WashACE

COMPETITIVENESS BRIEF

Washington Alliance for a Competitive Economy

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State Efforts to Expand Access to Health Care

THE BOTTOM LINE

States have implemented a wide variety of policy options in attempting to increase access to health insurance.

In this brief, we review recent reform efforts in New York, Tennessee, Massachusetts, and San Francisco.

According to the U.S. Census Bureau, the number of uninsured Americans reached 45.8 million (15.7 percent of the population) in 2004. While the percent of the population without insurance fluctuates each year, a persistently high number of Americans are without coverage.

To increase access to insurance, some states have focused on lowering the effective price of coverage. Others have expanded their health care safety nets. And some have passed legislation requiring employers to contribute to the cost of care.

In this brief, we review recent reform efforts in New York, Tennessee, Massachusetts, and San Francisco.

NEW YORK: COVERAGE FOR LOW INCOME WORKERS

In 2000, the state of New York enacted legislation increasing the availability of comprehensive health insurance for uninsured workers and their families. The Health Care Reform Act of 2000, popularly referred to as Healthy NY, is designed to assist small businesses in providing their employees with health insurance. The program is also available to sole proprietors and uninsured working individuals.

Eligibility: In order for an employer to qualify, the business can have no more than 50 employees, 30 percent of which must earn wages of $35,500 a year or less (adjusted annually for inflation). Additionally, the small employer cannot have provided group health insurance to its employees within the past twelve months (unless the contributed amount was very small). The employer must also ensure that at least 50 percent of eligible employees participate in the program and that at least one participating employee earns an annual wage of $35,500 or less. Finally, the employer must itself contribute at least 50 percent of the premium and must offer Healthy NY to all employees working 20 or more hours per week and earning $35,500 a year or less. Employers have the option of offering coverage to part-time and seasonal workers.

Individuals wishing to enroll must be currently employed (or have been employed within the past 12 months), cannot be receiving employer-provided comprehensive coverage, cannot have had private health insurance in effect within the past 12 months (unless lost due to a qualifying event), must be ineligible for Medicare, and must have a current gross household income that meets program guidelines (as of January 1, 2006 a family of four can have an annual household income of up to $49,875). The guidelines for sole proprietors are identical to that of in-

HEALTH CARE

A three-part series examining the rise in health care costs and the decline in health care coverage.

Part 2

Association of Washington Business
Washington Research Council
Washington Roundtable

Nonelderly (0-64) Health Insurance Coverage by State, 2003-2004

	Employer	Individual	Medicaid	Other Public	Uninsured
United States	61%	5%	13%	2%	18%
Alabama	62%	4%	14%	4%	16%
Alaska	55%	4%	15%	6%	20%
Arizona	55%	7%	16%	3%	20%
Arkansas	54%	6%	17%	4%	20%
California	55%	7%	16%	2%	21%
Colorado	63%	7%	8%	3%	19%
Connecticut	70%	4%	12%	2%	13%
Delaware	68%	3%	11%	3%	15%
Florida	56%	6%	12%	3%	23%
Georgia	61%	4%	13%	2%	19%
Hawaii	69%	3%	11%	5%	12%
Idaho	59%	8%	13%	2%	19%
Illinois	67%	6%	10%	2%	16%
Indiana	67%	4%	11%	2%	16%
Iowa	68%	8%	10%	2%	12%
Kansas	67%	7%	10%	3%	12%
Kentucky	60%	5%	15%	3%	16%
Louisiana	54%	6%	16%	3%	21%
Maine	60%	5%	21%	3%	12%
Maryland	69%	4%	8%	2%	16%
Massachusetts	68%	5%	13%	1%	13%
Michigan	68%	4%	14%	1%	13%
Minnesota	72%	8%	9%	1%	10%
Mississippi	54%	4%	19%	3%	20%
Missouri	65%	5%	14%	2%	14%
Montana	52%	9%	13%	4%	22%
Nebraska	65%	9%	10%	3%	13%
Nevada	64%	5%	7%	2%	21%
New Hampshire	76%	3%	6%	2%	12%
New Jersey	71%	3%	8%	1%	16%
New Mexico	48%	4%	20%	4%	25%
New York	61%	4%	18%	1%	17%
North Carolina	59%	5%	13%	4%	19%
North Dakota	64%	11%	9%	3%	13%
Ohio	69%	4%	12%	2%	13%
Oklahoma	56%	4%	12%	4%	24%
Oregon	61%	6%	12%	2%	19%
Pennsylvania	68%	5%	11%	2%	14%
Rhode Island	65%	5%	17%	2%	12%
South Carolina	59%	5%	15%	4%	17%
South Dakota	61%	10%	12%	3%	14%
Tennessee	58%	6%	17%	4%	16%
Texas	53%	4%	13%	2%	27%
Utah	67%	8%	9%	1%	14%
Vermont	60%	6%	19%	3%	12%
Virginia	67%	5%	8%	5%	15%
Washington	61%	6%	14%	3%	16%
West Virginia	57%	3%	16%	4%	19%
Wisconsin	68%	6%	12%	2%	12%
Wyoming	60%	8%	11%	4%	17%

