

# Issue Brief

## Innovations in State Health Reform

### Overview

Since the 1970s, health care costs have been rising faster than general inflation and the proportion of the population without health insurance has been rising. Currently, the number of people in the country without health insurance is about 45.7 million.<sup>1</sup>

States have been at the forefront of efforts to expand the numbers of the insured. In recent years, some states have also focused considerable attention on efforts to improve health care quality and control the rate of increase in health care spending. Among the many roles that states take on as overseers and administrators of the health care system in the United States, three are central to state efforts at reform. The most widely used vehicles for reform are:

- State administration of the Medicaid and State Children's Health Insurance (SCHIP) Programs. Because Medicaid and SCHIP are matched with federal dollars, most state access initiatives start with expansions of these programs.
- State regulation of the private insurance market. Another area of considerable state policy attention has been insurance market regulation, particularly for small businesses and individuals. Regulatory strategies are being used to assure broad access to private insurance and to influence price and cost structures within these markets. Recently, some states have experimented with ways to combine access initiatives with insurance market regulatory oversight by providing carefully targeted subsidies for the purchase of private insurance.
- State licensing and regulation of health care providers. Traditionally, states, work-

ing together with professional organizations, have used licensure to assure minimum standards among health care providers. Regulation through Certificate of Need programs is used in some states to control rates of capital expenditure on the health system infrastructure. Now, some states are experimenting with ways of working collaboratively with providers and payers to develop new quality tools and test new methods of delivering health care in efforts to enhance health care quality.

Within the context of these broadly defined areas, more specific examples of Maine and other state efforts are discussed below.

### Expansions of Coverage Through Medicaid and SCHIP

In recent years, restructured federal rules have allowed states greater flexibility in determining eligibility for Medicaid benefits. States have used this opportunity to extend coverage to special populations, such as persons with AIDS, and to cover previously ineligible low-income groups such as adults without children. The SCHIP program, enacted in 1997, extends coverage to low-income children who do not qualify for Medicaid. Some states have sought to expand coverage, building off their Medicaid and SCHIP programs.

The SCHIP Program covers children at somewhat higher income levels than Medicaid and in the past several years has been used as a springboard by several states for the enactment of programs to broadly expand coverage to all children within the state. These programs differ from state to state. Some (CN, FL, NJ, NY, OH, PA, TN, WA and WI) cover uninsured children up to an established income

### Fast Facts

- Average per capita health care spending in the U.S. more than doubled between 1990 and 2003, eroding private insurance coverage and putting budgetary strains on public health care programs.
- States are opening eligibility to higher income children and families as health costs rise. Seven states now cover children at or above 300% of the federal poverty level (~\$51,000 for a family of 3).
- Nationally, only 53% of small businesses with 25 or fewer workers have employer-based coverage. States are using their leverage as insurance regulators, as well as direct subsidies to shore up the individual and small group markets.
- Massachusetts, with their coverage mandate, has increased insurance coverage by over 300,000 individuals and reduced the state's uninsured rate to below 5%.

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threshold (e.g., 300% of the federal poverty level) and allow higher income families to buy coverage in the program for their children, at cost. Others establish premiums on a sliding scale, based on family income (IL, MN, PA). Some states limit eligibility to currently uninsured children or children who have been uninsured for a minimum period or who cannot obtain affordable coverage due to a pre-existing condition.<sup>2</sup>

To the extent that these children's programs extend coverage subsidies to persons ineligible for SCHIP coverage under federal rules, states have had to find alternative sources of funding. Choices have ranged from tobacco settlement dollars, cigarette taxes to general fund appropriations.

## Initiatives Targeting the Private Insurance Market

States use the power of licensure to establish minimum standards for insurance carriers including minimum reserve requirements and overview of contracts and marketing materials. In addition, legislatures have established mandatory requirements for insurers with regard to benefits that must be included in all products. (These rules apply to all insurance products but not to employer benefit plans that are self-insured.) The federal government entered the insurance market regulatory arena in 1996 with the passage of the Health Insurance Portability and Accountability Act (HIPAA). In the small group market, HIPAA prevents the selective denial of coverage within a small business employee pool and requires that all groups (and individuals within the groups) have the option to renew their policies when the coverage term has ended. In addition, HIPAA limits the time length that insurers can impose waiting periods for coverage (after enrollment) for pre-existing conditions.

