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Details: Hearing held in Madison, Wisconsin on July 26, 2006.

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2005-06
(session year)

Senate
(Assembly, Senate or Joint)

Select Committee on Health Care Reform...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (August 2012)

-----Original Message-----
From: J.P. Wieske [mailto:jpwieske@cahi.org]
Sent: Sunday, July 30, 2006 10:25 PM
To: Sen.Darling; Sen.Roessler
Cc: Volz, David
Subject: Testimony

Sen. Roessler and Sen. Darling:

Thank you for the opportunity to testify this last week. I have attached my slides as well as numerous CAHI publications I mentioned in my testimony. Additionally, there was a question about expanding coverage by mandating insurers cover dependent coverage to age 24 or 25. We understand this is an attractive idea to legislators because it costs the state nothing. Please understand that those costs will be bourne by someone -- most likely the insurers. This will lead to increased costs for the rest of the market. Listed below is the NCSL link that actually has followed the legislation on a state by state basis -- it was updated June 30.

http://www.ncsl.org/programs/health/dependentstatus.htm

Thanks again for the opportunity testify. Do not hesitate to contact me with any further questions.

Sincerely
JP

--
J.P. Wieske
Director of State Affairs
Council for Affordable Health Insurance
Phone: (920) 499-8803
Fax: (501) 639-1703
E-mail: jpwieske@cahi.org


FORWARD
E PLURIBUS UNUM

Review of proposed solutions

J.P. Wieske
Council for Affordable Health Insurance

Health Insurance Crisis

- Increasing number of uninsured
  - 45.8 million reported by U.S. Census (15.7% same as last year)
- Rising Costs
  - 9.2% (2005) preceded by double digit increases
- Fewer Businesses Offering Insurance
  - 59.8% of the population had employment based insurance down from 60.4% in 2003

Uninsured

- 45.8 million were uninsured in 2004
  - Up from 45 million in 2003
  - National Percentage has remained at 16%
  - Wisconsin 11 % -- below the national average
  - 1998 – 16.3% uninsured
  - 2000 14.2% uninsured
  - Majority of uninsured work for firms with less than 100 employees

Who are the uninsured

- 1/3 have incomes less than $25,000
- 1/6 have incomes over $75,000
- 41% 18-34 years Old
- 21% 45-64
- 79% were employed full or part time

Targeting Solutions

- The uninsured are diverse…young, older, rich, poor, employed, and unemployed
- Solutions should be targeted to specific populations

<u>There is no one solution to everyone's problem</u>

The Wisconsin Health Plan

- Government-Run Health Care
  - Government creates the single benefit plan
  - Government decides eligibility
  - Government determines premiums
  - Government collects revenue
  - Government remits premiums
  - Government determines claims payments
  - Contracts with a private entity to provide services

Wisconsin Health Plan

- Uses Health Savings Account – style plan but does not meet federal requirements (mandate colonoscopies and E.R.)
- Eliminates consumer choice by forcing individuals to choose from only one plan design
- Uses modified community rates and guaranteed issue – which have been proven to increase costs
- No one has figured out how to pay for it

COUNCIL FOR AFFORDABLE HEALTH INSURANCE

Wisconsin Health Plan

- Includes universal dental coverage
- Deductible adjusted annually
- Does absolutely nothing to solve underlying medical costs
- First dollar emergency room care will exacerbate cost increases

COUNCIL FOR AFFORDABLE HEALTH INSURANCE

Wisconsin Health Plan

- Lessons Learned from other states
  - Community rating and guaranteed issue lead to higher costs (NY, NJ, Mass, VT, Maine, etc)
  - Public-private partnerships controlled by the state or board do not work (Maine –Dirigo)
  - Government is a poor designer of health benefit plans (Basic and Standard Plans)
  - Managed competition does not work (Florida CHPAs)
  - Employer mandates not popular, and may not be legal

COUNCIL FOR AFFORDABLE HEALTH INSURANCE

Wisconsin Health Care Partnership Plan

- No plan design details
  - Use primary care physician
  - $15 co-pays encourage utilization
  - $300 limited cost-sharing
  - No specified cost-sharing for emergency room
  - "medically necessary" care
- No cost estimates
  - Employer contribution not determined
  - No employee contribution

COUNCIL FOR AFFORDABLE HEALTH INSURANCE

Wisconsin Health Care Partnership Plan

- CAHI has studied Medicare admin. costs – actually much higher than reported
  - Medicare pays bills – does not process claims
  - Does not collect premiums
  - Hides costs in other line items (buildings, advertising)
- Actually encourages utilization (low cost sharing)
- Insurance leads to increased utilization which leads to increased costs

COUNCIL FOR AFFORDABLE HEALTH INSURANCE

Wisconsin Health Care Partnership Plan

- Ignores the fundamental issues
  - Who is uninsured
  - Why are they uninsured
  - Forces most Wisconsinites to change plans
  - Exacerbates the cost pressures
  - Must inevitable lead to lower reimbursement (Medicaid/Medicare) and rationing of care
  - Eliminates numerous insurers and premium tax

COUNCIL FOR AFFORDABLE HEALTH INSURANCE

Wisconsin SB 388

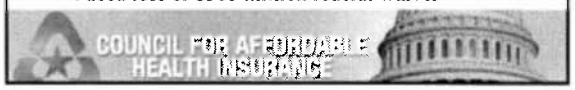
- Government-run insurance plan
  - Must define "medical service necessary to maintain health…."
  - No co-pays, deductibles
  - Determines provider reimbursement rates
  - Paid for by unspecified individual and employer tax
  - No indication of actual costs

Wisconsin SB 388

- Imposes single government solution to numerous problems (uninsurable, uninsured, costs)
- State will inevitable need to ration care, and cut costs
- Real fiscal estimates in other states indicate cost would be more than double the state budget
- Rejected by voters whenever it is on the ballot

Massachusetts

- Extremely High Health Insurance Costs
  - Boston most expensive region for individual health insurance (e-healthinurance)
  - Massachusetts small group market highest cost region in the country (2000 MEPS)
- Few Insurance Choices
  - Relatively few choices in the market
  - Only state-designed benefit plans in the individual market
- Faced loss of $385 million federal waiver



Massachusetts

- State will be tracking individual employers, income, insurance status, health history
- Connector will be defining whether or not a health plan meets "quality" standards
- Connector allowed to review employer records
- Connector determines agent commissions
- Connector will be required to aggregate and disaggregate premiums for thousands of businesses and millions of individuals on a monthly basis.

Massachusetts

- No reform of the underlying market
- Combining the individual and small group market – increasing uncertainty
- Mandated coverage for individuals and businesses
- Required Section 125 plans
- Repayment of employee and dependent medical expenses
- Significant invasion of privacy

Public-Private "Partnerships"

Dirigo Health – Sold as a public-private partnership
- Created to solve problems caused by guarantee issue and community rating
- Subsidized with tax on insured people
- Premiums and plan design based on sliding scale
- Limits on private healthcare investment
- Strict insurer rate review
- Only 25% previously uninsured
- Only 7300 currently enrollees

We've spent more than $40 million of federal money … to essentially insure 2,300 or 2,400 people" State Sen. Karl Turner

Public-Private "Partnerships"

- Healthy New York
  - New York has guarantee issue, community rating and no high risk pool
  - Covers 107,000 people
  - Reinsures coverage between $5,000 - $75,000
  - Community rated and guarantee issue (similar to NY)
  - HMO based (no out-of-network coverage)
  - Limited benefit policies (eliminates mandates)
  - Losses funded by the state of New York
  - Primarily targeted at uninsured poor (individual and small group coverage)

Can we do better?

1. Provide access to low-cost health insurance for those with low incomes
2. Decrease the uninsured rate
3. Ensure health insurance remains affordable

Private market responses

- Health Savings Accounts/ Consumer driven plans
- Low-cost / mandate free plans
- Limited Benefit Policies
- Plan Design Flexibility

Public – Private Partnerships

- Premium Subsidy Plans
  - Montana
    - Targeted at small employers 2-5
    - Tax credits for providing health insurance
    - Subsidies for those who do not
  - Oklahoma
    - 185% of Federal Poverty
    - Employer-based coverage
    - Funded by tobacco revenue

Mandate-Lite Insurance plans

- Lower cost benefit plans -- sometimes referred to as limited benefit plans
- Allow carriers to offer plans without state mandated benefits. (CAHI estimates Wisconsin has 30 benefit mandates.
- States often limit the ability of carriers to offer these plans. (uninsured, market share, poor, or limited plan design)

Health Savings Accounts

Health Savings Accounts have been successful at targeting some uninsured

- Consensus number is around 30% of H.S.A. purchasers were previously uninsured
- Successful at targeting very small businesses (50% previously uninsured)
- State Tax deductibility helps protect employees

High Risk Pools

- 32 states have them including Wisconsin
- Targets individuals who are uninsurable
- Pools should have broad-based funding
- Extremely successful in ensuring healthy individual market

List Billing

- Targets employed individuals not eligible for group insurance
- Allows individuals to purchase an individual insurance plan through payroll deduction
- Easier for individuals to purchase coverage
- No employer involvement except agreement to remit premiums
- May receive favorable tax treatment

Tax Credits / Tax deductibility

- Economic studies of tax credits targeted at the poor could substantially reduce the uninsured rate

  (Cutting Taxes for Insuring (AEI Press, 2002), Mark V. Pauly and Bradley Herring, Tax Credits for Health Insurance, (Urban-Brookings Tax Policy Center) Leonard E. Burman and Jonathan Gruber
- Many states have considered additional tax credits to encourage very small businesses (2-25) to offer insurance
- Individual health insurance is still not tax deductible

Underwriting

- Targets the young by making insurance more affordable
- Leads to more affordable insurance by creating a healthier pool
- Medical Waivers (or Riders) allow individuals with certain medical conditions to obtain standard coverage

Sound / Tonik Benefit Plan

- Offered BC/BS and Unicare in a variety of states
  - Premiums in California and Illinois from $60-$83, higher in other states
  - Successful at targeting "invincibles"
  - Unique plan designs
    - High deductible
    - 4 Dr Visits
    - Limited drug coverage
    - Includes dental and vision coverage

"Right Start" Plan

- Offered by Assurant Health
  - Premiums savings 15-20%
  - H.S.A. qualified plans
  - Targeting value buyer
  - Unique plan designs
    - High deductible
    - Savings through coverage options

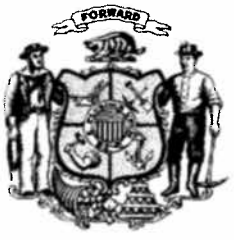
Limited Benefit Plans

- Offered by numerous carriers in the market
- Provides low co-pays and deductibles
- Benefits are limited
  - Limits on total reimbursement (sometimes allow buy-ups)
  - Benefits are scheduled per service (i.e. $100/ Dr. Visit)

Resources

- Visit www.cahi.org to download publications including:
  - Mandates in the States
  - State Legislator's Guide
  - Issues and Answers on Dirigo, Healthy New York and Massachusetts
  - Or contact me jpwieske@cahi.org


WISCONSIN STATE LEGISLATURE


FORWARD

The Council for Affordable Health Insurance's

ISSUES & ANSWERS

Solutions for Today's Health Policy Challenges

No. 136

July 2006

HSAs and the Chronically Ill

Smarter Patients and Better Care

Most people are relatively healthy thanks in part to modern medicine. However, some 90 million people have what is considered a chronic illness. Among the most common chronic illnesses are cancer, diabetes and heart disease.[1]

Employers and individuals are increasingly looking to consumer driven health plans (CDHPs), which often include a Health Savings Account (HSA), to help rein in expenditures. But questions have arisen about how such plans affect those with chronic illnesses. Because HSAs provide patients greater control over their health care decisions and empower consumers to be better-informed patients, the chronically ill may find HSAs a valuable new option which could transform chronic care.

What Is a Chronic Illness? According to the U.S. National Center for Health Statistics, a chronic illness is one that lasts three months or more.[2]

Fortunately, many chronic illnesses are not life threatening and are manageable with medical treatment. Indeed, most patients with chronic illnesses live long and productive lives.

However, some chronic illnesses are monetarily as well as physically draining. Some patients may need constant monitoring. And some chronic illnesses require medical equipment that may not be covered by a health plan, and therefore the patient has to pay for that equipment out of pocket.

What Is an HSA? An HSA combines an insurance policy that covers large medical bills and preventive care with a personal, tax-free savings account for routine expenses. The policy protects the insured from the cost of a catastrophic illness, prolonged hospitalization or a particularly unhealthy year. The savings account is controlled by the insured and is intended to pay small and routine health care expenses. Both employers and individuals are allowed to contribute to the account.

The insurance policy deductibles are higher than typical policies. For 2006, the deductible can be no less than $1,050 for an individual, or $2,100 for a family. However, many individuals find that higher deductibles will reduce their policy premiums by 30 to 40 percent, often more than offsetting the increase in the deductible.