Source: Kaiser Family Foundation, 2006

dividuals.

Enrollment. In 2005, net Healthy NY enrollment increased by 30,647 to a total of 106,944 members. Fifty-six percent of enrollees were self-enrolled working individuals, 18 percent were sole proprietors, and 26 percent were enrolled through small business groups (EP&P Consulting 2005, p. ii).

Coverage. Healthy NY is a standardized benefit package, covering a range of health care needs, including inpatient and outpatient hospital services, physician services, maternity care, preventative health services, diagnostic and x-ray services, and emergency care. Services not covered include dental care, mental health services, substance abuse treatment, chiropractic services, physical therapy, hospice care, and home health care. Service for a preexisting condition can be excluded from coverage for up to a year. Applicants have the option of choosing a benefit package with or without limited prescription drug coverage.

All 21 health maintenance organizations (HMOs) currently doing business in New York are required to offer eligible residents the Healthy NY benefit package. HMOs administer the program and contract with local health care providers for services.

Premiums. The benefit packages are the same, but HMOs charge different premium rates for their services. Premiums are determined based off of the contract type (individual, member with spouse, member with child, or family), the pharmacy benefit option, and the county of residence.

While the state originally had authority to approve and disapprove premiums, rates are now determined entirely by HMOs. Still, last year 56 percent of offerings were priced within 10 percent of the lowest-priced premium offering. The average monthly premium paid for individual coverage in July 2005 was $190 (EP&P Consulting 2005).

In addition to the monthly premium, covered services are subject to copayments. Copays range from $500 for inpatient hospital services to $0 for child immunizations.

Stop Loss Payment. In addition to premiums and copays, Healthy NY is funded through "stop-loss" reimbursement payments from the Department of Insurance. HMOs received annual stop-loss payments at a rate of 90 percent of costs incurred on a per person basis for claim between $5,000 and $75,000.

Employer Cost. Participating small businesses are required to contribute at least 50 percent of the cost of

the employee's premium. Many choose to contribute more. In fact, according to a recent survey by EP&P Consulting, approximately half of participating employers cover the full cost of individual premiums (2005, V-18).

Employers are not required to offer or pay for family coverage. However, 48 percent of surveyed employers pay at least some of the family premium (2005, V-18).

Cost to State. EP&P estimates that total stop-loss reimbursements will cost the state $38 million in 2004, $58 million in 2005, and $71 million in 2006. Healthy NY has been budgeted $49 million for 2004, $69 million for 2005, and $110 million for 2006 (2005, I-4). Since dedicated funds exceed costs, funding for Healthy NY is more than adequate given current enrollment levels.

Discussion. While the rate of uninsured adults has increased in the United States, the rate of uninsured New Yorkers has been decreasing. The largest decrease has been among households earning less than 200 percent of the Federal Poverty Level (FPL), the group that Healthy NY members fall into. But, even with Healthy NY, many non-elderly low-income New Yorkers remain uninsured. It is also unclear whether Healthy NY is a marketable product for HMOs or simply a state requirement (EP&P Consulting 2005, II-1 & II-20).

Still, according to EP&P Consulting, by establishing a streamlined benefit package and a stop-loss fund, the premiums charged by participating health plans have continued to be below market rates (2005, p. i).

In 2005, New York renewed its commitment to Healthy NY through the Health Care Reform Act of 2005. The state is also working to expand enrollment in the future and is seeking opportunities to leverage federal funds.

TENNESSEE: STRIPPED DOWN HEALTH INSURANCE

Last June, Tennessee Governor Phil Bredesen signed into law a stripped-down health care plan for low-income workers. The plan will provide basic coverage to many of the 600,000 (estimated) currently uninsured workers, a large portion of which lost their coverage when disenrolled from TennCare last year.

