Options for Reducing the Number of Uninsured and Controlling the Cost of Health Care

Prepared for the SJR 22 Subcommittee on Health Care and Health Insurance
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Introduction

The following paper identifies the various options raised and discussed during the last three meetings of the SJR 22 Subcommittee. The options appear in no particular order. Each includes a brief description of the concept based on the general information and discussion surrounding the idea.

It is clear that while a number of ideas remain, the Subcommittee must assign some level of priority or importance to each of the ideas to ensure that adequate time and additional research may be brought to bear on the development of recommendations to the next Legislature. It may be useful to assess each of the options using some standard set of criteria. Standard criteria to consider might be:

- Effectiveness. What is the likely impact on health insurance coverage and health care costs?
- Equity and Distribution. What is the impact on people with different incomes, individual circumstances, and access to insurance or health care facilities and providers?
- Administrative Feasibility. Will the implementation of recommendations correspond to the proposed benefits?
- Fiscal Impact. What is the cost to the state?

Some of these ideas may also be more effective when coupled with other recommendations. The Subcommittee should consider how each of these policies might interact with others and the overall effect each has, individually or collectively, on the existing health care and health insurance system.

This paper is not intended to provide a detailed analysis of the many options available to policymakers. Rather, it is designed to offer an initial concept that requires increased focus and research efforts to ensure that any recommendation is designed to target a particular problem, maximize the benefit, and minimize unintended consequences.

Sprinkled throughout the description of options are references to state efforts that other researchers, federal officials, health care policy organizations, and the program managers themselves find particularly appealing or innovative. In most cases, the states mentioned have a lower rate of uninsured than Montana experiences. However, in some cases, the programs are relatively new and are the product of study efforts much like SJR 22.

Finally, as the Subcommittee begins to narrow its interest, those policy choices having a fiscal impact must be developed in conjunction with a fiscal and budgetary component.

Strategies to Increase Health Insurance Coverage and Health Insurance Affordability

Tax Policy Changes

A credit against income taxes, either individual income tax or corporate license taxes, as an incentive to purchase health insurance or assist in making health insurance premiums more affordable. A few states, Montana included, offer an income tax credit program related to health insurance. Colorado, Kansas, and Maine each offer businesses a credit.[1] In Colorado, $200 is provided for employee if the employer pays at least 50% of the monthly premium.[2] In North Carolina, a tax credit is provided for families if the families pay health insurance premiums for dependent children. For families with income levels below 225% of the FPL, the annual credit is $300, and for all other families, the credit is $100.[3]

Issues to consider:

- ?? To whom should the tax credit be targeted, i.e., businesses, individuals, income levels, access to employer-sponsored health benefits, etc?
- ?? Should the tax credit be refundable?
- ?? If the tax credit is made refundable, what mechanisms are necessary to ensure the money is used to purchase health insurance?
- ?? Should participation in a purchasing pool be an additional requirement for eligibility?
- ?? At what point do overall cost and credit effectiveness merge?

Medical Savings Accounts

A Medical Savings Account is a tax-deferred account established by an individual to allow for the payment of out-of-pocket health care expenses. Federal MSA's were established as a demonstration project as a component of the Health Insurance Portability and Accountability Act of 1996. It allowed for small businesses and self-employed individuals to contribute to an account in combination with a high deductible health insurance plan. MSA's may also be used to accumulate savings to pay for future health care related expenses. In Montana, an employer may establish an account for an employee or an individual may establish an account. Title 15, chapter 61, parts 1 and 2, provide for the establishment and administration of medical savings accounts in Montana.

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[1] *Implementation of Incentives and Regulatory Mandates to Increase Health Insurance Coverage*, Arizona Health Care Cost Containment System, August 27, 2001.

[2] *Ibid.*

[3] *Ibid.*

Issues to consider:

- ?? Based on the experiences of individuals or employers, does the Montana Medical Care Savings Account Act of 1995 need to be amended to increase its usage?
- ?? Would changes to federal MSA law be required in order to realize greater participation and flexibility?
- ?? Is an MSA an effective tool to increase insurance coverage?