In addition, HSAs provide true catastrophic protection. For 2006, HSA insurance policies must limit total annual out-of-pocket expenses to no more than $5,250 for an individual, or $10,500 for a family.

Annual contributions to the account are permitted up to 100 percent of the policy deductible, up to $2,700 for an individual, and $5,450 for a family. Individuals aged 55 and over are permitted to "catch-up," or increase, their contributions by an additional $700.

The Explosion of HSAs. Since January 2004, the number of people enrolled in HSA plans has increased to about 3 million, according to a survey by America's Health Insurance Plans (AHIP). President George W. Bush, in his 2006 State of the Union Address, suggested that by enacting some of his proposed HSA reforms the number of Americans with HSAs would swell to 44 million by 2010.[3]

HSAs and the Chronically Ill. For years HSA critics have claimed that only healthy people would benefit from an HSA. Not true. In fact,

Websites Designed to Educate Patients

HealingWell.com is 10 years old and has more than 30,000 members. It provides access to information for nearly 40 chronic illnesses.

www.healingwell.com

HealthGrades, founded in 1999, provides patients and companies with ratings and profiles on hospitals, physicians and nursing homes.

www.healthgrades.com

HealthEquity has an education center on its website to improve learning about consumer driven health care.

www.healthequity.com/pages/?section=2

Destiny Health offers a nurse care manager to help coach the consumer through a chronic condition and an expectation management tool that provides an in-depth look at certain medical procedures. It narrates each step of the process so that the consumer knows exactly what is involved before the procedure is performed.

www.destinyhealth.com

The Blue Cross and Blue Shield Association has launched "Blue Distinction," is an online-based program that includes a price transparency demonstration for medical services for 17 Blue Cross and Blue Shield plans around the country.

www.bcbsa.com/bluedistinction

Aetna is expanding its price transparency demonstration project (August 2006) to eight states and plans to provide online access to physician costs, clinical quality and efficiency information for more than 14,800 specialist physicians and specific pricing for more than 70,000 physicians.

www.aetna.com/index.htm

Diagnostic Test Web Sites. There are several web sites that now offer consumers the opportunity to order the same diagnostic tests that they might get through traditional health care means – such as labs, hospitals and clinics. What makes these web sites unique is that consumers do not need a prescription from their doctor to have the test. Consumers pay upfront for the tests they want and receive a receipt to submit for reimbursement from their insurer, flexible spending account or HSA.

www.directlabs.com; www.healthcheckusa.com/tests.asp; www.med1-abusa.com; and www.mymedlab.com

those with chronic illnesses often fare better financially with an HSA. And they have more control over their health care decisions.

More importantly, consumer driven health plans and HSAs have created a new set of incentives that encourage better-informed patients.

- A recent study in the Journal of Medical Internet Research says: "The use of the Internet to deliver Web-based interventions to patients is increasing rapidly. In a 7-year period (1996 to 2003), there was a 12-fold increase in MEDLINE citations for 'Web-based therapies.'" [4]

- A three-year study of consumer driven plans, including 155 companies with 13,000 employees, recently released by Humana saw an increase in use of preventive services leading to fewer medical interventions and declining premium growth. The study concluded that most of the savings came from a change in behavior, not cost-shifting.[5]

Health insurers with a consumer focus have been incorporating elements that promote patient awareness for years. Even some large insurers that used to be critical of the consumer driven movement — preferring their longtime reliance on managed care instead — have joined the information campaign. [See the box.]

Case Study: A HealthEquity Patient.[6] HealthEquity is a third-party administrator that handles HSA policies. A diabetic patient who had been enrolled in a plan with a $10 copay for office visits and a $35 copay for insulin and diabetic supplies was satisfied with that coverage.

When her company switched to an HSA plan, she was worried that she would not enjoy the same benefits. However, she began to question her routine medical care such as lab work, blood tests and examinations. For example, she was surprised to learn that her doctor was charging $10 for a blood glucose test strip that she could buy one for less than 50 cents. She was also surprised at being charged $15 for a urinalysis test that she could purchase in bulk for less than 50 cents apiece. So, armed with this information, she took her monitor and test sample with her to the nurse.

In addition, she switched to generic medications when possible and compared prices for diabetic supplies.

The patient says she has become empowered to be a researcher for herself and her children. Before taking her family to the doctor, she goes first to the online resources to learn more about a possible diagnosis and suggested medical care. She says that she discovered that by being in control of her own medical dollars she is much more conscientious of the level and quality of her health care.

More Help for the Chronically Ill. While those with chronic illnesses can often fare better under an HSA plan, Congress can do more.

First, President Bush has proposed allowing a person to contribute enough money to his own HSA to cover all out-of-pocket expenses up to the health plan's out-of-pocket limit, not just the deductible as is allowed under current law. A plan's out-of-pocket limit is generally higher than the deductible. In addition, the president has proposed allowing contributions to the HSA to be made without paying income or payroll taxes on the contribution amount.

Second, under current law, an employer must contribute the same amount to each employee's Health Savings Account. Chronically ill employees are not allowed to receive a larger contribution. President Bush has proposed changing the "comparability rules" to allow employers to contribute additional amounts to the HSAs of chronically ill employees or their dependents.

Such a proposal raises the question: Who decides who is chronically ill? One solution would be to include all those who are on a "qualified medication" — one that treats a chronic illness. Or it could be one of the small number of illnesses identified as chronic by the Centers for Disease Control. Other options include tying eligibility to cost, such as a patient who regularly spends 150 percent of the average medical cost. Alternatively, the legislation could require a medical doctor or the patient's insurer to certify the patient as chronically ill. The president's proposal would let the employer decide who would qualify for the additional contributions because of a chronic illness or condition.

Generally speaking, though, employers are not going to want to make larger HSA deposits if they don't think the worker's condition requires it, which creates a checks-and-balance on the system.

However, we believe simply allowing workers and/or employers to contribute money to the HSA up to the out-of-pocket maximum should cover most chronic illness situations, and eliminate the need for other changes

Conclusion. Although HSAs usually reduce health care costs, they are not just about saving money. HSAs empower consumers to become better-informed patients and take more responsibility for their care.

Some chronically ill people may find that an HSA provides them with more flexibility for choosing their health care providers, medications and medical equipment. They may also find that, once they have become empowered consumers in the health care marketplace, they are better patients — which can only improve their outcomes and quality of life.

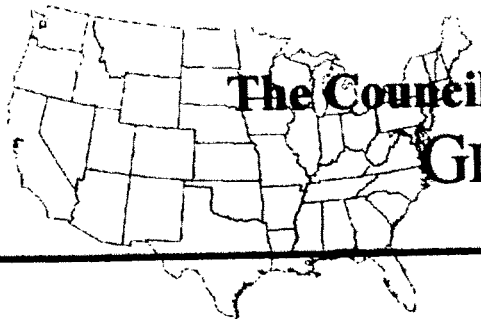
Note: Endnotes are available at http://www.cahi.org/cahi_contents/resources/pdf/n136HSAIllness.pdf

Prepared by: Victoria Craig Bunce, Director of Research and Policy, Council for Affordable Health Insurance

Council for Affordable Health Insurance
127 S. Peyton Street, Suite 210
Alexandria, VA 22314
Phone: 703/836-6200 Fax: 703/836-6550

Endnotes

[1] Centers for Disease Control, "Chronic Disease – Overview," http://apps.need.cdc.gov.
[2] Ibid.
[3] The White House's "Fact Sheet: Health Savings Accounts: Affordable and Accessible Health Care," http://www.whitehouse.gov/news/releases/2006/04/20060405-6.html.
[4] http://www.jmir.org/2004/4/e40/.
[5] Ann Meyer, "Wellness Pays as Health Costs Shift," *Chicago Tribune*, June 12, 2006. (www.chicagotribune.com/business/chi-0606120118jun12,1,5572555.story?coll=chi-business-hed)
[6] Case Study provided by HealthEquity March 2006; name withheld to protect the privacy of the patient.



The Council for Affordable Health Insurance's GREAT STATE DEBATE

ON HEALTH CARE REFORM

Massachusetts' Health Care Reform Plan:

Too Many Sticks; Not Enough Carrots

May 2006

On April 12, 2006, Massachusetts Gov. Mitt Romney (R) signed one of the most far-reaching state health reform plans since....Massachusetts Gov. Michael Dukakis (D) signed the "Universal Entitlement Act of 1988."

The Romney plan purports to:

- Fix the "free-rider problem," where those with insurance subsidize those without;
- Ensure access to a wide range of affordable policies — especially in the individual market; and,
- Subsidize insurance for those who can least afford it.

The goal is to get every Massachusetts citizen insured, known as "universal coverage." However, the plan is filled with punitive "sticks," which require massive new regulatory efforts to monitor compliance and punish wrongdoing, rather than "carrots" that encourage good economic decisions.

A Mixed Reform Gets a Mixed Response. The controversial plan has been widely praised *and* criticized by both liberals *and* conservatives.

Normally, liberals prefer schemes that mandate insurance coverage, impose strict regulations and heavily subsidize those who can't afford insurance.

Conservatives, by contrast, believe that markets can work in health insurance, and so support competition, minimal regulations and access to a wide range of choices, leaving consumers to decide what best fits their needs and budgets. Narrowly targeted safety-net programs also play an important role, because they help those for whom the private sector doesn't work very well.

The Massachusetts plan has tried to draw from both approaches. The resulting legislation is far from a panacea for Massachusetts' health insurance problems. While the legislation has different pieces many can love, it also has pieces many will hate.

Deja "Duke." Massachusetts is not new to health insurance reform. Gov. Dukakis — like Romney, another potential presidential candidate — pushed through a universal coverage plan in 1988. There was no individual mandate in the Dukakis plan, but it did include a "pay or play" provision applied to employers with 25 employees or more, which required them to provide insurance or pay an assessment of $1,680 to cover the costs of uncompensated care.

Even though the bill was never implemented — and was finally repealed in 1995 — Gov. Dukakis believed he experienced the "New Hampshire Effect," because the neighboring state attempted to draw businesses away from Massachusetts.

A Mess of Its Own Making. One of the reasons Massachusetts feels compelled to address the high cost of health insurance is that the state has some of the highest premiums in the country — largely as a result of its own doing.

In 1996, Massachusetts implemented numerous market-killing reforms including:

- A standardized benefit plan for HMOs, PPOs, and indemnity plans in the individual market;
- Guaranteed issue and modified community rating in the small group and individual markets;
- A bureaucratic rate review process.

The result of the 1996 reforms was predictable: approximately 20 health insurers stopped marketing plans in Massachusetts. Others didn't leave but stopped underwriting individual policies.

The reforms led to higher insurance rates for everyone. The 2000 Medical Expenditure Survey showed that small groups in Massachusetts face the highest family health insurance rates in the nation. Individuals purchasing insurance in the individual (i.e., non-group) market fared no better. According to the 2004 eHealthInsurance report, "The Most Affordable Cities for Family Health Insurance," Boston is the least affordable city for family coverage in the

nation. And a 2005 eHealthInsurance report comparing single coverage found Boston came in next to last.

The problem looks even worse when you compare plans across state lines. Again turning to the online brokerage service eHealthInsurance, a Blue Cross PPO policy for a family of four (parents both age 35) with a $250 deductible in Lacrosse, Wisconsin — recently named the highest health care cost region in the nation by the U.S. Government Accountability Office — costs $618 per month. Comparable coverage in Boston ($250 deductible for 35-year-old parents of a family of four) costs $1,438.

So it isn't surprising that Gov. Romney wanted to do something. The problem is that neither he nor the Legislature has learned anything from a decade of bad health insurance reforms.

Lots of "Sticks" and Not Enough "Carrots." Properly structured, health policy should encourage people to take personal responsibility for their health care, relying on carrots (rather than sticks) to encourage people to make the right decisions.

The Massachusetts plan is all sticks and few carrots.

Stick: Individual Mandates — While most states mandate auto insurance coverage, Massachusetts' individual health insurance mandate is the first of its kind in the nation. It is also one of the most controversial aspects of the legislation.

The law requires individuals to:

- Purchase committee-approved individual insurance.
- Provide proof of insurance to be included in tax filing. In the first year, individuals lose their personal tax deduction if they do not have health insurance coverage. Afterward, they face penalties equal to half the cost of an "affordable" policy.
- Sign a "Health Insurance Responsibility Disclosure" form *under oath*. This form requires employees and employers to certify on a regular basis that they have purchased health insurance.

Stick: Employer Mandates — Massachusetts law already contains several employer mandates — including a health insurance tax to help pay for free care, community rating and guaranteed issue (those 1996 reforms). The new law builds on those employer requirements including:

- Offering Section 125 plans to employees, thus allowing employee premiums to be paid on a pre-tax basis (note: ensuring employees can tax shelter their premiums through a Section 125 is good; mandating employers provide it isn't);
- Providing health insurance to every employee — and make a "fair and reasonable premium contribution";
- If not offering insurance, paying up to a $295 per-employee annual fee (i.e., tax) to the state; and,
- Paying for "free care" provided to employees and their dependents.

