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Research Report

Reaching the Goal: Expanding Health Insurance Coverage in New England

Current Strategies and New Initiatives

by Alicia Sasser

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–Alicia Sasser

Executive Summary

Reaching the Goal: Expanding Health Insurance Coverage in New England

Current Strategies and New Initiatives

As the number and percentage of people without health insurance continues to climb, the goal of expanding such coverage is even more pressing. Traditional strategies have had only limited success. And with little movement at the federal level, states have chosen to enact their own bold initiatives. Four New England states—Maine, Massachusetts, Rhode Island, and Vermont—have recently passed or implemented programs to expand health insurance coverage, some with the goal of achieving near-universal coverage. By combining different strategies from across the political spectrum, the new initiatives represent a unique amalgam approach to expanding health care coverage. This paper examines existing strategies that have taken a more incremental approach to expanding coverage and also explores the new initiatives in New England, comparing and contrasting their designs and strategies.

Over the past decade or so, states have had varying degrees of success in pursuing a number of traditional strategies, often in combination, to achieve incremental reductions in the rate of uninsured. Policies targeting the low-income population, such as Medicaid and SCHIP expansions, have been modestly successful in expanding coverage at a fairly low cost. Efforts to address the high-risk population have had mixed results. On the one hand, reinsurance programs appear to lower premiums by stabilizing the health insurance market. Yet high-risk pools provide coverage that is still expensive, often with limited benefits, resulting in low enrollment and pool losses.

Traditional policies to expand coverage in the individual and small group markets have also had limited success. Although limited benefit plans generate a small reduction in premiums, they are not very popular with consumers, and those who do buy them may still seek uncompensated care via the safety net. The main impact of group purchasing arrangements has been to expand plan choice among those already receiving job-based insurance, with little evidence that they reduce the number of uninsured.

In contrast to previous efforts to expand coverage, the new insurance initiatives in New England emphasize "shared responsibility," placing the onus for coverage on government, employers, and individuals alike. Several of the plans provide public subsidies to ensure affordability for low-income residents. Two states also impose financial penalties on employers that do not offer health insurance coverage. To encourage individual participation, most of the plans offer fairly comprehensive coverage, with relatively limited cost sharing. Massachusetts has gone further, mandating that individuals purchase coverage, either from the state, through their employer, or in the private market.

Yet, the New England states face various pitfalls as they expand coverage. For example, in setting subsidies for individual premiums, policymakers must balance the need to make coverage affordable with the desire to minimize the potential for disruption in the group insurance market. Another challenge is to maintain minimum benefits standards while negotiating premium discounts with insurers, a task that may prove difficult in the future if the new programs are unable to attract a sufficiently large share of the market. Finally, many of the new programs rely on cooperation between states and insurers, which can be difficult to sustain over time, especially in states with few players in the private market.

Even with the best program design, states face additional challenges as fundamental as whether these new programs will be able to attract enrollees and actually reduce the number of uninsured. Even states that have imposed employer fees or individual mandates cannot predict whether firms and individuals will find that the benefits of coverage outweigh the costs and penalties. Moreover, greater participation in health care coverage does not necessarily guarantee greater access to care.

A final concern is the long-term sustainability of current reforms in the face of changing economic and fiscal conditions. Some of New England's initiatives had unique sources of funding, such as matching Medicaid funds, an uncompensated care pool, or a large tobacco settlement, to help provide initial seed money. Going forward, states plan to rely on a variety of sources, including enrollee premium contributions, employer assessments, higher "sin" taxes, and general fund revenues. But with rising health care costs and changing demographics, states may face significant future funding shortfalls for these programs, even if fiscal conditions improve. Moreover, federal policy changes that affect the financing and administration of both Medicaid and SCHIP may impose additional cost concerns for states.

Nonetheless, the insurance expansion efforts in New England are serving as a national laboratory. Understanding the factors that contributed to their passage and monitoring their implementation will hopefully encourage more fruitful discussions in other states and at the national level about ways to reduce the number of uninsured.

Reaching the Goal: Expanding Health Insurance Coverage in New England

Current Strategies and New Initiatives

Introduction: Reaching the goal

As the number and percentage of people without insurance continues to climb, the goal of expanding health insurance grows more pressing. According to the Census Bureau, the number of people in New England without health insurance increased from 1.2 million in 2000 to 1.5 million in 2005. Most of this increase has been among the working-age population (individuals age 19 to 64 years), driven primarily by declining employer-sponsored health insurance over this period.

How to best structure health coverage for the uninsured has been a topic of considerable debate. Over the past decade or so, the New England states have pursued a number of traditional strategies, often in combination, to achieve incremental reductions in the rate of uninsured, with varying degrees of success. In the past, the debate about expanding coverage at the state level has generally centered on ways to reach more of the low-income, uninsured population, typically through expansions of either Medicaid or the State Children's Health Insurance Program (SCHIP).

More recently, states have also focused on policies aimed at other groups. For example, reinsurance programs and high-risk pools attempt to expand coverage among those with pre-existing or costly health problems. Other policies, such as limited benefit plans, group purchasing arrangements and employer mandates are primarily geared towards providing health insurance for individuals and small group purchasers—typically firms with 50 or fewer employees. Evaluations of these previous efforts offer insight into how to expand coverage and hopefully improve the health status of the uninsured population.

Over the past several years, four New England states—Maine, Massachusetts, Rhode Island, and Vermont—have passed or implemented new insurance programs with the goal of achieving near-universal coverage, putting the region at the forefront of the push to reduce the rate of uninsured. These new initiatives are aimed primarily at expanding coverage in the individual and small group markets. With the exception of DirigoChoice in Maine, most of these programs are still in the design stages or have only been partially implemented, so there is limited evidence to date on their effectiveness. Nevertheless, much can be learned from comparing and contrasting the design of these new programs as states attempt to reduce the rate of uninsured while simultaneously minimizing costs and maintaining quality of care.

This report explores policy alternatives for expanding health insurance coverage in New England, including existing strategies that have taken a more incremental approach, as well as bold initiatives that attempt to achieve near universal coverage. Specifically, this report focuses on addressing the following questions:

- **How far do we have to go?** How big is the gap in health insurance coverage in New England versus the rest of the nation? What populations are particularly affected?
- **What strategies have been tried in the past?** What can we learn from evaluations of existing strategies that have taken a more incremental approach to covering the uninsured?
- **What new initiatives are underway?** What innovative strategies are the New England states currently pursuing as part of their health care reform efforts?

The final section describes some of the pitfalls states face in expanding coverage and the challenges these new insurance programs are likely to face in the future.

How far do we have to go?

Though the percentage of people without health insurance coverage in New England is lower than that of the nation, it has been increasing since 2000, following national trends. Figure 1 shows that, as of 2005, the percentage of people without coverage in New England ranged from 9.2 percent in Massachusetts to 11.6 percent in Rhode Island, compared to 15.3 percent for the United States as a whole. Further breakdowns by age reveal that coverage gaps vary considerably across demographic groups. For example, the percentage of people aged 65 and older without health insurance is very low (typically 1 percent or less), with most of these individuals enrolled in the Medicare program.[1]

Moreover, the rate of uninsurance among children in New England is low, having fallen in recent years. With the introduction of SCHIP in 1998, the percentage of children without coverage fell sharply and has remained low in most New England states (see Figure 2). While 297,000 children lacked coverage in 1998, by 2005 that number had fallen by one-third to about 190,000, leaving the percentage of children who were uninsured in the region considerably below that of the nation (10.9 percent) in 2005.

In contrast, the percentage of people lacking health insurance coverage among the working-age population has been growing rapidly. Between 2000 and 2005, the number of individuals aged 19 to 64 years without health insurance increased by 193,000 in New England. As of 2005, the percentage of working-age individuals who were uninsured ranged from 12.7 percent in Massachusetts to 15.4 percent in Vermont, compared to 19.7 percent for the nation (see Figure 3).

As is the case nationally, the recent rise in the number of uninsured working-age individuals is driven primarily by declining employer-sponsored health insurance.[2] Figure 4 shows that the number and percentage of individuals covered by employers have been declining steadily relative to those covered by government health programs. The percentage of people covered by employment-based health insurance in New England in 2005 ranged from 62.8 percent in Maine to 76.5 percent in New Hampshire, compared to 63.5 percent nationally.

Research shows that the main reason that uninsured workers lack coverage is that their employers do not sponsor health benefits.[3] Since 2000, the percent of private sector establishments offering health insurance to their employees decreased in every New England state except Connecticut. Figure 5 shows that as of 2004, coverage in the private sector ranged from 49.7 percent of establishments in Maine to 68.8 percent in Connecticut, compared to 55.1 percent in the nation.

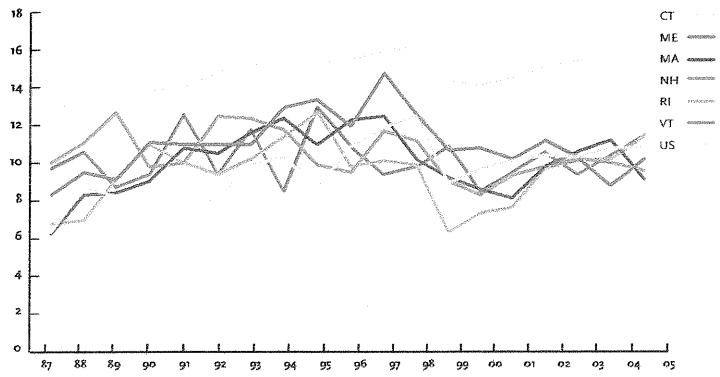
Across the nation, the erosion of employment-based insurance has been greatest among low-income workers. The share of employees with incomes less than the federal poverty level (FPL) who were covered through their own or their spouse's employer dropped from 37 percent in 2001 to 30 percent in 2005. The coverage rate among the near-poor, who earn between 100 percent and 200 percent FPL, dropped from 59 percent to 52 percent. In 2005, more than half of workers in poor families and more than one-third of those in near-poor families had no family member who was eligible for job-based coverage.[4]

Moreover, even uninsured workers who do have access to employer-sponsored coverage find that their share of the premium is often unaffordable. One study found that among uninsured workers who were eligible for but declined to enroll in their employer health plan in 2001, the most frequently cited reason (52 percent) was that it was too expensive.[5] And while the average share that employees are required to pay for family coverage held at around 27 percent between 2001 and 2005, increasing annual premiums meant that families saw their yearly contributions toward health insurance increase by nearly $1,000 over this period.[6]

Yet the lack of health insurance is not just a problem for the poor.[7] A growing percentage of young adults, middle-income households, and skilled workers are also finding they are uninsured. Nationally, the percentage of individuals between 25 and 34 who are not covered by health insurance increased from 21 percent in 2000 to 26 percent in 2005. And roughly one-third of the uninsured in 2005 came from families with annual incomes above the median household

Figure 1. The rate of uninsured in New England is lower than the United States but has been increasing since 2000.

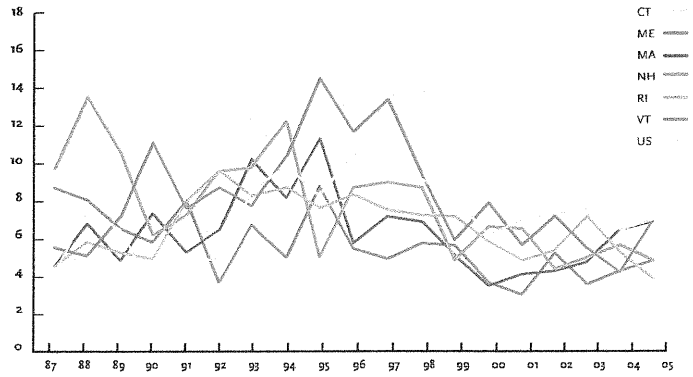
Percentage of people without health insurance coverage



Source: U.S. Census Bureau, Current Population Survey, Historical Health Insurance Tables

Figure 2. Although we have done a better job of covering children in recent years...

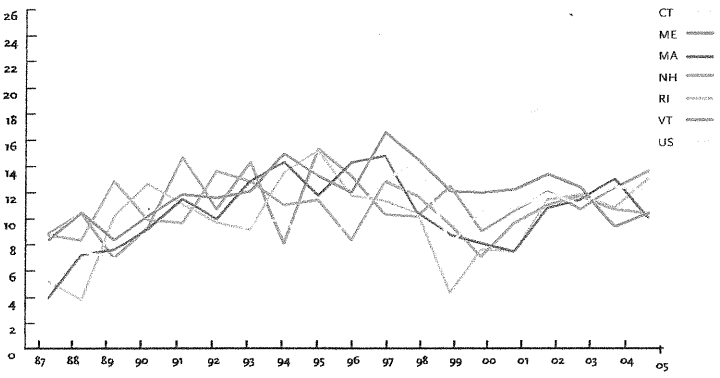
Percentage of children under age 18 without health insurance coverage



Source: U.S. Census Bureau, Current Population Survey, Historical Health Insurance Tables

Figure 3. ...we have not done such a good job covering the working-age population...

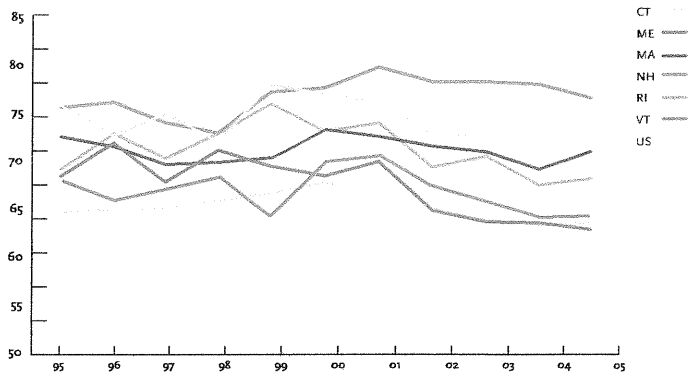
Percentage of people age 19-65 without health insurance coverage



Source: U.S. Census Bureau, Current Population Survey, Historical Health Insurance Tables

Figure 4. ...primarily due to a decrease in employer-sponsored insurance since 2000...

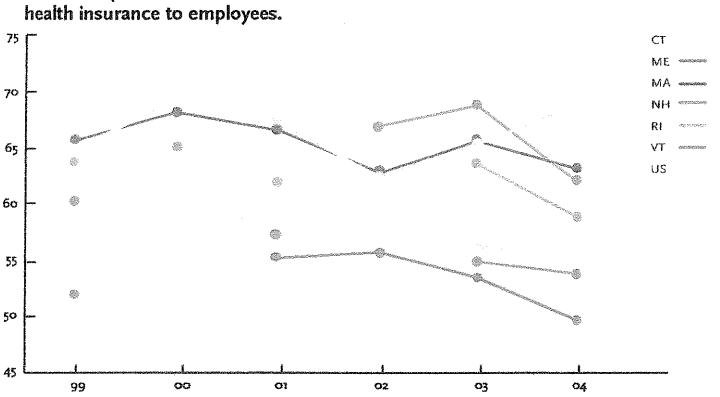
Percentage of people under 65 years with employer-sponsored coverage.



Source: U.S. Census Bureau, Current Population Survey, Historical Health Insurance Tables

Figure 5. ...with fewer employers offering health insurance to their employees in most New England states.

Percent of private sector establishments that offer health insurance to employees.



Source: Agency for Healthcare Research and Quality, Center for Cost and Financing Studies
Medical Expenditure Panel Survey - Insurance Component

income.[8] Moreover, at least 20 million workers—ranging from low-skill temp workers to highly skilled professionals in engineering, accounting, and consulting—are either self-employed or non-permanent (contract) employees who are ineligible for health benefits through their employer. If they lack coverage through another family member, their only option is to turn to costly individual or small group health insurance markets.

What can we learn from existing strategies?

As the number and percentage of people without insurance continues to climb, the need to expand health insurance grows more pressing. Yet how to best structure health coverage for the uninsured has been a topic of considerable debate.

In the past, the debate about expanding coverage at the state level has generally focused on ways to reach more of the low-income uninsured population, typically through expansions of either Medicaid or SCHIP. More recently, states have also focused on policies aimed at other groups. For example, reinsurance programs and high-risk pools are targeted at expanding coverage among those with pre-existing or costly health problems. Other policies, such as limited benefit plans, group purchasing arrangements and employer mandates are primarily geared towards expanding coverage of individual and small group purchasers.[9]

Over the past decade or so, the New England states have pursued a number of these strategies, often in combination, to achieve incremental reductions in the rate of uninsured (see Table 1). Evaluations of these previous efforts offer insight into how to expand coverage and hopefully improve the health status of the uninsured population. Drawing on studies of public health programs and evidence from health services research, this section of the report provides an analytic framework for the current policy debate regarding how to expand coverage. Taking into account the large body of evidence to date, this framework can be used to highlight the merits and shortcomings of alternative strategies and to shed some light on the potential impact of the new initiatives currently being pursued by some New England states.

Policies targeting low-income populations

States typically rely on two public programs to provide coverage for low-income families and children: Medicaid and SCHIP.

Medicaid. Medicaid is a jointly funded federal-state program that provides health insurance coverage for low-income families and children, people with disabilities, and the elderly. It is the nation's largest health insurance program, providing coverage for more than 50 million people at an annual cost of more than $300 billion.

Medicaid is often an integral part of state strategies to provide coverage for low-income populations, especially given the opportunity to obtain federal matching funds. Administration of Medicaid programs is left to the states, subject to federal guidelines. For example, each state establishes specific eligibility rules under Medicaid, but must also meet mandatory minimum federal requirements.

SCHIP. SCHIP allows states to provide insurance coverage to uninsured children in low-income families who are not otherwise eligible for Medicaid. Enacted in 1997, the program now covers more than four million children. Like Medicaid, states administer the SCHIP program and receive federal matching funds, though the federal government provides a higher matching rate for SCHIP than for Medicaid.

States also have greater flexibility under SCHIP than under Medicaid to define benefits and set cost-sharing requirements. States can use SCHIP funds to expand Medicaid eligibility for children or to establish stand-alone SCHIP programs. As of 2005, 14 states (including Washington D.C.) have opted to use federal SCHIP matching funds to finance Medicaid eligibility expansions for children; 19 states have created separate SCHIP programs; and 18 states have combination Medicaid and SCHIP programs.

Medicaid and SCHIP Waivers. In addition to covering optional groups under Medicaid and SCHIP, states can apply for waivers to bypass federal requirements for these pro-

Table 1. States have traditionally pursued a combination of strategies aimed at incremental reductions in the rate of uninsured.

State	Medicaid and SCHIP waivers	Reinsurance programs	High-risk pools	Limited benefit plans	Group purchasing arrangements	Employer mandates (EM) or fees (F)
Alabama			X			
Alaska			X			
Arizona	X	X				
Arkansas	X		X	X	X	
California	X		X		X	
Colorado	X		X	X		
Connecticut		X	X			
Delaware	X					
District of Columbia	X					
Florida	X		X	X		
Georgia				X		
Hawaii	X					EM
Idaho	X	X	X			
Illinois	X		X			
Indiana			X			
Iowa	X		X			
Kansas			X		X	
Kentucky	X		X	X		
Louisiana			X			
Maine	X					
Maryland	X		X	X		EM (struck down)
Massachusetts	X	X				F
Michigan	X					
Minnesota	X		X	X		
Mississippi	X		X			
Missouri	X		X			
Montana	X		X	X	X	
Nebraska			X			
Nevada						
New Hampshire		X	X			
New Jersey	X			X		
New Mexico	X	X	X		X	
New York	X	X			X	
North Carolina						
North Dakota			X	X		
Ohio					X	
Oklahoma	X		X			
Oregon	X		X			
Pennsylvania						
Rhode Island	X	Passed, not funded				
South Carolina			X			
South Dakota			X			
Tennessee	X					
Texas			X	X	X	
Utah	X		X	X		
Vermont	X					F
Virginia						
Washington			X	X		
West Virginia			X		X	
Wisconsin	X		X		X	
Wyoming			X			

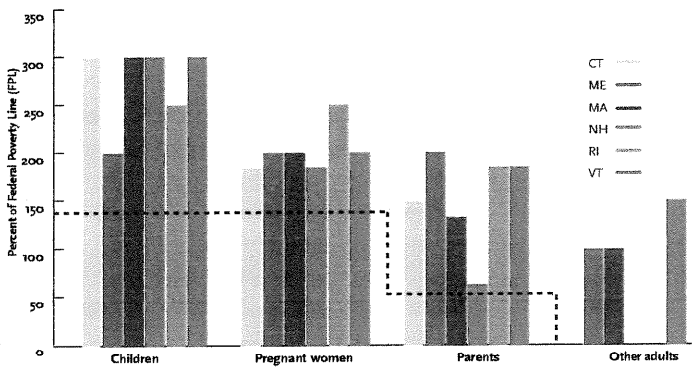
Sources: Academy Health, State coverage matrix, 2005. Available at http://www.statecoverage.net/matrix. Accessed 10/30/06; Last updated November 2005.
Supplemented with information from various state sources through November 2006.
National Conference of State Legislatures, Health Insurance: 2006 Pay or Play Bills. http://www.ncsl.org/programs/health/payorplay2006.htm

grams. Section 1115 of the Social Security Act grants the Secretary of the U.S. Department of Health and Human Services broad authority to waive certain federal requirements for the purpose of conducting pilot, experimental, or demonstration projects that are likely to promote the objectives of the program. For example, states have often used waivers to expand eligibility to new groups of people as well as to change other federal requirements related to the delivery system or benefit package design.[10] In recent years, states have been able to use waivers to offset coverage expansions in new ways by redirecting federal funds, scaling back benefits, charging higher cost sharing, or capping enrollment for newly eligible groups. In addition, states have been granted greater flexibility to provide premium assistance by using Medicaid or SCHIP funds to subsidize health coverage purchased through employers or in the individual market.[11]

By setting more lenient eligibility rules and applying for federal waivers, the New England states have succeeded in providing relatively generous coverage for children, pregnant women, parents, and other eligible adults through their Medicaid and SCHIP programs. In all six New England states, income eligibility thresholds for the first three groups exceed federal minimum cut-offs as well as those found in many other states (see Figure 6). Under certain conditions, some New England states even provide coverage for childless adults.