A number of states move beyond HIPAA requirements by also limiting insurance company discretion with regard to premium pricing in an effort to limit the extent to which insurers segment the market by risk.<sup>3</sup> Some, for example, bar differential pricing by gender. Others limit the differential in premium prices for different age groups or types of business. A few states require community rating whereby all individuals pay a premium based on the average cost of all covered lives within an insurer's small group product line. Some states apply these same, or similar, rules in the individual insurance market as well.<sup>4</sup>

Rapid increases in health coverage premiums throughout the insurance market have generated substantial debates in state legislatures as to appropriate responses and have led to a number of different initiatives specifically targeted to the small group (and sometimes, individual) markets. Among these initiatives are high risk pools, reinsurance programs and subsidized insurance products.

*High Risk Pools:* A high risk pool offers coverage to individuals with serious medical conditions who face excessively high premiums or who have been deemed uninsurable by carriers. High risk pools are usually administered, under contract, by a commercial insurer or administrative services organization and offer one or more benefit plans as determined by the

governing body. In regulatory environments where insurers in the individual market are allowed to medically underwrite or deny coverage based on health status, high risk pools provide a safety valve, but usually at a cost substantially higher than market rates in the individual insurance market. Despite the higher premiums, because of the extensive medical needs of the enrollees, high risk pools generally pay out more in claims than they receive in premium revenues and must be subsidized. Usually, all health insurers in the state are required to pay an assessment into a fund to cover excess losses.

High risk pools have been in existence in some states as far back as the 1980s. In recent years, these pools have been proposed or adopted in states in concert with a legislative decision to deregulate the individual insurance market – allowing insurers to medically underwrite and, except where barred by HIPAA, to discretionarily deny coverage. The argument for deregulation is that insurers can offer a greater variety of different products targeted to specific market segments thus encouraging broader voluntary purchase of insurance coverage and stimulating competition in the insurance market. The argument against deregulation is that, even with a high risk pool, coverage becomes less available and more costly for those who need health services the most. In addition, segmenting the market does not reduce underlying costs, it just shifts the cost burden to a smaller number of individuals.

Thirty-three states currently operate a high risk pool.<sup>5</sup> Of these, seven have been established since 2003 as responses to recent market conditions. Most high risk pools (including those that have been operating for 20 or more years) have low enrollments – around 1/10 or 2/10 of a percent of the adult population under age 65. The one exception is Minnesota which has about 1% of its adult population enrolled.<sup>6</sup> Maine operated a high risk pool program from 1988 to 1994 and served around 450 individuals at its highest level of enrollment. The program was terminated when funding was shifted from a hospital assessment to the general fund and funding levels were insufficient to assure that program costs could be covered.

*Reinsurance Programs:* Reinsurance programs provide protection and some cost relief to insurers in the small group and/or non-group market by transferring to a different entity the liability for some portion of the claims experience for the enrolled population. Insurers (and self-funded employer benefit plans) can voluntarily purchase reinsurance by paying a commercial reinsurer a premium per covered person. Generally, these arrangements provide protection against individual catastrophic cases where the reinsurer will cover the costs (or some portion of the costs) above a pre-established threshold amount (e.g., after the primary insurer has paid out \$30,000 for medical expenses for an individual in one contract period). The cost to the primary insurer for the premiums paid to the reinsurer is built into the premiums paid by enrollees.

There are a few programs where policymakers have used public funds or assessments across the insurance market to provide reinsurance as a mechanism to subsidize, or reduce costs, in the small group or individual market. In Arizona, the state

appropriated state funds to buy commercial reinsurance with a stop loss level of \$100,000 for insurance products restricted to small groups and sole proprietors. Connecticut and Idaho have reinsurance programs, funded in part by assessments on all insurers, where carriers in the small group market can discretionarily reinsure individual enrollees, based on the carrier's assessment of risk. New York has a program where the state, itself, provides reinsurance to HMOs for a coverage program limited to small groups where at least a third of the workers earn less than \$30,000, and sole proprietors and working individuals with incomes below 200% of the federal poverty level. In this program, the state covers 90% of claims costs between \$5,000 and \$75,000. The state limits, through regulation, the amount that the carriers can keep for administrative costs and profits to assure that savings are passed on to enrollees. This program has resulted in insurance products with premiums about 40% below the market for similar products.<sup>7</sup>