Subsidized Buy-in to State Employee Plan

Employers with a certain percentage of low income employees or employees without access to employer-sponsored insurance would have the ability to buy-in to the state employee benefit plan at a reduced premium rate. The state would subsidize the remainder of the premium.

Issues to consider:

- ?? What mechanisms are necessary to avoid the possibility of "adverse selection" and "crowd-out"?
- ?? How will this affect the state employee plan?

Full Cost Buy-in to Public Health Insurance Programs (FCBI)

A program designed to allow low-income individuals and families without access to employer-sponsored health insurance to purchase coverage in public programs, but unlike subsidized programs, have no upper income thresholds.[4] The general intent of the states that operate FCBI programs is to provide an affordable option for people who lose eligibility in subsidized programs due to increases in income, but find private insurance options difficult to afford or unavailable.[5] Also, each state uses their individual SCHIP program as the basis for coverage for children only. Examples are:

- ?? Connecticut HUSKY -- Children at 300% of FPL
- ?? Florida KidCare -- Children ages 5 - 9 at 200% of FPL
- ?? New York Child Health Plus -- Children at 230% of FPL
- ?? North Carolina Health Choice for Children -- Previously enrolled children between 200 and 225% of FPL for one year.

Issues to consider:

- ?? What design features are necessary to keep FCBI's separate from the state's high risk

[4]According to an issue brief produced by State Coverage Initiatives, the targeted population also includes people who cannot afford insurance in the individual market.

[5]Washington, Minnesota, Florida, New York, and Connecticut represent the five states with FCBI programs.

pool?
- ?? How should crowd-out be addressed?
- ?? What are the administrative issues to consider?

SCHIP Employer Buy-In and Other Premium Sharing and Assistance Programs

A program designed to subsidize health insurance premiums offered by employers, primarily targeted to employees having access to health insurance through their employer but fail to enroll due to cost. The subsidy may also be paid to employers to reduce the cost of offering health benefits. Examples of this type of approach are found in Maryland, Massachusetts (MassHealth), Mississippi, Wisconsin (BadgerCare), New Jersey, and Virginia. These states received approval from the Centers for Medicaid and Medicare (CMS) to use Title XXI funds to buy-in families.[6]

In order to receive federal approval to operate an employer buy-in program under SCHIP, states must demonstrate that the premium assistance will be directed to employer plans that meet SCHIP requirements, including benefit standards, enrollee cost-sharing limits, and minimum employer premium contribution levels. In addition, states must show that buying the private insurance plan is cost-effective in comparison to the cost of covering the enrollee directly through the state SCHIP program.

A few states operate state-only programs and do not receive federal match dollars. Programs in Illinois, Oregon, and Rhode Island are FCBI programs. Massachusetts, Minnesota, and Washington provide direct coverage through a variety of state-designed plans.

The state-funded Massachusetts premium assistance program is designed to serve children less than 19 years of age that are not eligible for the SCHIP buy-in. In essence, income levels greater than the 200% of FPL required in MassHealth.

The Family Health Insurance Assistance Program (FHIAP), Oregon's approach to assisting low-income families afford insurance benefits offered by their employer, or in some cases, access the individual market, serves approximately 4,100 enrollees. Families with incomes below 170% of the FPL are eligible to receive premium subsidies of 70%, 90%, or 95% based on income.

Issues to consider:

- ?? How should the state structure a premium assistance program; a federal/state partnership or a state-only program?
- ?? What mechanisms should be developed to avoid substitution of coverage or "crowd-out"?
- ?? To whom should the program be targeted and what will be the total cost?

SCHIP Expansion to Cover Parents

Three states, Rhode Island, New Jersey, and Wisconsin, were granted waivers by U.S. Department of Health and Human Services to expand each state's SCHIP to cover parents of SCHIP eligible children who have incomes that exceed Medicaid thresholds but is too low to purchase private health insurance.

[6]Title XXI (21) refers to the State Child Health Plans contained in the Social Security Act.

Rhode Island's waiver will allow it to enroll parents with incomes between 100 and 185 percent of the FPL and pregnant women with incomes between 185 and 250 percent of the FPL. Services will be provided through the RiteCare program.