The evidence to date. Studies show that state efforts to provide health insurance to low-income families and children through expansions of the Medicaid and SCHIP programs have been modestly successful at expanding coverage at minimal cost. Micro-simulations of different coverage options show that expanding public coverage reaches a larger majority of the uninsured and, as a result, yields more bang for the buck than other governmental strategies, such as tax credits or limited expansions to specific groups.[12] Another micro-simulation comparing coverage options shows that almost all of the public spending associated with an expansion of public insurance to adults goes to people below the poverty level, whereas only about one-third of the investment in tax credits goes to the poor.[13]

Figure 6. New England provides relatively generous coverage for low-income individuals through Medicaid and SCHIP.
Income eligibility (including waivers)



Source: Academy Health, 2005. Supplemented with information from state sources through November 2006.

In addition to more efficiently targeting the low-income population, costs under Medicaid are relatively low compared to private insurance. After adjustments for differences in health status between Medicaid recipients and low-income adults as a whole, Medicaid spending was $1,752 per person per year, compared to $2,253 for private insurance.[14] Lower Medicaid spending reflects, in part, the program's lower administrative costs, which are about half as large as those in private insurance. In 2003, administrative costs accounted for 6.9 percent of total Medicaid spending, compared to 13.6 percent of total private health insurance spending.[15] In addition, growth in Medicaid spending for acute care has been slower than that for private insurance. Between 2000 and 2004, acute-care spending per enrollee rose by 6.4 percent in Medicaid, while health spending per person increased by 9.5 percent among those who were privately insured and premiums for employer-sponsored insurance grew by 12.2 percent.[16]

Yet some of the cost-savings under Medicaid are also due to lower payments made to physicians and other health care providers. Lower payments for medical services can reduce the number of providers who participate in the Medicaid program and ultimately limit access to care for Medicaid beneficiaries. Research comparing access through Medicaid versus private insurance has produced mixed findings. In terms of primary care services, Medicaid performs at least as well as private

coverage on several key measures, particularly for children.[17] Yet access to specialty and dental care has been shown to be inadequate, due to low provider participation and limited program benefits. Other barriers, such as limited office hours, long office waits, and long travel times to appointments, also reduce access under Medicaid.[18]

Finally, although Medicaid is more efficiently targeted than other public programs, there is some evidence that the program may "crowd out" private insurance for families above the poverty line. In 2002, about 20 percent of parents and 10 percent of childless adults who earned between 100 and 200 percent of the federal poverty line (FPL) and were publicly insured, also had access to job-based coverage.[19] Other estimates suggest that when public insurance expands, between 17 percent and 50 percent of individuals who enroll also have access to job-based insurance.[20] This suggests that Medicaid's cost-effectiveness as a tool to increase coverage for those without access to job-based insurance may be limited to the very low-income population.

Policies targeting high-risk or high-cost populations

Concerned about the growing number of uninsured, many states have established mechanisms to provide insurance for and spread the risk of people who are considered "medically uninsurable." The hope is that directly addressing the insurance needs of these individuals will stabilize the individual and small group markets, thereby lowering premiums across the board. States typically rely on two common approaches to address the coverage needs of high-risk or high-cost populations: high-risk pools and reinsurance programs.

High-risk pools. States typically create high-risk pools through a state nonprofit association to offer health insurance to individuals with pre-existing health problems who are otherwise considered "medically uninsurable." These individuals have often been denied coverage in the private market due to a chronic illness or condition (e.g., cancer or diabetes) or may have access only to restricted coverage.[21]

High-risk pools provide insurance to individuals at a reduced rate compared to what they would find in the open market. Typically, states offer commercial plans to high-risk pool enrollees and subsidize premium payments to reduce the cost to participants. Yet, because individuals who enroll in high-risk pools usually have higher-than-average health care costs, they face premiums that are still higher than those paid by people in most other insurance arrangements.[22] States generally cap the premiums charged to enrollees relative to the average rates charged in the individual insurance market. For example, typical caps range from 125 to 200 percent of the average standard rate for comparable, individually purchased insurance.[23]

More than half of all states have a risk pool, including Connecticut (since 1976) and New Hampshire (since 2002). Rhode Island is currently pursuing federal funding for seed money to set up a high-risk pool. Characteristics of high-risk pools vary considerably by state in terms of the eligible population, annual/lifetime limits, plan design, and the degree of cost sharing (see Table 2).[24] High-risk pools generally operate at a loss due to the expense of the population covered, with claims typically exceeding premiums paid. As a result, funding is generally drawn from a variety of sources including assessments on insurers, service charges or taxes on hospitals, or state general fund revenues. Some federal funding is available in the form of grants, primarily as seed money for states to set up the administrative infrastructure of the pool or to offset losses if the pool meets certain conditions.

Reinsurance programs. States are increasingly considering reinsurance programs as a strategy to stabilize health insurance markets and to maintain or increase health insurance coverage. The idea is that government-based reinsurance can provide insurers some relief from the risk of adverse selection by assuming responsibility for people who have extraordinarily high medical costs in the coming year. Since insurers would no longer bear the entire risk and financial burden of enrolling those with very costly medical needs, they would charge lower insurance premiums across the board. Lower premiums would help stabilize the market and bring in more young and uninsured individuals, thereby reducing the risk level of the entire pool.[25]

Table 2. Characteristics of high-risk pools across New England states

State	Connecticut	New Hampshire	Rhode Island
Program	Connecticut Health Reinsurance Association	New Hampshire High-Risk Pool	Rhode Island High Risk Pool
Year established	1976	2002	2006
Eligible population	Medically uninsurable HIPAA eligible Anyone uninsured age 19-64 (no need to prove uninsurability)	Medically uninsurable HIPAA eligibles (verification of eligibility required)	TBD
Number of covered lives (As of 2004)	2,300	350	TBD
Annual/lifetime Limits	No annual limit $1,000,000 lifetime limit	$10,000 annual limit on prescription drugs $2,000,000 lifetime limit	TBD
Premium caps	At initial enrollment: 125% of standard risk rate for comparable coverage Up to 150% maximum	Between 125% and 150% of the standard risk rate for comparable coverage	TBD
Deductibles	$0 for HMO $500-2,500 for PPO $200-500 for indemnity plan	$1,000-7,500 for managed care plan $2,000-3,500 for indemnity plan	TBD
Co-payments	$10 for HMO 20-40% for PPO 25% for indemnity plan	0-40% for managed care plan 20% for indemnity plan	TBD
Out-of-pocket maximums	$2,500 for HMO $2,500-5,000 for PPO $200-2,500 for indemnity plan	$3,500-12,500 for managed care plan $5,500-7,000 for indemnity plan	TBD
Cost sharing	**HMO:** No deductible $10 office copay $500 inpatient copay $2,500 maximum out-of-pocket **PPO:** In-network: $500 deductible, 20% copay $2,500 out-of-pocket maximum Out-of-network: $500 deductible, 40% copay $5,000 out-of-pocket maximum **Low Income Indemnity:** $200 deductible, 25% copay $200 maximum out-of-pocket **Indeminty:** $500 deductible, 25% copay $2,500 maximum out-of-pocket	**Managed Care Plans:** In-network: $1,000-5,000 deductible 0-20% copay $3,500-7,500 maximum out-of-pocket Out-of-network: $2,000-7,500 deductible 20-40% copay $7,000-12,500 maximum out-of-pocket **Indemnity Plans:** $2,000-3,500 deductible 20% copay $5,500-7,000 out-of-pocket maximum	TBD

Sources: Academy Health, State coverage matrix, 2005. Available at http://www.statecoverage.net/matrix. Accessed 10/30/06; Last updated November 2005. Supplemented with information from various state sources through November 2006.
Note: HIPAA stands for the Health Insurance Portability and Accountability Act of 1996 which requires guaranteed issue of group coverage and renewal of individual coverage by insurers.

There are two types of reinsurance programs. The first, aggregate stop-loss reinsurance, covers aggregate losses for a group above some overall level of loss per insured person that exceeds a given threshold. In this case, reinsurance provides protection to insurers for the risk that a large number of enrollees may have above average but not necessarily extraordinary expenses—a situation where the insurer did not set premiums high enough.[26]

The second type, excess-of-loss reinsurance, covers the annual losses per insured person above some threshold, such as the top 5 percent or 1 percent of the overall health care expenditure distribution of the nation. In this case, reinsurance establishes a back-up reservoir of funds to help pay for catastrophic cases. Because insurers no longer need to hold these excess reserves, they can set lower premiums.[27]

In addition, depending on how they are structured, reinsurance programs may also provide an incentive for insurers to manage the medical care of high-cost individuals. For example, in Massachusetts, carriers also pay a 10 percent coinsurance rate for the next $50,000 above the deductible, giving insurers an incentive to manage the care of individuals whose medical expenses begin to go above $5,000. Insurers of small groups generally have up to 60 days from the date of the group's enrollment to cede risk to the reinsurance pool for the entire group or for specific eligible workers (and their dependents) within the group.[28]

Typically funding for reinsurance programs comes from premiums paid by insurers who cede risk to the pool. Carriers may be assessed additional fees for unanticipated program losses. However, since re-insurers have anticipated losses fairly accurately and have set premiums accordingly, such excess charges have been small and rare. Moreover, if a state finances a reinsurance program with state revenues—rather than raising revenues from the insurers themselves—its program is more likely to have the desired effect of encouraging insurers to reduce premiums and enroll more people.[29]

Currently only seven states, including three in New England (Connecticut, Massachusetts, and New Hampshire), have reinsurance programs. Average premiums in the region vary widely; premiums in Massachusetts are roughly twice what they are in Connecticut (see Table 3).[30] Rhode Island approved the establishment of a reinsurance program as part of its recent health reform package, but that program has yet to be funded.

The evidence to date. Policies targeting the high-risk population have had mixed results. On the one hand, high-risk pools do not appear to have been all that successful in increasing coverage. Although such pools offer better coverage than high-risk individuals can find in the private market, such coverage is often still expensive. In addition, benefits under such plans may be limited, cost sharing is relatively high, and the waiting periods for those with pre-existing conditions can be long. As a result, high-risk pools typically have low enrollment and, consequently, expand coverage only to a limited extent.[31]

On the other hand, reinsurance programs that cover the most expensive individuals seem to be a more promising strategy for reducing premiums in the individual and small group markets, thereby expanding coverage. For example, in 2001, the state of New York established Healthy New York (HNY), a state-subsidized excess-of-loss reinsurance mechanism that reimburses health plans for 90 percent of claims paid between $5,000 and $75,000 on behalf of a member in a calendar year. As of December 2006, there were approximately 131,000 active enrollees, of whom 55 percent were working individuals, 17 percent were sole proprietors, and 28 percent were enrolled through small employer groups.[32] The initial premiums offered under HNY in January 2001 were about half of those for individuals in the regular direct-pay individual market and were between 15 percent and 30 percent lower than premiums of comparable policies for small firms. Over the next two years, as enrollment increased, premiums under HNY decreased by another 20 percent.

Policies targeting individuals and small groups

In 2001, more than one in four uninsured workers was employed by a small firm (fewer than 10 employees).[33] To improve the stability and affordability of health insurance costs for individuals and small groups, state policies have focused on allowing limited benefit

Table 3. Characteristics of reinsurance programs across New England states

	Connecticut	Massachusetts		New Hampshire	Rhode Island
Program	Connecticut Small Employer Health Reinsurance Pool	Massachusetts Small Employer Health Reinsurance Plan	Massachusetts Nongroup Health Reinsurance Plan	New Hampshire Reinsurance Pool	The Rhode Island Affordable Health Plan
Year established	1990	1992	2001	2006	Authorized in 2006, contingent on funding
Coverage	Permanent employees who work at least 30 hours per week (and their dependents) in small groups (1-50)	Permanent employees who work at least 30 hours per week and are hired to work 5 months or more in small groups (1-50)	Individuals	Small groups (1-50)	Qualified low-wage individuals and small businesses
Participation by carriers	Voluntary	Voluntary	Required for all non-group insurers	Required	Required for all carriers that participate in the RIte Care and state employee program
Deductible	$5,000 per covered life	$5,000 per covered life	$10,000 per covered life	$5,000 per covered life	TBD
Co-insurance	NA	10% for the next $50,000 above the deductible	10% for the next $40,000 above the deductible	NA	TBD
Number of covered lives (as of October 2004)	3,116	13	3	—	—
Average premium per member (as of October 2004)	$4,500 per year	$800-$1,000 per person per month	Ranged from $4,000 to $6,500 per adult member per month and $4,500 to $7,800 per child member per month, depending on the primary plan type and whether it offered drug coverage.	—	TBD

Sources: Academy Health, State coverage matrix, 2005. Available at http://www.statecoverage.net/matrix. Accessed 10/30/06; Last updated November 2005. Supplemented with information from various state sources through November 2006. Deborah Chollet. "The Role of Reinsurance in State Efforts to Expand Coverage." State Coverage Initiatives Issue Brief. October 2004.

plans, establishing group purchasing plans, and imposing employer mandates or fees. However, these strategies have had limited success to date.

Limited benefit plans. States may allow insurers to offer limited benefit or "bare bones" plans that exclude certain benefits or services that the state has mandated to be carried by private insurers (e.g. fertility, chiropractic, or mental health services). These state mandates primarily affect small employers who, unlike their larger counterparts, are unable to self-insure and thereby escape state-level regulation. States hope that by allowing insurers to offer limited benefit plans, small employers will have more affordable health insurance options and will be more likely to offer coverage to their employees. In addition, because limited benefit plans typically have lower premiums, a greater share of individual purchasers may also take up coverage.

But prior experience suggests that removing state mandates from the benefits package alone does not generate sufficient cost savings for employers to begin to offer coverage or for uninsured individuals to afford the coverage offered to them.[34] In general, limited benefit plans cut costs only marginally, reducing premiums by only 5 percent to 9 percent on average. Yet even these minimal cost savings may be offset, since individuals holding bare-bones policies often access uncompensated care services through the safety net that are not covered under their policies.

The efficacy of limited benefit plans in reducing the number of uninsured is also a matter of debate. Much of the discussion hinges on the impact of such plans on the insurance market. Specifically, critics speculate whether limited benefit plans create a new coverage alternative for uninsured individuals or simply crowd out those who previously had more comprehensive health insurance.[35]

Moreover, limited benefit packages may leave some enrollees with significant unmet needs. For example, some low income uninsured populations tend to be in worse health or have greater health needs due to physical disability or a chronic condition (such as hypertension, asthma, diabetes, mental illness).[36] A recent survey found that nearly half (45 percent) of uninsured adults report having at least one chronic condition.[37]

Indeed, states that have limited benefits or imposed caps on prescription drugs under Medicaid have found that enrollees report reduced access to care and significant unmet needs. For example, when Utah reduced Medicaid benefits for current adult enrollees to finance an expansion of primary care services to other adults, the majority of both groups reported using or needing services that were not covered.[38] Among existing enrollees with reduced benefits, nearly one quarter missed or postponed care and more than a third reported difficulty in paying medical expenses. Among new enrollees, even higher proportions experienced access problems (one-third) and financial hardship (more than half). Studies of Medicaid prescription drug caps have shown that the use of clinically essential medications declines markedly, particularly for people with mental health problems or chronic pain, while the use of emergency services and admissions to nursing homes rise sharply.[39]

To date, only 13 states, none in New England, allow limited benefit plans. And these insurance products have not sold well in those states. Many insurers are reluctant to sell bare-bones policies, and consumers do not seem interested in buying them. However, these new efforts may become more successful as individuals become more familiar with limited benefit products and the continued increase in health care costs makes such products more attractive.

Group purchasing arrangements. States may develop or encourage group purchasing arrangements (GPAs) that allow small employers and/or individuals to pool together to purchase health insurance collectively. GPAs may be established by states (through legislation or regulation) or by associations of employers and/or individuals. The hope is that by bringing these smaller groups together, they can achieve the buying power of large groups and negotiate lower premiums. In addition, GPAs also create economies of scale that reduce the administrative costs associated with offering insurance and allow employees of small firms greater choice of plans and premiums.

GPAs typically take the form of employer alliances or health insurance purchasing coalitions, association health plans, or multiple employer welfare arrangements. These types differ from one another in their structure and operation, with some providing a better opportunity than others for coverage expansion. For example, whereas any employer may enroll in a health insurance purchasing coalition (with some restriction on size, typically 2 to 50 employees), association health plans generally restrict membership to a particular industry or trade.[40]

While existing GPAs have expanded consumer choice, there is little evidence that they significantly reduce premiums or expand coverage. Prices are comparable inside and outside the purchasing groups. A study of the three largest statewide small group insurance purchasing alliances (California, Connecticut, and Florida) showed that, while these voluntary pools led to greater choice of plans offered to employees, they did not appear to attract additional small firms to offer insurance or reduce health insurance premiums in the broader small group market.[41]

One reason for the lack of success of GPAs is their small size. Without attracting a critical mass of employers to the pool and maintaining their participation, major health plans have little incentive to participate in a GPA. Building market share has been a challenge for all but a few GPAs, and particularly for state-sponsored arrangements. Even in California and Florida, where enrollments are the highest, health insurance purchasing coalitions account for less than 5 percent of small group enrollment. Greater market share, on the order of 15 to 20 percent, would allow GPAs to attract large health plans and realize some cost savings.[42]

Moreover, because GPAs have trouble maintaining a large and stable population, insurers find it difficult to accurately price the risk associated with insuring the pool each year. This leads to greater variability in year-to-year premiums, giving health plans an incentive to hedge their bets with higher rates. In addition, because GPAs seek to offer more choices to employees, insurers get only a fraction of the pool's entire book of business in a given year. Health plans are concerned that in a given year they might end up insuring only the worst risks within a group of employees.[43]

Currently only 10 states, none of them in New England, have a GPA. Still, purchasing arrangements continue to interest both state and federal policymakers seeking to harness the buying power of large groups to expand health insurance coverage. But if GPAs are to succeed, it seems essential to improve their market shares and address the adverse selection concerns of insurers. Possible policy strategies to promote the growth of GPAs include requiring all health plans to participate, requiring all small employers to purchase coverage through a GPA, or temporarily subsidizing the purchase of insurance through a GPA.[44]

Employer mandates/fees. States may also increase coverage among individuals and small groups by compelling employers to offer coverage to their employees through the use of mandates or the imposition of fees—also known as "pay or play" bills. State mandates generally require employers to provide coverage or spend a certain percentage of their payroll costs on health benefits. In contrast, states may instead impose a fee (typically per full-time employee) on employers that do not provide coverage.

Employer mandates no longer appear to be a viable option for states. In 2005, Maryland passed the Fair Share Health Care Act, requiring private sector firms with 10,000 or more employees to spend at least 8 percent of their payroll on health care.[45] Dubbed the "Wal-Mart" law since Wal-Mart was the only firm in the state bound by the requirement, the law was struck down by a federal district judge, who ruled that the statute was preempted by the federal Employee Retirement Income Security Act (ERISA). The preemption clause states that ERISA "shall supersede any and all State laws insofar as they relate to any employee benefit plan." Because these benefits include health care, the court ruled that states cannot mandate that employers pay for health insurance, directly tax benefit plans, or require reports on cost or use of the plans from employers.[46] It is thus unlikely that similar statutes would withstand an ERISA challenge, though Hawaii's employer mandate, which predates ERISA, remains in effect.

Table 4. Characteristics of proposed employer fees and mandates across New England states

	Connecticut	Massachusetts	New Hampshire	Rhode Island	Vermont
Bill	SB 462	HB 4850	HB 1704	HB 6917	HB 861
Coverage	Retailers with 5,000 or more employees	Employers with 11 or more full-time equivalent employees that do not make a "fair and reasonable" premium contribution towards the cost of their employees' health insurance	Employers with 1,500 or more employees that do not offer health insurance	Employers with 1,000 or more employees that do not offer health insurance	Employers with 8 or more full-time equivalent employees who do not offer health insurance
Mandate/Fee	$2.50 per hour (not to exceed 40 hours per week) per employee	$295 per full-time equivalent employee per year	Spend 10% of total payroll on health care or pay the state the difference (8.5% for non-profits)	Spend 8% of total payroll on health care or pay the state the difference or pay a fine of $250,000	$365 per year per full-time equivalent employee above the minimum threshold of 8 full-time equivalent employees
Status	Did not pass out of committee during regular session	Passed on April 12, 2006	Died in committee	Did not pass out of committee during regular session	Signed into law May 2006

Source: National Conference of State Legislatures, Health Insurance: 2006 Pay or Play Bills. http://www.ncsl.org/programs/health/payorplay2006.htm. Supplemented with information from various state sources through November 2006.

However, employer fees are likely to withstand an ERISA challenge as long as the state is neutral on whether employers provide coverage or pay the fee. Yet policymakers must take into consideration a variety of factors when setting the employer fee. On the one hand, the fee must be high enough to minimize the possibility of employers choosing to drop coverage and pay the fee instead. On the other hand, the fee must be low enough so as to avoid imposing a disproportionate burden on small employers.

Employer mandates and fees are increasingly being considered as a strategy in New England. Of the 28 states that had introduced bills with employer mandates as of 2006, five were from New England (see Table 4). Yet only two of these five, Massachusetts and Vermont, were successful in passing laws that legislated employer fees.[47] And in Massachusetts, the measure was signed into law only after the legislature overturned the Governor's veto.

What have we learned?

Existing strategies to expand coverage have met with varying degrees of success. Policies targeting the low-income population, such as expansions of Medicaid and SCHIP, have been modestly successful at reducing the rate of uninsured at a fairly low cost. However, because this strategy achieves cost-effectiveness in part through low reimbursement rates to providers, low-income individuals on public insurance may experience less access to specialty care than those with private insurance. Above the poverty line, there may also be some crowding out of private insurance.

Efforts to address issues associated with high-risk populations have had mixed results. On the one hand, high-risk pools offer coverage that is expensive with limited benefits, often resulting in low enrollment and, therefore, operating losses and the need for public subsidization. On the other hand, reinsurance programs appear to lower premiums and stabilize the market, potentially attracting younger and healthier individuals and reducing the risk level of the entire pool.