*Publicly Subsidized Insurance:* Ten states have launched programs that provide direct subsidies to lower the cost of insurance of employees, employers, or both, in the small group market.<sup>8</sup> Most of these programs limit eligibility to businesses that are not currently offering coverage and have not for at least 12 months. Some programs limit eligibility to businesses of under 10 employees – others are open to businesses up to 50 employees. Income eligibility for subsidies also varies. Some states establish a maximum average wage (e.g., the average wage cannot exceed \$50,000). Others apply eligibility criteria to individual workers (for example, persons with household income below 200% of the federal poverty level). All the programs set a minimum requirement on the amount of the premium that the employer must contribute (usually 50%). Most states establish minimum credible coverage requirements and only contribute to policies that meet these requirements. Maine's DirigoChoice Program and New York's HealthyNY Program apply subsidies only to insurance products specified by a governing board.<sup>9</sup>

These programs have had only modest success in expanding coverage among small businesses. This may be due to structural barriers facing very small businesses. Small businesses have proportionately more part-time and/or part-year employees. In Maine, for example, more than 45% of workers in businesses smaller than 25 are either part-time or seasonal workers.<sup>10</sup> These workers are frequently ineligible for employer sponsored plans and, when eligible, face particularly high premiums since employers usually pro-rate their premium contributions.

An alternative subsidy strategy undertaken by a limited number of states is to target individuals rather than small businesses with a state-sponsored insurance plan offering sliding scale subsidies. The state of Washington's Basic Health Plan, a prototype that has been operating since the late 1980s, caps eligibility at 200% of the federal poverty level. Pennsylvania sponsors a similar program, AdultBasic, with similar eligibility guidelines. Both programs cap enrollment based on budgetary limitations and maintain waiting lists, adding individuals as enrollment declines through attrition. Vermont, Massachusetts and Maine (discussed in more detail below) all sponsor subsidized, sliding scale individual enrollment plans as part of their larger reform efforts.

Individual plans are advantageous to low income residents in that the coverage is portable and not linked to a particular job. However, these plans are costly to states because there is no employer contribution toward the premium costs of enrolled individuals.

## Comprehensive Reforms

Maine, Vermont and Massachusetts have recently enacted health system reform in a comprehensive manner, addressing issues of access, cost and quality simultaneously. These three states have all received federal Medicaid waivers to expand Medicaid to previously ineligible populations. In addition, all three states have implemented programs that provide coverage with sliding scale subsidies or discounts, based on ability to pay, for individuals and families with incomes slightly above Medicaid eligibility thresholds. With regard to many other particulars, the programs in these three states diverge. Most notably, Massachusetts is the only state in the nation that has enacted an individual mandate that requires all residents (with a few specified exceptions) to enroll in or purchase health insurance coverage. A brief overview contrasting elements of these state programs is provided below.

*Access Expansions:* All three states have used their Medicaid, State Children's Insurance Programs (SCHIP) and state access initiatives to create seamless eligibility for state citizens up to 300% of the federal poverty level. Those eligible for Medicaid or SCHIP have minimal cost sharing requirements while individuals and families enrolled in the state access initiatives pay premiums on a sliding scale based on income and have income-adjusted copayments or deductibles.

All three states have formed partnerships with private insurers or managed care companies to offer their coverage programs. The carriers insure the products, process claims, have a network of providers, and carry out some disease management functions. The states determine eligibility and manage the subsidy functions.

Some points on which these programs differ from each other are the following:

- In Massachusetts and Vermont, individuals must be uninsured to be eligible for the state-sponsored initiatives. In Maine, currently insured individuals can elect to enroll in the DirigoChoice Program – unless their employer dropped coverage, in which case they must wait 12 months. Maine chose this strategy so that under-insured individuals could purchase more comprehensive coverage and so that small employers who offered coverage but had low participation rates could offer discounted coverage to their low-income employees.
- The Massachusetts sponsored program – Commonwealth Care, is available to individuals and families only (no groups). Vermont enrolls individuals and families in its program, Catamount Health, but alternatively, will subsidize the premiums of employer-sponsored coverage

for eligible individuals, when they have an employer plan available to them that is cost-effective. Maine allows both small businesses and individuals to enroll in the Dirigo-Choice program.

