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Issue Brief

Issues Related to State and Employer Innovations in Insurance Coverage

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ABSTRACT: States and employers use a number of different programs and techniques to increase rates of insurance coverage. Successful strategies—whether based on Medicaid/SCHIP expansion, strengthening employer-based coverage, or regulating the individual market—require both flexibility to tailor approaches that best serve their residents and employees and basic protections to ensure that new programs do not leave vulnerable groups behind. In addition, continued financial, regulatory, and administrative support from the federal level is crucial for states and employers to explore innovative solutions to cover the uninsured.

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Background

The significant portion of Americans without health insurance coverage is a concern not only for the federal government but for state governments and employers as well. In fact, many states and private sector leaders are crafting innovative solutions despite financial and regulatory hurdles. Since these programs and initiatives often interact with federal programs and regulations, an understanding of current approaches is critical to making progress on reducing the number of uninsured. Further, results and evidence gathered from states' and employers' experiences can improve knowledge about reform options, offer practical ways to initiate reform, and may begin to promote consensus in regard to this issue.[1]

The Uninsured, States, and Employers

Rates of uninsurance vary widely across states, from a high of 24.6 percent in Texas to a low of 8.2 percent in Minnesota in 2003.[2] The recent national trend of increasing uninsured rates can be seen on a statewide basis as well, where 20 states experienced increases in their average uninsured rates in 2002–03 compared to 2001–02, while only two states experienced decreases.[3]

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The Institute of Medicine notes that variation in population characteristics, industries that make up the economic base, standards of eligibility for public insurance, and the relative purchasing power of family income are among the key factors driving the geographic disparities in uninsured rates.[4]

Insurance coverage also varies by employer size and industry. About 15 percent of full-time workers and individuals in a family with at least one full-time worker are uninsured.[5] While nearly all employers with 200 or more workers offered insurance coverage in 2004, only 63 percent of firms with 3 to 199 workers did—a percentage that has steadily declined since 2000. The coverage rate for workers in the retail industry was 47 percent, compared to 84 percent for state and local government workers and 82 percent for those working in the transportation, communication, and utility industries.[6]

The significant rates of uninsurance, and the associated health, productivity, and cost implications, all have direct impacts on states and employers. State budgets are among the first to feel the effects, especially during a weak economy. While states receive less in tax revenue, they may simultaneously face increased Medicaid and SCHIP eligibility and enrollment due to lower incomes, loss of jobs, and loss of employer-sponsored health insurance.[7] Unlike the federal government, every state is legally required to have a balanced budget. Just when a state's residents may need the option of public insurance coverage the most, balancing the state budget may require maintaining, if not cutting, Medicaid and SCHIP eligibility and benefits.

Maintaining Medicaid and SCHIP programs during an economic downturn is even more difficult because states are responsible for several expensive health care services. Long-term care and prescription drugs for the elderly are both covered under states' Medicaid programs, though some of the cost for prescription drugs will shift to the federal government when the new Medicare prescription drug benefit is implemented. High rates of uninsurance also lead to a significant amount of uncompensated and charity care provided by state and county hospitals. Not only does this adversely affect the financial situations of the providers, but cost-shifting often occurs, leading to higher fees and insurance premiums for everyone.[8] Higher insurance premiums can lead to more people dropping or losing coverage, which increases the amount of uncompensated care, perpetuating a cycle.

Whether or not their own workers have coverage, employers feel the impact of 15 percent of the population lacking health insurance. Cost shifting from uncompensated care increases premium costs for employer-provided coverage. Workers or family members who have trouble accessing the health care system because they are uninsured or inadequately insured can result in decreased productivity and increased absenteeism. Many employers, especially those with a small workforce, understand the physical, emotional, and financial costs of having an uninsured family member, and feel that offering coverage is "the right thing to do."[9]

Overview of State and Employer Approaches to Expanding Coverage

States and employers use a number of different programs and techniques to increase rates of insurance coverage. Successful strategies require both flexibility to tailor approaches that best serve their residents and employees and basic protections to ensure that new programs do not leave vulnerable groups behind. While a few methods described here require additional funding, others would use funds already included in charity care budgets and would result in little new spending overall.