Finally, policies aiming to expand coverage in the individual and small group markets have had limited success to date. Although limited benefit plans generate a small reduction in premiums, they are not very popular with consumers, and those who do buy them may still resort to using uncompensated care via the safety net. The main impact of group purchasing arrangements has been to expand plan choice among those already receiving job-based insurance. However, there is little evidence that they reduce the number of uninsured. As for employer fees, it is unclear whether they will actually encourage more employers to offer health insurance to their workers, or will, at best, help to offset the costs of uncompensated care and/or new governmental expansions of coverage.

The next section will use what we have learned from the evidence to date about the efficacy of these existing strategies to shed some light on the potential impact of the new initiatives currently being pursued by four of the New England states.

What new initiatives are currently underway in New England?

Over the past several years, New England has led the nation in developing policies aimed at reducing the rate of uninsured. Maine, Massachusetts, Rhode Island and Vermont have implemented or passed programs with the goal of achieving near universal coverage. This section describes the progress to date in designing and implementing these new programs. In each case, additional details on program implementation, eligibility, benefits, cost sharing, and individual subsidies are available in the appendix.

These new initiatives in New England are primarily aimed at expanding coverage in the individual and small group markets. Unlike limited benefit plans, which have had little success to date, these new programs offer comprehensive coverage, including prescription drugs, to qualified enrollees. In order to make coverage affordable, cost sharing is limited, with low or no deductibles, small copays, and some coinsurance. Three states (Maine, Massachusetts, and Vermont) subsidize premiums for those earning less than 300 percent of the federal poverty level.[48] In an effort to boost participation, two of these states (Massachusetts and Vermont) have chosen to levy fees on employers that do not offer health insurance coverage.

Table 5. Overview of new initiatives to expand health insurance coverage in New England

State	Program	Date implemented	Goal	Eligibility	Current (expected) enrollment
Maine	DirigoChoice	2005	Universal access for all 130,000 uninsured by 2009, starting with 31,000 by the end of 2005	Small businesses (2-50 employees), sole proprietors, and eligible individuals who do not have access to employer-sponsored insurance	13,800 as of April 2007
Massachusetts	Commonwealth Care	October 2006	Universal coverage	Uninsured individuals who earn less than 300% FPL and are ineligible for MassHealth, the state's Medicaid Program	79,000 as of June 2007
	Commonwealth Choice	July 2007	Universal coverage	Small businesses and residents of Massachusetts (or employed by a Massachusetts-based employer), age 19 or older, and not eligible for Commonwealth Care because of family income above 300% FPL	(215,000)
Rhode Island	Wellness Health Benefit Plan	October 2007	Increase enrollment among small-business employees by 15%, or 10,000 individuals	Employers with 50 or fewer employees as well as individuals who do not get insurance through an employer	(27,000)
Vermont	Catamount Health	October 2007	96% insured by 2010	Vermont residents 18 years or older who do not qualify for Medicaid and its extended programs, do not have access to employer-sponsored coverage, and have been uninsured for at least 12 months	(25,000)
	Employer Sponsored Insurance Program		96% insured by 2010	Individuals qualify if they: (1) Earn less than 150% FPL, are eligible for the current Vermont Health Access Plan (VHAP), and have access to an ESI plan. (2) Earn between 150% and 300% FPL, have access to an ESI plan, and have been uninsured for at least 12 months	(1,316)

Sources: See the Appendix.

Cost sharing	Monthly premiums	Individual subsidies	Program funding
•PPO plan with deductible of either $1,250 or $1,750 •Preventive care covered 100% •Office copays: $15 primary care $20 specialist •Rx copays: $10 generic/$20 preferred $40 non-preferred	As of 2006 Q4, the unadjusted community rate for individual coverage (with a $1,250 deductible) was $365	Sliding scale from a 100% subsidy for those earning up to 100% FPL to a 20% discount for those earning 300% FPL	General revenues, federal Medicaid matching funds, employer and employee contributions, Savings Offset Payment
•Managed care plan, $0 deductible •Radiology, x-rays, lab work covered 100% •Office copays: $0-$10 primary care/ $0-$20 specialist •Rx copays: $1-$10 generic/ $3-$20 preferred/ $3-$40 non-preferred	As of 2007, unadjusted community rate for individual coverage in central Massachusetts ranged from $295 to $388	Sliding scale from a 100% subsidy for those earning to 150% FPL to a 50% discount for those earning 300% FPL	Redistribution of federal Medicaid payments, Free Care Pool funds, employer contributions, and general fund revenues
•PPO plan, deductibles $0 - $2,000 •Radiology, x-rays, lab work covered 100% •Office copays: $0-$35 primary care/$10-$50 specialist •Rx copays: $10-$20 generic/ $25-$30 preferred / $45-$50 non-preferred	The typically uninsured 37-year-old in eastern Massachusetts, the state'smost expensive region can expect to pay monthly average premiums ranging from $175 to $288 per month	No subsidy	Redistribution of federal Medicaid payments, Free Care Pool funds, employer contributions, and general fund revenues
•HMO plan, deductibles $500 - $3,000- •Office copays: $15-$60 primary care/ $30-$80 specialist •Rx copays: $5 generic/ $40 preferred/ $75 non-preferred	Target: Average annualized individual rate to be less than 10% of average annual statewide wages. (Monthly individual individual premium target =$314)	No subsidy, participants may qualify for lower out-of-pocket costs	The Trust for Rhode Island Health Insurance, a $100 million fund from securitized tobacco payments, supplemented by an additional $5-10 million charged annually on surplus health plan administration costs and profits
•PPO plan, deductible $250 - $500 •Preventive care and chronic care covered 100% •Office copays: $10 primary care/ $10 specialist •Rx copays: $10 generic/ $30 preferred/ $50 non-preferred	Estimated at $362 per month	Sliding scale from a 80% subsidy for those earnings up to 200% FPL to a 60% discount for those earning 300% FPL	Individual premiums, employer assessments, increases in tobacco taxes, and matching federal dollars (if the federal government includes Catamount Health in the state's Section 1115 Medicaid waiver)
•Employer plan must have cost sharing equivalent to either VHAP or Catamount.	Estimated at $365 per month	Sliding scale up to 300% FPL where individual contributions set equal to VHAP or Catamount contributions	Individual premiums, employer assessments, increases in tobacco taxes, and matching federal dollars (if the federal government includes Catamount Health in the state's Section 1115 Medical waiver)

Massachusetts has gone so far as to mandate that individuals purchase coverage—either from the state, through their employer, or in the private market.

With the exception of Maine, most of these programs are still being designed or have only been partially implemented, so evidence about their effectiveness is limited (see Table 5). Nevertheless, by comparing and contrasting the design of these new programs, much can be learned, as other states attempt to reduce the rate of uninsured while simultaneously minimizing costs and avoiding unintended consequences for access and quality of care.

Maine: The DirigoChoice program

Maine was the first New England state to launch a new program when the Legislature overwhelmingly approved Dirigo Health, Governor Baldacci's health care reform package, in June 2003. To help achieve the program's goal to ensure universal access to quality and affordable health care for all Maine residents within five years, the state created a new insurance program, Dirigo Choice, as one component of the state's health reform strategy. Other components include:[49]

- Expanding income eligibility thresholds for parents of SCHIP children
- Strengthening the certificate of need (CON) process
- Imposing a one-year moratorium on capital expenditures
- Creating a capital investment fund
- Allowing for transparency in prices for common procedures
- Seeking voluntary caps on costs and operating margins by hospitals, insurers, and other providers
- Establishing the Maine Quality Forum to act as an informational resource for health care providers and consumers
- Improving Maine's data and information technology systems to measure quality
- Developing incentives and support for electronic health records
- Establishing new reporting requirements and minimum loss ratios for insurers in the small group market

DirigoChoice, currently a partnership between the state and Anthem Blue Cross Blue Shield of Maine, offers comprehensive coverage to small businesses, sole proprietors, and eligible individuals who do not have access to employer-sponsored insurance.[50] Benefits are comprehensive with no pre-existing exclusions or lifetime maximums. Enrollees are also eligible for disease management and other special Anthem programs. For example, under the Healthy Maine incentive program, cash incentives are provided to members and employers who select a primary care physician and who complete a health risk assessment.

Cost sharing under DirigoChoice is limited. Members are enrolled in a PPO plan under one of two options, which have annual deductibles of $1,250 and $1,750, respectively.[51] Visits for preventive services, such as routine check-ups, physicals, well-baby care, immunizations, mammograms, pap tests, and blood tests, are covered 100 percent in-network.[52] Copays for other office visits to primary care and specialists are $25.[53] Beneficiaries are responsible for a 20 percent coinsurance payment for other services, such as hospital, emergency room, inpatient, outpatient mental health, and diagnostic services.[54] Prescription drugs are subject to copays of $10, $30, or $50.[55]

Premiums for DirigoChoice are set by Anthem, using its small group adjusted community rating methodology, which allows a 20 percent variance for the factors of age, geographic location, and industry. Group size adjustments are not regulated. For the fourth quarter of 2006, the unadjusted monthly premiums for the $1,750 deductible option ranged from $337 for an individual to $1,011 for a family.[56] Small group employers and sole proprietors are required to contribute a minimum of 60 percent of employee-only (one adult) coverage cost for employees who work 30 or more hours per week.[57]

Subsidies reducing both premiums and deductibles are available on a sliding scale

to individuals and families with household incomes up to 300 percent of FPL. Individuals and families earning between 100 percent and 149 percent FPL receive the highest discounts, with the state paying 80 percent of the standard monthly premium and 70 percent of the standard deductible.[58]

Despite relatively generous benefits, limited cost sharing, and sizeable subsidies, enrollment in DirigoChoice has fallen short of the state's expectations. As of April 2007, the program covered roughly 13,800 people—less than one-half of the enrollment goal of 31,000 for the first year.[59] Moreover, according to a survey of people enrolled during the first quarter of 2005, approximately 60 percent were previously insured at some point during the previous 12 months, suggesting a rather high degree of crowding out of private coverage.[60] In December 2007, the Governor's Blue Ribbon Commission recommended that the state consider mandating employer group coverage for workers and/or requiring individuals above certain income levels to obtain coverage for themselves.[61]

Few individuals leave DirigoChoice, but those who do are more likely to be young and healthy. Approximately 94 percent of members who are eligible to renew choose to do so. A recent survey of "disenrollees" revealed that most were young adults, 18 to 24 years old. After disenrolling, roughly 60 percent had private coverage, 30 percent were uninsured, and the remainder had public coverage. Those who disenrolled voluntarily (60 percent) cited costs, inadequate benefits, and other issues such as dissatisfaction with administration of subsidies and a feeling that "Dirigo wasn't going to last."[62]

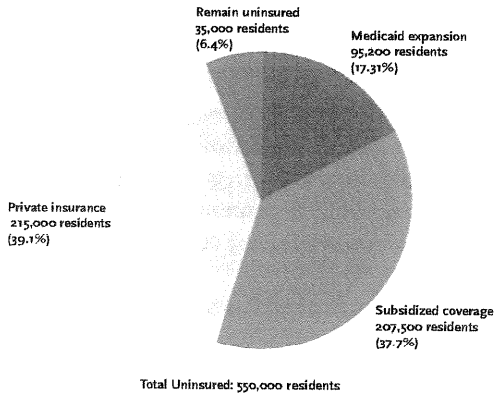
Costs under the DirigoChoice program have been higher than anticipated. During the first year of operation, total costs were $348 per member per month, half of which was subsidized by the state. Some of this higher cost reflects the fact that a greater percentage of enrollees (more than 60 percent) qualified for the highest subsidy category, which was an 80 percent discount off the standard premium.[63]

In addition, medical claims of beneficiaries have been "significantly higher" than expected—roughly double those of non-Dirigo plans.[64] Much of the difference in costs between DirigoChoice and private plans is driven by Dirigo's more generous benefit levels.[65] However, utilization is high in the DirigoChoice population and the plan seems to have experienced some adverse selection. Anthem speculates that one reason for the higher medical expenses was pent-up demand by enrollees who had been deferring visits to doctors while they were uninsured. It is also likely that those with the greatest medical needs were more likely to enroll initially. As of January 2007, premiums under DirigoChoice increased by 13.4 percent and enrollees faced higher copays for office visits and prescription drugs.[66]

State general revenues and federal funds generated by an increase in the Medicaid federal matching percentage provided the initial seed money for DirigoChoice during the first year of operations.[67] Employer and employee contributions were also a significant source of funding during the first year, accounting for just over half (51 percent) of total coverage costs.[68] But funding for the DirigoChoice program is now in jeopardy. After the initial year of the program, funding for DirigoChoice premium discounts was to be generated through the Savings Offset Payment (SOP), an assessment of up to four percent on insurers and third party administrators. The SOP is levied on insurers only when the Superintendent of Insurance determines that Dirigo Health Reform initiatives have resulted in savings to the health care system through expanded coverage and other cost containment provisions.[69]

However, determining the annual amount of the SOP has been a major hurdle in funding the program each year. After reviewing Dirigo Health Agency's estimates, the Maine Insurance Superintendent found that the program had accrued $43.7 million in savings in its first year, of which $33.7 million was from voluntary measures implemented by hospitals, $7.3 million from the provider fee initiative, and $2.7 million from averted bad debt and charity care.[70] Insurers challenged the determination of the SOP, stating that they would have to pass on the additional financial burden by raising premiums in the private market. The Cumberland County Superior Court ruled that the SOP was constitutional and reasonable, a decision which was upheld by the Maine Superior Court.

Figure 7. How the uninsured are covered under the Massachusetts health care reform plan



Source: Kaiser Commission on Medicaid and the Uninsured, "Massachusetts Health Care Reform Plan," Key Facts, April 2006

In response to the controversy over funding of the program, Governor Baldacci created a Blue Ribbon Commission to study funding alternatives and make recommendations regarding long-term funding of the program. The Commission's preliminary report in December 2006 recommended replacing the SOP with money from the general fund or possibly new revenues from higher sin taxes. While hoping for new sources of funding, the Dirigo Health Agency voted to collect the second-year SOP payments of $34.3 million to keep DirigoChoice running. However, the Board also authorized agency staff to stop enrolling new policyholders if funding remains problematic.[71]

Massachusetts: Commonwealth Care and Commonwealth Choice

In April 2006, former Massachusetts Governor Mitt Romney signed into law Chapter 58, landmark legislation designed to achieve nearly universal health care coverage among state residents. The unique provisions of the bill place the responsibility for coverage on the government, individuals, and employers alike, by providing public subsidies to ensure affordability for low-income residents, creating a mandate requiring individuals to purchase health insurance, and imposing financial penalties on employers that do not offer health insurance coverage.

Components of the plan include the creation of two insurance programs. The first, Commonwealth Care, a subsidized insurance program, is expected to serve roughly 207,500 uninsured individuals who earn up to 300 percent FPL. The second, Commonwealth Choice, a non-subsidized insurance program for individuals and small employers, is expected to serve another 215,000 Massachusetts residents (see Figure 7). Other provisions of the health reform package include:[72]

- Merging the non-group (individual) and small group insurance markets
- Expanding Medicaid to children up to 300 percent FPL
- Raising Medicaid enrollment caps for adults
- Restoring Medicaid benefits that were cut in 2002 (dental and vision services)
- Increasing provider rates under Medicaid [73]
- Expanding the Insurance Partnership program from 200 percent to 300 percent FPL

Chapter 58 created a new public entity, the Commonwealth Health Insurance Connector Authority (known as the Connector), to serve as a bridge between eligible individuals, small employers, and health plans. The Connector oversees both the Commonwealth Care and Commonwealth Choice programs and also sets the standards for minimum creditable coverage that meet the state's individual mandate.

Enrollment in Commonwealth Care began in October of 2006. As of June 1, 2007, the program covered nearly 79,000 people. The new insurance product is available to uninsured individuals[74] who earn less than 300 percent FPL and are ineligible for MassHealth, the state's Medicaid program.[75] The program is currently run as a partnership between the Connector and the four private insurers currently serving the state's Medicaid managed care program. The plans offered under the Commonwealth Care program are comprehensive and have limited cost sharing and no deductibles.[76] Prices are set for each plan based on a community rating methodology that takes into account factors such as age and geographic location. Premiums are set on a sliding scale, based on household income.

Individuals earning up to 150 percent FPL pay no premium, while monthly enrollee contributions for those with higher incomes for a single adult for the least expensive plan range from $18 to $137.[77]

Enrollment in the second program, Commonwealth Choice, began on May 1, 2007, for effective coverage beginning July 1, 2007—just in time to satisfy the state's individual mandate. By October 2007, small employers will have the option of either making these plans available to their employees or allowing their employees to purchase one of the plans directly from the Connector, using pre-tax dollars.[78] Commonwealth Choice offers four levels of coverage—Premier, Value, Basic, and Young Adult—intended to meet the needs of different individuals and families.[79] Each plan will offer the same set of comprehensive benefits, upholding the state's new standards of Minimum Creditable Coverage, which is the minimum level of insurance that individuals will be required to buy as of January 2009. Premiums for the typically uninsured 37-year old in eastern Massachusetts, the most expensive region in the state, range from $175 to $288 per month.[80] Although Commonwealth Choice offers no individual subsidies, if purchased on a pre-tax basis through an employer's Section 125 plan, the net cost of the $175 premium is reduced to $109 for an individual earning $50,000 per year.

The most innovative component of the Massachusetts reform plan is the mandate requiring individuals who can afford health insurance to purchase it by July 1, 2007.[81] The purpose of the individual mandate is to strengthen and stabilize the functioning of health insurance risk pools by making sure they include young and healthy people, who are more likely to go without insurance if it is not offered (and paid for) by their employer.[82] A recent survey of state residents found that more than half (57 percent) support the individual mandate because they believe "it is the right thing to do" and that broader coverage will keep costs down. Those who oppose the law (36 percent) say "people shouldn't be required to buy insurance if they can't afford it."[83]

The Department of Revenue will enforce the individual mandate through the tax collection process. Individuals who cannot show proof of health insurance coverage by December 31, 2007, will lose their personal income tax exemption when filing their 2007 income taxes.[84] Failure to meet the requirement in 2008 will result in larger financial penalties, equal to a fine for each month the individual does not have coverage. The fine will equal 50 percent of the least costly, available insurance premium that meets the standard for creditable coverage.

To make the individual mandate both effective and enforceable, the Connector is charged with offering health insurance that is both *comprehensive* and *affordable*, to ensure that individuals and families, particularly those with low-incomes and those in poor health, are able to obtain adequate coverage. In response to health care activists who questioned the affordability of the proposed plans, the Connector voted to exempt approximately 60,000 individuals from the mandate to purchase health insurance. Half of those exempted are individuals who earn less than 300 percent of the FPL but are not eligible for subsidies because their employers offer them insurance.[85] The other half is individuals earning just above 300 percent of poverty for whom the costs of obtaining minimal creditable coverage would exceed $150 per month.[86] These are primarily older individuals on fixed incomes, who face higher premiums because of their age.[87] There is also an exemption process for individuals of any income level who believe purchasing a health insurance plan is not affordable for them.

The final component of the Massachusetts health care reform plan is to require participation by employers. All employers with more than 10 full-time equivalent employees are required to make a "fair and reasonable" premium contribution towards the cost of their employees' health insurance.[88] Employers can satisfy this requirement if they pass one of two tests. The primary test requires that at least 25 percent of the employer's full-time employees be enrolled in the employer's group health plan.[89] The secondary test requires that the employer offer to contribute at least 33 percent of the premium cost of its health plan to all full-time employees employed for more than 90 days during the

determination period.[90] This includes all employees at Massachusetts locations, whether or not the employees are Massachusetts residents.[91] Employers who fail to make a "fair and reasonable" contribution will be required to pay a air Share Contribution of up to $295 per year per employee.[92]

In addition to this fair and reasonable contribution to health insurance premiums, employers with more than 10 full-time equivalent employees were required to offer a Section 125 cafeteria plan as of July 1, 2007.[93] A Section 125 plan allows employees to pay for health insurance coverage on a pre-tax basis and is not subject to state and federal taxes or federal FICA withholding taxes. Using these pre-tax dollars, workers who are not offered insurance through their employer will be able to purchase insurance products directly through the Connector.

Under certain conditions, employers with more than 10 employees that do not offer a Section 125 plan that meets the regulations established by the Connector may be subject to a Free Rider Surcharge.[94] The surcharge is levied on firms which do not offer a Section 125 plan and whose employees (and their dependents) incur charges for state-funded health services that are in excess of $50,000 in one hospital fiscal year. The surcharge is intended to offset charges for uncompensated care paid by the state through the Uncompensated Care Trust Fund (also known as the Uncompensated Care Pool (UCP)) or the newly created Health Safety Net Trust Fund.[95] The annual amount of the additional surcharge, still to be determined, will vary based on the number of employees, the utilization of the uncompensated care pool, total state-funded costs, and the percentage of employees enrolled in the employer's health plan.[96]

The impact of these requirements on the incentive for employers to offer coverage remains unclear. First, although the amount of the Fair Share Contribution is much less than the cost of offering health insurance to an employee, it is unlikely that employers who currently provide insurance to compete with similar firms in the attraction and retention of good employees will drop coverage. In addition, the Fair Share Contribution is unlikely to motivate employers who do not currently provide coverage to do so.

Second, it is also unclear whether allowing workers to buy coverage through the Connector will change the incentives for employers to offer coverage. Although larger firms are likely to still offer health insurance to maintain control over benefit design and lower administrative costs, small employers on the cusp may drop coverage, depending upon the attractiveness of Connector plans to their workers. However, waiting periods for CommonwealthCare place some restrictions on enrollment, so an employer cannot drop coverage and have employees covered by the program the next day.[97]

Interestingly, the greatest impact on employers will likely come from the imposition of the individual mandate. Requiring individuals to purchase insurance is likely to increase the number of employees that take up employer provided insurance. If more employees suddenly enroll in their employers' plans, it may significantly increase costs for those employers currently offering coverage and may have large consequences for small businesses who may not have budgeted for such a cost increase.[98] Such firms may see costs increase to the point that they decide to drop coverage altogether. Employers will also face additional indirect costs, such as setting up a Section 125 plan and quarterly reporting of the health insurance status of their employees.