Massachusetts was not the first state to pass an employer mandate. Earlier this year, Maryland's Legislature voted to override Gov. Robert Ehrlich's veto of the "Wal-Mart bill," which mandates employers with more than 10,000 employees provide health insurance or pay a tax. And Hawaii has had an employer mandate since the 1970s.

Massachusetts also passed its own version of an employer mandate in 1988, as part of the never-implemented Dukakis plan.

Stick: Privacy Invasions — With an employer and individual mandate and a free-rider surcharge, the state will be required to gather a lot more information. The invasions of individual privacy are manifold, including:

- A "Health Insurance Responsibility Disclosure" form — signed under oath — which tracks employees' and employers' health coverage;
- A "proof of insurance" provision required on tax forms;
- The creation of a "Connector," which will gather income data from the Department of Revenue;
- Monitoring an individual's employment status to verify health insurance;
- Collection of health care data from insurers and health care providers to guarantee quality; and,
- The "free-rider surcharge," which requires the state to keep ongoing records of employers and their employees (and dependents) and linked to their health care records.

Clearly, this law gives Massachusetts bureaucrats and others access and the right to track sensitive health care information.

Stick or Carrot: The Connector — The Connector is a new mechanism intended to serve as an insurance clearinghouse — the ultimate middleman. In theory, the Connector will contract with several insurers that will provide health insurance plans. The Connector will also contract with employers and individuals who will purchase insurance plans through the Connector.

Modeled after the Federal Employees Health Benefits Plan, the Connector is intended to create choice and competition — both of which are goals of a consumer driven health care system.

While simple in concept, the Connector is a massive new undertaking that requires a new and sophisticated bureaucracy. Some of the duties of the Connector:

- Marketing of the Connector;
- Collecting premiums from both employers and individuals, which are then remitted to the insurers;
- Determining eligibility for premium assistance;
- Evaluating plans for quality and affordability;
- Examining every plan for its compliance with all state and federal laws;
- Reviewing every employer for discrimination in health insurance;
- Verifying employee eligibility;
- Collecting fees from those who purchase insurance, which fund the cost of maintaining the Connector;
- Establishing and paying agent commissions; and
- Contracting with "Subconnectors," insurers, government agencies and others for services.

The result is a quasi-public entity that has huge responsibilities. If successful, the Connector will be called upon to perform millions of transactions per month. If unsuccessful, it is likely the Connector will be the symbol of the reform's failure — allowing critics of consumer choice to say the country has tried the private sector and it failed.

Carrot: Subsidies for Those with Low Incomes. The one real "carrot" in the bill is the governor's subsidies for low-income individuals. The program helps those, based on a sliding scale, with incomes up to 300 percent of the federal poverty level and who are not eligible for Mass Health (the state's Medicaid and SCHIP programs).

But even here the Romney plan gets it wrong. The only plans eligible for the subsidy are those offered through the Connector, and they must have been certified as "high value and good quality." The plans also must be offered without deductibles, ensuring that even with state assistance the plans may be unaffordable — both for individuals *and* the state.

Been There, Done That. Health insurers have a good deal of experience in government-designed health benefit plans — in many states called "basic" and "standard plans" — and *the experience is not good.*

- Sales of those types of insurance products have typically been slow;
- Benefit plans are slow to adjust to changing market needs; and,
- The policies have been expensive.

State subsidies will mitigate some of these issues, but costs and plan-design problems remain a huge impediment to a thriving and dynamic market.

How Insurance Rates Measure Up

Cities are ranked from the most affordable to least affordable monthly health insurance premiums for a family of four. Criteria: Family of four, ages 37, 35, 11 and nine; $2,000 deductible with 20% coinsurance.

1.	Kansas City, MO ($171.86)
2.	Long Beach, CA ($180.00)
3.	Columbus, OH ($182.28)
4.	Tucson, AZ ($184.88)
	Mesa, AZ ($184.88)
5.	San Jose, CA ($190.00)
	San Francisco, CA ($190.00)
	Oakland, CA ($190.00)
	Sacramento, CA ($190.00)
	Fresno, CA ($190.00)
6.	Omaha, NE ($190.09)
7.	San Diego, CA ($199.00)
8.	Cleveland, OH ($208.32)
9.	Phoenix, AZ ($210.92)
10.	Los Angeles, CA ($212.00)
~	
36	Seattle, WA ($410.00)
37.	Albuquerque, NM ($422.26)
38.	Houston, TX ($429.00)
39.	Washington, DC ($436.00)
40.	Portland, OR ($441.00)
41.	Miami, FL ($524.18)
42.	Minneapolis, MN ($529.00)
43.	Charlotte, NC ($541.85)
44.	New York, NY ($712.77)
45.	**Boston, MA ($767.30)**

Source: *"The Most Affordable Cities for Family Health Insurance"* eHealthInsurance, *December 7, 2004.*

Conclusion. The Romney reform plan includes numerous new mandates and does little to solve the problems caused by the state's guaranteed issue and community rating laws. Without addressing those problems, there is little hope that the new legislation will make health insurance more affordable.

The Heritage Foundation is promoting the Connector as one of the most important pieces of the Massachusetts reform effort. The reason Massachusetts needs that change is that guaranteed issue and community rating drove numerous carriers out of the market. In addition, the Legislature passed laws that limited plan-design choices in the individual market to only two plans of each type (HMO, PPO and indemnity).

While the Connector purports to increase choice and competition, consumers in most states already have access to a wide range of affordable policies. Only in Massachusetts would allowing individuals to make their own choices be considered a "reform."

Moreover, the expensive additional layers of bureaucracy required to create the Connector, the merging of the individual and small group markets (which will further increase costs), and the invasions of personal privacy coupled with the state's tracking of personal medical information make this bill one of the most expansive government bureaucracies in state history. It simply has too many sticks and not enough carrots to achieve a workable and affordable health insurance market.

Prepared by JP Wieske, director of state affairs, Council for Affordable Health Insurance.

Other CAHI state health reform publications available at www.cahi.org:

- Issues and Answers #135, "The Pitfalls of Mandating Insurance," by Greg Scandlen
- Issues and Answers #134, "Healthy New York: A Poor Way to Fix a Dysfunctional Insurance Market," by JP Wieske
- Issues and Answers #132, "Dirigo Health: A Series of Broken Promises," by Adam Brackemyre and Tarren Bragdon
- "Health Insurance Mandates in the States 2006," by Victoria Craig Bunce, JP Wieske and Vlasta Prikazsky

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127 S. Peyton Street, Suite 210
Alexandria, VA 22314
www.cahi.org

For additional information please contact the Council for Affordable Health Insurance at 703/836-6200 or by email at publications@cahi.org

The Council for Affordable Health Insurance's

ISSUES & ANSWERS

Solutions for Today's Health Policy Challenges

No. 135

April 2006

The Pitfalls of Mandating Health Insurance Coverage

Massachusetts is being celebrated in the press and in some health policy circles for being the first state to pass a law requiring all of its citizens to have health insurance coverage. However, this mandate will likely be more hype than help.

The real impact of the Massachusetts law will be a major expansion of costly public programs such as Medicaid and tax-payer-financed subsidies to help lower-income residents. That may help more people afford coverage, but mandating that they buy it opens the door to widespread government micromanaging of the insurance market, which eliminates competition and innovation in insurance.

The New Infatuation with Mandating Coverage. The idea of enforcing "personal responsibility" by requiring people to have coverage is growing in popularity among Republicans, conservatives and even some libertarians such as *Reason Magazine*.

The argument goes something like this: Failing to have health insurance means that insured people and taxpayers end up paying for the health care expenses of the "free-riding" uninsured, either through cost-shifting or public financing. Requiring everyone to have coverage will spread health care costs more equitably and lower the cost of care for those paying premiums.

Misdiagnosing the Problem. But the history of health policy is rife with misdiagnosing the problems and the unintended consequences of what seem to be simple solutions. For example:

1. The "Free Rider" Problem — Free riders are not the problem they are often portrayed to be. The journal *Health Affairs* ran a study showing that uncompensated care is about 3.5 percent of total health care costs, a relatively small portion of the health care system. Of course, the uninsured pay about one-third of the cost of the care they receive. And those uncompensated-care figures reflect hospital prices that may be inflated three or four times over what those with insurance would actually pay.

2. Insured vs. Uninsured — Conventional wisdom believes that the lack of "universal" insurance coverage is the key problem in health care. But having coverage is no guarantee of access to services, and many people are only partly uninsured. They may have coverage part of the year, or they may have insurance that covers only major expenses. Insurance coverage is not magic. It is only one of many ways to pay for health care services.

3. Uninsured and Illegal — Uncompensated care is largely concentrated among a relatively small number of health care facilities. These providers tend to be in areas where there are large numbers of illegal immigrants. Mandatory coverage will do absolutely nothing to help with that problem.

4. The Comparison to Auto Insurance — Mandating health insurance coverage is often compared to mandatory auto insurance coverage. However, mandated auto coverage has not solved the problem of uninsured motorists. Those states that mandate auto insurance coverage typically still have 15 percent of their drivers uninsured — about the same proportion without health insurance.

5. Looking for Affordable Coverage — The government can't force people to buy what they can't find or afford. If a state requires people to buy health insurance, it will have to guarantee that affordable policies are available, and provide substantial subsidies to low-income families that can't afford coverage. Of course, if people have access to affordable coverage in the first place, most will buy it — greatly reducing the need for a mandate.

6. What Must the Insurance Cover? — If the government requires coverage, it must determine what policies and coverage meet the requirements of the legislation. Should chiropractors be covered? Abortions? Sex change operations? Herbal therapy? With mandatory insurance, being part of the benefits package will mean life or death for every health care provider and service. Imagine the lobbying campaigns as each interest group lines up to get its particular service covered under the "standard" package.

7. The Availability of Coverage — Will insurers be willing to sell an insurance policy that meets the coverage and cost guidelines set by the government? What happens if no company wants to offer a policy? Or offer it in Montana? What if a company does offer it in Montana, but provides lousy service? Consumers will have no choice but to buy it no matter how lousy the service.

8. Overregulation — Once the government requires people to buy a product, it has to make sure the providers of that product aren't overcharging consumers. That means regulatory control over premiums. That means scrutiny of carrier efficiency. That means examination of administrative expenses to make sure they are "reasonable."

9. Job Lock — Being required to have health insurance at all times will make people reluctant to leave their current jobs to find a better one, to start a business, or to improve their educations. Some people will be forced to stay in jobs they don't like to avoid being out of compliance. Others will have to sacrifice more productive uses of their money, such as buying a car to get to a better job, because they are required to pay for health insurance above all other purchases.

10. Micromanaging Providers — Many physicians (and other providers) support a mandate, but they haven't considered the impact on themselves. If carriers are scrutinized as described above, it won't be long until physicians get the same treatment. If people are forced to buy a product and companies are forced to sell it at "reasonable" rates, it isn't much of a leap to start looking at the inputs that drive those rates. Regulators will begin to scrutinize physicians to ensure they aren't overcharging or providing unnecessary services.

11. Invasion of Privacy — Mandating coverage means government agencies scrutinizing every individual's health and financial circumstances and having access to medical records: Were you insured? When were you insured? What were you insured for? How much money do you make? How much money do your spouse and dependents make? Who did you work for? Did that employer provide coverage? Can you prove it?

A Better Way to Expand Coverage. There are much better ways to address the problem of the uninsured. Here are some several workable suggestions.

(1) The states have played a major role in increasing the cost of health insurance and the number of uninsured. Every state requires insurance to cover a range of providers and services that make coverage more expensive. And several states passed guaranteed issue and community rating laws which have made their policies unaffordable. By reducing mandates and especially repealing guaranteed issue and community rating laws, the price of policies will drastically drop.

(2) Allow the insurance industry to come up with innovative products that people will want to buy. Health Savings Accounts are one such example.

(3) Equalizing the tax treatment for people who buy their own coverage would also help a lot. That way people wouldn't have to rely on their employer to decide whether to get coverage.

Conclusion. Mandatory coverage is an idea that won't solve the problems it is supposed to address, but will create a whole host of new problems and have serious consequences throughout the economy. Mandatory coverage is nothing more than the latest bromide, the newest simple solution, to a complex problem. That problem has been aggravated by previous simple solutions that made bad situations worse.

The state and federal efforts in the 1990s at "small group reforms" are one example of such a misguided policy prescription. These reforms all but destroyed the market for small group health coverage, drove competitors out of business, raised prices through the roof, and resulted in enormous numbers of newly uninsured workers. Today, fewer than half of the people who work for small employers get health insurance coverage on the job. Now policy makers are blaming the uninsured for being "irresponsible," when the real blame should be placed at the feet of those very same politicians.

