reduced benefits would bring down the premium sufficiently to induce some uninsured employers and employees to buy coverage. Health Savings Accounts incorporate this idea.

Pros

- Such coverage would be less expensive than comprehensive plans that cover all expenses after payment of a small deductible and minimal cost sharing.
- Such coverage would be especially useful for young, healthy, low-income adults, who make up a significant portion of the uninsured. They use little primary care, but they need protection against an acute episode that would leave them with a burdensome debt to pay. Also, individuals aged 50 to –65 who lack other insurance may find these plans attractive as a way of protecting themselves against the catastrophic losses associated with heart attacks, cancer, and other major illnesses.
- This is what insurance is “supposed to be.” a means for spreading the risk of expensive, unpredictable losses among a population group.

Cons

- Past experience with efforts to sell this kind of “bare bones” policy—often in the form of state-defined “basic” plans—suggests that few people are willing to purchase it. They want more comprehensive coverage.
- Many would think it inappropriate to allow sale of insurance that includes a financial disincentive to seek preventive care or early primary care for conditions that might become acute without early attention.
- Because a very high proportion of medical expenses go for acute-care episodes, the cost of such coverage might not be low enough to induce many of the insured to purchase coverage without subsidies.
- Proliferation of such plans could create risk segmentation and adverse selection by siphoning off younger, healthier individuals. If this happened, premiums for others would increase because there would be fewer healthier individuals to subsidize the less healthy.

Financing

The expectation would be that the lower premium would induce some uninsured employers, employees, and individuals to buy this coverage without other forms of subsidy.

14 “BARE BONES” INSURANCE — PRIMARY CARE

The Approach

The legislature could permit insurers to sell a “bare bones” insurance package that included coverage for only cost-effective primary care and preventive services and prescription drugs. This would require that the legislature waive mandated benefits for this particular insurance package. The idea would be that this insurance might appeal to lower-income people because the cost would be relatively low and they would be more likely to purchase it than catastrophic coverage because they would anticipate using the covered services. If these people needed hospitalization or other acute-care services, they would be no worse off than if they had no insurance. These expenses would most likely become uncompensated care for providers. (This approach is similar to the approach described above in reference to the plan in effect in Ingham County Michigan, although that product is not considered insurance.)

Pros

- Removing the financial barriers to use of primary and preventive care services would encourage early use before people get so ill that they require more expensive acute care.
- Such coverage might be especially cost-effective and useful for low-income adults who suffer from chronic conditions like hypertension and diabetes, where regular primary care can prevent onset of acute conditions.

Cons

- From an actuarial standpoint, such coverage is more pre-payment than insurance; unless the cost is subsidized, the “premium” is not likely to be much lower than sum of what the typical person would pay out of pocket during a year if he or she paid for services as they are used. There is little spreading of risk of the cost of unpredictable losses, which is the purpose of insurance.
- The coverage provides no protection for those people who need really expensive care. Those who needed such care would be left with a major financial burden, and the costs would often have to be absorbed by providers.
- Allowing sale of such coverage sets what many would see as a bad precedent by allowing sale of coverage that provides inadequate protection against the kinds of expensive events that are the real purpose of the insurance.
- Insurers who sell such coverage may become victims of adverse selection: people who find the coverage attractive are likely to be those who know they will need many of these services. Healthy, young adults will often see little benefit in buying such coverage.

Financing

Since the cost of coverage would be relatively small, the expectation would be that low-income consumers would pay the cost themselves. Of course the cost could be subsidized.

15 MANDATE THAT INDIVIDUALS HAVE COVERAGE

The Approach

The state could pass legislation requiring everyone to acquire health coverage of one kind or another. Or it could require that just higher-income people (perhaps those with incomes in excess of 400% of the federal poverty level) have coverage. 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, or the penalty could be much less punitive; for example, non-compliers could lose their tax exemption on the state income tax. 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.

Pros

- This approach creates strong incentives for everyone or a limited population (over 400% 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 now and thus lessen the “free-loader” problem.