The Massachusetts health care reform plan, which is expected to cost $1.2 billion over three years, initially relies heavily on existing financing from two unique sources—federal Medicaid contributions and the UCP. Federal Medicaid funds, including $385 million in annual federal Medicaid payments that would have been lost in the absence of a plan to reduce the number of uninsured, provided much of the plan's initial seed money.

As of October 2007, the UCP, which reimburses providers for uncompensated care, will be replaced by the Health Safety Net Trust Fund, which will combine UCP funds with other Medicaid sources, such as the Disproportionate Share Program. The intent is that as more of the uninsured gain coverage and the level of uncompensated care falls, the Health Safety Net Trust Fund will be gradually drawn down and funds will be shifted to supporting subsidies for the Commonwealth Care program. A new Health Safety Net Office will administer a

methodology for equitably allocating free-care reimbursements from the Trust Fund to hospitals and community health centers.[99] One particular concern is that a growing number of undocumented residents who are not eligible for Medicaid or the new programs will still need to depend on the free care pool.

Given the limited commitment of new funds and rising health care costs, a fundamental question is whether the plan is adequately financed, particularly in future years. Estimated new funding of about $308 million over three years will come from employer contributions and General Fund revenues. The state anticipates that no additional funding will be needed beyond three years.[100] Yet taking into account health care inflation, subsidies for enrollees, and the size of the population eligible for Commonwealth Care, the Connector projected that enrolling all eligible individuals by July 2007 would compel it to exceed its current budget and that enrollment may have to be capped in future years.[101]

Rhode Island: HealthPact RI

In July 2006, Governor Donald Carcieri signed into law a health reform package designed to expand access to health insurance for employees of small businesses, lower costs by promoting better personal health, and ensure a more balanced system of health care, with a focus on primary and preventive care. The legislation creates a new affordable health insurance product, HealthPact RI, which aims to reduce premium costs for small businesses by 25 percent[102] and increase enrollment among their employees by 15 percent, or 10,000 individuals.[103] Other provisions of the health care reform package include:[104]

- Authorization for a reinsurance subsidy program (contingent upon state funding)
- Development of a high-risk insurance pool for individuals (contingent upon federal funding)
- Enhancement of transparency regarding health care costs and quality
- Wellness promotion, including mandates for healthy snacks in schools and expanding coverage of smoking cessation programs and medications
- Modification of the Certificate of Need (CON) process to evaluate proposed expansions based on the state's existing health care needs

Beginning in October 2007, HealthPact RI will be offered to employers with 50 or fewer employees. The product will later be expanded to individuals purchasing insurance directly in the individual market, sometime in 2008.[105] The state estimates that about 27,000 people, or about one-quarter of the state's 120,000 uninsured individuals who are eligible for the plan, will enroll.

The new product specifically targets employers who, in the absence of the program, might otherwise switch to a high-deductible health plan or drop coverage altogether.[106] It is an HMO-type plan that includes all mandated benefits, including primary and preventive care, dental care, diagnostic testing, acute episodic care, hospital services, mental health and substance abuse services, infertility services, and prescription drug coverage. Chiropractic and vision care are not covered.

To keep premiums low, HealthPact RI offers financial incentives to enrollees who actively manage their own health care. The program aims to achieve this in two ways. First, participants who meet certain wellness requirements qualify for the "Advantage" level of coverage, which has more generous benefits and lower out-of-pocket costs.[107] For example, Advantage Plan beneficiaries face a deductible of $750 for medical services, copays of $10/50 for physician office visits (PCP/specialists), 10 percent coinsurance for most inpatient and outpatient services, an out-of-pocket maximum of $2,000, and no lifetime limit on benefits. In contrast, Basic Plan beneficiaries face a deductible of $5,000 for medical services and $250 for pharmacy benefits, copays of $30/60 for physician office visits (PCP/specialist), 20 percent coinsurance for most inpatient and outpatient services, an out-of pocket maximum of $5,000, and a $1 million lifetime limit on benefits. Prescription drugs for either plan are also subject to copays ranging from $10 to $75, depending on the preferred status of the drug.

Second, the plan encourages enrollees to use more cost-efficient providers by creating a two-tier system based on quality and cost indicators. Beneficiaries will be required to pay more for physicians who are not in the first, or most cost-efficient, tier of the plan. However, it is not clear whether enough data exist, at least initially, to identify the most cost-efficient providers.[108] As a result, the two-tier network is scheduled to be implemented in October, 2008.

In addition to creating a product that would be attractive to individuals and small employers while satisfying the state's minimum benefits standards, program designers faced price constraints in the legislation.[109] Specifically, the bill required that the target for the average annualized premium rate be less than 10 percent of the "average annual statewide wage," or about $314 per individual per month.

There has been considerable speculation about whether insurers would be able to offer plans that both satisfy the state's benefit requirements and meet the legislated premium target. Yet by April 2007, the state had approved two plans, submitted by Blue Cross Blue Shield of Rhode Island and United Healthcare of New England, which had average rates for an individual monthly premium of $321 and $310, respectively.[110] However, with no direct public subsidies and no requirements on employers to make any contributions towards monthly premiums, it remains to be seen whether the target premium will be affordable to most of the uninsured individuals in the state.

Like other health insurance expansion programs in New England, HealthPact RI funding comes from a variety of sources. Primary funding is through the creation of the Trust for Rhode Island Health Insurance, a $100 million fund from securitized tobacco payments that would provide perpetual annual contributions of $5 million to $7 million. The trust fund will be used to help reduce the amount of risk to which insurers will be exposed, which in turn would allow insurers to offer lower-cost premiums to businesses.[111] This will be supplemented by "fees levied on health insurers that generate excess profits or incur additional administrative costs," bringing in an additional $5 million to $10 million annually.[112]

Vermont: Catamount Health and Employer-Sponsored Insurance Premium Assistance programs

In May 2006, Governor Jim Douglas signed into law Acts 190 and 191, Vermont's health care reform initiatives, with the goal of insuring 96 percent of the state's residents within five years. The acts create two insurance programs. The first, Catamount Health, is a state-subsidized program expected to serve roughly 25,000 uninsured individuals who meet certain income eligibility requirements.[113] The second is a separate Employer-Sponsored Insurance Premium Assistance program that will allow uninsured employees whose incomes are less than 300 percent of the FPL to receive assistance to purchase their employer's health insurance plan. The state will determine the most cost-effective way to cover individuals who qualify for both Catamount Health and the premium assistance program.

The health reform package also endeavors to improve quality, reduce costs, and promote healthy behavior and disease prevention. Additional provisions include:[114]

- Providing assistance to carriers in the individual market to reduce premiums by 5 percent
- Reducing Medicaid premiums for low-income individuals and families receiving health care coverage through the Vermont Health Access Plan and "Dr. Dynasaur"
- Raising Medicaid reimbursements for providers
- Creating a reinsurance program
- Creating a statewide integrated delivery system using an electronic database to improve management and coordination of care for chronic illnesses
- Establishing a new payment system for government insurance programs that reimburses physicians for activities that promote wellness, such as telephone consultations with patients

Like Massachusetts, the Vermont plan imposes financial penalties for employers who do not offer health insurance coverage.

Unlike Massachusetts, individuals are not mandated to purchase insurance. As of April 1, 2007, an employer may be levied an assessment on their employees if (1) they do not offer to pay any part of the cost of health coverage for their employees, (2) they offer insurance to pay for health coverage for only some of their employees, or (3) their employees do not choose to enroll in the plan they provide and they have no other source of health coverage. Employers falling into any one of these three categories will be required to pay an annual assessment of $365 per uninsured full-time equivalent employee (FTE).[115]

The first program, Catamount Health, will be available to Vermont residents as of October 2007. To enroll, individuals must be 18 years or older, not eligible for Medicaid and its extended programs (Vermont Health Access Plan and Dr. Dynasaur), not have access to employer-sponsored coverage (with some exceptions),[116] and have been uninsured for at least 12 months.[117] In January 2009, the legislature may consider eliminating some or all of this 12-month waiting period, allowing the underinsured to buy into the plan, and allowing employers to buy into the plan.[118] An individual mandate to purchase insurance may also be considered if the goal of 96 percent coverage is not achieved by 2010.[119]

The new insurance product is a PPO plan that will provide enrollees with a comprehensive package similar to the median Blue Cross Blue Shield plan offered in the state.[120] Unlike most other states, Acts 190 and 191 specify, in detail, cost sharing under Catamount Health.[121] For example, deductibles for individuals range from $250 in-network to $500 out-of-network, after which patients are expected to pay 20 percent of their medical bills, with a cap on out-of-pocket costs. Preventive care is covered 100 percent and is not subject to deductibles, coinsurance, or copayments. Chronic care is also fully covered for individuals who are enrolled in a chronic care management program Prescription drugs are subject to copays ranging from $10 to $50, depending upon the preferred status of the drug.

Through Catamount Health the state intends to gain the cooperation of private insurers to offer lower-cost, reasonably comprehensive policies to the uninsured under defined conditions, with the state subsidizing the cost of these private policies where needed. Insurers go through the usual rate-setting process at the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA). The state is authorized to require that hospital and medical service corporations and nonprofit HMOs operating within the state offer Catamount Health if no private insurers offer it voluntarily.[122] Thus far, two insurers, Blue Cross Blue Shield of Vermont and MVP Health Plan, have indicated their willingness to participate.[123]

Premium rates for Catamount Health are actuarially determined and designed to balance the need for consumer affordability with insurer financial stability.[124] The average monthly premium for the first year is estimated to be $362 with premium assistance to uninsured individuals and families with incomes below 300 percent of the FPL. For example, uninsured individuals in the lowest income bracket (below $19,600) would only be required to pay a premium of $60 per month for the least expensive plan, thereby receiving a discount of roughly 80 percent (depending on the final cost of the product). For an uninsured individual in the most highly subsidized income bracket ($26,950 to $29,400), the state subsidy would be about 60 percent, leaving the individual with a monthly premium payment of $135.[125]

The second program, the Employer-Sponsored Insurance Premium Assistance Program, is the other key component of Vermont's health care reform plan. Under this program, individuals are eligible for premium assistance if they earn between 150 percent and 300 percent FPL, have access to an ESI plan, and have been uninsured for at least 12 months. Individuals earning less than 150 percent FPL (185 percent for parents) may qualify if they are eligible for the current Vermont Health Access Plan (VHAP) and have access to an ESI plan.[126]

The intent of the program is to assist workers in purchasing insurance through their employer, thereby allowing for a more cost-effective deployment of public funds to expand coverage by piggybacking on employer contributions. The hope is that the state will thus be able to assist more Vermonters in obtaining coverage for a given level of funding. In each case, the state will

review the employer's plan and determine which option—providing assistance through the premium assistance program or enrolling the individual directly in Catamount Health or another public program (e.g. VHAP)—would be more cost-effective to the state.[127]

The employer's plan must meet certain requirements, depending on whether the individual would otherwise qualify for VHAP or Catamount.[128] If the individual would otherwise be eligible for VHAP, the employer's plan must be equivalent to the typical plan offered by the four largest insurers in the small group and association market. If the individual earns between 151 percent and 300 percent FPL and would otherwise be eligible for Catamount Health, the employer's plan must be equivalent to Catamount Health.

Regardless, the premium paid by the individual would be no higher than the monthly VHAP or Catamount premium. In addition, the individual would not be responsible for any cost sharing (deductibles, coinsurance, and copays) above those for VHAP or Catamount. Subsidies are to be provided on a sliding scale, based on the eligible individual's household income. For VHAP eligible individuals, the Agency for Human Services is proposing that the individual contributions to ESI under the premium assistance program be equal to the VHAP premiums as of July 1, 2007. For individuals not eligible for VHAP, the Agency is proposing that individual contribution levels be the same as those for Catamount Health.

It is not clear how effective the premium assistance program will ultimately be in expanding coverage among the low-income population. Of the 17,000 individuals earning less than 150 percent FPL who quality for (VHAP), only 10 percent (or 4,830) are eligible to enroll in an ESI plan, either because employers do not offer health insurance or because individuals do not work enough hours to qualify for their employer's plan.[129] Of those eligible for ESI, only half (about 2,400) would have cost-effective ESI plans, thereby making them eligible for the premium assistance program. Moreover, the difference between the unsubsidized and subsidized premium cost to the employee is not considered to be large enough to entice many people to enroll. Finally, people who have not already enrolled in a relatively inexpensive ESI plan tend to be fairly healthy and have a low demand for health insurance. [130]

As in Massachusetts, it is not clear what the ultimate impact on employers will be. Across both low- and moderate-income groups, the state estimates that initial enrollment in the premium assistance program will cause employers to increase their aggregate premium contributions as more workers enroll in their employers' plans. Based on an average monthly premium of $456 and using an average employer contribution of 80 percent, the average monthly cost of providing ESI is roughly $365 per enrolled employee. However, it is unclear whether employers who currently offer coverage will continue to find it affordable do so, particularly small employers, as more and more employees take up the health insurance benefit.

Funding for both the Catamount Health and the premium assistance programs comes from a combination of individual contributions to premiums, employer assessments, and increases in tobacco taxes. In addition, the state may be able to leverage matching federal dollars, if the federal government includes Catamount Health in the state's Section 1115 Medicaid waiver (Global Commitment to Health).[131] If the waiver is granted, the federal government will pay about 60 percent of the cost of Catamount Health.[132] Regardless, the state's fiscal obligation would not be open-ended, as Act 191 enables the state to establish caps on enrollment in the two programs if sufficient funds are not available to sustain them.[133]

Conclusion: Remaining challenges to expanding coverage

A number of pitfalls face states as they expand health insurance coverage. While some of these challenges can be ameliorated by incorporating specific elements into the design of the programs, others are more macro in nature and are beyond the scope of the program or even beyond the control of the state. This section highlights some of these potential hazards and how they relate to the initiatives under way in New England.

Program design issues: The devil is in the details

Components of the new insurance programs face a range of difficult design issues that are critical for success. For example, can subsidies be set so as to make coverage affordable without disrupting the private market? Will insurance exchanges, such as the Commonwealth Health Insurance Connector in Massachusetts, be able to attract enough of the individual and small group market to keep premiums low? How can states sustain the public/private partnerships they were able to broker during the launch of these new programs?

Subsidizing premiums on a sliding scale. Maine, Massachusetts, and Vermont all subsidize individual premiums on a sliding scale for those earning below 300 percent FPL. Subsidizing premiums may stimulate the purchase of private insurance, thus increasing coverage. Subsidies can also ease the financial burden of obtaining health insurance on currently insured low-income individuals and families.

But for low-income individuals who do not currently have insurance, the subsidy amounts may not be high enough to encourage significant take-up. This has certainly been the experience in Maine, where only 14,000 of an estimated 100,000 individuals eligible for the program have actually enrolled. A Congressional Budget Office study estimates that a 60 percent premium subsidy targeted to families below 200 percent FPL who do not have access to group insurance would reduce the number of uninsured families by 16 percent. Over three-quarters of the subsidy benefit would be realized by low-income families who currently purchase individual insurance at the full price.[134]

Individual subsidies may also cause some disruption of the group insurance market. Simulations of the impact of proposed subsidies show that some firms would stop offering health benefits to their workers.[135] The new subsidy would also make individual coverage more attractive than group coverage for some workers, who might thus switch. For example, approximately 60 percent of Maine's DirigoChoice enrollees previously had private coverage. This means that to some extent, then, the reduction in the number of uninsured would be offset by those losing job-based coverage.

Finally, depending on the level of demand for subsidized coverage and the premiums negotiated with the health plans, funding might not be sufficient to cover all of those who are eligible, possibly resulting in eventual caps on enrollment. For example, the Dirigo Health Board in Maine authorized agency staff to stop enrolling new policyholders if funding for the program is problematic.[136] Vermont's legislation similarly limits the state's fiscal obligation by enabling the Emergency Board to cap enrollment in Catamount Health and the ESI program.

Developing insurance exchanges. Insurance exchanges generally act as clearinghouses through which individuals and small businesses can obtain coverage. In Massachusetts, the Commonwealth Health Insurance Connector offers unsubsidized coverage from private insurance carriers to individuals and families and to small businesses through the Commonwealth Choice program. Exchanges such as the Connector also offer other benefits, such as allowing individuals to pay for health care coverage on a pre-tax basis, thereby enjoying tax advantages similar to those associated with employer-based coverage. In addition, coverage can often be portable as individuals switch jobs, and more than one employer can contribute towards the worker's premium.

Many insurance exchanges typically keep premiums low by combining high-deductible plans (HDHPs) with health savings accounts (HSAs). An HSA is a type of medical savings account that is linked to HDHPs and allows an employee to save for medical expenses on a tax-free basis. In addition, employee contributions to HSAs may be matched, in whole or in part, by their employer. Compared to more traditional insurance plans, HDHPs generally require greater out-of-pocket spending, although the premiums may be lower. Once the HSA is exhausted however, there are no further tax advantages to help defray additional out-of-pocket expenses.[137]

Yet studies have found that HSAs and HDHPs are no more affordable for low-income families than existing plans and that their high deductibles may shift even more

health care costs onto these families. This is because employer contributions to HSAs are typically much lower than the deductible amount, leaving enrollees to face sizeable up-front, out-of-pocket costs. In 2006, the average annual deductibles in such arrangements were $2,000 for single coverage and $4,000 for family coverage, while firms' average contributions were $700 and $1,100, respectively. Moreover, although the tax-free treatment of HSAs gives the employee some additional relief from paying the high deductible, most low-income individuals and families do not face a high enough tax liability to benefit in a significant way.[138]

The Connector attempts to address these issues in two ways. First, Commonwealth Choice enrollees have four different levels of coverage from which to choose, each with varying degrees of cost sharing. For example, deductibles range from zero to $2,000, and some of the plans with the $2,000 deductible allow unlimited office visits, subject only to a copayment prior to the deductible.

Second, the new reform law requires the Connector to negotiate with carriers to provide plans that would satisfy Minimum Creditable Coverage (MCC) criteria, while also meeting the legislated requirement of affordability. The MCC standards are designed to provide individuals with financial access to a broad range of health care services, including preventive health care, without incurring severe financial losses as a result of serious illness or injury. While this affordability is a necessary condition in order for the individual mandate to be enforceable, it remains to be seen whether the Connector will be able to attract a large enough share of the market to negotiate similar premium discounts with insurers in the future.

Creating and sustaining public/private partnerships. Many of the new programs rely on cooperation between states and insurers, which can be difficult to sustain over time, particularly in states with few players in the private health insurance market. In Maine, for example, funding for DirigoChoice premium discounts was to be generated through the Savings Offset Payment (SOP) after the initial year of the program. But it has been difficult for the program to determine the amount of the SOP, leading Anthem, the state's only carrier in the individual market, to challenge the ability of the state to levy the SOP on insurers. Although Anthem agreed to extend its initial two-year contract through 2007, if the legislature does not authorize the program to become self-insured, the state may need to find a new insurance partner.[139]

Similarly, Rhode Island and Vermont will also rely on private carriers to offer and administer health care coverage that meets minimum benefit criteria and explicit cost targets. In Rhode Island, the proposed average rates for HealthPact RI for an individual monthly premium come close to the state target of $314 per month, yet the copays and coinsurance rates offered by the private plans differ significantly from the state's recommended levels. In addition, the annual premium can vary from this average, based on age, gender, family size, and, to some extent, the claims experience of the group.[140]

In Vermont, initial estimates of premium rates for the first year of Catamount Health were generated based on the benefit levels and amount of cost sharing as specified by the legislation. Yet the ultimate cost of Catamount Health to the state will depend on how closely the proposed premium rates submitted by private insurers match these initial estimates. Because the law also stipulates individual premium contributions by income bracket, any gap between the individual contributions set by statute and the actual premiums charged by insurers will be borne by the state.[141] After two years, the state will review the cost-effectiveness of the private plans—if the current situation is not found to be cost-effective, the state may choose to self-insure and assume the risk of providing insurance, only relying on private insurers to administer the program.[142]

Additional obstacles

Even with the best program design, states face additional challenges as fundamental as whether these new programs will be able to attract enrollees and actually reduce the number of uninsured. Expanding coverage does not in itself ensure 100 percent participation. Indeed, voluntary take-up rates have been low in previous public insurance expansions, typically on the order of 50 percent, and can lead to greater crowding out of private insur-

ance as individuals move up the income ladder. To boost participation among workers, Massachusetts and Vermont will levy fees on employers that do not offer health insurance coverage. Massachusetts goes one major step further, also requiring that individuals purchase coverage, whether from the state or from their employer.

Yet states can do only so much to affect the behavior of employers and individuals. Among employers, firms may choose to pay the annual fee, thereby limiting the availability of employer-sponsored insurance. Among individuals, participation can be hindered by a number of factors, including a lack of knowledge about eligibility rules, the burden of application and enrollment procedures, and the level of perceived value of health insurance coverage. Moreover, young and healthy adults, after weighing costs and benefits, may choose to go without insurance and instead pay the individual penalty.

Second, greater participation in health care coverage does not guarantee access to care. Many low-income people cycle on and off health insurance throughout the course of a year, limiting their access to regular care. Other barriers, such as transportation costs, an inability to navigate the health care system, language and cultural differences, and racial/ethnic disparities in care also serve to reduce access. Provider surveys have found that low Medicaid payment rates and burdensome administrative requirements are the leading barriers to provider participation in Medicaid, particularly among specialists. Moreover, expanding access to care may be limited by the existing resources of the healthcare system, such as the availability of community health centers and the number of primary care physicians accepting new patients.

Third, coverage expansion is subject to changing budget constraints. Between 2001 and 2004, states experienced severe fiscal stress, with revenues falling even as Medicaid spending and enrollment peaked. Many states responded by freezing provider payment rates, cutting benefits, and restricting eligibility. The good news is that in FY 2006, state revenue growth exceeded Medicaid cost growth for the first time since 1998.