TennCare. In 1994, Tennessee's Medicaid program was replaced with TennCare, a managed care plan serving the state's poor, uninsured, and uninsurable. The plan was considered to be one of the nation's most generous and inclusive, with 23 percent of the state's population enrolled at its height (Bureau of Tenser 2006). By 2005, TennCare served 1.3 million residents, with an annual budget of over $8 billion.

In an attempt to mitigate rising costs and budgetary pressures, TennCare has undergone a series of recent cutbacks. Last August adults aged 19 and over were disenrolled form TennCare Standard and adults aged 21 and older were disenrolled from TennCare Medically Needy. For remaining adults, benefits such as over-the-counter medication and dental care were cut. Likewise, copays were introduced and restrictions were placed on the number of prescription drugs covered each month by TennCare Medicaid. The State also took steps to return to a managed-care model by requiring Managed Care Organizations to assume more financial risk in the delivery

of benefits. (In 2002 the state relieved MCOs of all financial risk, replacing TennCare's managed care plan with an "Administrative Services Only" arrangement.)

As a result of cut backs, an estimated 170,000 were disenrolled by the end of 2005. Full coverage continues to be provided for all 612,000 children enrolled in TennCare and reduced benefits continue to be provided for adults eligible for Medicaid.

In the words of Governor Bredesen, "It might not be the level of care we want to provide, but it's the level of care we can afford without bankrupting our state" (cited in WATE 6 News, 2005). The recent changes to TennCare are projected to reduce costs by as much as 25 percent.

Cover Tennessee. In order to provide low-cost health insurance for Tennessee's children, medically needy, and working poor, SB 3895 was signed into law on June 12, 2006.

The main provision of the bill, Cover Tennessee, establishes a public-private partnership between small businesses, uninsured workers and the state in order to make subsidized basic health insurance available to all eligible workers. To qualify, a person must be below 250 percent of the poverty level, be currently employed, and have been without health insurance for the past six months.

The program is structured to keep costs low by focusing on prevention. To do this, low deductibles will be charged for routine costs such as doctor visits and generic prescriptions while coverage for more expensive health care items such as hospital visits will be more limited.

The plan is also designed to be portable, meaning individuals remain eligible even upon termination of employment and are able to continue to receive the same coverage under a new employer.

To provide these services, the state will contract with health insurance carriers or third party administrators. Contractors will be required to accept for enrollment every eligible individual that applies for coverage, with certain exceptions for applicants with preexisting medical conditions.

The average premium for a working uninsured adult will be approximately $150 a month. The exact amount will be determined based off of a member's age, smoking status, and weight. The state will contribute $50 towards the premium. Employees and qualified small employers (should they choose to participate) will pay the remainder. A participating small employer is an employer with 50 or fewer employees, a significant portion of which earn below 250 percent of the Federal Poverty Level.

In addition to providing basic health coverage for uninsured workers, the bill includes the Diabetes Prevention and Health Improvement Act (to promote the understanding and prevention of diabetes and to provide funding for the treatment of pre-diabetes and diabetes), the Access Tennessee Act (creating a nonprofit entity to operate an insurance pool for residents unable to purchase coverage due to a pre-existing medical condition), and the Cover Kids Act (providing coverage for uninsured children under 18 not eligible for coverage under Medicaid and for pregnant women).

The State estimates that 100,000 adults, 75,000 children and 15,000 chronically ill residents will enroll in the new programs within the first

State by State Comparison of Health Insurance Coverage for the Nonelderly, 2003-2004

	Private		Public		Uninsured
	Employer	Individual	Medicaid	Other	
U.S.	61.5%	5.3%	13.1%	2.3%	17.8%
CA	54.7%	7.0%	16.0%	1.5%	20.6%
MA	67.7%	4.8%	13.5%	1.2%	12.7%
NY	60.6%	3.8%	17.7%	1.3%	16.7%
TN	57.6%	6.3%	16.7%	3.9%	15.6%
WA	61.1%	5.9%	14.4%	2.6%	16.0%

Source: Kaiser Commission on Medicaid and the Uninsured, 2006

three years (French, 2006). In total, the programs are expected to cost the State $350 million for the first three years, to be financed using existing TennCare reserves.

MASSACHUSETTS: MANDATORY COVERAGE

Last April, Massachusetts lawmakers passed a bi-partisan health insurance bill indented to achieve near universal coverage at a rate affordable to all residents. With a focus on private sector coverage and personal responsibility, House Bill 4479 makes coverage available to individuals and small businesses while imposing sanctions on those that do not participate.