Cons

- To make this realistically workable and fair, subsidies may be required for low-income people: mandating that they buy coverage when they have insufficient income to cover necessities accomplishes nothing useful.
- This approach would be likely to face stiff political opposition.
- Enforcement would be difficult, especially for people who do not pay income tax.

Financing

The state may need to subsidize the cost of coverage for low-income people.

16 COVERAGE FOR PEOPLE IN TRANSITION

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, movement from student to worker status, etc. The idea is to provide options to people at transition points—that is, 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. For example, even the simple step of insuring that people receive a packet of materials that spells out their options would be helpful.

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 CORBRA coverage, but the cost (102% of the full premium, which averages \$663 for family coverage and \$255 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 tax credits to subsidize purchase of COBRA coverage.
- Provide 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 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.

Young Adults "Aging Out" of Family Coverage

Another target group for transition coverage is adult children who "age out" of their parents' policies. This is dealt with in Option 17.

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 for 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.

17 EXTENDING COVERAGE FOR YOUNG ADULTS (AGES 19-24)

The Approach

One element of 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 25 or 26. A second approach involves having Medicaid coverage extended to beyond the 19th birthday.

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. Some older children maintain coverage under their parents' policies if they attend college on a full-time basis, but 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, many 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.

There are at least four potential approaches to address this issue:

1. One approach would be to require that all insurers alter their family policies to automatically extend coverage through age 25 or 26 for dependent children (just as such policies automatically cover younger children, typically up to age 18). All families that purchase family coverage would automatically have such coverage. (Such a plan has been in place for several years in Utah.) Employers would contribute on the same basis as they do for other children.
2. A second approach would be to make such coverage an option at the parents' choice. The problem with this approach is that it is likely to create significant adverse selection, since the families most likely to choose this option would be those who expect that their adult children may need expensive care.
3. A third approach would be to allow children who can no longer be considered as dependents on their parents' plans (typically because of age or school status) to be automatically eligible for individual coverage under the same rates and benefits as they received as a dependent on their parents' policy as long as there was no significant gap in coverage (to prevent severe adverse selection, though the likelihood of adverse selection would be similar to the second approach.)
4. A fourth approach would be to extend Medicaid/CHIP beyond age 19.

Pros

- Young adults represent relatively low actuarial risks, and thus extending parental coverage to them may cause only a slight increase in insurance premiums.

Cons

- The approach of extending Medicaid 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.
- 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.
- 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.
- Extending the age bracket of Medicaid coverage would increase the costs of 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.

Financing

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. As mentioned, though, since young adults represent relatively low actuarial risks, this approach might incur only a slight increase in insurance premiums. On the other hand, the young people who are most likely to take up this coverage are those who expect to incur higher-than-average medical expenses; so some adverse selection should be expected, which could raise premiums.

The state and federal government would have to provide sufficient funds to support the Medicaid/SCHIP expansion approach. If the state had excess SCHIP allotments, it could use those to fund this extended coverage to young adults instead of returning the funds to the federal government for redistribution.

18 EMPLOYER “PLAY OR PAY” MANDATE

The Approach

The state could require that all employers either offer coverage to their employees and their employees’ dependents and pay at least some minimum proportion of the cost of the premium (the “play” option) or, alternatively, pay a tax approximately equal to the employer’s portion of the cost of providing coverage had the employer chosen the play option (the “pay” option). The state would use the tax money collected from “non-playing” employers to either finance subsidies in the form of vouchers for those employers’ workers to buy coverage on their own or to subsidize care for these workers under new or existing public programs. This option is sometimes coupled with an “individual mandate,” where all individuals are required to obtain health care coverage of one sort or another. (To avoid ERISA challenges, the proposal would probably need to be structured to levy a tax on *all* employers and then to waive the tax or give a tax credit to employers that choose to provide coverage for their employees and dependents.)

The California legislature passed an employer play or pay mandate, but it was repealed by the people through a referendum.