Yet it is unclear that current reforms will be sustainable over the long-run as economic and fiscal conditions change. Some of the insurance initiatives in New England had unique sources of funding, such as matching Medicaid funds, an uncompensated care pool, or a large tobacco settlement, to help provide initial seed money. Going forward, states plan to rely on a variety of sources, including enrollee premium contributions, employer assessments, higher sin taxes, and general fund revenues. However, in the face of changing economic and fiscal conditions, rising health care costs, and changing demographics, states may face significant shortfalls in future funding of these programs, even with improving fiscal conditions.

Finally, changes in federal policy that affect the financing and administration of both Medicaid and SCHIP impose additional cost concerns for states. For example, as of January 2006, the Medicare Modernization Act transitioned more than 6 million low-income seniors and individuals with disabilities from Medicaid drug coverage to the newly created Medicare Part D plan. In addition, the Deficit Reduction Act, signed into law in February 2006, includes a number of new requirements for state Medicaid programs with regard to documentation of eligibility as well as some flexibility with alternative benefit packages and cost sharing. Also, the President's proposal for the upcoming reauthorization of SCHIP provides less than half of the funding states need to maintain their existing SCHIP caseloads, resulting in an estimated funding shortfall of $7 billion over the next five years.[143]

Yet despite these caveats and concerns, the New England states are forging ahead and the rest of the country is watching to see how these experiments will play out. By combining different strategies from across the political spectrum, the new initiatives represent a unique amalgam approach to expanding health care coverage. Elements of these plans, as well as the strategy for reaching political agreement, may be useful to other states interested in expanding coverage. Understanding the factors that contributed to the passage of these reforms and monitoring their implementation will hopefully encourage more fruitful discussions in other states and at the national level about ways to reduce the number of uninsured.

Endnotes

[1] For a brief definition of the Medicare program and other health care related terms, please see the glossary.

[2] Kaiser Commission on Medicaid and the Uninsured, "Health Coverage for Low-Income Americans: An Evidence-Based Approach to Public Policy." November 2006, p. 6.

[3] Lisa Clemans-Cope, Bowen Garrett, and Catherine Hoffman. "Changes in Employees' Health Insurance Coverage, 2001-2005." Kaiser Commission on Medicaid and the Uninsured. October 2006, p.7.

[4] Clemans-Cope et al., 2006, p. 8.

[5] Bowen Garrett. "Employer-Sponsored Health insurance Coverage: Sponsorship, Eligibility, and participation Patterns in 2001." Kaiser Commission on Medicaid and the Uninsured. July 2004.

[6] The Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits: 2005 Annual Survey.* 2005, p. 61.

[7] Katherine Swartz. *Reinsuring Health: Why More Middle-class People Are Uninsured and What Government Can Do.* New York: Russell Sage Foundation, 2006.

[8] Median household income in 2005 was $46,326.

[9] Small group purchasers are typically firms with 50 or fewer employees.

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[72] For more information on these other provisions, see Commonwealth Health Insurance Connector Authority, "Health Care Access and Affordability Conference Committee Report." April 3, 2006.

[73] Hospitals and physicians will receive Medicaid rate increases of $90 million per year in FY07, FY08, and FY09. Increases in the latter two years will be tied to quality and other performance measures.

[74] Individuals are considered insured if their (or a family member's) current employer offered them health insurance coverage within the last six months and the employer covered at least 20 percent of the annual premium costs for a family and 33 percent of the annual premium costs for an individual. Individuals are considered uninsured if they are currently insured under COBRA, pay the full premium in the non-group market, or are in a waiting period prior to becoming eligible for an employer-provided plan.

[75] Individuals must be a U.S. citizen/national, qualified alien, or alien with special status.

[76] For more details on program implementation, eligibility, benefits, cost-sharing, and subsidies, please see the appendix.

[77] Commonwealth Health Insurance Connector Authority, "Enrollee Premiums by Commonwealth Care Service Area." http://www.mass.gov . Accessed on February 22, 2007. Updated with "Commonwealth care Frequently Asked Questions: Program Update May 1, 2007."

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[81] An individual may file a sworn affidavit with his income tax return stating that he/she did not have creditable coverage during the 12 months of the taxable year for which the return was filed because of sincerely held religious beliefs. Additionally, an individual may be exempt from the mandate on the basis that he/she is unable to afford health insurance that meets minimum creditable coverage. Guidance affordability and what constitutes minimum creditable coverage is still to be determined by the Connector. See Frequently Asked Questions for Individuals on the Commonwealth Health Insurance Connector Authority web site: http://www.mass.gov.

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[90] The determination period for 2007 is from October 1, 2006 through September 30, 2007.

[91] Note that employers will not be held responsible if employees refuse employer-sponsored health insurance. See the appendix for more details.

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Appendix

Details of New Initiatives to Expand Coverage in New England

Maine's DirigoChoice program

The DirigoChoice program was created in June 2003 as part of Dirigo Health, Maine's health care reform package. Available to both small employers and uninsured individuals, the program allows qualified enrollees to receive discounts on monthly payments and reductions in deductibles and out-of-pocket expenses, based on their income and family size. The next section describes the program in more detail, including its implementation, eligibility, benefits, cost sharing, and subsidies.

Implementation: Enrollment in DirigoChoice began in January 2005. The program is currently run as a partnership between the state and Anthem Blue Cross Blue Shield of Maine. Anthem agreed to extend its initial two-year contract through the end of 2007, after an effort to give the state's Dirigo Health Board the authority to self-insure the DirigoChoice health plan product failed to pass in the legislature. If the legislature continues to refuse to allow the program to become self-insured, the state will likely have to find a new insurance partner.[1]

Eligibility: The new insurance product is available to small businesses, sole proprietors, and eligible individuals who do not have access to employer-sponsored insurance.[2] Sliding scale subsidies are available to individuals and families with household incomes up to 300 percent of the federal poverty level (see Appendix Table 1).

Benefits: The program offers comprehensive coverage, including mental health services. There are no pre-existing exclusions or lifetime maximums. Enrollees are also eligible for disease management and other special Anthem programs. For example, under the Healthy Maine incentive program, cash incentives are provided to members and employers who select a primary care physician and who complete a health risk assessment.[3]

Appendix Table 1. 2007 Federal poverty level (FPL) by household size

Number of persons in family or household	Federal poverty level (FPL)	300% FPL
1	$10,210	$30,630
2	13,690	$41,070
3	17,170	$51,510
4	20,650	$61,950
5	24,130	$72,390
6	27,610	$82,830
7	31,090	$93,270
8	34,570	$103,710

Source: U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, http://aspe.hhs.gov/poverty/07poverty.shtml
Note: For each additional family member add $3,480.

Cost sharing: Cost sharing under DirigoChoice is limited. Members are enrolled in a PPO plan under one of two options with deductibles of $1,250 and $1,750, respectively.[4] Preventive visits for services, such as routine check-ups, physicals, well-baby care, immunizations, mammograms, pap tests, and blood tests, are covered 100 percent in-network.[5] Copays for other office visits to primary care and specialists are $25.[6] Beneficiaries are responsible for a 20 percent coinsurance payment for other services, such as hospital, emergency room, inpatient, outpatient, mental health, and diagnostic services.[7] Prescription drugs are subject to copays of $10, $30 or $50 (see Appendix Table 2).[8]

Pricing: Appendix Table 3 shows the unadjusted community rates for Dirigo Choice for the fourth quarter of calendar year 2006. Anthem sets prices for Dirigo Choice based on their small group adjusted community rating methodology, which allows a 20 percent variance for the factors of age, geographic location, and industry. Group size adjustments are not regulated. Anthem then modifies the community rate for the specific benefits included in Dirigo Choice. A final adjustment on the order of an additional 2.5 percent—is made to account for the additional risk associated with not knowing in advance who will sign up for the DirigoChoice program.[9]

Appendix Table 2. Cost sharing for selected benefits under DirigoChoice plan option (1)

	Network benefit	Non-network benefit
Preventive care (including any associated diagnostic tests and x-rays)	Covered 100%	Covered 50% after $35 copay
Physician office visits		
Office visit to PCP	$25 copay	$35 copay
Office visit to specialist	$25 copay	$35 copay
Outpatient care		
Radiology, x-rays, lab work	20% after deductible	50% after deductible
Outpatient surgery	20% after deductible	50% after deductible
Inpatient care	20% after deductible	50% after deductible
Hospital services	20% after deductible	50% after deductible
Emergency room services	20% after deductible	20% after deductible
Prescription drugs		
Generic drug, 30-day supply	$10	$10
Preferred drug, 30-day supply	$30	$30
Non-preferred drug, 30-day supply	$50	$50
Mental health and substance abuse (for listed illnesses)		
Outpatient office visit	Covered 100% after $20 copay	Covered 100% after $20 copay
Inpatient care (per visit)	20% after deductible	50% after deductible
Rehabilitation services		
Home health care	20% after deductible	20% after deductible
Physical/occupational/speech therapy	20% after deductible	50% after deductible

Source: Anthem Blue Cross Blue Shield
Note: Listed mental illnesses include psychotic disorders, dissociative disorders, mood disorders, anxiety disorders, personality disorders, paraphilias, attention deficit and disruptive behavior disorders, pervasive developmental disorders, tic disorders, eating disorders, and substance abuse-related disorders.

Appendix Table 3. Unadjusted community rates for DirigoChoice, 2006 Q4

Plan option	One adult	Two adults	One adult and child(ren)	Two adults and child(ren)
(1) $1,250 deductible	$365	$766	$656	$1,094
(2) $1,750 deductible	$337	$708	$607	$1,011

Source: Karynlee Harrington and Will Kilbreth. "Dirigo Health: A Snapshot of the Program 2005 & 2006." Dirigo Health Agency. 2006.

The Dirigo Health Agency also established an Experience Modification Program (EMP) for the first two years of the contract, to further protect Anthem from the risks associated with potential adverse selection into the DirigoChoice pool. Under the EMP, the agency makes payments to Anthem prior to enrollment. If the experience outcome is more favorable in the DirigoChoice plan—that is, the loss ratio is at or close to 80 percent—Anthem returns all or some of the EMP payments to the agency. In calendar year 2005, of the approximately $8 million initially paid to Anthem, about $7.3 million was returned to the agency at the end of the year.[10]

Individual subsidies: The program offers discounts on monthly payments and reductions in deductibles and out-of-pocket costs up to 300 percent FPL (see Appendix Table 4).[11] Discount eligibility is based on household size.[12] The subsidies are structured on a sliding scale, with five separate discount levels. Small group employers and sole proprietors are required to contribute a minimum of 60 percent of employee-only (one adult) coverage cost for employees who work 30 or more hours per week. The employer contribution is pro-rated for employees working less than 30 hours per week.

Appendix Table 4. Discount rates for DirigoChoice enrollees

Discount Group	A MaineCare eligible	B 100-149% FPL	C 150-199% FPL	D 200-249% FPL	E 250-299% FPL	F 300% FPL
Discount on monthly coverage	100%	80%	60%	40%	20%	0%
(1) $1,250 deductible plan						
Annual deductible						
Single	$0	$250	$500	$750	$1,000	$1,250
Family	$0	$500	$1,000	$1,500	$2,000	$2,500
Out-of-pocket maximum						
Single	$0	$800	$1,600	$2,400	$3,200	$4,000
Family	$0	$1,600	$3,200	$4,800	$6,400	$8,000
(2) $1,750 deductible plan						
Annual deductible						
Single	$0	$500	$800	$1,125	$1,450	$1,750
Family	$0	$1,000	$1,600	$2,250	$2,900	$3,500
Out-of-pocket maximum						
Single	$0	$1,600	$2,600	$3,600	$4,600	$5,600
Family	$0	$3,200	$5,200	$7,200	$9,200	$11,200

Source: Karynlee Harrington and Will Kilbreth. "Dirigo Health: A Snapshot of the Program 2005 & 2006." Dirigo Health Agency. 2006.
Note: Group A members are MaineCare eligible. MaineCare eligibility is based on income level as well as other factors. Out of pocket maximum includes deductibles but not premiums or co-pays. FPL is based on the 2005 Federal Poverty Line limits.

To see how the subsidies work in practice, consider what it would cost for a family with two adults and two children, earning a total annual household income of $27,000, to obtain coverage under plan option (1). With no discount, the monthly premium would be $1,094 for family coverage, with an annual deductible of $2,500 and annual out-of-pocket expenses of $8,000 (see Appendix Table 5).

However, the family's household income makes them eligible for discount group B. If the family can obtain coverage through an employer, the employer pays 60 percent of the employee-only (one adult) coverage ($365*0.60=$219), and the remainder is with-

Appendix Table 5. DirigoChoice subsidies in practice
Example: Family of four (two adults and two children) qualifying for discount group B under plan option (1)

	Full cost without discount	Discount if coverage obtained through an employer	Discount if coverage obtained through a direct payer
Full-cost monthly premium	$1,094	$1,094	$1,094
Employer subsidy required (60% of employee-only coverage)	NA	$219	NA
Remaining premium (after required employer subsidy)	$1,094	$875	$1,094
Individual subsidy provided by state (80% of remaining premium)	N/A	$700	$875
Final monthly premium paid by family	$1,094	$175	$219
Annual deductible	$2,500	$500	$500
Maximum out-of-pocket costs	$8,000	$1,600	$1,600

Source: Author's calculations based on unadjusted community rates and individual subsidies

held from the employee's paycheck ($875). However, because the family qualifies for an 80 percent discount, the employee receives a monthly cash payment of ($875*0.80=$700) through a debit card. Thus, the family's net monthly premium obligation is only $175. In addition, the family qualifies for a discounted annual deductible cost of $500, and its maximum annual out-of-pocket expenses are limited to $1,600.

In contrast, if coverage cannot be obtained through an employer, the family would qualify for an 80 percent discount on the total monthly premium and would receive a monthly cash payment of ($1,094*0.80=$875) through a debit card. The net monthly premium obligation is now $219, slightly higher than under the employee scenario. However, the family is still eligible for the same annual deductible of $500 and the same maximum annual out-of-pocket expenses of $1,600. The difference in the dollar amount of the premium subsidy reflects the tradeoff between the need to give employers an incentive to join DirigoChoice and pay part of the coverage cost, and the desire to encourage universal coverage through generous subsidies regardless of employer decisions.

Characteristics of enrollees: Enrollment over the first two years has been evenly distributed across individuals (40 percent), sole proprietors (28 percent), and small groups (32 percent). Nearly half of individual enrollees were unemployed, and an additional 20 percent worked less than 20 hours per week. Roughly half of all enrollees had incomes between 100 percent and 149 percent FPL, qualifying them for an 80 percent discount off the standard premium.[13]

According to a survey of people enrolled during the first quarter of 2005, approximately 40 percent of Dirigo enrollees were uninsured at some point during the previous 12 months. Another 23 percent were underinsured prior to enrolling, meaning they had incomes under 200 percent FPL and coverage such that their deductibles exceeded 5 percent of income.[14]

When asked to compare DirigoChoice with their prior insurance coverage, more than half of the respondents said coverage under DirigoChoice was better.[15] About 40 percent of first-quarter enrollees who had prior coverage reported that the annual deductible under their previous plan exceeded $2,500, considerably higher than the $1,250 or $1,750 deductible under DirigoChoice. Nearly one-third of previously insured respondents did not have coverage for routine check-ups, screenings, or prescriptions, and about one-quarter did not have access to mental health care. Of the enrollees who were previously insured, 28 percent reported not getting care when they needed it, and of these, more than 80 percent said it was too costly to do so.[16]

Almost all DirigoChoice members eligible to renew choose to do so (94 percent). Most of those who chose to disenroll were young adults 18 to 24 years old. A recent survey of disenrollees revealed that about 40 percent of them disenrolled involuntarily, due to job loss, employer leaving the program, or non-payment of premiums. Voluntary disenrollees cited costs, inadequate benefits, and other issues, such as dissatisfaction with the administration of subsidies and a feeling that "Dirigo wasn't going to last." After disenrolling, roughly 60 percent had private coverage, 30 percent were uninsured, and the remainder had public coverage.[17]

Utilization and costs: Costs under the DirigoChoice program have been higher than anticipated. During the first year of operation, total costs were $348 per member per month, half of which was subsidized by the state. Some of this higher cost reflects the fact that a greater percentage of enrollees (over 60 percent) qualified for the highest subsidy category, a discount of 80 percent off of the standard premium.[18] In addition, according to Anthem, the medical claims of beneficiaries have been "significantly higher" than expected, roughly double those of non-Dirigo plans. Anthem speculates that one reason for the higher medical expenses was pent-up demand by enrollees who had been deferring visits to doctors while they were uninsured. It is also likely that those with the greatest medical needs were more likely to enroll. As of January 2007, premiums under DirigoChoice increased by 13.4 percent, and enrollees faced higher copays for office visits and prescription drugs.[19]

Massachusetts: Commonwealth Care and Commonwealth Choice

In April 2006, Massachusetts passed legislation creating two new insurance programs—Commonwealth Care and Commonwealth Choice—to be overseen by a new public entity, the Commonwealth Health Insurance Connector Authority (known as the Connector). Commonwealth Care, a state-subsidized insurance program, is expected to serve roughly 207,500 uninsured individuals who meet certain income eligibility requirements. Commonwealth Choice, a non-subsidized insurance program for individuals and small employers, is expected to serve another 215,000 Massachusetts residents. The next two sections describe in more detail the progress in designing the insurance packages under both programs.

Commonwealth Care

Implementation: Enrollment in Commonwealth Care began in October of 2006. As of June 1, 2007, the program covered roughly 79,000 people or about one-half of eligible individuals. Because most of these individuals were previously receiving services from the Uncompensated Care Pool (UCP), they were automatically enrolled in Commonwealth Care by the Connector, based on information they provided when they applied for UCP services.[20]

The program is a partnership between the Connector and the four managed care organizations (MCOs) that currently contract with the state's Medicaid program. These four MCOs—Boston Medical Center HealthNet Plan, Fallon Community Health Plan, Network Health, and Neighborhood Health Plan—will be the sole providers for the initial years of the program, provided that they meet certain enrollment targets. After July 2009, Commonwealth Care enrollees will be able to enroll in other plans.[21]

The new insurance product is a managed care plan with four differentplan types based on income:

- Plan Type I: 100 percent FPL or less
- Plan Type II: 100.1 percent FPL to 200 percent FPL
- Plan Type III: 200.1 percent FPL to 300 percent FPL (low premium option)
- Plan Type III: 200.1 percent FPL to 300 percent FPL (low copay option)

The Connector helps eligible individuals choose and enroll in a health plan. Once enrolled, individuals become members of the health plan they select.

Eligibility: The new insurance product is available to uninsured individuals who earn less than 300 percent FPL and are ineligible for MassHealth, the state's Medicaid program.[22] Individuals are considered insured if their (or a family member's) current employer offered them health insurance coverage within the last six months and covered at least 20 percent of the annual premium costs for a family and 33 percent of the annual premium costs for an individual. Individuals are considered uninsured if they are currently insured under COBRA, pay the full premium in the non-group market, or are in a waiting period prior to becoming eligible for an employer-provided plan.

Benefits: Commonwealth Care benefits are comprehensive and cover preventive care, outpatient services, inpatient care, emergency care, prescription drugs, mental health and substance abuse services, rehabilitation services, and vision care (exam and free glasses).[23] Although each of the health plans provides the same core benefits, some may offer special programs (e.g. weight loss or diabetes management) or value-added services (e.g. discounts at fitness centers). Enrollees are urged to compare health plans and choose the one that is right for them and available in their service area. Not all health plans are available statewide.[24]

Cost sharing: Commonwealth Care has no deductibles and cost sharing is limited. The amount of cost sharing also varies by plan type, with copays ranging from $0 to $10 for primary care visits and from $0 to $20 for visits to specialists, depending on plan type (see Appendix Table 6). Radiology, x-rays, and lab work are covered 100 percent

Appendix Table 6. Co-payments for selected benefits under Commonwealth Care

	Plan Type I <100% FPL	Plan Type II 100% to 200% FPL	Plan Type III 200% to 300% FPL Low Premium Option	Plan Type IV 200% to 300% FPL Low Copay Option
Preventive care				
Office visit to PCP	$0	$5	$10	$5
Office visit to specialist	$0	$10	$20	$10
Outpatient care				
Radiology, x-rays, lab work	$0	$0	$0	$0
Outpatient surgery	$0	$50	$100	$50
Hospital visit	$0	$50	$250	$50
Emergency room visit ($0 if admitted)	$0	$50	$75	$50
Prescription drugs				
Generic drug, 30-day supply	$1	$5	$10	$5
Preferred drug, 30-day supply	$3	$10	$20	$10
Non-preferred drug, 30-day supply	$3	$30	$40	$30
Mental health and substance abuse				
Outpatient office visit	$0	$10	$20	$10
Inpatient care (per visit)	$0	$50	$250	$50
Rehabilitation services				
Home health care	$0	$0	$0	$0
Physical/occupational/speech therapy	$0	$10	$20	$10
Vision benefits				
Eye exam every 24 months	$0	$10	$20	$10
Free glasses every 24 months	$0	$0	$0	$0

Source: Commonwealth Health Insurance Connector Authority, "Commonwealth Care Frequently Asked Questions." December 29, 2006. http://www.mass.gov. Accessed on February 26, 2007.

in-network. Prescription drugs are subject to copays ranging from $0 to $40, depending on plan type and formulary restrictions. Higher copays on the order of $50 to $250 exist for inpatient care, emergency services, and outpatient surgery.

Similar limits on cost sharing are also in place for pharmacy benefits and out-of-pocket costs. Individuals enrolled in Plan Type I pay a maximum of $200 per year for pharmacy benefits and $36 per year for all other services (e.g. emergency room use when not admitted). Maximum annual out-of-pocket copayments for plan types II, III, and IV range from $250 to $750 for inpatient medical care or outpatient surgery.[25]

Pricing: Prices are set for each plan based on a community rating methodology that takes into account factors such as age and location. Actual premium costs vary slightly across the four plans—even those in the same geographic area—due to differences in benefits (special programs or value-added

Appendix Table 7. Enrollee premiums for central Massachusetts ($s per member per month)
As of 12/15/2006

Plan type	Boston Medical Center HealthNet Plan	Fallon Community Health Plan	Network Health	Neighborhood Health Plan
(I) Less than 100% FPL	$334.30	$387.65	$327.38	$357.06
(II) 100.1% - 200% FPL	$298.40	$352.06	$295.84	$332.21
(III) 200.1% - 300% FPL (low premium option)	$278.15	$295.04	$276.43	$322.59
(IV) 200.1% - 300% FPL (low co-pay option)	$322.87	$343.32	$339.50	$359.72

Source: Commonwealth Health Insurance Connector Authority, "Enrollee Premiums by Commonwealth Care Service Area." http://www.mass.gov. Accessed on February 22, 2007.
Note: Central Massachusetts includes Athol, Framingham, Gardner-Fitchburg, Southbridge, Waltham, and Worcester.