Of the approximately 500,000–550,000 uninsured residents, about 100,000 will be eligible for Medicaid, 200,000 will be eligible for subsidized private sector insurance, and the remaining 200,000 will be required to purchase insurance, either on their own, through their employer, or through the newly established Connector.

The Connector. To facilitate coverage, the bill establishes the Commonwealth Health Insurance Connector, a quasi-governmental entity designed to connect individuals and small businesses with private sector health insurance. The goal of the Connector is to lower premium rates by banding people together in groups. By merging the non– and small-group markets, the cost of non-group premiums are estimated to drop by 24 percent.

Coverage received through the Connector is both personal and portable and employees are allowed to purchase health insurance using voluntary employer-contributions and pre-tax dollars. Part-time and seasonal workers can receive contributions from multiple employers.

All individuals and businesses with 50 or fewer employees are eligible to participate.

Subsidies for low-income residents. For low-income residents, the bill creates the Commonwealth Care Health Insurance Program. In this program, private sector health insurance will be offered through the Connector at a subsidized rate for individuals ineligible for MassHealth but earning less than 300 percent of the Federal Poverty Level (about $48,000 for a family of three). Premiums for enrolled members will be set using a sliding scale, based off of household income, and will be waived entirely for individuals earning less than 100 percent of the FPL. Subsidized residents will not be subject to medical copays.

On October 1, 2007 the Uncompensated Care Pool will be replaced with the Health Safety Net Fund. Administrators of the new fund will develop a new standard fee schedule for hospital reimbursements. As the use of free care declines, funds will be transferred to the Commonwealth Care Health Insurance Program.

Individual Responsibility. Starting July 1, 2007, all residents are required to have health insurance. Individuals that fail to comply will loose their

personal tax exemption for 2007. If they continue to go without insurance, the fine will increase to as much as 50 percent of the cost of credible coverage.

Employer Responsibility. Under the new legislation, employers with 11 or more employees that do not provide or contribute to employee health insurance will be required to pay a "Fair Share Contribution," estimated to be $295 a year per full time employee. The fee will be pro-rated for employers with seasonal or part-time workers.

The bill also tacks a "Free Rider" surcharge on employers who do not provide health insurance and whose employees use free care. The surcharge will be triggered when an employee receives free care more than three times or when a company has five or more instances of employees receiving free care in a single year. The surcharge will be between 10 percent and 100 percent of the cost to the state, with the first $50,000 exempt.

Finally, the bill makes it mandatory for all employers with more than ten employees to offer a Section 125 Plan (commonly referred to as a "cafeteria plan") in order for employees to use pre-tax dollars to pay for health insurance.

Medicaid. In addition to expanding access to private sector health insurance, the bill expands access to Medicaid. Eligibility for children is expanded from 200 percent of the Federal Poverty Level to 300 percent. Money is also allocated to reach out to people eligible for Medicaid but not yet enrolled. All of the MassHealth benefits cut in 2002, including dental and vision, are restored.

In response to concerns that providers have been underpaid, additional money for rate relief will be allocated in FY 2007, 2008 and 2009. The bill also ties future rate increases to specific performance goals.

Coverage. With the exception of policies that incorporate Health Savings Accounts and plans designed specifically for 19–26 year-olds, insurance policies will be required to meet current regulations regarding deductibles and copays. Policies will also be required to offer mandated services. However, a moratorium on the creation of new health insurance mandates is in effect for the first two years.

Cost. The new program will in large part be financed by redirecting public funds currently spent on reimbursing hospitals for providing "free care" to uninsured patients. The plan will also leverage federal dollars and use revenue generated by employer contributions. An additional $125 million will come from the general fund. After the first three years, officials anticipate that no additional funding will be needed.

Discussion. According to the Heritage Foundation, "the new Massachusetts plan points the way to greatly expanded coverage, slower cost growth, and greater consumer choice and satisfaction" (Herzlinger 2006). But many remain skeptical, arguing that low-income residents will still be unable to afford sufficient coverage, that the Connector limits consumer choice, and that the program encourages employers to discontinue insurance. Others believe that the costs will exceed the state's projections, that the mandate opens the door for widespread regulation of the health care industry, and that the program imposes an unfair burden on businesses (Serafini 2006; Tanner 2006).

SAN FRANCISCO: UNIVERSAL HEALTH CARE

In addition to statewide initiatives, some cities are taking on the issue of health reform. On July 25, the San Francisco Board of Supervisors unanimously voted for the second time to provide health care services to uninsured residents. Mayor Gavin Newsom signed the ordinance on August 7. All of the 82,000 currently uninsured adult residents are eligible to participate, regardless of income, employment status, and pre-existing conditions.