Medicaid and SCHIP

Major routes by which states finance and provide health insurance coverage to their residents are Medicaid and the State Children's Health Insurance Program (SCHIP). In 2003, 35.6 million people, including over 19 million children under age 18, were insured under states' Medicaid and SCHIP programs. This was an increase from 33.2 million people in 2002.[10] Although the slack economy and myriad of competing priorities have put pressure on states' Medicaid programs, several states successfully expanded Medicaid and SCHIP coverage to new population groups over the past few years.[11] However, continued fiscal pressures are leading all states to implement cost-control measures in 2004 and 2005, including changes to benefits, eligibility, and copayment requirements.[12]

In most states, eligibility for Medicaid and SCHIP is tied to the categories for cash assistance under welfare, notably families with children, the aged, and disabled. To receive federal cost sharing dollars, states must cover these mandatory populations, offer the same benefits package to all participants, implement only limited cost-sharing provisions, and not cap enrollment. Several states, including Arizona and Rhode Island, have chosen to use state-only funds to expand coverage to groups that aren't covered by federal cost sharing.[13]

States have several ways to expand their Medicaid/SCHIP programs and access federal matching funds. Section 1115 Research and Demonstration Waivers allow states to ignore certain Medicaid requirements in order to test innovative policy initiatives. The provisions regarding cost-sharing limits, benefit packages, and income eligibility limits may be waived, but a budget neutrality condition requires that the federal government spend no more than it would have spent without the waiver. As of August 2003, 18 states and the District of Columbia had implemented Section 1115 waivers to test innovative approaches to expand coverage.[14]

States also may experiment with the design of their Medicaid and SCHIP programs through the Centers for Medicare and Medicaid Services' (CMS) Health Insurance Flexibility and Accountability Initiative (HIFA). HIFA provides a streamlined application for a Section 1115 waiver if the proposal is a broad statewide approach that maximizes private health insurance coverage options and targets Medicaid and SCHIP resources to populations with income below 200 percent of the federal poverty level. Proposals under this initiative must be budget neutral for the federal government, and may be financed by offering a reduced benefit package to optional populations, participant premium payments, or unspent SCHIP funds.[15]

In addition to expanding their Medicaid/SCHIP programs, some states have created new sources of coverage. Maine, for example, enacted the Dirigo Health Reform Act to simultaneously address cost, quality, and access. It will provide coverage for currently uninsured individuals, families, small business employees, and the self-employed with subsidies available for those with household incomes below 300 percent of the federal poverty level. The initiative will be funded by enrollee and employer contributions, Medicaid dollars, funds recovered from bad debt and charity care, assessments on insurance company revenues (contingent on realized savings), and state general revenue (in the first year only).[16] Anthem Blue Cross Blue Shield of Maine will administer the Dirigo Health Plan; coverage began in January 2005.[17]

The States and Employer-Sponsored Health Insurance

Employment-based health insurance forms the bedrock of coverage in the United States. Some 174 million people (60 percent of the population) were covered by employment-based insurance in 2003, a slight decrease from 2002.[18] More than two-thirds of the nonelderly uninsured had at least one full-time worker in their family in 2003.[19] Many view expanding and strengthening employer-based coverage as a promising strategy to reach this large group of uninsured with ties to the labor force.

One way to increase rates of employer-based health insurance is to provide subsidies to help employers offer coverage or to help employees purchase the coverage their employer offers. Although many federal tax credit proposals take this approach, states also have pursued this strategy by paying for Medicaid and SCHIP enrollees' costs for their employer-sponsored plan when it is cost-effective to do so.[20] One difficulty with this approach arises from states' inability to regulate insurance plans offered by self-insured employers under the Employee Retirement Income Security Act (ERISA). As a result, states must make provisions to cover services that are provided under Medicaid but not under less generous employer plans as well as any waiting periods that employers impose. Cost-effectiveness must often be certified on a case-by-case basis, placing a significant administrative burden on states that want to use this approach.[21]