Pros

- The approach expands coverage without requiring large new expenditures by state government. Instead, employers and employees pay the bill. (The state might have to bear some new costs because without state subsidies for marginal firms, some might be forced out of business or at least find it necessary to lay off workers).
- Rather than creating new public coverage programs, this approach largely builds upon the employer-based system that already covers most employees.
- All employees in firms affected by the policy would be offered health coverage, a voucher, or coverage through a public program. The employer, the voucher, or the government would pay a significant portion of the cost. So the approach would reach many of the currently uninsured.

Cons

- The approach involves a degree of compulsion that would likely be politically objectionable to sectors of the business community and others.
- The approach would likely be challenged under ERISA—which prohibits states from regulating employers’ benefits—but if carefully crafted, might survive the challenge.
- The effect of requiring employers to pay for health insurance has a similar effect on the work force as raising the minimum wage: some employers now paying at or near the minimum wage would be forced to lay-off workers, because the workers are not productive enough to justify raising their compensation by the amount represented by their employer’s insurance premium.
- Enforcement would require some new administrative apparatus. It might be difficult to enforce a provision requiring individual employees to purchase coverage.

- The added cost to employers might deter some from locating in Michigan (although this would presumably affect only employers not planning to provide health coverage).

Financing

In its most basic form, this approach would not necessarily require any new state monies beyond those raised by the payroll tax that is part of the idea, although see above regarding the desirability of subsidies for marginal firms.

Economists would generally argue that a tax levied on employers would ultimately be shifted back to employees in the form of lower money wages. Non-employed individuals would have to pay the costs of individual coverage out of their own pockets.

19 THE “SINGLE-PAYER” OR SOCIAL INSURANCE APPROACH

The Approach

The state would guarantee that all Michigan residents are automatically covered for a defined set of health care benefits, which would be publicly financed. Similar to Medicare, coverage under the system is a “right” of all citizens 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 Senate of the State of California recently passed a single payer bill.

Pros

- This approach guarantees universal coverage. There are, by definition, no uninsured; nobody “falls through the cracks.”
- The approach 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.

Cons

- Because the state would now be paying for a very large proportion of health costs now covered by employer and employee premiums contributions, the cost to state government would be very high, requiring a major increase in state revenues. It might be very difficult for the state to negotiate with the federal government to avoid losing money now provided by the federal government for Medicaid and SCHIP (and other smaller federally subsidized programs).
- 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 from other states of people with serious medical problems who move to become eligible for publicly financed coverage.

- 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.
- Given the current political environment and the wariness about expanding government's role, the political opposition to such a system would likely be intense, particularly from insurers and providers.

Financing

The state would have to increase revenues very substantially. Many options exist for the kinds of taxes that could be levied.

Target Population

The entire population.

20 THE MULTI-PAYER SINGLE STATE POOL APPROACH

The Approach

All legal residents of the state not covered by Medicare would be automatically covered through a single state pool (which could be thought of as like the Federal Employees Health Benefit Program or the state employees plan). The pool would contract with some minimum number of health plans. Everyone would choose any insurer offering coverage through the pool, and those who failed to choose an insurer would be assigned to one when they seek care. The approach would be financed primarily by income-related premiums paid by households plus an employer payroll tax.

Pros

Coverage would be automatic for all legal residents, so universal coverage would be achieved.

The approach would achieve substantial administrative savings compared to the status quo but not as much as with a single payer approach.

Much smaller increase in state budgetary cost than a single payer approach because the approach is heavily financed by premiums and employer contributions.

Health plans rather than the state would contract and negotiate with providers regarding rates, etc., which is more similar to the present system.

In general, compared to a single payer approach this approach is less disruptive because it involves less change from the status quo.

Cons

This still would be a major, disruptive change from the status quo and likely to engender strong political opposition.

There would still be a need for substantial administrative machinery for coordination of benefits, claims submission and payments, etc., which also adds complexity.

The potential for controlling costs is less than with a single payer system.