State Strategies to Expand Health Insurance Coverage

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States With Less Than 12% Uninsured, 2003–2004

<table>
<thead>
<tr>
<th></th>
<th>Percent Uninsured (ages 0-64)</th>
<th>Percent Employer (ages 0-64)</th>
<th>CHIP/ Medicaid Kids Eligibility Level* (%FPL)</th>
<th>Working Parents Eligibility for Public Insurance (%FPL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minnesota</td>
<td>9.3</td>
<td>73.1</td>
<td>275</td>
<td>275</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>11.4</td>
<td>76.6</td>
<td>300/185</td>
<td>61</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>11.5</td>
<td>66.6</td>
<td>250</td>
<td>192</td>
</tr>
<tr>
<td>Vermont</td>
<td>11.5</td>
<td>61.9</td>
<td>300/300</td>
<td>192</td>
</tr>
<tr>
<td>Hawaii</td>
<td>11.7</td>
<td>69.0</td>
<td>200</td>
<td>100</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>11.7</td>
<td>69.1</td>
<td>185</td>
<td>185</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>11.8</td>
<td>69.8</td>
<td>200/150</td>
<td>133</td>
</tr>
<tr>
<td>Delaware</td>
<td>11.9</td>
<td>69.7</td>
<td>200/133/100</td>
<td>120</td>
</tr>
<tr>
<td><strong>U.S. Average</strong></td>
<td><strong>17.5</strong></td>
<td><strong>62.6</strong></td>
<td><strong>Median= 200%</strong></td>
<td><strong>Most don’t cover</strong></td>
</tr>
</tbody>
</table>

*Children’s eligibility levels vary by age.
Primary Strategies Being Used by States to Expand Health Insurance Coverage

- Retain and expand employer participation
- Leverage federal matching funds
- Redesign programs
- Simplify and streamline program eligibility and redetermination
- Target special populations
- Generate new revenue
Retaining and Expanding Employer Participation: Maine’s Dirigo Health

- New insurance product; $1250 deductible; sliding scale deductibles and premiums below 300% poverty
- Employers pay fee covering 60% of worker premium
- Began Jan 2005; Enrollment 6,369 as of 5/1/05
- MaineCare expansion proposed to cover parents up to 200% poverty

<table>
<thead>
<tr>
<th>$1,250 Deductible</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
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</thead>
<tbody>
<tr>
<td>Monthly Discount</td>
<td>100%</td>
<td>80%</td>
<td>60%</td>
<td>40%</td>
<td>20%</td>
<td>None</td>
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<tr>
<td>Deductible</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
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<td>250</td>
<td>500</td>
<td>750</td>
<td>1,000</td>
<td>1,250</td>
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<tr>
<td>Out of Pocket</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$0</td>
<td>800</td>
<td>1,600</td>
<td>2,400</td>
<td>3,200</td>
<td>4,000</td>
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<tr>
<td>Employee Share of Premium*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$0</td>
<td>25</td>
<td>50</td>
<td>74</td>
<td>99</td>
<td>124</td>
</tr>
</tbody>
</table>

Note:
A=MaineCare; Poverty thresholds per discount:
B=150% FPL; C=200% FPL; D=250% FPL; E=300% FPL; F>300% FPL

* After discount and employer payment (for illustrative purposes only).
Retaining and Expanding Employer Participation: Healthy New York

- State provides stop-loss funds:
  - 90% of claims between $5,000 and $75,000

- Slimmed down HMO benefit package

- Low-wage small firms, self-employed eligible

- Began January 2001; At the end of 2004, enrollment of 76,704

- Lowers premium relative to individual and small group market

Avg. monthly individual premium in NYC

$496

$270

$194

Self pay

HMOs, Small Group

Healthy New York

Retaining and Expanding Employer Participation: Premium Assistance

Examples of Premium Assistance Programs

Number of enrollees

<table>
<thead>
<tr>
<th>State</th>
<th>Number of enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>IL</td>
<td>54,000</td>
</tr>
<tr>
<td>PA</td>
<td>21,000</td>
</tr>
<tr>
<td>MA</td>
<td>14,390</td>
</tr>
<tr>
<td>RI</td>
<td>5,500</td>
</tr>
</tbody>
</table>

• 12 states subsidize private employer-sponsored insurance for Medicaid/CHIP eligibles

• Program complexity has been a barrier; Rhode Island has simplified to promote participation

Sources: Silow-Carroll, Stretching State Health Care Dollars: Building on Employer Based Coverage, Commonwealth Fund, October 2004; and www.statecoverage.net
Retaining and Expanding Employer Participation: Leveraging Public Coverage

- **Minnesota**
  - Launched Smart-Buy Alliance in 11/04 – coalition of purchasers covering 70% of state residents

- **Connecticut**
  - Nonprofit organizations contracting with state can buy coverage through municipal employees health benefit plan; 14,000 enrolled; savings of 3.75%