For more information, see CAHI's:

"Can the Government Force People to Buy Insurance?"

(http://www.cahi.org/cahi_contents/resources/pdf/n123GovernmentMandate.pdf)

"Health Insurance Mandates in the States: 2006"

(http://www.cahi.org/cahi_contents/resources/pdf/MandatePub2006.pdf)

Prepared by: Greg Scandlen, President & CEO of Consumers for Health Care Choices, a consumer advocacy membership organization.

Council for Affordable Health Insurance
127 S. Peyton Street, Suite 210
Alexandria, VA 22314
Phone: 703/836-6200 Fax: 703/836-6550
Email: mail@cahi.org
www.cahi.org

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Healthy New York: A Poor Fix to a Dysfunctional Insurance System

"[T]onight I propose a new endeavor called Healthy Wisconsin, to help lower health care costs and pass along the savings to middle class families."

-Wisconsin Governor Jim Doyle

With those words, Wisconsin Governor Jim Doyle (D) introduced his proposal to replicate New York's program for the uninsured. Known as Healthy New York, the program combines a private mandate-lite benefit plan with a state reinsurance subsidy, and is only available to lower-income workers. Advocates are touting the purported success of Healthy New York, and State Coverage Initiatives — a Robert Wood Johnson project — has published a profile of the program.

But is the program really addressing the problem of the uninsured? Or are New York policymakers merely tinkering with a dysfunctional health insurance system of their own making?

The High Cost of Health Insurance in New York. New Yorkers currently pay among the highest health insurance premiums in the country.

Is Healthy New York a Good Deal?

Albany County, NY (25-year-old male)

- $500 co-pay for inpatient services
- $200 (or 20%) co-pay for surgical services
- $50 co-pay for emergency services
- $20 co-pay for other services
- Limits drug coverage ($100 deductible) to only $3,000 per year
- Does not include coverage for many mandated benefits, including some important services
- Is only available to those individuals with annual incomes below $25,125, or $58,125 for family of five
- Is subsidized by the state of New York

Cost: $158 to $222 per month for an individual

Lacrosse, WI (25-year-old male)

- $500 deductible
- $25 co-pay for primary care physician visit
- No limit on drug coverage
- Includes full coverage for all mandated benefits in Wisconsin
- Needs no state subsidy
- Is not limited to low-income workers
- Is one of 37 options available to those in the individual market

Cost: $160 per month for an individual

According to a 2004 eHealthInsurance report, only Boston tops New York City's individual health insurance rates.[1] In another eHealthInsurance report, the cost of New York State's individual health insurance policies is second only to New Jersey.

In the group market, New York doesn't fare any better. The Medical Expenditure Panel Survey (MEPS) found that New York is the second most expensive state for group family coverage.[2]

That's important because the more insurance costs, the more people choose to forgo it and join the ranks of the uninsured. The U.S. Census Bureau reports that 14.7 percent of New Yorkers are uninsured — higher than its neighboring states, including Pennsylvania (11.5 percent), New Hampshire (11 percent), Connecticut (11 percent) and Vermont (10.3 percent). New Jersey, where insurance usually costs a little more than New York, has about the same percentage of uninsured (14.6 percent).

A Self-Made Problem. New York's health insurance affordability problem is largely self-made.

In 1993, legislators responded to an Empire Blue Cross Blue Shield financial crisis by imposing guaranteed issue and community rating on the small group and individual markets. By requiring insurers to accept any applicant regardless of health status (guaranteed issue) and charging everyone the same premium (community rating), lawmakers hoped to make health insurance policies more affordable for people with pre-existing medical conditions.

They did, but younger and healthier people were forced to pay much more than they would have had insurers been able to underwrite the policies. As a result, younger and healthier people began to cancel their policies. Those dwindling numbers who remained in the pool saw their premiums rise significantly, making insurance unaffordable for most.

Thus the high cost of health insurance in New York and the inevitable growth in the number of uninsured — both products of previous government reform efforts — forced New York lawmakers to create yet another reform: the Health Care Reform Act of 2000, which established Healthy New York.

The Healthy New York Program. Healthy New York, which is heavily promoted through paid media (radio, television and newspaper ads) and other methods, limits enrollment to lower-income individuals (sliding scale up to $25,125) who have been uninsured for 12 months and small employers (50 employees or fewer).

The program lowers premium costs in two ways. First, Healthy New York limits costs by allowing insurers to offer mandate-lite plans not available in the private market. Second, the program subsidizes the coverage by covering 90 percent of insurer claims costs between $5,000 and $75,000.

The Fight for Mandate-Lite. Mandated benefits, which require insurers to cover specified providers and treatments, can significantly increase the cost of health insurance. According to CAHI's "2006 Health Insurance Mandates in the States," New York has 49 benefit mandates.[3]

Unlike the private market, Healthy New York is able to offer mandate-lite benefit plans, which exclude mandated coverage for mental health service, alcohol and substance abuse, chiropractic coverage, hospice care and more.

CAHI and many other organizations and health policy experts have supported reducing or eliminating state mandates for years, and more than 10 other states offer some form of mandate-lite programs. What makes Healthy New York unique is that it limits access to mandate-lite policies to uninsured individuals and small businesses who meet the income criteria.

State Reinsurance Efforts. As a presidential candidate, Sen. John Kerry proposed a national reinsurance pool to reimburse 75 percent of health insurance claims losses over $50,000. While the proposal was relatively new, the concept was not. A healthy private reinsurance industry provides similar coverage to carriers across the country, and several states operate voluntary reinsurance pools funded by the insurance industry.

New York's program began by reimbursing carrier claims for individual-market losses between $30,000 and $100,000. However, covering catastrophic losses provides limited savings because very few people incur claims that exceed $30,000. New York's results were no different, and eventually the state changed the funding arrangement to cover 90 percent of claims losses between $5,000 and $75,000. According to the 2004 program report, this change resulted in a 17 percent decrease in premiums.

Does Healthy New York Really Save Money? Despite the lower premium costs and heavy promotion, Healthy New York attracted just under 107,000 people by December 2005. The program's 2005 budget of $58 million is expected to grow to about $125 million by 2007.[4]

However, the more important question is, does the program make health insurance premiums affordable?

In Albany County, the monthly rates for the Healthy New York plan vary between a low of $158 (Empire HealthChoice, Inc.) to a high of $222 (Capital District Physicians' Health Plan). The only plan available through eHealthInsurance's website for a 25-year-old male would cost more than $335 a month. Clearly, Healthy New York provides some savings, but the higher prices in the individual market are primarily because New York's 1993 health insurance reforms destroyed its individual market.

The same person applying for coverage in Lacrosse, Wisconsin — recently named the most costly health care region in the country by the U.S. Government Accountability Office — would receive quotes as low as $41 a month for a policy with a $5,000 deductible. A policy comparable to Healthy New York's would cost $160 a month. [See the table.]

Thus residents of this Wisconsin town:

- Will pay about the same as a Healthy New York participant in Albany County, but without access to mandate-lite plans, and the state doesn't subsidize their premiums.
- Have the choice of 37 benefit plans, according to eHealthInsurance, versus one choice in Albany County
- And those 37 options aren't restricted to just lower-income families.

Assessing Healthy New York. Allowing people to have access to less-expensive mandate-lite policies is a good idea. But why restrict them to low-income uninsured people? Remember, many New Yorkers who currently have coverage also have lower or moderate incomes. If mandate-lite policies increase access to affordable coverage, why not let every New Yorker have that opportunity?

The attempt to subsidize coverage for lower-income, uninsured workers could be helpful. But why do it through a reinsurance mechanism, in essence, making the state an insurer? A direct subsidy, perhaps with a tax credit applied towards one's state income tax, would be more efficient and transparent. Besides, becoming a reinsurer is a sure way to get the state micro-managing health insurance. And as New York's 1993 reforms clearly demonstrated, New York *does not* know how to regulate insurance.

Conclusion. Healthy New York is a poor way to fix the state's dysfunctional health insurance market. What the state should do is repeal its guaranteed issue and community rating laws, relax some of its mandates and regulations, and allow more choice and innovation in the health insurance market. If it did, insurers would return to the state, premiums would drop, and the state wouldn't need Healthy New York. Plus, New York would finally have a health care reform model worth imitating.

Note: Endnotes can be found at http://www.cahi.org/cahi_contents/resources/pdf/n134NY.pdf

CAHI's 2006 "Health Insurance Mandates in the States" http://www.cahi.org/cahi_contents/resources/pdf/MandatePub2006.pdf

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Prepared by JP Wieske, Director of State Affairs, Council for Affordable Health Insurance

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Council for Affordable Health Insurance
127 S. Peyton Street, Suite 210
Alexandria, VA 22314
Phone: 703/836-6200 Fax: 703/836-6550
Email: mail@cahi.org
www.cahi.org

Endnotes

1. "Most Affordable Cities for Family Health Insurance, eHealthInsurance, December 7, 2004.
2. http://www.meps.ahrq.gov/
3. Available at www.cahi.org
4. http://www.ins.state.ny.us/website2/hny/reports/hny2005.pdf


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ISSUES & ANSWERS

Solutions for Today's Health Policy Challenges

No. 127 Updated January 2005

The Grand Illusion:
The Perennial Quest for a Single-Payer Health Care System that Works

First in a Series on Single-Payer Systems

There is a specter haunting the U.S. health care system: it is the perennial hope that somewhere, somehow, someone has figured out how to make a single-payer health care system that actually works.

Recently, three states — Maine on the East Coast, Illinois in the Heartland and Oregon on the West Coast — have explored creating their own state-based single-payer health care systems. The Oregon plan was resoundingly rejected by voters because the program would have exceeded the entire state budget, the Illinois legislation was reduced to a study, and Maine adopted a scaled-down "voluntary" system in 2004 known as Dirigo Health, which is already way behind schedule. Ironically, states already have a single-payer health care system: Medicaid. Anyone who thinks single-payer systems would be a panacea for increasing access to high-quality health care at lower costs need only look at the chronic problems plaguing Medicaid.

A Legacy of Failed Single-Payer Attempts. Over the past decade, numerous states — energized by the debate over the Clinton health care plan — considered implementing single-payer systems. A few states succeeded in passing a first step, and have been struggling ever since to limit or undo what they did.

Tennessee: The closest thing to a state-based single-payer system was Tennessee's TennCare, which as originally envisioned in 1993 would cover every uninsured and poor person in the state for *less* money than the state was currently spending on Medicaid.

The magic bullet that would make this feat possible? Savings from putting everyone in managed care.

However, within a few years after implementation, the rich benefits package and coverage expansion — a hallmark of all single-payer proposals — was straining the state budget. The state's health care expenditures grew by 69 percent between 1992 and 1999, while personal income increased by only 38 percent, and covered 24 percent of the population. A 1999 audit of the program found that TennCare:

- Included 16,500 enrollees who lived out of state;
- Paid $6 million to cover 14,000 dead enrollees; and
- Enrolled 450 state employees who had access to the state employees' health plan.

A 2003 audit of TennCare also found massive problems, including "Inadequately monitoring the $850 million pharmacy program . . . ." and "Not ensuring providers are licensed to work in Tennessee . . . ." according to an article in the newspaper *The Tennessean*. As a result of the program's financing problems, Governor Bresden announced in January 2005 that TennCare will revert to a Medicaid managed care program and drop 323,000 people who will not qualify for Medicaid.

The Difference in Medicaid Spending versus Education Spending
(Millions of Dollars)

State	2004 Medicaid (est)	2004 Education (est)	Difference
Pennsylvania	$14,375	$9,065	**$5,310**
New York	$27,562	$18,828	**$8,734**
Tennessee	$7,246	$3,628	**$3,618**
Connecticut	$5,444	$2,881	**$2,563**
Missouri	$5,725	$4,552	**$1,173**
Louisiana	$4,772	$3,635	**$1,137**
Florida	$12,159	$11,050	**$1,109**
Rhode Island	$1,568	$972	**$596**
Illinois	$11,590	$8,419	**$3,171**
Massachusetts	$5,856	$4,758	**$1,098**
Maine	$1,772	$1,098	**$674**
Arizona	$5,007	$4,080	**$927**
Ohio	$12,073	$9,754	**$2,319**
South Carolina	$3,808	$2,813	**$995**
South Dakota	$557	$511	**$46**
North Dakota	$508	$444	**$64**
Nebraska	$1,317	$1,111	**$206**
New Hampsire	$1,080	$1,057	**$23**
Arkansas	$2,760	$2,243	**$517**
North Carolina	$7,011	$6,996	**$15**
Mississippi	$3,175	$2,589	**$586**
Kentucky	$4,009	$3,662	**$347**
Maryland	$4,713	$4,324	**$389**

Source: National Association of State Budget Officers, 2003 State Expenditure Report, published in 2004.