Appendix Table 8. Enrollee contributions for central Massachusetts (monthly)
Single Adult
As of 12/15/2006

Plan option	Boston Medical Center HealthNet Plan	Fallon Community Health Plan	Network Health	Neighborhood Health Plan
Type I:				
Less than 100% FPL	$0	$0	$0	$0
Plan Type II:				
100.1% - 150% FPL	$20.56	$74.22	$0	$54.37
150.1% - 200% FPL	$42.56	$96.22	$35.00	$76.37
Plan Type III: (low premium option)				
200.1% - 250% FPL	$71.72	$88.61	$70.00	$116.16
250.1% - 300% FPL	$107.72	$124.61	$105.00	$152.16
Plan Type IV: (low co-pay option)				
200.1% - 250% FPL	$94.08	$112.75	$70.00	$134.73
250.1% - 300% FPL	$130.08	$148.75	$105.00	$170.73

Source: Commonwealth Health Insurance Connector Authority, "Enrollee Premiums by Commonwealth Care Service Area." http://www.mass.gov. Accessed on February 22, 2007. Updated with "Commonwealth care Frequently Asked Questions: Program Update May 1, 2007."
Notes: Central Massachusetts includes Athol, Framingham, Gardner-Fitchburg, Southbridge, Waltham, and Worcester. The state subsidizes half of the difference in premiums between high and low co-pay options for those earning between 200 and 300 percent FPL to reduce the potential for selection bias across these two choices.

services) and provider networks (Appendix Table 7 shows costs for one region, central Massachusetts).

Individual subsidies: A central piece of the plan is the provision of government-funded subsidies to low-income individuals to assist with the purchase of health insurance. Commonwealth Care provides sliding-scale subsidies to individuals with incomes up to 300 percent of the federal poverty level ($61,950 for a family of four) for the purchase of health insurance.

The Connector set the subsidy schedule to make health insurance affordable for individuals, while also leaving the employer-based private system of health care financing largely intact. Individuals with incomes less than 150 percent of the federal poverty level ($15,315 for an individual) are not required to pay any premiums.[26] For households with children, the state has agreed to waive the Medicaid premiums for children with MassHealth coverage whose parents enroll in Commonwealth Care.[27]

Monthly enrollee contributions for those with higher incomes vary, with contributions for a single adult for the least expensive plan ranging from $18 to $137, depending upon income level (see Appendix Table 8). Individuals with household incomes between 150 percent and 200 percent FPL receive subsidies of about 75 percent to 90 percent, depending upon household income and the specific plan selected. This is in keeping with the range of subsidies already set for similar individuals under the Massachusetts Insurance Partnership Program. Subsidies of 50 percent to 70 percent exist for those earning between 200 percent and 300 percent FPL—comparable to the average employee contribution toward group coverage, such as that offered to employees of the Commonwealth.[28]

Characteristics of enrollees: As of April 2006, approximately 550,000 people were uninsured in Massachusetts. Many of these individuals had limited or no access to employer-sponsored coverage and were low-income, part-time or seasonal workers, single childless adults, young adults, or children.

The Connector estimates that approximately 140,000 individuals may be eligible for Commonwealth Care, of which 79,000 were enrolled as of June 1, 2007. Most of these individuals were automatically enrolled by the Connector as previous members of the Uncompensated Care Pool. Approximately 54,000 of enrollees earn below 100 percent FPL, which represents roughly 90 percent of all uninsured individuals in this income

category. In contrast, only 15,560 enrollees earn between 100 percent and 300 percent FPL—about 19 percent of all uninsured individuals in this income category.

Commonwealth Choice

Commonwealth Choice is a separate health insurance program administered through the Connector. The program offers unsubsidized coverage from private insurance carriers to individuals and families and to small businesses. Commonwealth Choice plans are available through the Connector, from brokers, and directly from participating insurance carriers.

Implementation: The Commonwealth Choice program began offering health plans to individuals in May 2007, for effective coverage beginning July 1, 2007, just in time to satisfy the state's mandate requiring individuals to obtain coverage. Individuals can choose from four levels of coverage offered by seven carriers.[29] As of October 2007, small employers[30] will have the option of either making these plans available to their employees or allowing their employees to purchase one of the plans directly from the Connector, using pre-tax dollars through a Section 125 plan. The Connector will help eligible individuals to choose and enroll in a health plan, and once enrolled, individuals will become a member of the health plan they select.

Eligibility: Individuals are eligible for Commonwealth Choice if they are a resident of Massachusetts or employed by a Massachusetts-based employer, are 19 or older, and are not eligible for Commonwealth Care because their family income is above 300 percent FPL. The target market is young adults, small employers, and employers not currently offering a Section 125 plan. Framers of the initial legislation estimated that about 215,000 individuals would enroll in a Commonwealth Choice plan.

Benefits: Commonwealth Choice offers enrollees four levels of coverage—Premier, Value, Basic, and Young Adult—intended to meet the needs of different individuals and families. For example, products for young adults between the ages of 19 and 26 will offer "first dollar" coverage for primary care visits and comprehensive benefits, which is an important feature for this group. Each of the plans offers the same core benefits including:

- Inpatient services
- Outpatient services and preventive care by participating providers
- Prescription drugs
- Inpatient and outpatient mental health and substance abuse services
- Dental care, including preventive and restorative services
- Vision care

Moreover, each of the plans will uphold the state's new standards of Minimum Creditable Coverage (MCC), the minimum level of insurance that individuals will be required to buy as of January 2009. MCC, which is designed to provide individuals with financial access to a broad range of health care services, including preventive health care, without incurring severe financial losses as a result of serious illness or injury, applies to all insurance products in the state. Although health plans may still impose reasonable exclusions and limitations, the final regulations mandate that health insurance products must satisfy the following requirements:[31]

- They must provide a broad range of medical benefits, including preventive and primary care, emergency services, hospitalization, ambulatory patient services, prescription drugs, and mental health services.
- They cannot have annual maximum benefits or per-illness annual maximum benefits for core covered services.
- They cannot impose a fee schedule of indemnity benefits for in-network covered services that are medical benefits required to be part of a health benefit plan providing minimum creditable coverage.
- Deductibles for in-network covered services shall not exceed $2,000 for an individual and $4,000 for a family.

- Separate deductibles imposed for prescription drug coverage shall not exceed $250 for an individual and $500 for a family.

- If a health benefit plan includes deductibles or coinsurance for in-network core services, the plan must set out-of-pocket maximums for in-network covered core services that do not exceed $5,000 for an individual and $10,000 for a family. Amounts paid for prescription drugs, whether through deductibles, coinsurance or copayments, need not be considered in calculating the out-of pocket maximum.

- If the health plan imposes a deductible for in-network benefits, then the following must be covered on an annual basis before imposing a deductible: for an individual, at least three preventive care visits to a physician or other health care provider; and for a family, at least a total of six preventive care visits to a physician or other health care provider.

- Prescription drugs must be covered in one of the following ways:

- The plan includes prescription drugs as a covered medical benefit, after a deductible ranging from $0 to $250 for individuals and from $0 to $500 for families; or

- If specified in an administrative bulletin issued pursuant to approval of the Connector's Board, alternative plan designs would allow for coverage of pre-

Appendix Table 9
Cost sharing across Commonwealth Choice plan types

	Premier	Value	Basic	Young adult
Deductibles	None	• $500 to $1,000 • After deductible, no cost sharing for hospital inpatient and outpatient surgery • Office visits covered, pre-deductible	• Choice of no deductible or a deductible of $1,000, $1,500, or $2,000 • Preventive care covered pre-deductible	• $0 to $2,000 • Preventive care covered, pre-deductible
Copays for office visit	$10	• PCP: $15 to $25 • Specialist: $15 to $40	• PCP: $25 to $35 • Specialist: $25 to $50 • One plan charges 20% coinsurance for office visits	• PCP: $25 to $50 • Specialist: $25 to $50 • One plan charges 20% coinsurance for office visits after the first three visits
Inpatient admission	No charge	• $250 per admission to $500 per day • $2,000 annual max	• No charge after deductible to 35% coinsurance for the plan with no annual deductible	• 20% / 30% / 60% coinsurance after deductible • One plan requires no copay after the deductible
Outpatient surgery	No charge	—	• No charge after deductible to $150-$250 copay after deductible, to 25%-35% coinsurance	• 20% / 30% / 60% coinsurance after deductible • One plan requires no copay after the deductible
Prescription drug coverage	$10/$25/$45	• Standard formulary • Generic-based formulary	• Six of the plans cover Rx prior to the annual deductible • Two plans have a separate Rx deductible of $100 and $250 per individual	• Three of the carriers offer plans without Rx coverage • Plans with Rx coverage have copays for: Tier 1: $10-$20 Tier 2: $30 to 50% of cost Tier 3: $50 to 50% of cost

Source: Commonwealth Health Insurance Connector Authority, "Staff Recommendations Seal of Approval." March 8, 2007. http://www.mahealthconnector.org/portal/site/connector. Accessed on May 20, 2007.

Appendix Table 10. Weighted average individual premium by plan type
37 Year-old Individual

	Premier	Value	Basic (w/ Rx coverage)	Young adult
Neighborhood Health Plan	$285.08	$225.30	$164.47	$134.78
Fallon Community Health Plan	$366.00	$226.00	$172.00	$122.00
Tufts Health Plan	$397.13	$291.81	$236.05	$201.76
ConnectiCare	$421.75	$306.03	$245.74	$202.03
Blue Cross Blue Shield of MA	$455.58	$332.05	$265.84	$205.25
Harvard Pilgrim Health Care	$568.20	$412.97	$280.79	$144.02
Health New England	$406.45	$297.55	$237.59	$201.15

Source: Commonwealth Health Insurance Connector Authority, "Staff Recommendations for Health Insurance Carriers for Commonwealth Choice." March 3, 2007.
Notes: Basic plan and Young Adult plan includes prescription drug coverage. Value plan is for the low premium / high deductible option.

ventive prescription drugs without any deductible, in addition to coverage of other prescription drugs with a deductible, copayment or coinsurance, for a projected average increase of no more than 5 percent in the price of premiums.

Cost sharing: Affordability was a key issue in designing the plans. Although monthly premium costs were the primary factor in choosing among health plans, focus group participants were also concerned about the amount of cost sharing for office visits, prescription drugs, and inpatient services. As a result, deductibles and cost sharing vary by individual plan, although they must still meet the minimum creditable coverage guidelines established by the Connector (see Appendix Table 9).[32] Key features of the plans include: [33]

- Deductibles ranging from zero to $2,000. Three of the four plans with a $2,000 deductible allow unlimited office visits subject only to a copayment prior to the deductible.
- Prescription drugs are covered prior to the annual deductible by six of the seven carriers. The other two carriers offer separate prescription drug deductibles of $100 and $250.
- Preventive care physician visits have copays ranging from zero to $35. All plans provide at least three preventive care visits for individuals and six for families before the deductible can be applied.
- Office visits copays range from $25 to $50, with one carrier paying for 80 percent of the visit.
- Outpatient surgery cost sharing ranges from no charge after the deductible to copays of $150 to $250 after the deductible and/or coinsurance of 20 to 35 percent.
- Routine vision exams have copays from zero to $35.

Pricing: The Connector was charged with the difficult task of negotiating with carriers to provide plans that would satisfy Minimum Creditable Coverage criteria, while also meeting the legislated requirement of affordability, a necessary condition in order for the individual mandate to be enforceable.[34] Although the plans vary by deductibles and amount of cost sharing, premiums for many groups fall within (or even below) the affordable range as suggested by policymakers (see Appendix Table 10). While Chapter 58 does not specifically define "affordable," legislators have indicated that premiums for low-cost products should range from $200 to $250 per month.[35] For example, the typically uninsured 37-year-old in eastern Massachusetts, the state's most expensive region, can expect to pay monthly average premiums ranging from $175 to $288 (with some cost sharing). If purchased on a pre-tax basis through an employer's Section 125 plan, the net cost of the $175 average premium is reduced to $109 for an individual earning $50,000 per year.

Yet because specific prices for each individual vary based on plan, age, and region, some healthcare advocates are concerned that plans for some groups are not affordable. For

example, monthly premiums for basic plans for people 56 years old or older in the eastern part of the state vary from $309.19 to $504.69 per month.[36] In response to health care activists who questioned the affordability of the proposed plans, the Connector voted to exempt approximately 60,000 individuals from the mandate to purchase health insurance. Half of those exempted are individuals who earn below 300 percent FPL but who are not eligible for subsidies because their employers offer insurance.[37] The other half is individuals earning just above 300 percent FPL, for whom the costs of obtaining minimal creditable coverage would exceed $150 per month.[38] These are primarily older individuals on fixed incomes who face higher premiums because of their age.[39]

Individual discounts: There are no subsidies under Commonwealth Choice. Individuals and/or employers pay monthly premiums, which vary depending on the health plan and benefit package chosen. However, the monthly premium is reduced when individuals are able to pay for coverage on a pre-tax basis through a Section 125 plan. In addition, more than one employer may contribute to an employee's insurance premium, helping employees with more than one job. [40] Commonwealth Choice also has the advantage of portability for employees who switch jobs.

Employer fees

Fair Share Contribution: The Fair Share Contribution is a fee that employers pay if they do not make a "fair and reasonable" premium contribution to the health insurance of their employees.[41] This includes all employees at Massachusetts locations, whether or not they are Massachusetts residents.[42] Employers are subject to the Fair Share Contribution if:

1. The employer has 11 or more full-time equivalent employees who are employed at Massachusetts locations, and;

2. The employer does not make a "fair and reasonable" premium contribution towards health insurance for its employees.

An employer satisfies the "fair and reasonable" premium contribution if either:

a. At least 25 percent of its full-time employees are enrolled in the employer's group health plan. The percentage of participation is calculated as:

$$\frac{\text{Total Annual Payroll Hours of Enrolled Full-Time Employees}}{\text{Total Annual Payroll Hours of all Full-Time Employees}*100}$$

A full-time employee is defined as someone who works 35 hours or more per week. Independent contractors, seasonal employees whose employment does not exceed 16 weeks, and temporary employees who do not work for more than 12 consecutive weeks are excluded from the numerator. Note that the numerator also excludes employees who receive health care from other parties (e.g. a spouse's health plan or a government program).

Or,

b. The employer offers to contribute at least 33 percent of the premium cost of its health plan to all full-time employees employed for more than 90 days during the determination period, from October 1, 2006 through September 30, 2007.

Employers who fail to make a "fair and reasonable" contribution will be required to pay a "Fair Share Contribution" of up to $295 per year per employee. The amount is pro-rated for part-time employees. The exact amount, which will be determined by the Director of Workforce Development and the Division of Health Care Finance and Policy, will be collected by the Division of Unemployment Assistance.

Free Rider Surcharge: The Free Rider Surcharge is a surcharge on employers who do not comply with the requirement to establish a Section 125 plan that meets the regulations of the Connector.[43] A Section 125 plan allows employees to pay for heath insurance coverage on a pre-tax basis and is not subject to state and federal taxes or federal FICA withholding taxes, thereby reducing payroll-related taxes. The surcharge is assessed for "state-funded health services" that are incurred by employees or their dependents.

More specifically, employers may be subject to the Free Rider Surcharge if they meet all of the following criteria:[44]

1. The employer has 11 or more employees.

2. Employees or their dependents received "state-funded health services"—health services that were paid for by the state through the Uncompensated Care Trust Fund (also known as the "uncompensated care pool") or the newly created Health Safety Net Trust Fund. To be counted as receiving health care services, within one hospital fiscal year either:

    a. The total number of visits to hospitals or clinics (including community health centers) made by a single employee and his/her dependents must be greater than three, or,

    b. The total number of visits to hospitals or clinics (including community health centers) by all the employees and their dependents must be greater than five.

3. These employees were not offered a Section 125 plan that meets the regulations of the Connector.

4. These "state-funded health services" are at least $50,000 in one hospital fiscal year.

Note that employers are not subject to the Free Rider Surcharge for those employees who are covered by certain collective bargaining agreements or who participate in the state's Insurance Partnership Program. The annual amount of the additional surcharge, still to be determined, will vary based on the number of employees, the utilization of the uncompensated care pool, total state-funded costs, and the percentage of employees enrolled in the employer's health plan.[45]

Rhode Island's HealthPact RI

In July 2006, Governor Carcieri signed into law health care legislation creating a new affordable health insurance product, Health Pact,RI. The program aims to reduce premium costs for small businesses by 25 percent[46] and increase enrollment among their employees by 15 percent or 10,000 individuals.[47]

Implementation: The state's role has been to design HealthPact RI and work with insurers so that it is offered in the commercial market to small employers. The Office of the Health Insurance also negotiates low premium rates on behalf of small employers. There are no requirements or guidelines for employer contributions towards premiums.

Eligibility: Beginning in October 2007, HealthPact RI will be offered to employers with 50 or fewer employees. The product will later be expanded to individuals purchasing insurance directly in the individual market, sometime in 2008.[48] The state estimates that of the 120,000 uninsured individuals who are eligible for the plan, roughly one-quarter, or 27,000 people, would be expected to enroll.

Benefits: One key challenge in designing HealthPact RI was to create an affordable health plan that would be attractive to individuals and small employers, satisfy the state's minimum benefits standards, and meet the price constraints set by the legislation.[49] To that end, the WellCare Advisory Committee, comprised of small employers, individual subscribers, employer organizations, health insurance brokers, consumer advocates, and labor unions, developed a set of plan specifications for HealthPact RI.

The resulting product specifically targets employers who, in the absence of the program, might otherwise switch to a high-deductible health plan or drop coverage altogether. It is an HMO-type plan that includes all mandated benefits, including primary and preventive care, dental care, diagnostic testing, acute episodic care, hospital services, mental health and substance abuse services, infertility services, and prescription drug coverage. Chiropractic and vision care are not covered.

Cost sharing: There are two levels of coverage, Advantage and Basic. Participants who meet certain wellness requirements qualify for the Advantage level and have lower out-of-pocket costs (see Appendix Table 11). For example, Advantage Plan beneficiaries face

a deductible of $750 for medical services, copays of $10/$50 for physician office visits (PCP/specialists), 10 percent coinsurance for most inpatient and outpatient services, an out-of-pocket maximum of $2,000, and no lifetime limit on benefits.

In contrast, Basic Plan beneficiaries face a deductible of $5,000 for medical services and $250 for pharmacy benefits, copays of $30/$60 for physician office visits (PCP/specialist), 20 percent coinsurance for most inpatient and outpatient services, an out-of-pocket maximum of $5,000, and a $1 million lifetime limit on benefits. Prescription drugs for either plan are also subject to copays ranging from $10 to $75, depending on the preferred status of the drug.

Finally, in an effort to control rising health care costs, the plan provides enrollees an incentive to use more cost-efficient providers. Within each of the two plans, there will be a two-tier system of health care providers "who have demonstrated cost-effective, high-quality practice patterns," based on quality and cost indicators. Beneficiaries will be required to pay more for physicians who are not in the most cost-efficient (first tier) of the plan. For example, an Advantage level individual would face only a $15 copay to see a primary care physician in Tier 1 versus a $30 copay to see a primary care physician in Tier 2. However, it is not clear whether there will be enough data to identify the most cost-efficient providers, at least initially.[50] Network-based tiering is scheduled to be implemented in year two of the product rollout—targeting October, 2008.

Pricing: The goal in pricing HealthPact RI was to offer an affordable health insurance product to small businesses and the individual market in order to encourage these groups to remain insured and not drop their health insurance coverage. To that end, the legislation required that the target for the average annualized premium rate would be less than 10 percent of the "average annual statewide wage," as reported by the Rhode Island Department of Labor and Training. This translates into an average monthly premium of about $314 per individual. Actual rates will vary based on group demographics.[51] However, it is not clear that the $314 target premium will be affordable to most of the uninsured individuals as there are no direct public subsidies and no requirements on employers to make any contributions towards monthly premiums.

As of April 2007, the state had approved plans submitted by Blue Cross Blue Shield

Appendix Table 11. Final specifications for HealthPact RI cost sharing, effective October 2007

	Advantage plan	Basic plan
Annual deductible		
Single	$750	$5,000
Family	$1,500	$10,000
Primary care physician office visit		
Tier 1 (most cost-efficient)	$10 copay	$30 copay
Tier 2 (least cost-efficient)	TBD – Oct 2008	TBD – Oct 2008
Specialist office visit		
Tier 1 (most cost-efficient)	$30 copay	$60 copay
Tier 2 (least cost-efficient)	TBD – Oct 2008	TBD – Oct 2008
Inpatient/outpatient facility services		
Tier 1 (most cost-efficient)	90% after deductible	80% after
Tier 2 (least cost-efficient)	TBD	TBD
Laboratory tests/ diagnostic imaging		
Tier 1 (most cost-efficient)	90% after deductible	80% after deductible
Tier 2 (least cost-efficient)	TBD	TBD
Hospital emergency room visit	No charge after $200 copay (waived if admitted)	No charge after $200 copay (waived if admitted)
Mental health & substance abuse		
Inpatient		
Tier 1 facility	90% after deductible	80% after deductible
Tier 2 facility	TBD	TBD
Outpatient		
Tier 1 visit	$50 copay	$60 copay
Tier 2 visit	TBD	TBD
Prescription Drugs		
Deductible (does not apply to generics)		
Single	None	$250
Family	None	$500
Retail (30 day supply)		
Generic	$5	$5
Select brand	$40	$40
Non-select brand	$75	$75
Annual out-of-pocket maximum		
Single	$2,000	$5,000
Family	$4,000	$10,000
Lifetime benefit maximum	Unlimited	$1 million per participant

Source: Office of the Health insurance Commissioner, State of Rhode Island. Wellness Health Benefit Plan Final (Revised) plan design details. May 2007.
Note: Annual out-of-pocket maximum excludes both medical and pharmacy deductibles.