- **West Virginia**
  - Small business insurance pays providers at same rates negotiated by the state public employees plan; savings of 20%; began 1/05
Retaining and Expanding Employer Participation: Pay or Play

- Maryland legislature passed bill requiring employers with 10,000+ workers spend 8% of payroll on health benefits, or contribute to state program
  - Governor not yet responded
- California S.B. 2: employers with 50+ workers provide health insurance or pay into a pool, potentially covering 1 million people
  - Repealed in a ballot initiative
- Other states working on designing new pay or play legislation that can withstand ERISA challenge
Leveraging Federal Matching Funds

• Illinois CHIP Expansions
  – Children up to 200% of poverty, with presumptive eligibility; parents up to 133% of poverty; 320,000 new eligibles

• Iowa Pilots Medicaid-like coverage
  – New law creates modified Medicaid program for 30,000 residents. Charity care dollars draw federal match, plus some existing Medicaid funds. Reduced benefit package.

• States Use Disproportionate Share Hospital (DSH), Uncompensated Care Funds
  – DSH funds targeted on access to primary and preventive care to reduce emergency room and inpatient hospital use by the uninsured
  – Wisconsin, Georgia, Massachusetts, Michigan, and Maine have programs serving 1,000 to 15,000 enrollees each
Medicaid/CHIP Redesign Can Help Stretch Dollars

- California maintaining recent coverage expansions by moving more enrollees into managed care
  - 262,000 parents and children
  - 554,000 seniors and persons with disabilities
- Utah’s Primary Care Network is testing a primary/preventive care benefit to reach more of the uninsured
  - Over 19,000 enrolled
  - Downside – funded out of reduced benefits for poor/near-poor Medicaid beneficiaries
  - New York Child Health Plus and Minnesota care began with primary care; expanded to inpatient care
Existing and Proposed Managed Care Counties

Simplifying and Streamlining Eligibility and Redetermination

• Minnesota uses single eligibility form for its 3 coverage programs
• Georgia has electronic application and eligibility determination, single application for children
• California has electronic application and express lane eligibility for enrolling children eligible for other public benefits
• Multiple states have gone to passive re-enrollment, longer eligibility periods, and presumptive eligibility
**Targeting Special Populations**

- **High Risk Pools**
  - About 32 states have high risk pools, mostly insuring small numbers of residents with high cost illnesses
  - Minnesota is the largest, with 30,000
  - Colorado subsidizes low income enrollees in its ColoradoCare program

- **Workers displaced by the Trade Act** are eligible for Federal tax credits of 65% of premiums; take up rates greatly influenced by state implementation
  - Low take up so far, with leading states experiencing 8–11% of eligibles enrolling
  - Premiums still unaffordable for most eligibles

- **Four states let families with incomes above CHIP income limits buy children in**, no state subsidy
  - Connecticut, Florida, New York, North Carolina
Revenue Sources for Coverage Expansions

- Minnesota
  - 2% tax on hospitals (since 1/1/93), and health care providers (since 1/1/94)
- Maine
  - Dirigo includes a 4% surcharge on insurance premiums conditional on reduction of bad debt and charity care from expanded coverage and other savings offsets
- Maryland
  - A new (12/04) 2% tax on HMO premiums helps fund Maryland Health Insurance Program
- Oklahoma, Colorado, and Montana
  - Enacted new tobacco taxes in 2004 earmarked for health care
Outlook

• Difficult for states to find funds, so they need to be creative
• In some states, not cutting Medicaid coverage will be the only progress
• Most expansion states pursuing incremental steps building on employer coverage and Medicaid/CHIP
• Linking quality improvement, cost reduction, and coverage expansions may help states gain support of key stakeholders
• Collaboration between public and private insurers promising, e.g. Minnesota Smart-Buy Alliance
Federal Support for State Experimentation

• HRSA Pilot Project Planning Grants
  – 46 states have state planning grants averaging $1 million each to develop coverage options
  – 9 states received up to $400,000 each to pilot test a coverage expansion this year
  – New funding is available for next year

• IOM recommended state coverage demonstrations with federal funding
Acknowledgements

• Jennifer Edwards, Senior Program Officer, Director, State Innovations Program, The Commonwealth Fund

• Alice Ho, Research Associate, The Commonwealth Fund

• Sharon Silow-Carroll et al., Stretching State Health Care Dollars (5 Reports), The Commonwealth Fund, October 2004.

• States in Action: A Quarterly Look at Innovations in Health Policy – Fund newsletter to be released next week

• More reports on state innovations on the Fund website: Visit www.cmwf.org/tools/tools.htm
Panel Overview

- Michael Deily, Director, Division of Health Care Financing, Utah State Medicaid Agency
  - Primary Care Network and Covered at Work
- Trisha Leddy, Administrator, Center for Child and Family Health, Rhode Island Department of Human Services
  - RIte Care
- Barbara Brett, Executive Director, CoverColorado
  - CoverColorado
- Karl Ideman, President, Pool Administrators, Inc.
  - Reinsurance