A New Magic Bullet? Undaunted by repeated failures, single payer proponents have a magic bullet: bulk purchasing

According to Citizen Action Illinois, which advocated for a single-payer system, "Using the purchasing power of a massive risk pool consisting of the vast majority of uninsured 'Healthy Illinois' will make quality, affordable healthcare available to residents and will initiate new processes for cost and quality improvement."

Sure, just like they did in Tennessee!

States Already Have a Single-Payer System. If states want to see how well a single-payer system works, they should look no further than their own Medicaid programs. If "a massive risk pool" is the answer, some state Medicaid programs already include more than a million people. Do state Medicaid programs increase access to quality care while saving the state money? In fact, virtually every state is cutting benefits, rationing care and trying to control costs — and pulling funds from other sources, such as education.

For years, education was the states' biggest spending item. But by 2004, 23 states spent more on Medicaid (including federal matching grants) than education up from 19 in 2002. [See the chart.] In an effort to slow that spending trend, most states have cut services, removed or restricted certain populations and limited access to prescription drugs.

Does a Single-Payer System Save Money? Proponents argue that a single-payer system is less expensive than a private health care system. While it is true that data show that every country with a single-payer system spends less per capita on health care than the U.S., that doesn't mean they are more efficient. They simply impose a global budget and refuse to spend more, letting Americans with private insurance subsidize medical and pharmaceutical innovations. But those in single-payer systems also get less.

Price controls: The states on average reimburse doctors and hospitals for Medicaid recipients only about 60 percent of what large employer groups reimburse those same providers for the same services. But utilization of services in Medicaid is vastly greater than that experienced by the general population, more than two-and-a-half times greater! That's partly because the services are "free" to people with Medicaid coverage. It may also be that providers do more — much more — to compensate for the lower reimbursements.

Administrative costs: Proponents also claim that single-payer systems are much more cost efficient than the private sector because of vastly lower administrative costs.

Based on an earlier CAHI analysis, the actual administrative costs for Medicaid and Medicare — both single-payer systems — are estimated at roughly 31 percent of benefit costs and 23 percent, respectively. That is because a large amount of the cost is hidden in the general budgets of governments, whether in the budgets of the legislative or other branches, or in interest payments created by the deficits such programs help produce.

Government services do not come free. For example, conservatives in England claimed on July 6 that cutting red tape would save the National Health Service £1.7 billion. So much for efficient government services!

Why Single-Payer Systems Always Lead to Rationing. In a single-payer system, health care dollars must compete with other valid claims on government funds such as education, welfare and defense. As a result, there is never enough money. There is not one single-payer country in the world — and that is almost every other country — with adequate funds. Not one. And so, some patients — usually the very old, very young, sickest, poorest and the least powerful — don't get the care they need in a timely fashion.

All anyone interested has to do is look at the newspapers from single-payer countries. Just consider some recent stories (all citations are found at www.factcheckers.org):

- *The Gazette* (Canada, December 3, 2004): "More than 5,500 children are on waiting lists as long as one year for corrective surgery in Montreal's two pediatric hospitals."
- *The Evening News* (Scotland, December 28, 2004): "The number of Scots opting to pay for private operations rather than join record NHS waiting lists has soared, according to independent hospitals."
- *National Post* (UK, January 8, 2005): "Thousands of patients are languishing on 'hidden' hospital waiting lists which are not counted in official figures, it emerged last night."

Conclusion. Every state is struggling with Medicaid access and funding problems — just like every single-payer country. Every state legislator is aware of the challenges, and yet some foolishly believe that a state-based single-payer system will work. It is a grand illusion built on an unwillingness to learn from the evidence in front of them.

Prepared by Merrill Matthews, Jr., Ph.D., Director, Council for Affordable Health Insurance

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Council for Affordable Health Insurance
112 S. West Street, Suite 400
Alexandria, VA 22314
Phone: 703/836-6200 Fax: 703/836-6550
Email: mail@cahi.org
www.cahi.org


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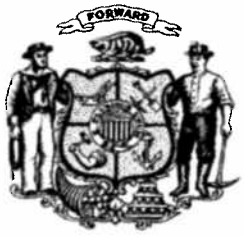
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Seniors Issues & Answers

Council for Affordable Health Insurance | United Seniors Association

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The Myths of Canadian Health Care

Many politicians are asking us to look north to Canada if we want to see a health care system that really works. Can Canada's government-run health care system really provide universal coverage for less money? Maybe the Canadian newspapers will tell us what proponents of socialized medicine won't.

Claim #1: Canada's System of Socialized Medicine Is Sufficiently Funded to Provide Care to All. Canada spends about 9 percent of its GDP on health care and provides coverage for all, while the U.S. spends 14 percent and has millions of people uninsured. Proponents of a Canadian model thus conclude that the federal government could cover every American for what the country is spending now -- *or less*.

That argument ignores the fact that there is no government-run health care system in the world that is adequately funded. And the reason is simple: health care must compete with education, welfare, defense and other valid claims on government funds. As a result, every government-run system rations care, with bureaucrats and elected officials deciding who gets what and when.

Case Study: Canadian hospitals need money. On Dec. 24, 1999, the *Toronto Star* reported, "The Ontario government is bailing out deficit-ridden hospitals to the tune of $196 million." This infusion marked "the second year in a row the Tory government has come to the rescue of about half of the province's hospitals." Indeed, the Ontario hospital system was forced to absorb a 10 percent decrease in funding between 1997 and 1999.

Case Study: The shortage of doctors. Just one day earlier, Dec. 23, 1999, the *Toronto Star* ran the headline: "Ontario government report calls for up to 1,000 more MDs." In response to the report, the province's health minister said the government would provide "$11 million in 'short-term' aid . . ." and try to attract more foreign doctors, according to the article.

Case Study: Shortages in the ER. Residents of Montreal can rest a little easier this summer. Doctors reached an agreement with the provincial government in Quebec so that emergency rooms will remain open, according to the *Montreal Gazette* (June 20, 2003). "In the summer and fall of 2002," the paper reports, "Quebec's general practitioners fought a pitched battle against Bill 114, a new law that compelled doctors to work in understaffed ERs or face $5,000 fines." Instead of fining non-ER doctors for *not* working in emergency rooms, the government will be giving them a bonus if they do.

Claim #2: Canada Provides Universal Access to Care. Proponents of socialized medicine argue that the uninsured typically postpone seeing a doctor and end up in the emergency room, which costs the system a lot more than it would had they just gone to see a family doctor. If everyone has government-provided coverage, then you remove that costly inefficiency and people have access to care when they need it. Or do they?

Case Study: Waiting lines in Canada. Access to a waiting line is not the same (nor as good) as access to a doctor. On Jan. 18, 2003, the Canadian Press carried the headline, "Send cancer patients to U.S., Alberta MDs urge." The story begins, "Breast-cancer patients whose wait to see a specialist has jumped up to eight weeks from less than four should be sent out of province for treatment, the president of the Alberta Medical Association says."

In a story about a proposal to allow private day surgeries in Vancouver, British Columbia, to reduce waiting times, the *Vancouver Province* (June 11, 2003) reports, "But even when the (Richmond) hospital was at its most efficient, 40 per cent of patients were waiting three months or more (for elective surgery)."

As bad as that is, it's better than England, where 57-year-old Peter Smith got his heart surgery a full five months after he first complained of chest pains to his general practitioner (*London Observer*, May 25, 2003).

Claim #3: The Quality of Care in Canada Is as Good as or Better than the U.S. "Quality health care" means different things to different people. For individuals, quality health care usually means a good outcome, conveniently obtained at a reasonable price. But can you have quality health care if a patient can't see a doctor?

Case Study: The quest for quality health care. The headline in the June 16, 2003, *Vancouver Sun* pretty much says it all: "Doctors Demand Patient Care Guarantees." The

British Columbia Medical Association has released a paper calling for "the establishment of maximum wait times, or 'care guarantees' for various medical procedures," according to the story. The report "proposes that patients not helped within the guaranteed time frame should be able to seek care out of province – in a public or private facility – at no cost to themselves."

In Canada it is against the law for a citizen to pay out of pocket for care that is provided by the government-run health care system. The only other countries that criminalize privately paying for health care are North Korea and Cuba.

Case Study: Canadians heading south. But it isn't against the law for Canadians to cross the U.S. border and pay for care they can't get in Canada. In fact, the U.S. has become the safety valve for a foreign health care system that would implode economically and politically without access to U.S. doctors, hospitals *and* drugs.

On Jan. 16, 2000, the *New York Times* titled a story, "Full Hospitals Make Canadians Wait and Look South." The article concludes: "As a result, Canada has moved informally to a two-tier, public-private system. Although private practice is limited to dentists and veterinarians, 90 percent of Canadians live within 100 miles of the United States, and many people are crossing the border for private care."

Claim #4: In Canada's System, Everyone Is Treated the Same. The push for socialized medicine isn't just about health care; it's also a quest for social justice. Advocates don't want the rich to get better care than the poor. But the rationing that *always* accompanies a government-run system means that some people will not get the care they need, and it is nearly always society's marginal citizens – the poor, the very old and those with very high costs – who get substandard care, if they get care at all.

Just consider some of these headlines from England:

- "Am I too old to be treated?" *The Sunday Times*, April 17, 1994.
- "Kidney patients die as costly dialysis machines lie idle," *The Times*, July 26, 1993.
- "Too old to be cured of cancer," *The Times*, Aug. 16, 1993.

But there can be other perverse results from rationing. Greg Moulton of Guelph, Ontario, was in a three-month wait to get a CT scan "to learn the cause of his 'excruciating' headaches." Since York Central Hospital's radiology department was only open to the public at specified hours, the hospital decided to allow pet owners to bring in their animals in need of a CT scan after hours — for $300 a scan. "For dogs, a scan can be arranged within 24 hours," according to the Canadian Press ("Humans wait in pain, dogs don't," June 14, 1991).

Another Canadian was more resourceful. On Dec. 18, 1999, the *Washington Post* reported that waiting lines for MRIs in Ontario had grown so long that one Ontario resident "booked himself into a private veterinary clinic that happened to have one of the machines, listing himself as 'Fido.'"

In a socialist effort to avoid a two-tiered system where wealthy people can get health care but the poor can't, Canada has created a different kind of two-tiered system – where people can't get care, but dogs can.

Conclusion. These news articles (and many more not included) tell the story of a financially strapped health care system that threatens the health and lives of its citizens. The dates on the articles, ranging over a decade, tell the story that these are not simply past problems nor current problems, but systemic problems inherent to government-run health care.

Seniors in the U.S. Medicare program are already in a government-run system; and they are experiencing many of the same problems Canadians face every day. If we emulate Canada, America's health choices will narrow, and health innovations and breakthroughs will be suppressed. And while price controls and rationing mean we may spend a little less money, we will get a lot less care – just look at Canada. That is the story we are not being told.

Prepared by Merrill Matthews, Jr., Ph.D., Director, Council for Affordable Health Insurance and Charles W. Jarvis, President & Chief Executive, United Seniors Association.

The Council for Affordable Health Insurance
www.cahi.org
703/836-6200

United Seniors Association
www.unitedseniors.org
703/359-6500

112 S. West Street, Suite 400
Alexandria, VA 22314
Fax: 703/836-6550

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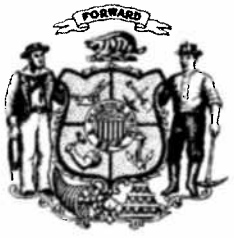

The Council for Affordable Health Insurance's

ISSUES & ANSWERS

Solutions for Today's Health Policy Challenges

No. 120 November 2003

An Affordable Way to Help the Uninsured

The newly released U.S. Census Bureau figures show that the number of Americans without health insurance rose from 41.2 million in 2001 to 43.6 million in 2002, an increase from 14.6 percent of the population to 15.2 percent.

The increase is creating political pressure for Congress and the Bush administration to address the situation. But how? What's the best way to ensure that uninsured Americans can afford health insurance? The answer has already been introduced in the House and Senate, with bipartisan support: the Fair Care for the Uninsured Act.

The Growing Number of Uninsured. There is a reason 43.6 million Americans lack health insurance: tax discrimination. Until the federal government redresses that problem, millions of Americans, especially low-income workers, will remain uninsured with little or no access to affordable health insurance.

Tax Breaks for Some but Not for All. For 60 years, the IRS has allowed employers to deduct their contributions to employee health coverage, while employees receive a "tax exclusion," which means employer money spent on health coverage is excluded from employee income.

In addition to providing a tax break for employer-provided health insurance, Congress allows the self-employed to deduct what they spend on health insurance premiums.

However, individuals working for employers who don't provide health insurance get no tax relief. They must pay their taxes first and buy a policy with what's left over.