Appendix Table 12. Comparison of cost sharing under HealthPact RI recommendations and approved plans

	HealthPact RI recommendations	United Healthcare	Blue Cross Blue Shield
Advantage cost sharing			
Average individual premium	$314	$310	$321
Individual deductible	$500	$750	$750
Individual out-of-pocket maximum	$1,500	$2,000	$2,000
Primary care office visit copay	$15	$10	$10
Specialist office visit copay	$30	$50	$50
Coinsurance (does not apply to office visits)	100%	90%	90%
Prescription coverage	$5/$40/$75	$10/$40/$75	$10/$40/$75
Basic cost sharing			
Average individual premium	$314	$310	$321
Individual deductible	$3,000	$5,000	$5,000
Individual out-of-pocket maximum	$3,000	$5,000	$5,000
Primary care office visit copay	$30	$30	$30
Specialist office visit copay	$60	$60	$60
Coinsurance (does not apply to office visits)	100%	90%	90%
Prescription coverage	$5/$40/$75	$10/$40/$75	$10/$40/$75

Source: "OHIC Approves United and Blue Cross Wellness Health Benefit Plans for Small Employers." Rhode Island Government Press Release. April 2007.
Note: HealthPact RI recommendations are for beneficiaries who see providers in Tier 1.

of Rhode Island and UnitedHealthcare of New England. The average rates for an individual monthly premium come close to the state target, at $310 for United and $321 for Blue Cross Blue Shield (see Appendix Table 12). The difference in premiums reflects small differences in plan designs as well as different operational costs for each insurer in implementing the Advantage and Basic cost-sharing levels. For the Basic level, cost sharing under both United and BCBS differs significantly from the recommended levels. As with all products in the small group market, an employer's annual premium will vary from the average based on age, gender, family size, and to some extent, the claims of the group.[52]

Prior to the annual renewal process, insurers must report the actual premium, actuarial paid claims, actual incurred claims, number of member months, and the number of subscribers by demographic group. Evaluation against the target premium will be adjusted for actual demographics (age, sex, and family size), using the relative cost factors set by the state. Health status will be assumed to be rate-neutral and will not be an allowable factor for ex-post evaluation.[53]

Individual subsidies: Although individuals do not receive direct public subsidies when enrolling in HealthPact RI, a key component of the state's health care reform plan is to achieve significant cost savings by giving enrollees financial incentives to improve and maintain their own health, reflected in the two benefit levels. All individuals qualify for the Basic level. To qualify for the Advantage level, participants must meet five key wellness initiatives:[51]

- Selection of a primary care physician
- Completion a health risk assessment
- Pledge to either remain at a healthy weight or participate in weight management programs if morbidly obese[55]
- Pledge to either remain smoke-free or participate in smoking cessation programs[56]
- Pledge to participate in disease and case management programs when offered by insurance carriers

The Advantage level requires that the subscriber and other family members actively engage in their own health by continuing to comply with the wellness criteria each year. In return, Advantage participants have lower copays for physician visits, lower coinsurance for specific procedures, lower annual deductibles, and lower out-of-pocket costs.[57]

Vermont: Catamount Health and Employer-Sponsored Insurance Premium Assistance programs

Passage: In May 2006, Governor Jim Douglas signed into law Acts 190 and 191 of Vermont's health care reform initiative, with the goal of insuring 96 percent of the state's residents within the next five years. In the move toward universal access, the law creates two new insurance programs. The first, Catamount Health, is a state-subsidized insurance program expected to serve roughly 25,000 uninsured individuals who meet certain income eligibility requirements.[58] The second is a separate Employer-Sponsored Insurance Premium Assistance program that will allow uninsured employees whose incomes are less than 300 percent FPL to receive assistance in purchasing their employer's health insurance plan. The next two sections describe these programs in more detail.

Catamount Health

Implementation: Catamount Health is intended to gain the cooperation of private insurers to offer lower-cost, reasonably comprehensive policies to the uninsured under defined conditions, with the state subsidizing the cost of these private policies where needed. Insurers go through the usual rate-setting process at the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA). The state is authorized to require that hospital and medical service corporations and nonprofit HMOs operating within the state offer Catamount Health if no private insurers offer it voluntarily.[59] Thus far, two insurers, Blue Cross Blue Shield of Vermont and MVP Health Plan, have indicated their willingness to participate.[60]

Enrollment in Catamount Health will begin in October 2007. The state estimates that about 63,000 individuals in Vermont are uninsured, of whom about 60 percent, or 38,000 people, are eligible for Medicaid or one of its programs.[61] The remaining 25,000 uninsured individuals would be eligible for Catamount Health if they have been uninsured for at least 12 months. Of these 25,000, the state estimates that about 16 percent would sign up for Catamount Health in year one, followed by 33 percent in year two, and the remaining 50 percent in year three (see Appendix Table 13).[62]

Appendix Table 13. Expected enrollment in Catamount Health

Plan year beginning:	Single	Two-person	Family
October 1, 2007	2,933	586	391
October 1, 2008	5,998	1,200	800
October 1, 2009	9,365	1,873	1,249

Source: Susan Besio. "Preliminary Estimates for Catamount Health Insurance Premiums." Memorandum to the State of Vermont Agency of Administration. October 30, 2006.

In January 2009, the legislature may consider several expansions to Catamount Health. These include eliminating some or all of the 12-month waiting period, allowing the underinsured to buy into the plan, and allowing employers to buy into the plan.[63] If the goal of 96 percent coverage is not achieved by 2010, an individual mandate to purchase insurance may be considered.[64]

Eligibility: Catamount Health will be made available to Vermont residents 18 years or older who do not qualify for Medicaid and its extended programs (Vermont Health Access Plan and Dr. Dynasaur), do not have access to employer-sponsored coverage (with some exceptions),[65] and have been uninsured for at least 12 months.[66]

Benefits: The new insurance product is a PPO plan that will provide enrollees with a comprehensive package similar to the median Blue Cross Blue Shield plan offered in the state.[67] Plan benefits include primary care, preventive care, acute episodic care, and hospital services. All new enrollees in the program will also receive a health risk appraisal that will be used to develop a "best clinical practice" care plan for each individual.[68]

Catamount Health does include a pre-existing condition limitation, whereby a carrier may limit coverage for a condition that existed during the 12-month period before the effective date of coverage. However, the limitation does not apply to chronic care services as long as the individual participates in a chronic care management program.[69] Also, carriers are instructed to waive any pre-existing condition provisions for all individuals and their covered dependents who produce evidence of continuous cred-

Appendix Table 14. Cost sharing for Catamount Health

Deductibles	In-Network: Out-of-Network:	$250/individual $500/individual	$500/family $1,000/family
Co-insurance	20%		
Copays for office visit	$10		
Prescription drug coverage	No deductible $10 for generic drugs $30 for drugs on the preferred list $50 for non-preferred drugs		
Out-of-pocket maximum	In-Network: Out-of-Network:	$800/individual $1,500/individual	$1,600/family $3,000/family
Preventive care	$0		
Chronic care	$0 for individuals enrolled in the chronic care management program. Subject to the above amounts otherwise.		

Source: "2006 Health Care Reform Initiatives – The Details." The State of Vermont Legislature. http://www.leg.state.vt.us/HealthCare/2006_Health_Care_Constituent_Information_Sheet.htm. Accessed on March 20, 2007.
Note: Preventive care is not subject to deductible, co-insurance, and co-payments. Out-of-pocket maximum does not include premium payments; includes deductibles, co-insurance, and co-payments.

itable coverage during the previous nine months.[70]

Cost sharing: Unlike most other states, cost sharing under Catamount Health has been specified in detail under Acts 190 and 191.[71] For example, deductibles for individuals range from $250 in-network to $500 out-of-network, after which patients are expected to pay 20 percent of their medical bills, with a cap on out-of-pocket costs (see Appendix Table 14). Preventive care is covered 100 percent and is not subject to deductibles, coinsurance, or copayments. Chronic care is also fully covered for individuals who are enrolled in a chronic care management program. Prescription drugs are subject to copays ranging from $10 to $50, depending on the preferred status of the drug.

Pricing: Premium rates for Catamount Health are actuarially determined and designed to balance the need for consumer affordability with insurer financial stability. Premiums are community rated and are to be based on reasonable projections of anticipated or incurred utilization under the program. In addition to the expected costs of medical claims, community rates may allow for administrative expenses, taxes, profit or contribution to reserves, and the cost of reinsurance. However, just like the rest of the individual market in Vermont, medical underwriting and screening to exclude or individually rate a Catamount insured is not allowed. Moreover, premium rates are not adjusted for demographics (including age or gender), geographic area, or industry.[72]

Initial estimates of premium rates for the first year were generated using the Blue Cross Blue Shield PPO rates for the fourth quarter of 2006 as a baseline and adjusting for the different benefit levels and administrative costs of the Catamount Health plan, the age distribution of the uninsured population in Vermont, and provider reimbursement levels under the program. These initial rates were then projected forward for years two and three, using an inflation factor for hospital services, professional services, and prescription drug costs. Additional corrections to premiums in years two and three were made for declining adverse selection (e.g. individuals who have greater medical needs are expected to enroll first), reduced cost shifting (as more individuals obtain coverage and no longer rely on the safety net), and greater chronic care management.[73]

The ultimate cost of Catamount Health to the state will thus depend on how well the proposed premium rates submitted by private insurers match up to these initial estimates. Act 191 specifies benefit levels as well as exact dollar amounts for deductibles, copays, and out-of-pocket expenses, as well as premium contributions by income bracket. This means that any gap between the individual premium contributions set by statute and the premiums charged by insurers will be borne by the state.[74]

After two years, the state will review the cost-effectiveness of the private plans, taking into consideration premium rates, costs of administration and reserves, premium assistance to individuals, affordability to individuals, and enrollment numbers.[75] If the current situation is not found to be cost-effective, the state may choose to self-insure and assume the risk of providing insurance, while still relying on private insurers to administer the program.[76] The risk to the state could be capped by reinsurance or a stop-loss policy beyond a certain point.[77]

Individual subsidies: A key element of Catamount Health is to make the program affordable to all residents by providing premium assistance to low-income uninsured individuals and families. Sliding scale subsidies will be available to individuals and families with household incomes up to 300 percent FPL (see Appendix Table 15). Depending on the final cost of the product, the amount of subsidy ranges from 80 percent for individuals in the lowest income bracket (below $19,600) to 60 percent for individuals in the highest income bracket (between $26,950 and $29,400). Uninsured individuals with incomes greater than 300 percent FPL will be eligible to buy coverage under Catamount Health but would receive no subsidy, paying the full premium, estimated at $362 per month.[78]

Appendix Table 15. 2006 Catamount Health premium subsidies for individuals least expensive plan

Income by federal poverty level (FPL)	Subsidy (percent)	Monthly premium cost (dollars)
Below 200% FPL ($19,600)	82%	$60
200-225% ($19,600 – 22,050)	74%	$90
225-250% ($22,050 – 24,500)	68%	$110
250-275% ($24,500 – 26,950)	63%	$125
275-300% ($26,950 – 29,400)	60%	$135
Over 300% ($29,400)	0%	Full cost, estimated at $362

Source: Susan Besio. "Preliminary Estimates for Catamount Health Insurance Premiums." Memorandum to the State of Vermont Agency of Administration. October 30, 2006.

Employer-Sponsored Insurance Premium Assistance Program

Implementation: The second feature of Vermont's health care reform plan is the Employer-Sponsored Insurance (ESI) Premium Assistance Program, which allows the state to assist more Vermonters in obtaining coverage for a given level of funding. This is because employer contributions to ESI premiums are likely to make ESI premium assistance a lower cost option, compared to enrolling individuals in Catamount Health. In each case, the state will review the employer's plan and determine which option would be more cost-effective to the state—providing assistance through the premium assistance program or enrolling the individual directly in Catamount Health or another public program.[79] The state estimates that expanding coverage under the premium assistance program would result in an additional 1,316 individuals enrolling in the Vermont Health Access Plan (VHAP), of which 85 percent would have cost-effective ESI plans, allowing them to be enrolled in the premium assistance program.[80]

Eligibility: Under the program, two groups of uninsured individuals are eligible for premium assistance:[81]

- Individuals with incomes under 150 percent FPL and parents under 185 percent FPL who are eligible for VHAP and have access to ESI plans.
- Individuals with incomes between 150 percent and 300 percent FPL who have access to ESI plans.[82] Individuals in this category must also be uninsured for at least 12 months to be eligible for premium assistance, with some exceptions.[83]

Benefits/Cost sharing/Pricing: If the individual earns less than 150 percent FPL (185 percent FPL for parents or caretakers) and would otherwise be eligible for VHAP, the employer's plan must be equivalent to the typical plan offered by the four largest insurers in the small group and association market. In addition, the Office of Vermont Health Access will provide "wrap-around" coverage to ensure that the individual receives the same benefits as would be available through VHAP.[84] The individual would pay no more than the monthly VHAP premium and would not be responsible for any cost sharing (deductibles, coinsurance, and copays) above those for VHAP.[85]

If the individual earns between 151

Appendix Table 16. 2006 Monthly premium costs for individuals

Income by federal poverty level (FPL)	VHAP	VHAP ESI	ESI	Catamount
50-75%	$7	$7	—	—
75-100%	$25	$25	—	—
100-150%	$33	$33	—	—
150-185%	$49	$49	$60	$60
185-200%	—	—	$60	$60
200-225%	—	—	$90	$90
225-250%	—	—	$110	$110
250-275%	—	—	$125	$125
275-300%	—	—	$135	$135

Source: Office of Vermont Health Access, Agency of Human Services, "Employer-Sponsored Insurance Premium Assistance." Report to Health Access Oversight Committee and Joint Fiscal Committee. November 22, 2006.
Note: VHAP = Vermont Health Access Plan
VHAP ESI = Premium assistance for people eligible for VHAP and enrolled in an ESI plan
ESI = Premium assistance for people not eligible for VHAP and enrolled in an ESI plan
Catamount = assistance for people enrolled in Catamount Health and earning less than 300% FPL

percent (186 percent for parents or caretakers) and 300 percent FPL and would otherwise be eligible for Catamount Health, the employer's plan must be equivalent to Catamount Health and provide appropriate coverage of chronic conditions. In addition, any cost sharing for chronic care through the employer's plan would be covered by a wrap-around benefit.[86]

Individual discounts: The state's health care reform legislation requires that the premium assistance program provide a premium subsidy on a sliding scale, based on the household income of the eligible individual. For VHAP eligible individuals, the Agency for Human Services is proposing to set the individual contributions to ESI under the premium assistance program equal to the VHAP premiums as of July 1, 2007. For individuals not eligible for VHAP, the agency is proposing that individual contribution levels be the same as the contributions for Catamount Health (see Appendix Table 16).

Employer contributions: The state estimates that initial enrollment in the premium assistance program will cause employers to increase contributions by about $6 million. Based on an average monthly premium of $456 and using an average employer contribution of 80 percent, the average monthly cost of providing ESI is roughly $365 per enrolled employee. Given estimates that 1,443 individuals would enroll in ESI plans as a result of the premium assistance program, the total annual cost to employers is estimated to be $6.3 million. Offsetting this cost is the requirement that employers pay an annual assessment of $365 per year per full-time worker not enrolled in an ESI plan and with no other source of coverage. Assuming all 1,443 individuals work full-time, this would cost $526,695. On net, employers would be contributing an additional $5.8 million for ESI under the program.[87]

Characteristics of enrollees: According to a recent survey, about 17,000 Vermont residents are eligible for, but are not enrolled in, VHAP. Although 63 percent have some earned income, only 10 percent (or 4,830) are eligible to enroll in an ESI plan, either because employers do not offer health insurance or because individuals do not work enough hours to qualify for their employer's plan.[88]

Using actual claims costs for VHAP recipients who were also eligible for ESI, the Office for Vermont Health Access simulated potential costs under the premium assistance program and Catamount Health, including premiums, deductibles, coinsurance, and out-of-pocket costs. It found that about half of VHAP beneficiaries who had access to and were eligible for ESI (about 5 percent of the total VHAP population) would have cost-effective ESI plans, thereby making them eligible for the premium assistance program. The difference between the estimated claims costs for this group versus the estimated costs of their ESI premium plus wrap-around coverage could potentially save the state about $5 million for the three-year period of FY08 through FY10.[89]

Employer fees

Like Massachusetts, the Vermont plan imposes financial penalties on employers who do not offer coverage (although unlike Massachusetts individuals are not mandated to purchase insurance). As of April 1, 2007, employers may be levied an assessment on their employees if (1) they do not offer to pay any part of the cost of health coverage for their employees, (2) they offer insurance to pay for health coverage for only some of their employees, or (3) their employees do not choose to enroll in the plan they provide and they have no other source of health coverage.

Employers falling into any of these

three categories will be required to pay an annual assessment based on the number of uninsured full-time equivalent (FTE) employees. To defray some portion of the costs for small employers, the first eight FTE are excluded, meaning that firms with only eight FTE will pay no penalty.[90] The assessment is equal to $365 ($1 per day) per uninsured FTE in 2008 and will increase in future years at a rate equal to the annual growth rate of Catamount Health premiums (estimated to be 5 percent per year).[91]

More specifically, employer health care premium contributions are calculated in the following manner:[92]

- Add the total hours worked by all uncovered employees during the quarter.
- For each salaried employee, use 520 hours a quarter;
- For each employee who works in excess of 520 hours in the quarter, use only 520 hours per quarter;
- Divide the resulting number by 520 to represent one FTE and round down to the nearest whole number.
- Subtract 8 FTE in 2008 (6 FTE in 2009, 4 FTE in 2010).
- Multiply the resulting number by the quarterly health care premium contribution, currently established as $91.25.

Endnotes

1 HealthLeaders-InterStudy, *New England Health Plan Analysis*. Vol. 5 No. 4, Fall 2006.

2 Specifically, individuals who are unemployed, work for a small business that does not offer insurance, own a small business but cannot get enough employees to join a small group plan, work less than 20 hours a week for any single employer, or are early retirees whose employer does not contribute to health benefits.

3 Karynlee Harrington and Will Kilbreth. "Dirigo Health: A Snapshot of the Program 2005 & 2006." Dirigo Health Agency. 2006.

4 Individuals and sole proprietors are only eligible for the $1,750 deductible option.

5 Karynlee Harrington and Will Kilbreth. "Dirigo Health: A Snapshot of the Program 2005 & 2006." Dirigo Health Agency. 2006.

6 Anthem Blue Cross Blue Shield DirigoChoice Individual Rate Filing.

7 Karynlee Harrington and Will Kilbreth. "Dirigo Health: A Snapshot of the Program 2005 & 2006." Dirigo Health Agency. 2006.

8 Anthem Blue Cross Blue Shield DirigoChoice Individual Rate Filing.

9 Karynlee Harrington and Will Kilbreth. "Dirigo Health: A Snapshot of the Program 2005 & 2006." Dirigo Health Agency. 2006.

10 Karynlee Harrington and Will Kilbreth. "Dirigo Health: A Snapshot of the Program 2005 & 2006." Dirigo Health Agency. 2006.

11 Household income at 300 percent FPL was $58,050 for a family of four and $28,710 for a single adult in 2005.

12 Household income is based on all forms of income, including gross wages, tips and salaries, net self-employment income, investment income, IRA and 401K distributions, pensions and annuities, net rental income, unemployment compensation, Social Security, and gross child support and/or alimony received.

13 Karynlee Harrington and Will Kilbreth. "Dirigo Health: A Snapshot of the Program 2005 & 2006." Dirigo Health Agency. 2006.

14 Karynlee Harrington and Will Kilbreth. "Dirigo Health: A Snapshot of the Program 2005 & 2006." Dirigo Health Agency. 2006.

15 Taryn Bowe. "DirigoChoice Member Survey. A Snapshot of the Program's Early Adopters." Institute for Health Policy, Muskie School of Public Service, University of Southern Maine. August 2005.

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19 Pam Belluck. "Maine Learns an Expensive Lesson as Universal Health Plan Stalls." *The New York Times*. April 30, 2007.

20 Commonwealth Health Insurance Connector Authority, "Commonwealth Care." http://www.mass.gov. Accessed on February 26, 2007.

21 Commonwealth Health Insurance Connector Authority, "Health Care Access and Affordability Conference Committee Report." April 3, 2006.

22 Individuals must be a U.S. citizen/national, qualified alien, or alien with special status.

23 Plan Type I also covers dental care, including preventive and restorative services. See "Commonwealth Care Frequently Asked Questions," December 29, 2006, on the Commonwealth Health Insurance Connector Authority web site: http://www.mass.gov. Accessed on February 26, 2007.

24 See "Commonwealth Care Frequently Asked Questions," December 29, 2006, on the Commonwealth Health Insurance Connector Authority web site: http://www.mass.gov. Accessed on February 26, 2007.

25 "Commonwealth Care Frequently Asked Questions," December 29, 2006, on the Commonwealth Health Insurance Connector Authority web site: http://www.mass.gov. Accessed on February 26, 2007.

26 Kaiser Commission on Medicaid and the Uninsured. "Massachusetts Health Care Reform Plan." Key Facts. April 2006.

27 Alice Dembner. "Health Plan May Exempt 20% of the Uninsured." *The Boston Globe*. April 12, 2007.

28 Jon Kingsdale. "Commonwealth Enrollee Contributions, Benefits & Cost-Sharing." Memorandum to Connector Board of Directors, Commonwealth Health Insurance Connector Authority. August 30, 2006.

29 Note that not all carriers operate in all parts of the state so some individuals have fewer carriers to choose from.

30 Small group employers are defined as having 50 or fewer workers.

31 Commonwealth Health Insurance Connector. "956 CMR 5.00 MINIMUM CREDITABLE COVERAGE."

32 Policies sold with a Health Savings Account (HSA) may have slightly higher deductibles than that specified by the minimum creditable coverage guidelines, but only when offered with the account.