Pay-or-play legislation, like that recently enacted and then repealed in California, is another route states can take to increasing rates of employer-sponsored health insurance coverage. Under this approach, employers are required to offer insurance to workers directly or to pay a fee to the state if they choose not to provide coverage. The state then uses

these funds to purchase coverage for workers whose employers do not offer it. The California legislation did not apply to firms with fewer than 25 employees and applied to firms with between 25 and 49 employees only if a tax credit were enacted to cover a portion of the employers' fee. Proponents argue that pay-or-play is a way for states to expand employer-based coverage without major public outlays and that it equalizes the costs of providing coverage among all medium and large employers.[22] Opponents counter that this approach puts an undue burden on employers and can have an adverse effect on employment. The California legislation was recently overturned by the narrow defeat of Proposition 72 in November 2004. Other challenges to pay-or-play legislation could come in the form of litigation based on the premise that ERISA prohibits states from regulating whether and what kind of insurance self-insured employers offer or a challenge based on the state's constitution.

In their role as employers of state workers, states can increase insurance coverage by offering choices among plans that range in terms of comprehensiveness, premium cost, and cost-sharing. Making Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs) available to state and municipal employees in combination with high-deductible insurance policies would provide another option for employees who prefer this type of coverage.[23] Maximizing their buying power by combining all the groups they provide coverage for and rewarding plans that provide the most cost-effective care, states can limit the premium increases faced by their employees.[24] States also can help make coverage more affordable to individuals and small businesses by using their purchasing power and negotiating on behalf of individuals and small groups for pharmaceutical prices or reimbursement rates for health care providers.[25]

Employer Options

Despite facing rapidly increasing costs for both health insurance and health care services, some private employers are taking the initiative to expand coverage among employees. In May 2004, the Affordable Health Care Solutions Coalition, made up of about 50 of the nation's largest employers, announced plans to form a health insurance pool for 4 million of their uninsured workers and dependents: part-time, temporary and contract employees who lack insurance coverage, early retirees, former employees who exhausted their COBRA coverage, and children of employees who are students but no longer qualify for coverage.[26] They plan to offer a range of coverage options at different prices and require that certain benefits be covered regardless of preexisting conditions. By pooling employees across companies and contracting with one health insurance company, they aim to offer coverage at a lower cost than is available in the individual market.

Employers may maximize health insurance coverage for their employees while minimizing their own costs by pursuing consumer-directed health care plans (CDHC). CHDC plans encompass several types of arrangements, including a high-deductible insurance plan combined with a health reimbursement account to cover out-of-pocket expenses, point-of-care tiered models that reduce consumers' cost sharing if they select a provider that the insurer regards as lower cost or higher quality, and cafeteria-style plans that allow employees to select their own package of benefits, providers, and premiums.[27] This approach is based on the idea that if consumers consider price when choosing health care providers and services, they will purchase more cost-effective care. These types of plans hold the promise of cost savings and some companies have experienced lower rates of increase in health care expenses since implementing CDHC plans.[28] However, the preliminary evidence on CDHC also highlights concerns that they are more attractive to high-income, healthier individuals, which can result in adverse selection and rising premiums for traditional plans.[29] These plans may be problematic for the uninsured with low incomes or chronic conditions since they are less likely to have accumulated savings to pay a high deductible and may go without needed care as a result. Consumer-directed health plans currently make up a very small percentage of the health insurance plans offered by employers and they often do not provide the critical information to empower individuals to make informed choices about their care.[30]

Small employers, who have little purchasing power on their own, are pursuing other options to

offer coverage to employees. Some shift a portion of the costs of employer-sponsored coverage to employees. Others subsidize insurance that employees purchase in the private nongroup market.[31] The option for small employers to join together to purchase coverage collectively in Association Health Plans (AHP) or Health Insurance Purchasing Cooperatives (HIPC) has a broad base of support since it does not require major institutional change, government regulation, or new financing. The success of these purchasing pools to date has been mainly in terms of increasing health plan choice for participants rather than significantly decreasing costs or the number of uninsured.[32] However, increased support for this approach from the Bush administration may give AHPs a broader role and increased impact in providing health insurance coverage.[33]

The Private Market

Options also exist for states to increase rates of coverage through interaction with the private market. State action that may increase the availability of private nongroup coverage includes requiring that insurers accept all applicants without regard to health status (guaranteed issue), that insurers renew existing policies, or by restricting the use of preexisting condition exclusions. Individual coverage can be made more affordable through the use of rating bands and community rating. Minimum benefit mandates can protect consumers from policies that provide little to no protection from financial loss.