The Program. Under the San Francisco Health Care Security Ordinance, the Department of Health will coordinate with a third party vendor to administer the Health Access Program. Participants can be enrolled by their employers or can enroll themselves as individuals.

Members will receive health care from the San Francisco General Hospital, the Department of Public Health's clinics, and other community nonprofit and private providers that meet the program's criteria.

While technically not considered health insurance, the plan does provide enrolled members with access to medical services such as primary care, prescription drug coverage, hospital services, and emergency care. The plan will also emphasize preventative care in an attempt to lower the reliance on emergency room services. The program does not cover vision, dental, infertility, or cosmetic services. And, since it is not insurance, the Health Access Program will not cover services outside the city.

Cost. The Health Access Program will be funded from a variety of sources, including payments from the city, covered employers, and individuals.

According to the city's Department of Health, the program will cost approximately $2,415 a year per enrollee. If all 82,000 currently uninsured adults enroll, the annual cost of the program will be approximately $200 million. The city will contribute $104 million, members $60 million; federal and state programs $10-$20 million, and employers $30–$49 million (San Francisco City & County 2006).

Member contributions will be collected through individual enrollment copays. These copays are established using a sliding scale based on income. Uninsured residents earning less than 200 percent of the Federal Poverty Line will have a $3 per month copay, individuals between 200 percent and 500 percent of the FPL will have $35 per month copay, and individuals earning more than 500 percent of the FPL will have a $200 per month copay (San Francisco City & County 2006).

Cost to Businesses. All medium and large-sized businesses engaged in business within the city are required to contribute either to the new health care program or to the cost of their employees' health care through other means, such as private insurance or Health Savings Accounts. As defined by the ordinance, a large business has on average 100 or more persons per week perform work for compensation. A medium-sized business has on average between 20 and 99 persons perform work for compensation per week.

In order to prevent cost evasion, an employer that reduces the number of employees below the number that would have resulted in the employer be-

ing considered a "covered employer" is required to demonstrate that the reductions were not done for the purpose of evading obligations.

Employer contributions are based off of the health care expenditure rate, the amount to be paid for each hour of work performed by each covered employee. From the date of inception until June 30, 2007, the health care expenditure rate will be $1.60 for large businesses and $1.06 for medium-sized businesses. From July 1, 2007 through December 31, 2009, the rates will increase 5 percent over the expenditure rate calculated for the preceding year. Starting January 1, 2010, the rate will be determined annually based off of the "average contribution" for a full-time employee to the City Health Services System.

While the Health Access Program will open for enrollment on July 1, 2007, business obligations will be phased in.

Discussion. According to the introduction of the ordinance, "by establishing [the Health Access Program] for uninsured San Francisco residents with an emphasis on preventative care and by requiring businesses to make reasonable health care expenditures on behalf of their employees depending on the businesses' ability to pay, the burden on San Francisco taxpayers for providing health care for the uninsured can be reduced."

But while San Francisco's Health Access Program has been broadly defined, many of the finer details have yet to be established. In addition, there are a lot of questions regarding the impact and implication of the program that will need to be addressed: For example, will those that are typically treated for free or at very reduced rates be willing to pay for coverage? And if so, will they be willing to pay for a plan under which coverage is primarily provided by public and nonprofit hospitals and clinics? For a plan that only covers medical needs within city limits? Likewise, is the current network of care providers sufficient and robust enough to take on thousands of new members? And will the medical services required by the uninsured population be similar to those currently enrolled in the San Francisco Health Plan? Finally, what effect will the program have on businesses? Will any chose to relocate, close, or curtail expansion? Will it prevent business from moving into the city? And what effect, if any, will the costs to business have on wages? On the cost of goods and services? There is also some concern that opponents in the businesses community could choose to challenge the ordinance in court.

DISCUSSION

In addition to New York, Massachusetts, Tennessee, and San Francisco, a number of other states and cities have enacted legislation in an attempt to make health care and health insurance more affordable and accessible, including Vermont's Health Care Affordability Act, Maryland's Fair Share Health Care Fund Act, Maine's Dirigo Health Reform Act, New Mexico's State Coverage Insurance Program, Oklahoma's Health Care Recovery Act, Montana's Insure Montana, and New York City's Healthcare Security Act.

With so many reform efforts underway, Washington policymakers can greatly benefit from taking the time to evaluate the effectiveness and state-applicability of the each option.

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