Penalizing the Poor. Workers who lack access to employer-provided coverage tend to have lower incomes than those who work for employers who do offer it. According to a Kaiser Family Foundation survey of the uninsured for the year 2001:

- Of those under age 65 whose incomes were 100 percent of the federal poverty level (FPL) or less, 17 percent received health insurance from an employer, while 37 percent were uninsured.
- For those with incomes between 100 and 199 percent of FPL, 43 percent had employer-provided insurance and 27 percent were uninsured.
- However, for those making 300 percent of FPL or more, 86 percent had employer coverage while only 6 percent were uninsured.

Thus, the federal government is providing a sizable tax subsidy to middle- and higher-income workers and little or no help to those who can least afford health insurance coverage. *And then we wonder why so many low-income workers are uninsured.*

Why Tax Credits Are the Answer. A tax credit is not the same as a tax deduction. With a deduction, you subtract the amount of money spent on a deductible item from your income, so you pay taxes on a smaller income. With a tax credit, by contrast,

How Would Tax Credits Affect Working Families?

Adjusted Gross Income	Fair Care Tax Credit *per adult*	Fair Care Tax Credit* *per child*	Maximum Fair Care Tax Credit	Presidential Tax Credit *per adult*	Presidential Tax Credit* *per child*	Maximum Presidential Tax Credit
$15,000 individual	$1,000		$1,000	$1,000		$1,000
$20,000 individual	$1,000		$1,000	$556		$556
$30,000 individual	$1,000		$1,000	$0		$0
$25,000 family	$1,000	$500	$3,000	$2,000	$500	$3,000
$40,000 family	$1,000	$500	$3,000	$1,143	$286	$1,714
$60,000 family	$1,000	$500	$3,000	$0	$0	$0

*2 credit max.

the allowable amount is subtracted directly from the amount of taxes owed. Thus, a worker with a family who owes $5,000 in income tax and qualifies for, say, a $3,000 health insurance tax credit would pay only $2,000 in taxes ($5,000-$3,000 = $2,000). The $3,000 would have to be used, in this case, for the purchase of health insurance. If the policy cost more, the worker would pay the difference out of pocket.

In order for a tax credit to help low-income workers, it has to be "refundable," which means the worker still receives the full value of the credit even if he doesn't owe income taxes. For example, if the same worker mentioned above owed no income taxes, he or she would simply receive an "assignable" credit for the full $3,000, which would be signed over to an insurance company to purchase a policy.

Finally, low-income workers targeted by the tax credit often do not have enough money to pay for a policy. Making the tax credit "advancable" gets the money to workers — or insurers — up front. The lack of advancability is why some low-income families failed to use the Earned Income Tax Credit — a refundable tax credit program for low-income workers implemented in 1974 — for the purchase of health insurance.

Thus, with a refundable, advancable tax credit, the uninsured would have access to funds that would help them purchase their own health coverage.

The Fair Care for the Uninsured Act. The Fair Care for the Uninsured Act (H.R. 583) was introduced in the House of Representatives in February by Reps. Mark Kennedy (R-MN) and Bill Lipinski (D-IL), and currently has more than a hundred cosponsors. The Senate version (S. 1570) was introduced August 1 by Sen. Rick Santorum (R-PA).

The legislation provides a refundable, advancable tax credit of $1,000 for an individual, $2,000 per couple, and $500 per child for a maximum of $3,000 per household for those who do not receive subsidized health benefits through their employer or government health plans.

President Bush has proposed similar legislation, only he would impose a means test which would restrict the program to lower- and middle-income families. Eligible families with two or more children and incomes below $25,000 annually would be eligible for the full $3,000 tax credit, which would phase out at $60,000. Individuals earning $15,000 or less would receive the full $1,000 tax credit, phasing out at $30,000.

Fair Care also provides for people with a preexisting medical condition by increasing the current funding for state high-risk pools, which sell health coverage to those who have been denied it because of a medical condition.

Finally, Fair Care includes a provision for Individual Medical Associations (IMAs). Bona fide membership associations, such as the Kiwanis Club, could offer individual health insurance to their members through an IMA. The associations would contract with state-licensed and regulated health insurance companies to provide at least two fully insured options: one that complies with all state mandates and one that is not required to do so. IMAs would provide tailored benefit packages in response to membership needs in addition to providing flexibility and affordability.

The Impact of a Tax Credit. Economists Mark Pauly and Bradley Herring of the University of Pennsylvania and David Song of Yale University recently analyzed the response to a tax credit for health insurance. The authors looked at a "fixed" $1,000 refundable tax credit for self-only coverage when purchased in the individual market. According to Pauly et al., "[W]e find that 85 percent of the uninsured sample requires a subsidy of under $1,000 for the purchase of a $1,000 deductible PPO plan, while only 34 percent of the uninsured would respond to such a subsidy for the purchase of a [more costly] $250 deductible plan." That is, the authors found that the take-up rate is in almost direct proportion to the amount of the subsidy.

The Cost of Fair Care. How much would such a program cost the government? Economists Gary and Aldona Robbins have estimated the annual cost of such a tax credit at $15.8 billion. Mark Litow, a principal of Milliman USA, has estimated that a similar tax credit that would vary by income and health status – providing more help to those who need it most — would cost between $20 billion and $25 billion a year.

Because the administration's plan has an income cap, it is estimated to cost less than Fair Care: $89 billion over 10 years, or roughly $8.9 billion per year.

Conclusion. Why are so many low-income people uninsured? Because they cannot afford it. What does a health insurance tax credit do? Makes health insurance more affordable.

Eliminating tax discrimination in health insurance would decrease the number of uninsured, especially among low-income workers, because it would make policies more affordable. It's time to end the current policy of tax discrimination and give the uninsured the opportunity to join the ranks of those with health insurance.

Prepared by Merrill Matthews, Jr., Ph.D., Director, Council for Affordable Health Insurance, and Victoria Craig Bunce, Director of Research and Policy, Council for Affordable Health Insurance

Council for Affordable Health Insurance
112 S. West Street, Suite 400
Alexandria, VA 22314
Phone: 703/836-6200 Fax: 703/836-6550
Email: mail@cahi.org
www.cahi.org

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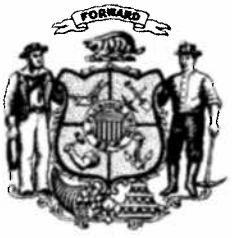

The Council for Affordable Health Insurance's

ISSUES & ANSWERS

Solutions for Today's Health Policy Challenges

No. 128 February 2005

The Health Care Safety Net We Want and Need

First in the Series on the U.S Health Care Safety Net System

One of the most vexing public policy problems is how to ensure that people have access to affordable health care. Currently, the U.S. health care system relies on a patchwork of funding mechanisms. Most Americans get their health insurance through the private sector, but millions are covered by an ad hoc safety net.

Two problems emerge from this patchwork system:

- There are millions of Americans who should be in the safety net but are not;
- And there are millions who have no business being in the safety net but are.

Such problems make the safety net both inefficient and very costly. The public policy challenge facing the U.S. and its elected representatives is to develop a safety net that provides quality and timely care for those who need it most, and allow the market to work for everyone else.

Two Safety Net Philosophies. There are two different safety net philosophies: The U.S. (along with South Africa and Singapore) holds one view, and just about every other country takes the other.

Historically, the U.S. has held that individuals should be responsible for obtaining their own health care and health insurance, but there should also be a government-supported safety net for those who are too poor, elderly or sick to access the system. Medicare and Medicaid — the two largest safety net programs — were intended for the elderly and poor because it was thought they had limited funds to pay for care.

Most other countries do not believe that markets work in health care, nor do they believe that individual responsibility and accountability can or should play a significant role. Thus a safety net isn't just part of their system; it IS the system. Everyone is entitled to a rich package of health benefits. These countries have, in effect, *turned the safety net into a hammock*.

Over the past four decades, U.S. politicians have frequently expanded the Medicare and Medicaid safety net programs so that they too look like a hammock. But the government also has been cutting reimbursement rates so that people in these programs are increasingly experiencing access problems as health care providers limit or reduce participation, and costs are shifted to the private sector.

U.S. Health Insurance Coverage. Most Americans with health insurance get it through the private sector.[1]

- 159.2 million Americans (workers and dependents) have employer-provided coverage;
- Another 17 million buy their own policies in what is known as the individual market.

But the U.S. also has an extensive public sector health care system — accounting for about 45 percent of all U.S. health care spending.[2] [See the Sidebar.] Despite all of these private and public sector options, there are still some 45 million uninsured Americans.[3]

Public Hospitals and Clinics. Historically, states and local communities have filled in the cracks for the uninsured, largely by funding public hospitals and clinics that will take the poor, the uninsured and the uninsurable.

The Public Sector Safety Net*

- Medicare covers about 35 million seniors and 6 million disabled people (2003).[4]
- Medicaid covers 42.4 million Americans, of whom 4.3 million are aged and also participate in Medicare, and 7.9 million are blind or disabled and may participate in Medicare. That leaves about 30.2 million mostly low-income Americans who rely on Medicaid for insurance coverage.[5]
- In addition, there are nearly 7 million Americans in Tricare (a program run by the Department of Defense for military retirees or the dependents of those on active duty and others) or CHAMPVA (for low-income and disabled veterans).[6]
- The State Children's Health Insurance Program (SCHIP) is the federal-state partnership program designed to expand health insurance coverage to children whose families earn too much money to be eligible for Medicaid but not enough money to purchase private health insurance coverage. For 2003, there were 5.8 million children enrolled in SCHIP at some point during the year.[7]

* *Some of the figures are derived from separate sources and so populations may be in more than one safety net and therefore counted more than once.*

According to the Institute of Medicine (IOM), of the $34 billion to $38 billion in uncompensated charity care delivered to the uninsured (but not paid for) in 2001, the public sector is estimated to have financed up to 85 percent of the cost.[8]

However, providing that care is straining government budgets, a situation exacerbated by the fact that many states expanded Medicaid eligibility limits in the 1990s — in some cases to solidly middle-income families — when most state coffers were overflowing. For years, education was the states' biggest spending item. But by 2004, 23 states spent more on Medicaid (when federal subsidies were included) than education.[9]

Tax Breaks for Health Insurance. Another way government provides a safety net, at least indirectly, is by providing a tax break for the purchase of health insurance — a significant benefit for those who get health insurance through an employer and for the self-employed. The journal *Health Affairs* estimates that the government "spends" — that is, forgoes — about $188 billion each year on such tax breaks.[10]

However, individuals working for employers who don't provide health insurance get no similar tax relief. They must pay their taxes first and buy a policy with what's left over.

High-Risk Pools. High-risk pools act as a safety net for people who are uninsurable, or whose premiums cost more than the standard. Established more than 25 years ago, high-risk pools operate in 33 states and covered more than 181,000 people as of June 2004, according to Communicating for Agriculture.[11]

In most states with high-risk pools, applicants have a choice among HMOs or PPOs, and most offer a range of deductibles and copays. Applicants can purchase a plan that meets their needs and budget. State high-risk pools are usually funded by assessing health insurers operating within a state, based on the amount of business the insurer writes. Some states have relied on broad-based funding sources such as lotteries or general tax revenues.

However, in 2002 Congress passed legislation that provided federal "seed" money (through 2004) to be used for start-up costs in states where no high-risk pool existed or was closed to new applicants. The legislation further provided funds for states that already had operational high-risk pools, so long as existing pools were consistent with regulatory guidelines.

Congress should continue to provide federal funding and remove legal barriers to states' efforts to broadly fund their pools, which are the most efficient way to provide a safety net for the uninsurable while letting the private sector work for most other Americans.

Returning to a Real Safety Net. One goal of any U.S. health care reform effort should be to ensure that the safety net system is just that: a safety net that actually helps those who need help most. For example:

- Even though the Congressional Budget Office documented that about 75 percent of seniors on Medicare had some type of prescription drug coverage, Congress passed a new entitlement that will include even the richest seniors.
- Some states have expanded SCHIP eligibility beyond the 200 percent of the Federal Poverty Level (FPL) limit and some are also covering entire families and not just children.
- Middle- and upper-income families routinely "spend down" or hide the assets of a family member who must go to a nursing home, thus qualifying for Medicaid coverage.
- And, as mentioned above, those with employer-provided coverage tend to be higher-income workers, yet they get an unlimited tax break; those without employer coverage tend to have lower incomes, but get no tax subsidy.
- Local governments may also provide other safety nets that are not coordinated with any of the federal or state programs discussed above, resulting in confusion as well as overlapping coverage.

For a safety net to be both effective and affordable, it must provide sufficient help to the poor, the uninsured and the uninsurable, but let the market work for the vast majority of Americans who are willing and able to take responsibility for their own actions. It should also encourage individuals to eventually take care of and help themselves, not make them dependent on the program forever, unless their physical health necessitates it. Such a safety net would:

- Build on a free market system, not detract from it;
- Attempt, as much as possible, to "mainstream" those in the safety net so that if and when the day comes that they can move back into the private sector, the transition will be as seamless and painless as possible;
- Fund it with public dollars, rather than trying to impose those costs on business;
- Provide reasonable incentives within the programs to encourage people to spend the money as though it was their own, while providing the ability to receive timely and high quality care; and
- Ensure that only those who really need help are in the safety net.