Another way for states to increase access to insurance is to spread risk in the nongroup market by acting as reinsurers, by taking responsibility for paying the highest cost claims, or by creating high-risk pools that separate those who cost the most to insure from the general risk pool. Reinsurance should improve the private market for health insurance by lowering premium costs for both employer-based policies and those sold on the individual market.[34] Some experts argue that reinsurance is the key to making health insurance available and affordable for the growing ranks of the uninsured middle class, since this is an important way to reduce the incentive for insurance companies to compete by avoiding high-risk individuals.[35]

Lessons learned from states that have implemented these types of private insurance market reforms indicate that the combination of guaranteed issue and community rating can increase availability for high-risk individuals. However, improvements in access are modest at best, since these reforms do not lower premiums enough to be affordable for many uninsured.[36] Further, without provisions for spreading risk such as reinsurance pools, nongroup coverage rates among younger and healthier people declined and private nongroup insurers were left with more expensive enrollees. Regulations such as community rating, guaranteed issue and minimum benefit requirements can benefit sick and high-risk individuals by lowering insurance costs and increasing access, but they also can increase costs for those who are low-risk or who seek only basic insurance coverage. Some have suggested that the benefits of these regulations be explicitly compared to the costs and that states act to reduce regulation that does not pass the test, particularly for those who are uninsured.[37]

108th Congress Proposals

Federal legislation can create more flexibility for states and employers to innovate while providing structure to protect consumers and vulnerable groups. Proposals to facilitate states' and employers' attempts to expand health insurance coverage in the 108th Congress include many of approaches described above.

Provisions of proposed legislation that affect states' Medicaid and SCHIP programs include:

- Increasing the income eligibility level in Medicaid and SCHIP for currently eligible population groups
- Making parents of children eligible at existing income levels for children and expanding coverage to childless adults
- Covering legal immigrant women and children who meet existing state program income criteria
- Allowing states to cover low-income young adults up to age 23 under Medicaid and SCHIP at an enhanced federal matching rate
- Establishing Medicaid eligibility for all disabled children[38]
- Establishing temporary Medicaid eligibility for the unemployed

- Allowing states the option of providing coverage to targeted low-income children in excess of the state's SCHIP allotment

Legislation proposed in the 108th Congress that affects employer-sponsored health insurance includes:

- Establishing regulations for new group purchasing pools for small employers or self-employed individuals
- Allowing small businesses or the self-employed to buy into existing publicly sponsored programs such as the FEHBP, state-run pools, or private group purchasing alliances
- Promoting the formation of small employer association health plans (AHPs)
- Creating a new option for small employers by having the Department of Labor contract with health insurers to provide lower rates and more choice than small employers could get on their own

Highlights of proposed legislation that affects the private health insurance market include:

- Providing funding for states to create and operate high-risk pools
- Establishing purchasing pools and setting guidelines for insurer policies regarding denial of coverage and premium increases in order to contract with the pool
- Creating grants to cover part of the administrative costs of purchasing pools operated by state or local governments

Conclusion

In the absence of large-scale, comprehensive reforms to cover the uninsured, efforts by the federal government, state governments, and the private sector will all be necessary to fill the gaps. States and employers are in a position to tailor reforms to best meet the needs of their residents and employees. Experimenting with a broad range of approaches at the local level can yield evidence and perhaps even consensus about whether, and which, reforms will work best at the national level. Continued financial, regulatory, and administrative support from the federal level is crucial for states and employers to explore innovative solutions to cover the uninsured.

Notes

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[20] Social Security Adminstration, Section 1906 allows state Medicaid programs to pay beneficiaries' premiums, deductibles, coinsurance, and other cost-sharing obligations for participation in an employers' group health plan and receive federal matching funds for those payments.

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