- In Maine and Vermont, individuals with incomes above the eligibility threshold for subsidies may purchase coverage through the state programs at cost. In Massachusetts, enrollment in Commonwealth Care is limited to persons with incomes below 300% of the poverty level. An agency called the Connector has been established to approve affordable plans with credible coverage available through the private market. The Connector serves as a point of entry for individuals ineligible for the Commonwealth Care program in accessing coverage and provides a mechanism to pool contributions from employers for individuals with more than one job.
- Massachusetts and Vermont both instituted a financial assessment on employers for employees who are not insured through an employer-sponsored health benefit plan. Determined on an FTE basis, the assessment affects both employers who provide coverage but may have part-time or other workers who are not eligible, and employers who do not offer coverage. The assessment in each of these states is set well below the cost of insurance coverage so that the state-subsidized programs must draw on additional sources of funding. In Maine, participation in the DirigoChoice plan (or other insurance) is voluntary and no assessment is levied based on employment of uninsured workers. However, the Maine program is funded in part through an assessment on insurance claims and self-funded employer plans' claims volume – an assessment that is triggered by a showing of cost-savings in the health care system that matches or exceeds the value of the assessment. This Savings Offset Payment mechanism has been controversial and cumbersome. In the last legislative session the legislature replaced it with an increased tax on certain beverages and a fixed assessment on premiums. This reform was reversed through referendum in November, reverting the program to the prior Savings Offset Payment funding structure.

*Cost and Quality Initiatives:* All three states have initiated efforts to improve quality of care, efficiency, and to reduce costs. An interest shared across the three states is the development of an integrated electronic medical record system that would make patients' medical histories and test results immediately available to the range of providers participating in a patient's treatment. In Vermont, a 1% levy on insurance premiums was enacted by the legislature to fund the development of the necessary infrastructure and training for such a system.

Maine and Vermont are both testing, on a pilot basis, a medical home model of care which shifts both medical management responsibilities and reimbursement for care to a team model, based on each patient's comprehensive health care needs. Vermont's health reform law includes a "Blue Print for Health" which will facilitate a disease management approach for indi-

viduals with chronic illnesses regardless of insurance program (Medicaid, private insurance, or Medicare).

Massachusetts has passed a law that prevents hospitals and other facilities from charging for the costs of care in cases of certain serious and avoidable medical errors. The state is establishing uniform billing and coding among providers and payers to reduce administrative costs. They have also established a Special Commission on Health Payment Reform which will investigate strategies for restructuring the health care payment system to provide incentives for efficient and effective care.

Maine's reform law established the Maine Quality Forum (MQF) which has multiple initiatives underway. Among its activities are efforts to increase transparency and public awareness of differences in quality and volume of services among providers across the state. The MQF is also engaged, together with providers and consumers, in developing standardized treatment protocols and in measuring performance against agreed upon standards. Working together with coalitions, the MQF is engaged with a number of pilot projects which include but are not limited to: efforts to reduce hospital infection rates; reduce the incidence of pressure ulcers in hospitals; and improve quality and safety in small, rural hospitals. Maine's health reform also addresses health care costs directly by limiting the total new dollars that can be invested in certain health system capital projects. In addition, the state has negotiated voluntary benchmarks with the hospital industry to slow the rate of growth in hospital spending.

## Conclusion

The states, through their various initiatives have often served as a laboratory for reforms to be considered at the federal level. With the new administration and its commitment to health care, the interest in state reforms may be particularly pronounced. Maine's DirigoChoice Program (as well as the Catamount Health Plan in Vermont and the Commonwealth Care Program in Massachusetts) may well serve as prototypes for Obama Administration's stated interest in public insurance alternatives for persons without access to employer health benefits.

## References

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4. States with community rating or modified community rating with rate bands include: CT, ME, MD, MA, NH, NJ, OR, PA (only for some Blue Cross, Blue Shield Plans and HMOS), RI, and WA.
5. States with high risk pools include: AL, AK, AR, CA, CO, CT, FL, ID, IL, IN, IA, KS, KY, LA, MD, MN, MS, MO, MT, NE, NH, NM, ND, OK, OR, SC, SD, TN, TX, UT, WA, WV, WI and WY.

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8. These 10 states are: ID, KY, ME, MD, MA, MT, NM, NY, OK, and TN.
9. State Premium Assistance Programs. Kaiser State Health Facts: <http://www.statehealthfacts.org/comparetable.jsp?ind=380&cat=7>
10. Source: Current Population Survey Data averaged for the years 2004 through 2006. (Conducted by the Census Bureau for the federal Bureau of Labor Statistics.)