33 Commonwealth Health Insurance Connector Authority, "Connector Board Endorses Plans from Seven Carriers." March 8, 2007.

34 Chapter 58 of the Acts of 2006, Massachusetts.

35 Kaiser Commission on Medicaid and the Uninsured. "Massachusetts Health Care Reform Plan." Key Facts. April 2006.

36 Commonwealth Health Insurance Connector Authority, "New Health Insurance Plan Will be Available for Under $200." March 3, 2007.

37 Priscilla Yeon. "Expressions of Optimism, Doubts about Affordability Greet New Health Plans." *State House News Service*. March 8, 2007.

38 Alice Dember. "Health Plan May Exempt 20% of the Uninsured." *The Boston Globe*. April 12, 2007.

39 Comments by Professor Jonathan Gruber at the New England Study Group on May 15, 2007.

40 Commonwealth Health Insurance Connector Authority, "Health Care Access and Affordability Conference Committee Report." April 3, 2006.

[41] Commonwealth Health Insurance Connector Authority, "Employer Handbook." February 15, 2007. Available at www.mass.gov/connector.

[42] Note that employers will not be held responsible if employees refuse employer-sponsored health insurance. See the appendix for more details.

[43] The Connector anticipates publishing regulations related to the Section 125 plan requirements in April 2007.

[44] Commonwealth Health Insurance Connector Authority, "Employer Handbook." February 15, 2007. Available at www.mass.gov/connector. See the appendix for further details.

[45] See "Bulletin for Employers - Update on Division's Health Care Reform Regulations" on the Connector web site: http://www.mass.gov. Accessed March 6, 2007.

[46] "Carcieri Signs Health Care Reform Package." Office of the Governor, State of Rhode Island, Press Release. July 6, 2006.

[47] "Toward a More Affordable Health Care System for Rhode Island: The Governor's Agenda." Office of the Governor, State of Rhode Island. www.governor.ri.gov/documents/Governors-Health-Care-Agenda.pdf. Accessed July 6, 2007.

[48] Office of the Health insurance Commissioner, State of Rhode Island. HealthPact RI Products Requirement Document. November 16, 2006.

[49] Office of the Health insurance Commissioner, State of Rhode Island. HealthPact RI Products Requirement Document. November 16, 2006.

[50] "Rhode Island Announces Requirement for Low Premium Wellness Health Benefit Plan." *Medical News Today*. January 2, 2007.

[51] Office of the Health insurance Commissioner, State of Rhode Island. HealthPact RI Products Requirement Document. November 16, 2006.

[52] "OHIC Approves United and Blue Cross Wellness Health Benefit Plans for Small Employers." Rhode Island Government Press Release. April 2007.

[53] Office of the Health insurance Commissioner, State of Rhode Island. HealthPact RI Products Requirement Document. November 16, 2006.

[54] "OHIC Issues Innovative Health Insurance Product Requirements to Blue Cross and United." Rhode Island Government Press Release. December 18, 2006

[55] In year two, participants must also have their PCP complete a "Wellness Checklist," and if identified for weight loss, the PCP confirms that the participant is participating in a weight loss program. In year three, the PCP uses the checklist to confirm that the individual has made progress with weight loss goals.

[56] In year two, participants must also have their PCP complete a "Wellness Checklist," and if identified for smoking, the PCP confirms that the participant is participating in a smoking cessation program. In year three, the PCP uses the checklist to confirm that the individual is tobacco free.

[57] Office of the Health insurance Commissioner, State of Rhode Island. HealthPact RI Products Requirement Document. November 16, 2006.

[58] Ross Sneyd. "Douglas Signs into Law Catamount Health Reform Initiative." *The Associated Press*. May 25, 2006.

[59] "An Act Relating to Health Care Affordability for Vermonters." Act No. 191 of the Vermont General Assembly.

[60] John Kasprak. "Vermont Health Care Legislation." OLR Research Report, 2006-R-0358. June 6, 2006.

[61] Deb Richter and Terry Doran. "Catamount Health: The 2006 Health Care Affordability Act." Vermont Health Care for All. http://www.vthca.org/pdfs/Catamount_Health_Bill_simplified.pdf. Accessed on March 21, 2007.

[62] Susan Besio. "Preliminary Estimates for Catamount Health Insurance Premiums." Memorandum to the State of Vermont Agency of Administration. October 30, 2006.

[63] "2006 Health Care Reform Initiatives – Questions and Answers." The State of Vermont Legislature. http://www.leg.state.vt.us/HealthCare/2006_HC_Affordability_Act_Details_Leddy.htm. Accessed on March 20, 2007.

[64] "2006 Health Care Reform Initiatives, Quick Overview." The State of Vermont Legislature. http://www.leg.state.vt.us/HealthCare/2006_HC_Affordability_Act_Leddy_Summary.htm, Accessed November 6, 2006.

[65] Individuals with employer-sponsored coverage are eligible if (1) the employer's plan does not satisfy the state's criteria for comprehensive benefits, or (2) it costs the state less to offer premium assistance under Catamount Health than through the Employer-Sponsored Insurance (ESI) program, or (3) the individual is waiting for the open enrollment period to enroll in their employer's plan. Act No. 191 of the Vermont General Assembly. "An Act Relating to Health Care Affordability for Vermonters."

[66] Uninsured is defined as not having employer-sponsored coverage that includes both hospital and physician services within the last 12 months, or having lost private insurance or employer-sponsored coverage during the prior 12 months due to loss of employment, death of the principal policyholder, divorce or dissolution of civil union, no longer qualifying as a dependent, no longer qualifying for COBRA, or having lost student status. "An Act Relating to Health Care Affordability for Vermonters." Act No. 191 of the Vermont General Assembly.

[67] Kenneth Thorpe. "Overview of Catamount Health." February 23, 2006. http://www.leg.state.vt.us/HealthCare/Overview_of_catamount_health. Accessed on November 2, 2006.

[68] Kenneth Thorpe. "Overview of Catamount Health." February 23, 2006. http://www.leg.state.vt.us/HealthCare/Overview_of_catamount_health. Accessed on November 2, 2006.

[69] Vermont's health reform act makes chronic care management available to every resident, whether privately insured, covered under a public program, or currently uninsured. A chronic condition is defined as an established clinical condition that is expected to last a year or more and requires ongoing clinical management. Examples include diabetes, high blood pressure, cardio vascular disease, cancer, asthma, pulmonary disease, substance abuse, mental illness, high cholesterol, and spinal cord injury. John Kasprak. "Vermont Health Care Legislation." OLR Research Report, 2006-R-0358. June 6, 2006.

[70] Vermont Department of Banking, Insurance, Securities and Health Care Administration. Rule H-2006-01. Catamount Health Insurance, effective date: September 8, 2006.

[71] Ross Sneyd. "Douglas Signs into Law Catamount Health Reform Initiative." *The Associated Press*. May 25, 2006.

[72] Vermont Department of Banking, Insurance, Securities and Health Care Administration. Rule H-2006-01. Catamount Health Insurance, effective date: September 8, 2006.

[73] Susan Besio. "Preliminary Estimates for Catamount Health Insurance Premiums." Memorandum to the State of Vermont Agency of Administration. October 30, 2006.

[74] Vermont Initiative for Universal Health Access, "Catamount Health Plan: The Shape of What's to Come." *Toward Evidence-Based Health Care Reform*, Volume 3, Number 1. July 20, 2006.

[75] "An Act Relating to Health Care Affordability for Vermonters." Act No. 191 of the Vermont General Assembly.

[76] "An Act Relating to Health Care Affordability for Vermonters." Act No. 191 of the Vermont General Assembly.

[77] "An Act Relating to Health Care Affordability for Vermonters." Act No. 191 of the Vermont General Assembly.

[78] The full premium cost is estimated to be $723 for two-person coverage and $976 for family coverage. Susan Besio. "Preliminary Estimates for Catamount Health Insurance Premiums." Memorandum to the State of Vermont Agency of Administration. October 30, 2006.

[79] Office of Vermont Health Access, Agency of Human Services, "Employer-Sponsored Insurance Premium Assistance." Report to Health Access Oversight Committee and Joint Fiscal Committee. November 22, 2006.

[80] Office of Vermont Health Access, Agency of Human Services, "Employer-Sponsored Insurance Premium Assistance." Report to Health Access Oversight Committee and Joint Fiscal Committee. November 22, 2006.

[81] Office of Vermont Health Access, Agency of Human Services, "Employer-Sponsored Insurance Premium Assistance." Report to Health Access Oversight Committee and Joint Fiscal Committee. November 22, 2006.

[82] Individuals with incomes equal to 300 percent FPL earn $2,463 per month or $29,556 per year. For a family with two adults, the equivalent dollar amounts are $3,313 per month or $39,756 per year.

[83] Individuals do not have to wait 12 months for premium assistance if they lose coverage due to one of the following reasons: loss of employment, death of the principal insurance policyholder, divorce or dissolution of a civil union, no longer qualifying as a dependent under the plan of a parent or caretaker relative, no longer qualifying for COBRA, VIPER, or other state continuation coverage, or having a college-sponsored plan become unavailable because the individual graduated, took a leave of absence, or otherwise terminated studies.

[84] For example, some services covered under VHAP but not covered by some private plans are outpatient physical therapy, occupational therapy, speech therapy, skilled nursing facility, nurse practitioner services, eye exams, family planning services, mammograms, home health nursing, vasectomies/tubal ligations.

[85] Office of Vermont Health Access, Agency of Human Services, "Employer-Sponsored Insurance Premium Assistance." Report to Health Access Oversight Committee and Joint Fiscal Committee. November 22, 2006.

[86] Office of Vermont Health Access, Agency of Human Services, "Employer-Sponsored Insurance Premium Assistance." Report to Health Access Oversight Committee and Joint Fiscal Committee. November 22, 2006.

[87] Office of Vermont Health Access, Agency of Human Services, "Employer-Sponsored Insurance Premium Assistance." Report to Health Access Oversight Committee and Joint Fiscal Committee. November 22, 2006.

[88] Office of Vermont Health Access, Agency of Human Services, "Employer-Sponsored Insurance Premium Assistance." Report to Health Access Oversight Committee and Joint Fiscal Committee. November 22, 2006.

[89] Office of Vermont Health Access, Agency of Human Services, "Employer-Sponsored Insurance Premium Assistance." Report to Health Access Oversight Committee and Joint Fiscal Committee. November 22, 2006.

[90] In 2009, the requirement holds for firms with six or more FTE, and in 2010, it holds for firms with 4 or more FTE. "2006 Health Care Reform Initiatives – Questions and Answers." The State of Vermont Legislature. http://www.leg.state.vt.us/HealthCare/2006_HC_Affordability_Act_Details_Leddy.htm. Accessed November 6, 2006.

[91] "2006 Health Care Reform Initiatives, Questions and Answers." The State of Vermont Legislature.http://www.leg.state.vt.us/HealthCare/2006_HC_Affordability_Act_Details_Leddy.htm. Accessed November 6, 2006.

[92] "Rules for the Administration and Collection of the Employers' Health Care Premium Contribution." State of Vermont Department of Labor.

Glossary

Acute care: A full range of medical care, usually over the short term, for sickness or injury. In medicine, "acute" refers to a symptom or illness that appears suddenly.

Adverse selection: An occurrence, typical for voluntary insurance markets, in which people tend to choose a level of health insurance based on their expected need for medical care. At any given price, people who have a relatively high perceived need for medical care and expect to incur high medical expenses as a result, are more likely to want coverage than people with a lower perceived need. If health insurance is mandatory or all eligible individuals choose to enroll, the potential for adverse selection is eliminated or greatly reduced.

Beneficiary: An individual who is eligible for and enrolled in a health insurance plan.

Certificate of Need (CON): A certificate issued by a governmental body to an individual or organization proposing to construct, modify, or close a health facility, acquire major new medical equipment, modify a health facility, offer a new or different health service, or discontinue a service. Such issuance recognizes that a facility or service, when available, will meet the needs of those for whom it is intended.

Claim: An itemized statement of health-care services and their costs provided by a hospital, physician's office, or other provider facility. Claims are submitted to the insurer or managed care plan by either the plan member or the provider for payment of the costs incurred.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1986. Part of this law requires employers to continue offering health coverage for enrollees and their dependents for a period of time after an enrollee leaves the firm. This is commonly referred to as COBRA coverage. Typically, the enrollee pays the entire monthly premium when covered by COBRA.

Coinsurance: A form of cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid.

Community rating: A rating method that sets premiums for financing medical care according to the health plan's expected costs of providing medical benefits to the community as a whole rather than to any sub-group within the community. Both low-risk and high-risk classes are factored into community rating, which spreads the expected medical care costs across the entire community.

Connector: The Commonwealth Health Insurance Connector Authority, known as the Connector, is a new public entity in Massachusetts, established to serve as a bridge between eligible individuals, small employers, and health plans. The Connector oversees both the Commonwealth Care and Commonwealth Choice programs and sets the standards for minimum creditable coverage that meet the state's individual mandate.

Copay (also called copayment): A form of medical cost sharing in a health insurance plan that requires an insured person to pay a fixed dollar amount when a medical service is received, regardless of the total charge for service.

Cost sharing: The share of medical expenses covered under a health insurance plan for which the enrollee is responsible. Cost sharing may take the form of copays, coinsurance, and/or deductibles.

Coverage: The medical services or items, including prescription drugs, provided or paid for, partially or fully, by a health insurance plan.

Crowding out: Crowding out of specific forms of health insurance (private insurance, for example) occurs when enrollees who would have retained their private health coverage in the absence of a new program (such as a subsidized form of coverage), drop it in order to enroll in the new program.

Deductible: A fixed dollar amount during the benefits period that an insured person must pay before the insurer will make any benefit payments.

Employer mandates/fees: State regulations that generally require employers to provide coverage to their employees or spend a certain percentage of their payroll costs on health benefits. States may also choose to impose a fee (typically per full-time employee) on employers that do not provide coverage.

Employee-plus-one coverage: Health insurance that covers the employee and another family member at a lower premium level than family coverage.

Employer-sponsored insurance (ESI): A health insurance contract, made available through an employer, that provides hospital and/or physician coverage to an employee or a retiree for an agreed-upon fee for a defined benefit period, usually a year. The employer typically contributes at least a part of the cost of the health insurance plans it provides.

Enrollment: The process of joining a health insurance plan. People enroll in health plans through employers, professional associations or clubs, public benefits programs, or as individuals.

Family coverage: Health insurance that covers the employee and one or more members of his/her immediate family (spouse and/or children, as defined by the plan).

Federal poverty limit (FPL): The federal government's working definition of poverty, which is used as the reference point for the income standard for eligibility for certain plans or benefits, including Medicaid. Also called federal poverty line, the FPL is adjusted annually for inflation and published by the Department of Health and Human Services in the form of Poverty Guidelines. The FPL in calendar year 2007 was $17,170 for a family of three in 48 contiguous states and the District of Columbia, $21,470 in Alaska, and $19,750 in Hawaii.

Formulary: A list of prescription drugs that are preferred for use by a specific health insurance plan. A formulary may include both brand-name and generic drugs.

Full-time equivalent (FTE): The full-time equivalent is a way to measure a worker's productivity and/or involvement in a project. An FTE of 1.0 means that the person is equivalent to a full-time worker.

Group purchasing arrangement (GPA): An arrangement by which two or more small employers purchase health insurance collectively, often through a common intermediary who acts on their collective behalf, in the hope that they can achieve the buying power of large groups and negotiate lower premiums. GPAs may be established by states (through legislation or regulation) or by associations of employers and/or individuals.

Health maintenance organization (HMO): A healthcare system that assumes or shares both the financial risks and the delivery risks associated with providing comprehensive medical services to a voluntarily enrolled population in a particular geographic area, usually in return for a fixed, prepaid fee.

Health savings account (HSA): A trust account owned by an employee for the purpose of paying for medical expenses not covered by the employer's health plan. In order to qualify for an HSA, the employee must be enrolled in a high-deductible health plan that is HSA eligible. Both employers and employees can contribute to an HSA. Unused funds carry over to the following year.

High deductible health plan (HDHP): A health plan with a deductible high enough to meet the IRS requirements for favorable tax treatment of contributions made to a Health Savings Account. For a plan to be considered an HDHP, it needs to mandate minimum deductibles of $1,100 for single coverage and $2,200 for family coverage.

High-risk pool: Pools, typically created by states through state nonprofit associations, that offer health insurance to individuals with pre-existing health problems who are otherwise considered "medically uninsurable."

Individual (non-group) health insurance market: A health insurance market where individuals, typically ineligible for Medicare, Medicaid, or employer-sponsored insurance, purchase health insurance plans for themselves and/or their families.

Individual mandate: State regulations that require individuals to be responsible for purchasing their own health insurance. Individual mandates may be enforced through the tax collection process or through the imposition of other financial penalties.

Insurance carrier: A corporation that engages in the business of selling insurance protection to the public, either directly or through employers, unions, etc.

Lifetime limit: The maximum amount payable by the insurer for covered expenses for the insured and each dependent while covered under the health plan. A typical lifetime limit amount is $1 million per individual.

Limited benefit plans: Also known as "bare bones" plans, these plans exclude certain benefits or services that the state has mandated to be carried by private insurers (e.g. chiropractic or mental health services). Limited benefit plans typically have lower premiums, which may encourage take-up among uninsured individuals.

Maximum out-of-pocket expense: The maximum dollar amount an insured person is required to pay out-of-pocket during a benefits period, typically a year. Until this maximum is met, the plan member shares the cost of covered expenses. After the maximum is reached, the insurance carrier pays all covered expenses, often up to a lifetime maximum.

Managed care organization (MCO): A health organization that contracts to finance and deliver a wide variety of healthcare services to enrolled members through a network of participating providers. Examples of managed care organizations include health maintenance organizations (HMO) and preferred provider organizations (PPO).

Mandated benefits: A law that requires a health insurance policy or health plan to cover or offer to cover specific benefits, procedures, services, providers, or people.

Medicaid: Medicaid is a state-administered program that provides health insurance coverage for low-income families and children, people with disabilities, and the elderly. The program covers more than 50 million people at an annual cost of more than $300 billion. Medicaid is jointly funded by the states and the federal government, with the administration of the program left to the states and subject to federal guidelines.

Medicaid and SCHIP waivers: Through Section 1115 of the Social Security Act, states can apply for waivers to bypass federal requirements for either Medicaid or SCHIP. The U.S. Department of Health and Human Services may agree to waive certain federal requirements for the purpose of conducting pilot, experimental, or demonstration projects that are likely to promote the objectives of the program. For example, states have often used waivers to expand eligibility to new groups of people as well as to change other federal requirements related to the delivery system or benefit package design.

Medical savings account (MSA): A savings account designated for out-of-pocket medical expenses. In an MSA, employers and individuals are allowed to contribute to a savings account on a pre-tax basis and carry over the unused funds at the end of the year.

Pre-existing condition limitation: A provision imposed by insurers which restricts coverage for medical or health conditions that existed prior to the individual's enrollment in a health plan. Pre-existing conditions may be excluded from coverage, or enrollees may have to wait a specified length of time, before medical care related to the pre-existing condition is covered by the health plan.

Preferred provider organization (PPO): A healthcare benefit arrangement designed to supply services at a discounted cost by providing incentives for members to use designated healthcare providers (who contract with the PPO at a discount), but which also provides coverage for services rendered by healthcare providers who are not part of the PPO network.

Preferred("in-network"/participating) provider: A medical provider (doctor, hospital, pharmacy) who is a member of a health plan's network. Enrollees generally pay lower or no copays for services from a preferred provider.

Premium: Agreed-upon fees paid for coverage of medical benefits for a defined benefit period. Premiums can be paid by employers, unions, or employees, or shared by both the insured individual and the plan sponsor.

Primary care: General medical care provided directly to a patient without referral from another physician. It is focused on preventative care and the treatment of routine injuries and illnesses.

Primary care provider (PCP): A physician or other medical professional who serves as a group member's first contact with a plan's healthcare system. A PCP is also known as a primary care physician, personal care physician, or personal care provider.

Provider network: A group of doctors, hospitals, and other health care providers who work together with a health insurance plan to provide health care services.

Reinsurance: The acceptance by one or more insurers, called reinsurers or assuming companies, of a portion of the risk underwritten by another insurer that has contracted with an employer for the entire coverage. Under a reinsurance plan, for example, a reinsurance carrier or the government may assume most of the costs of patients with the highest medical expenses in the small group and/or individual markets.

Risk pooling: A mechanism through which health insurance providers pool the health care risks of a group of people in order to make individual costs predictable, manageable, and relatively stable over time. Health coverage providers usually strive to maintain risk pools of people whose health, on average, is the same as that of the general population.

Savings offset payment (SOP): An assessment of up to 4 percent on insurers and third-party administrators used to finance Maine's DirigoHealth program. The SOP is levied only when the state Superintendent of Insurance determines that Dirigo Health Reform initiatives have resulted in savings to the health care system.

Section 125 plan: Under federal tax law, a Section 125 plan is a written plan that permits employees to choose between receiving cash (the employee's normal cash wages) and certain qualified benefits that can be paid for on a pre-tax basis by employees. A Section 125 plan can be used to allow employees to pay for heath insurance coverage on a pre-tax basis, and is not subject to state and federal taxes or federal FICA withholding taxes. For example, a Section 125 "premium-only plan" allows employees to pay their health care coverage premiums on a pre-tax basis, thus lowering their taxable income and, consequently, their tax liability.

SCHIP: The State Children's Health Insurance Program (SCHIP) allows states to provide insurance coverage to uninsured children in low-income families who are not otherwise eligible for Medicaid. Like Medicaid, states administer the SCHIP program and receive federal matching funds.

Single coverage: Health insurance that covers the employee only. This type of coverage is also known as employee-only coverage.

Small group health insurance market: A health insurance market in which small businesses, typically with fewer than 50 employees, purchase health insurance plans for their employees.

Take-up rate: The percentage of eligible individuals who choose to enroll in health insurance plans available to them.