If the U.S. can implement these health care reform principles, it will fundamentally restructure the health care system so that all Americans have access to affordable, quality health care.

Note: Endnotes are available at http://www.cahi.org/cahi_contents/resources/pdf/n128safetynet.pdf.

Prepared by: Victoria Craig Bunce, Director of Research and Policy, Council for Affordable Health Insurance and Merrill Matthews, Ph.D., Director, Council for Affordable Health Insurance.

Council for Affordable Health Insurance
112 S. West Street, Suite 400
Alexandria, VA 22314
Phone: 703/836-6200 Fax: 703/836-6550 Email: mail@cahi.org
www.cahi.org

Endnotes

[1]Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2004 Current Population Survey," Employee Benefit Research Institute, Issue Brief No. 276, December 2004, p. 5, Figure 1.

[2]Organization for Economic Cooperation and Development, "OECD Health Data 2004," 1st Edition (http://www.oecd.org/dataoecd/13/12/31963479.xls).

[3]Ibid.

[4]Centers for Medicare and Medicaid Services, "Medicare Enrollment: National Trends, 1996-2003" (http://www.cms.hhs.gov/statistics/enrollment/natltrends/hi_smi.asp).

[5]Centers for Medicare and Medicaid Services, "Medicaid Enrollment for Beneficiaries, Selected Fiscal Years," November 2003.

[6]Fronstin, Ibid.

[7]See http://www.cms.hhs.gov/schip/.

[8]See Institute of Medicine, "A Shared Destiny: Community Effects of Uninsurance," March 6, 2003. http://www.iom.edu/report.asp?id=5404.

[9]See National Association of State Budget Officers, "2003 State Expenditure Report," 2003.

[10]John Sheils and Randall Haught, "The Cost of Tax-Exempt Health Benefits in 2004," Health Affairs, Web Exclusive, February 25, 2004.

[11]"Comprehensive Health Insurance for High-Risk Individuals — A State-by-State Analysis," Communicating for Agriculture, Inc., Eighteenth Edition, 2004/2005, November 4, 2004.


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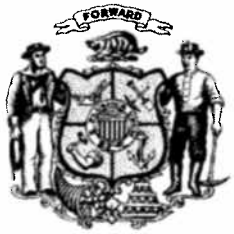
FORWARD

The Council for Affordable Health Insurance's

ISSUES & ANSWERS

Solutions for Today's Health Policy Challenges

No. 129 March 2005

Tough Lessons from TennCare

TennCare — a managed care program that replaced and expanded Medicaid in Tennessee — has been troubled from its inception. Hastily implemented so as to minimize evaluation and opposition, Tennesseans have been paying the high price for an ill-conceived program ever since.

Initially, TennCare covered 1.1 million people — the 766,000 residents then enrolled in Medicaid and an additional 340,000 who were uninsured or uninsurable. Today, it covers more than 1.3 million, nearly a quarter of the state's population, and requires almost a third of the state's budget.[1] A recent independent study concluded that if no changes were made to TennCare, health care costs could consume as much as 40 percent of the state budget by 2008.[2]

Now, 11 years after implementation, Tennessee is a poorer, but wiser, state. In an attempt to address the fiscal crisis, Gov. Phil Bresden announced in January 2005 that TennCare will revert to a Medicaid managed care program and drop 323,000 people who will not qualify for Medicaid. However, a court has told the governor he cannot implement his plan before June.[3]

The governor and numerous legislators have learned some tough lessons from TennCare, and they want an "exit strategy" — if the courts will let them.

A 1999 audit of the program found that TennCare:[i]

- Included 16,500 enrollees who lived out of state;
- Paid $6 million to cover 14,000 dead enrollees; and
- Enrolled 450 state employees who had access to the state employees' health plan.

A 2003 audit by the state Medicaid Fraud Control Units recovered $268 million in court ordered restitutions, fines, civil settlements and penalties and was instrumental in obtaining 1,096 convictions.[ii]

And a 2004 investigation by WSMV-TV (Nashville) found rampant prescription drug abuse as TennCare beneficiaries would get drugs they didn't need and sell them for a profit. One official is quoted as saying, "TennCare is the biggest supplier of the drugs we are seeing on the streets." According to the story, 47 percent of the population of Fentress County was on TennCare, and 224 people were indicted for drug sales.[iii]

The Origins of TennCare. Then-Gov. Ned McWherter proposed TennCare on April 8, 1993. By May 5, the Legislature had approved only an outline of the program and authorized the governor to proceed. By June, the state submitted a request for a federal waiver to the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services), and by January 1, 1994, the program was operational.[4]

In return for the waiver, the federal government required the state to cover all Tennesseans who qualified for Medicaid, plus the uninsured and the uninsurable (i.e., those who could not obtain coverage because of a pre-existing condition).

Thus, only about eight months passed between TennCare's inception to its implementation, with minimal input from elected representatives and stakeholders in the health care system. The political objective appears to have been to get a Clinton-style health care reform plan in place before opposition forces could form.

Tough Lessons for Legislators. What does Tennessee know now that it didn't know in 1993 — and, considering all of the new state proposals to create some variation of TennCare, what several states have yet to learn?

States have limited ability to fix the health care system. Most Americans' health coverage falls under federal, rather than state, law. For example, about 160 million Americans get their health coverage from their employer, and roughly half of them are self-insured under the federal Employee Retirement Income Security Act of 1974 (ERISA). Another 44 million seniors and disabled people get coverage through the federal Medicare program, and about 7 million receive federal coverage from a military-related program.[5]

Thus, grandiose state schemes to move to a single-payer system — some TennCare supporters envisioned expanding it into a statewide single-payer if the more limited version proved successful — are almost certainly doomed to failure because so much of the population's health coverage isn't under state control.[6] A much better approach is for states to ask how they can create a limited, viable and affordable safety net to catch those who really need the help.

Government-run systems don't really save money. Proponents of government-run health care systems claim they cost less than market-oriented systems because they are more efficient and eliminate profits.

The truth is that government-run programs simply *spend less*, because they can cut reimbursements and ration care.

The states on average reimburse doctors for Medicaid recipients only about 69 percent of Medicare fees, up from 62 percent in 1998.[7] And Medicare only pays a little more than cost.

According to a recent Kaiser Family Foundation report on Medicaid, "According to the [50 state] survey 39 states were facing increased pressure and another 12 states were facing constant, but intense pressure to control Medicaid costs. For FY 2005, 47 states adopted plans to freeze or reduce provider payments, and 43 states planned pharmacy cost controls to reduce overall Medicaid spending growth. In addition, 15 states made plans to restrict eligibility, nine states planned to reduce or restrict benefits and nine states reported plans to increase copayments in FY 2005."[8]

That may be saving money, but it's not because of efficiency; it's rationing.

TennCare is no different. For example, a March 1999 actuarial review by PricewaterhouseCoopers found that capitated reimbursement rates were $11 per-member, per-month below what would be considered "actuarially sound."[9] In May 2004, the Legislature approved proposed cuts that would limit patients to 10 (later raised to 12) doctor visits a year and six prescriptions a month.[10]

"What began as a grand vision had become a political scramble to cut the program as fast as possible," says one of TennCare's current defenders.[11]

Unfortunately, when the government sets provider reimbursements below market value, providers must recoup their costs in other ways — like unbundling provided services or limiting access to health care, which leads to higher health care costs at a later point in time.

Managed care is not a panacea. Gov. McWherter and other supporters of TennCare sold the program to the public in part by claiming that managed care would save the system so much money that the state would be able to cover not only the Medicaid population, but the uninsured and uninsurables as well.

They were in for a rude awakening. In 1995, TennCare cost $2.5 billion. By 2004, the program's cost had swollen to $8.04 billion ($2.54 billion state share, $5.04 billion federal share, and $462 million other, including drug rebates). That's one third of the state's budget.[12]

Managed care attempts to reduce costs by controlling utilization from the top down, by telling patients what they can and can't have. However, the only effective way to control health care utilization is by ensuring that patients have an incentive to control it. Consumer-driven plans such as Health Savings Accounts do that; managed care doesn't.

Fraud is rampant in government-run systems. When government creates a rich, taxpayer-funded health insurance package, it is an invitation for fraud. [See the sidebar on the front page.]

Quality of care always declines when the government is paying the bills. Government health care dollars must compete with other valid claims on government funds such as education, welfare and defense. As a result, there is never enough money. Limited funds mean patients suffer. For example, low reimbursements force doctors to limit the number of TennCare patients they treat. And while the governor's plan to allow only six prescriptions per month may work well for most patients, some may need more and would not be able to get them — at least through TennCare.

Once started, it is hard to end the program. Just ask Gov. Bredesen. The governor announced a TennCare reform plan that included the removal of as many as 323,000 adults currently enrolled in TennCare, as well as new benefit limits for others, saving an estimated $575 million during the next fiscal year.

However, a lawsuit is preventing the governor from taking action to fix the ailing program, and a federal district court has ruled that the governor's plan requires its approval.[13] If this ruling is overturned, you can bet that there will be others. Hundreds of thousands of people who have been receiving free health care at taxpayer expense for more than a decade won't give it up easily.[14]

Less Expensive Ways to Solve the Uninsured Problem. TennCare was supposed to be an affordable way for Tennessee to provide quality health care for all of the state's uninsured. It was anything but.

There are much better — and far less expensive — ways to ensure people have access to affordable coverage.[15] For example, states can:

- Eliminate costly state mandates and regulations that make health insurance unaffordable for many;
- Ensure people have access to consumer driven plans, which provide incentives to control utilization;
- Create a fully funded high-risk pool for the uninsurables; and
- Provide tax credits for the uninsured to buy insurance.

Note: Endnotes are available at http://www.cahi.org/cahi_contents/resources/pdf/n129tenncare.pdf.

Prepared by: Victoria Craig Bunce, Director of Research and Policy, Council for Affordable Health Insurance and Merrill Matthews, Ph.D., Director, Council for Affordable Health Insurance.

Council for Affordable Health Insurance
112 S. West Street, Suite 400
Alexandria, VA 22314
Phone: 703/836-6200 Fax: 703/836-6550
Email: mail@cahi.org
www.cahi.org

Endnotes

[1]Rick Lyman, "Once a Model, a Health Plan Is Endangered," *New York Times*, Nov. 20, 2004.
[2]"Tennessee Governor Bredesen to Dissolve Medicaid Program TennCare," NewsMax.com Wires, November 10, 2004 http://www.newsmax.com/archives/articles/2004/11/10/152447.shtml.
[3]Anaita Wadhwani, "TennCare cuts can't be before June; lag to cost $90 million," *The Tennessean*, February 8, 2005.
[4]For a brief overview of TennCare's implementation, see Merrill Matthews Jr., "Lessons from Tennessee's Failed Health Care Reform," Heritage Foundation Backgrounder No. 1357, April 7, 2000.
[5]Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2004 Current Population Survey," Employee Benefits Research Institute Issue Brief Number 276, December 2004. www.ebri.org.
[6]For other examples, see Merrill Mathews, "The Grand Illusion: The Perennial Qwest for a Single-Payer Health Care System that Works," Council for Affordable Health Insurance, Issues & Answers No. 127, January 2005. http://www.cahi.org/cahi_contents/resources/pdf/n127Singlepayer.pdf.
[7]Stephen Zuckerman, Joshua McFeeters, Peter Cunningham and Len Nichols, "Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation," *Health Affairs,* June 23, 2004. 10.1377/hlthaff.w4.374.
[8]Vernon Smith, Rekka Ramesh, Kathleen Gifford, Eileen Ellis, Robin Rudowitz and Molly O'Malley, "The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in FY 2004 and 2005. Results from a 50 State Survey," October 2004. http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=48004.
[9]Sandra Hunt, et al., "Actuarial Review of Capitation Rates in the TennCare Program," PricewaterhouseCoopers, March 1999, p. iv.
[10]Lyman, "Once a Model, a Health Plan Is Endangered."
[11]Ibid.
[12]Please see the Governor's Communications Briefing on TennCare, January 2005, at http://www.newsmax.com/archives/articles/2004/11/10/152447.shtml.
[13]Rosen v. Tennessee Commissioner of Finance and Administration, M.D. Tenn., No. 3:98-0627, January 25, 2002.
[14]"Federal Court Asserts Approval Authority for Plan to Reduce TennCare's Enrollment," Bureau of National Affairs' Health Care Daily, Volume 10, Number 20, February 1, 2005.
[15]For more detailed information, please see www.cahi.org.