New Jersey will use its waiver to enroll parents of children who are eligible for Medicaid and SCHIP and have incomes up to 200 percent of the federal poverty level. The state will extend coverage to pregnant women with family incomes between 185 and 200 percent of the FPL. Services will be provided through the NJ KidCare program.

Wisconsin will use its waiver to enroll parents with incomes between 100 and 185 percent of the FPL. Services will be provided through the BadgerCare program and they will receive the Medicaid benefit package.
Issues to consider:

- ?? What are the programmatic and fiscal implications of offering coverage to parents of SCHIP eligible children?
- ?? If budgetary constraints make immediate action unlikely, should the Legislature consider asking the Administration and the Department of Public Health and Human Services review the necessary requirements and report on available options at a later date?

Single-Payer System

A single-payer health insurance system is distinguished by the state providing, and financing, insurance coverage for each person in the state. Senate Bill No. 258, Laws of 1993, defined a single-payer system as "a method of financing health care services predominately through public funds so that each resident of Montana receives a uniform set of benefits as established through statute or administrative rule. Policies governing all aspects of the management of the single payor system would reside with state government, and benefits must be administered by a single entity".

Issues to consider:

- ?? What is the overall cost of a single-payer system to the state?
- ?? What are the implications to the current health care and health insurance system?

Purchasing Pools for Health Insurance[7]

Purchasing pools for health insurance combine small groups into one larger pool to mimic the benefits of large group purchasers. The purchasing pool concept could include a statewide K-12 pool, a local government pool, or combining all public employees under the state employee benefit system.

Issues to consider:

- ?? Can the existing purchasing pool concept be redesigned to meet the needs of both pool participants and insurance providers?

[7] A voluntary purchasing pool was created by the Legislature in 1995. It can be found in section 33-22-1815, MCA.

- ?? Considering that a K-12 purchasing pool has been discussed during the HB625 Education Funding Study, should the Subcommittee ask the various stakeholders in this issue to gather more information?

Mandated Benefits

Montana has 12 mandated benefits (two of which, minimum maternity stays and breast reconstruction are federally mandated), one mandated offering (home health care), 13 mandated providers, and six mandates delineating who must be covered. The most recent mandate approved by the Legislature in Montana occurred during the 2001 session and required insurers to cover diabetes-related services.

Twenty-five states have passed laws creating a mandated benefit evaluation or cost analysis. Seven of those 25 states passed legislation during 2001. A number of possibilities exist for housing this function. States use legislative branch analysts, departments' of insurance, and proponent analysis. Of the states that seem to have the most intricate requirements, independent commissions review legislation, gather data, conduct public hearings, and make recommendations to the legislature and in some cases the governor.[8]

Issues to Consider

- ?? What percent of the total monthly premium cost of mandated benefits on health insurance?
- ?? Is there a relationship between mandated benefits and insurance overage?
- ?? Should Montana implement a mandated benefit analysis, and if so, should it be structured under an independent commission model, housed in the Office of the Insurance Commissioner, the Office of Budget and Program Planning, or in Legislative Branch?

Montana Comprehensive Health Association (MCHA)[9]

The MCHA serves as the states high-risk insurance pool and guaranteed portability pool as required under the federal Health Insurance Portability and Accountability Act of 1996. The program is funded through participant premiums and assessments paid by health insurers doing business in Montana. The 57th Legislature enabled MCHA to provide for low-income participation through a sliding scale premium rate funded by either private donations or federal funding. MCHA did receive $1.25 million federal dollars to begin implementing a low-income insurance program. The last Legislature also approved a bill that allows for a study of alternative or expanded funding mechanisms for the entire program.

Issues to consider:

- ?? Should the Legislature consider amending the requirements to secure funding for the low-

[8]The states of New Jersey, Pennsylvania, Maryland, and Virginia conduct mandated benefit analysis using independent commissions and internal and external actuaries.

[9]The statutory authorization for MCHA is found in Title 33, chapter 22, part 15, MCA.

income health insurance component of MCHA to include a state appropriation?

?? If increased participation in MCHA by low-income, difficult to insure, individuals addresses some aspects of cost shifting, what are the appropriate measures available to the Legislature to promote that participation.

Strategies to Address Health Care Costs

Hospital Rate Review/Regulation

In general terms, a hospital rate review process is designed to gather financial information, including rates, costs, and proposed capital expenditures from hospitals in order to establish a reasonable budget under which the facility will operate. While no longer in existence, the voluntary Montana Hospitals Rate Review System, a private, non-profit entity, did independently review financial information of participating hospitals to assist facilities in containing health care costs. In Vermont, a mandatory rate review system is in place to establish and monitor hospital budgets and the facilities progress in meeting long-term strategic state health care related objectives.

Issues to consider:

- ?? Should a hospital rate review process be mandatory or voluntary?
- ?? Who is the appropriate agency or entity for reviewing hospital rates?
- ?? If mandatory, what enforcement mechanisms are needed?

Certificate of Need

Montana's Certificate of Need program is housed within the Department of Public Health and Human Services. The program is designed to "maintain quality of care, control a portion of health costs to communities, and promote rational distribution of certain health care services".[10] Certain health care facilities wishing to begin or expand services are required to submit applications to the Department who then reviews the proposals to determine whether the need exists and the proposed increase in capital expenditures. The 57th Legislature passed SB 221 to require that ambulatory surgical centers in counties with a population of greater than 20,000, home health care facilities, nursing homes, and long-term care facilities comply with the Certificate of Need statutes.

Issues to consider:

- ?? Are Certificate of Need programs effective in controlling health care costs related to facilities?
- ?? What effect does certificate of need have on overall health care and health insurance systems costs?
- ?? What effect, if any, do certificate of need programs have on access to quality care?

[10]http://www.dphhs.mt.gov

Prescription Drug Costs

Prescription drugs are a major component of overall health care spending and rising costs. Increased efforts by pharmaceutical manufacturers to develop more effective drugs result in greater research and development spending, as well as direct-to-consumer advertising efforts to ensure that consumers and providers are made aware of new prescription drug opportunities. While Congress continues to review feasible means of providing a meaningful drug benefit package, states, perhaps having more flexibility have recently begun efforts to lower cost of prescription drugs. A few examples include:

Assistance for Seniors

In 2001, 16 states created or expanded prescription drug benefit programs for seniors. The mechanisms vary, but purchasing pools and cost-sharing arrangements are the most common. Some of the recent developments include:

Arizona: Established a pilot program to provide prescription drug coverage to seniors with incomes between 100% and 200% of FPL who do not have access to Medicare managed care. Seniors pay a deductible and the state contributes 50% of the cost of prescriptions.

Michigan: Created the Elder Prescription Insurance Coverage program to enhance access to prescription drugs for low-income seniors without coverage. The program covers most prescription drug for residents over 65.

Rhode Island: Expanded the Rhode Island Pharmaceutical Assistance to the Elderly Program to allow for the state to pay 100% of drug costs for eligible individuals who spend at least $1,500 in co-payments through the program during the state fiscal year.

Purchasing Pools

Tri-State Prescription Drug Purchasing Pool

Maine, New Hampshire, and Vermont united to address the cost of prescription drugs for people enrolled in public programs, the uninsured, and the underinsured. The states believe that the arrangement will increase purchasing power and increase access to low-cost prescription drugs.

"Southern States Coalition" Pharmacy Working Group

Alabama, Arkansas, Georgia, Louisiana, Maryland, Mississippi, Missouri, New Mexico, North Carolina, South Carolina, Tennessee, Washington, West Virginia, and Wyoming have each expressed interest in working cooperatively to address the cost of prescription drugs for a variety of populations and programs, including Medicaid eligibles, public employees, and workers' compensation programs.

Assuming the Subcommittee will choose to address prescription drug prices, the issues to consider are:

- What population should be targeted for assistance?
- Is entering a purchasing arrangement with other states in the best interest of Montana's

public?

?? Should Montana adopt a resolution similar to Idaho, which authorizes the appropriate entities to begin the process of developing a multi-state purchasing arrangement?

General Recommendations and Information

Health Care Authority

The 1993 Legislature, through Senate Bill No. 285, created the Montana Health Care Authority and charged the Authority with developing a comprehensive, statewide health care reform strategy that would provide all Montanans with improved access to high quality, affordable health care.[11] As part of the Authority's responsibilities, it was required to submit two plans for achieving the enacting legislation's objectives; a single-payer plan (discussed above) and a regulated multiple-payer system. It accomplished its tasks and provided the Governor and the Legislature with a third alternative that the Authority termed a market-based, sequential reform package.

In 1995, the Legislature replaced the Health Care Authority with the Health Care Advisory Council (discussed below).

Issues to consider:

- ?? Is there a need to recreate an entity like the Health Care Authority to gather information, conduct research and analysis, and provide guidance to the Executive and Legislative Branches, the health care industry, and the public?
- ?? If there is an interest, what specific duties and tasks should the Legislature consider assigning to the Authority?

Montana Health Care Advisory Council

In 1995, the Legislature authorized the creation of the Health Care Advisory Council and provided that the Council monitor and evaluate incremental and market-based approaches for health care reform. In 1999, the Council, with assistance from the State Coverage Initiatives, an Alpha Center program funded by the Robert Wood Johnson Foundation, drafted a whitepaper outlining strategies to reduce the number of uninsured Montanans.[12] SJR22 requests the Subcommittee to review the feasibility of recreating the Health Care Advisory Council.

Issues to consider:

- ?? Will recreating the Council provide for a long-term process to review information, establish trends, and provide information and advice to policymakers?

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[11] *A Market-Based Sequential Health Care Reform Plan for Montana.* Montana Health Care Authority Report to the Governor and the Legislature, December 1994.

[12] The Health Care Advisory Council whitepaper can be found at: http://www.dphhs.mt.gov/hpsd/index.htm

- ?? Should the Subcommittee consider establishing specific goals in statute for the Council to meet?

Health Care Inventory

An electronic database of health care services and facilities that are available in Montana to allow policymakers, health care professionals, and the public to access information related to cost, types of services provided to allow for informed decisionmaking.

Issues to consider:

- ?? How will an inventory assist legislators, administrators, providers, consumers, insurance providers, etc., make better decisions about health care use, cost trends, and other issues associated with the health care system?
- ?? Who should be responsible for gathering, maintaining, analyzing, and reporting information from the inventory database?
- ?? How will information be used and confidentiality be protected?

Health Care Ombudsman

The traditional role of an ombudsman is to receive and investigate citizen complaints against administrative acts of government. Since the first public sector ombudsman was appointed by the Swedish Parliament in 1809, the responsibilities and expectations of ombudsmen have been changed according to the needs of the appointing authorities. Generally, a public sector ombudsman is either appointed by the Governor or chief elected official of a government jurisdiction or established in statute and appointed by the legislative body.

Issues to consider:

- ?? What role should a health care ombudsman play in Montana?
- ?? How would the ombudsman's duties interact with other state agencies and elected officials responsible for health care policy development and implementation?

Defined Contribution for Health Benefits

Defined contribution for health benefits borrow from the defined contributions model for pensions. An employer contributes a set dollar amount toward health benefits and shifts the responsibility of purchasing health benefits to the employee.

Issues to consider:

- ?? Since it's unlikely that statutory change is necessary to allow employers to offer a defined contribution, what role, if any, should the state play in encouraging it?
- ?? Do consumers have access to good information related to availability of health insurance?
- ?? What might the effect be, if any, on traditional employer-sponsored insurance?

Funding Sources

Obviously, many of the recommendations contained in this paper require the expenditure of state funds for

implementation. Financing these options may come from new revenue sources, the shifting of legislative priorities, or a more defined approach of using the expendable portion of the interest off of the tobacco settlement trust fund. The marriage between policy development and financing should occur simultaneously once the Subcommittee begins to better define and prioritize its approach to options development.

Conclusion

The options listed in this paper are broadly described and represent a starting point for continued discussion. If there is general agreement on the concept among the Subcommittee members and the interested persons, a working group concept may be appropriate to focus on the various design issues as well as the fiscal implications associated with any of the recommendations. Each of the options provided are intended to meet the goals adopted by the Subcommittee, and should be evaluated as to each recommendations ability to influence favorable trends toward reducing cost shifting, slowing the rate of growth in health care costs, and providing a sustainable health care policy that future decisionmakers can use as a foundation for long-term solutions.