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[i]Bonnie M. de la Cruz, "Audit: TennCare Paid $6 Million to Insure Dead People," *The Tennessean*, July 9, 1999, and Paula Wade, "TennCare Finds 16,500 Ineligible," *The Commercial Appeal*, August 11, 1999.
[ii]Department of Health and Human Services State Medicaid Fraud Control Units Annual Report, Fiscal Year 2003. http://oig.hhs.gov/publications/docs/mfcu/MCFU2003.pdf.
[iii]See http://www.wsmv.com/Global/category.asp?C=28416&nav=9Tb0.


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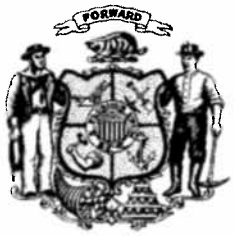
FORWARD

The Council for Affordable Health Insurance's

ISSUES & ANSWERS

Solutions for Today's Health Policy Challenges

No. 130 April 2005

HSAs: Need Only the Healthy and Wealthy Apply?

Health Savings Accounts (HSAs) became available in January 2004 as part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. These accounts were designed to fix the flaws in the original 1996 Medical Savings Account (MSA) legislation — making the program permanent and available to a wider population. Since its inception, there has been a groundswell of individuals attracted to HSAs, and by most accounts that interest will grow significantly in the next few years.

Results from the Industry HSA Surveys

eHealthInsurance, which markets health insurance policies from more than 140 insurers in almost all of the states, began offering HSAs on January 1, 2004. For its first year of HSA sales, eHealthInsurance reported:[1]

- The average age of those purchasing HSA plans was 40, whereas the average age of purchasers of non-HSA-eligible plans was 35.
- HSAs were equally attractive to individuals and families, with individuals purchasing 51 percent and families purchasing 49 percent (37 percentage points of those families had children).
- HSAs are being adopted by all income levels; people with incomes of $50,000 or below purchased 40 percent of the HSA-eligible plans, and more than two-thirds of HSA-eligible plan purchasers were previously uninsured for more than six months.

In addition to the eHealthInsurance data, America's Health Insurance Plans (AHIP) surveyed its members selling HSA plans and found that through September 2004 — only nine months after they became available — of the 29 AHIP member companies that responded to the survey:[2]

- A total of about 438,000 people had established HSAs, with 346,000 in the individual market, 79,000 in the small group market, and 13,000 in the large group market.
- Among individuals choosing HSAs, 30 percent were previously uninsured and nearly half were over the age of 40.

Finally, a new survey by Watson Wyatt and the National Business Group on Health of 555 large employers found that 8 percent currently offer HSAs, and that 18 percent plan on offering them in 2006.[3]

[1]eHealthInsurance. "Health Savings Accounts: The First Year in Review, January – December, 2004." February 15, 2005. Please see www.ehealthinsurance.com

[2]Teresa Chovan and Hannah Yool, "Health Savings Accounts Off to a Fast Start in the Individual Market," January 12, 2005. Please see http://www.ahip.org/content/pressrelease.aspx?bc=174|7303.

[3]"Managing Health Care Costs in a New Era: 10th Annual National Business Group on Health/Watson Wyatt Survey Report 2005," March 17, 2005. Please see http://www.watsonwyatt.com/research/recorender.asp?id=w-821&page=1.

Naysayers Still Exist Despite the Evidence. For more than a decade, critics of consumer driven policies have claimed HSAs would only attract healthy people and lead to adverse selection, in which some plans end up covering a disproportionate number of sick people. Adverse selection drives up premiums, making policies unaffordable. The critics also assert that wealthy people will want HSAs, but not those with lower incomes.

Clearly the recent HSA survey data prove the critics wrong. Middle-aged workers are more likely to choose an HSA, and lower-income workers often choose HSAs when given the chance. But it is also important to understand why the naysayers' arguments are so flawed.

High Deductibles and Adverse Selection. Healthy people tend to want less-expensive policies that may have high deductibles or provide fewer benefits. People with medical conditions tend to want lower deductibles and more benefits to reduce their out-of-pocket exposure.

Because HSA plans come with high deductibles, critics claim that HSAs will only attract healthy people, leaving a disproportionate number of sick people in traditional insurance — and forced to pay very high premiums because the healthy people have switched to HSAs.

However, the criticism overlooks two important facts:

- People often switch to higher deductibles with auto or homeowners insurance, and no one claims that will destroy those markets.
- The role played by the Health Savings Account.

HSAs Reduce the Out-of-Pocket Cost of High-Deductible Plans. An HSA is a savings account controlled by the insured person and used to pay for smaller and routine health care expenses below the deductible. The HSA law requires that account holders have a high-deductible health insurance policy to cover catastrophic medical costs such as prolonged hospitalization or a particularly unhealthy year.

HSAs reduce the out-of-pocket exposure of a traditional high-deductible policy because people can use money in their tax-free HSA, which is usually funded all or in part by the employer, to pay the costs below the deductible.

For example, an employer may provide employees with a $3,000 deductible health insurance policy, while depositing $2,000 in the tax-free HSA. [Note: the cost of HSA-eligible plans, including the HSA contribution, is often less expensive that a traditional insurance policy with a low deductible, which also makes them attractive to employers.]

The first time the employee needs medical care or prescription drugs, the money in the account is used to pay for it. The employee pays nothing out of pocket until the $2,000 in the HSA has been exhausted. After spending the next $1,000 out of pocket, in this example, the health insurance would kick in.

Under a traditional health insurance policy, by contrast, the employee might have a $500 or $1,000 deductible — with no HSA. The first time the employee or a covered family member goes to the doctor, the employee has to pay those costs out of pocket, up to the $1,000 deductible. In other words, the employee has to spend $1,000 out of pocket for each family member before insurance pays a dime.

Workers Are Doing the Math. So, under which plan does a sick person do better? Most will say it's the plan that provides the first $2,000 to pay for care.

The fact is that middle-aged families — which, on average, are more likely to have higher health care bills than young workers — are choosing HSA plans, just as the eHealthInsurance and AHIP data show. And it isn't a mystery why: they're simply doing the math.

Are HSAs Only Attractive to the Wealthy? Clearly the data prove the answer is no, but again it is important to understand why.

An employer contribution of $2,000 to an HSA is equal to 10 percent of a $20,000-per-year worker's income; but it is 2 percent of a $100,000-per-year household.

Assume both families spend $1,000 from their HSA during the year, and so have $1,000 left over. That's 5 percent of a lower-income worker's salary — a significant year-end bonus — which can roll over to the next year and grow with interest tax free. When combined with the $2,000 deposited the next year, meaning there would be $3,000 in the HSA, the family would effectively face no out-of-pocket costs, even if there were a number of health care related expenses that year.

Higher-income families can generally afford an extra $500 or $1,000 in unexpected medical or dental bills. Lower-income families can't, which is why HSAs are attractive to lower-income people — just as the data show.

One might counter that the self-employed have to fund the HSA out of their own pocket, there being no employer to fund it for them, making it likely that *they* would have to have higher incomes in order to have the additional funds to put in the HSA. However, the self-employed tend to be middle-class workers and not the wealthy, and thousands of them are switching to HSAs.

Getting the Incentives Right. There is also a reason why society benefits from HSAs. What HSAs accomplish is to change consumer behavior. They give consumers a reason to be value-conscious shoppers in the health care marketplace. They give patients a reason to discuss with their doctors both their medical options and the costs of those options. Do they want to try ibuprofen for $5 or a brand name pain killer for $80? If someone else is paying the bill, it makes little difference. If the money is coming out of the patient's HSA, he or she has a strong incentive to weigh the costs and benefits of each health care choice and to pay close attention to the doctor's recommendations.

When patients are paying more attention to the cost of health care and demanding value for their dollars, total health care spending will decline. And when spending declines, health insurance will be much more affordable, which will reduce the number of uninsured.

HSA Critics Haven't Been Right Yet. Critics have been predicting for more than a decade that HSAs — and their predecessor, MSAs — would destroy the health insurance market. They were wrong then; they are wrong today. It is time for the critics to look at the data and abandon their doomsday warnings. HSAs are here and they are doing very well, and they are changing the way people think about and shop for health care.

Prepared by: Victoria Craig Bunce, Director of Research and Policy, Council for Affordable Health Insurance and Merrill Matthews, Ph.D., Director, Council for Affordable Health Insurance

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Council for Affordable Health Insurance
112 S. West Street, Suite 400
Alexandria, VA 22314
Phone: 703/836-6200 Fax: 703/836-6550
Email: mail@cahi.org
www.cahi.org


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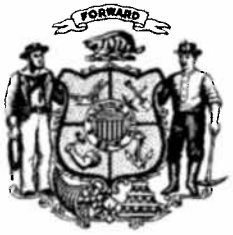
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The Council for Affordable Health Insurance's

ISSUES & ANSWERS

Solutions for Today's Health Policy Challenges

No. 134 March 2006

Healthy New York: A Poor Fix to a Dysfunctional Insurance System

"[T]onight I propose a new endeavor called Healthy Wisconsin, to help lower health care costs and pass along the savings to middle class families."

-Wisconsin Governor Jim Doyle

With those words, Wisconsin Governor Jim Doyle (D) introduced his proposal to replicate New York's program for the uninsured. Known as Healthy New York, the program combines a private mandate-lite benefit plan with a state reinsurance subsidy, and is only available to lower-income workers. Advocates are touting the purported success of Healthy New York, and State Coverage Initiatives — a Robert Wood Johnson project — has published a profile of the program.

But is the program really addressing the problem of the uninsured? Or are New York policymakers merely tinkering with a dysfunctional health insurance system of their own making?

The High Cost of Health Insurance in New York. New Yorkers currently pay among the highest health insurance premiums in the country.

According to a 2004 eHealthInsurance report, only Boston tops New York City's individual health insurance rates.[1] In another eHealthInsurance report, the cost of New York State's individual health insurance policies is second only to New Jersey.

In the group market, New York doesn't fare any better. The Medical Expenditure Panel Survey (MEPS) found that New York is the second most expensive state for group family coverage.[2]

That's important because the more insurance costs, the more people choose to forgo it and join the ranks of the uninsured. The U.S. Census Bureau reports that 14.7 percent of New Yorkers are uninsured — higher than its neighboring states, including Pennsylvania (11.5 percent), New Hampshire (11 percent), Connecticut (11 percent) and Vermont (10.3 percent). New Jersey, where insurance usually costs a little more than New York, has about the same percentage of uninsured (14.6 percent).

A Self-Made Problem. New York's health insurance affordability problem is largely self-made.

In 1993, legislators responded to an Empire Blue Cross Blue Shield financial crisis by imposing guaranteed issue and community rating on the small group and individual markets. By requiring insurers to accept any applicant regardless of health status (guaranteed issue) and charging everyone the same premium (community rating), lawmakers hoped to make health insurance policies more affordable for people with pre-existing medical conditions.

They did, but younger and healthier people were forced to pay much more than they would have had insurers been able to underwrite the policies. As a result, younger and healthier people began to cancel their policies. Those dwindling numbers who remained in the pool saw their premiums rise significantly, making insurance unaffordable for most.

Thus the high cost of health insurance in New York and the inevitable growth in the number of uninsured — both products of previous government reform efforts — forced New York lawmakers to create yet another reform: the Health Care Reform Act of 2000, which established Healthy New York.

The Healthy New York Program. Healthy New York, which is heavily promoted through paid media (radio, television and newspaper ads) and other methods, limits enrollment to lower-income individuals (sliding scale up to $25,125) who have been uninsured for 12 months and small employers (50 employees or fewer).

Is Healthy New York a Good Deal?

Albany County, NY (25-year-old male)

- $500 co-pay for inpatient services
- $200 (or 20%) co-pay for surgical services
- $50 co-pay for emergency services
- $20 co-pay for other services
- Limits drug coverage ($100 deductible) to only $3,000 per year
- Does not include coverage for many mandated benefits, including some important services
- Is only available to those individuals with annual incomes below $25,125, or $58,125 for family of five
- Is subsidized by the state of New York

Cost: $158 to $222 per month for an individual

Lacrosse, WI (25-year-old male)

- $500 deductible
- $25 co-pay for primary care physician visit
- No limit on drug coverage
- Includes full coverage for all mandated benefits in Wisconsin
- Needs no state subsidy
- Is not limited to low-income workers
- Is one of 37 options available to those in the individual market

Cost: $160 per month for an individual

The program lowers premium costs in two ways. First, Healthy New York limits costs by allowing insurers to offer mandate-lite plans not available in the private market. Second, the program subsidizes the coverage by covering 90 percent of insurer claims costs between $5,000 and $75,000.

The Fight for Mandate-Lite. Mandated benefits, which require insurers to cover specified providers and treatments, can significantly increase the cost of health insurance. According to CAHI's "2006 Health Insurance Mandates in the States," New York has 49 benefit mandates.[3]

Unlike the private market, Healthy New York is able to offer mandate-lite benefit plans, which exclude mandated coverage for mental health service, alcohol and substance abuse, chiropractic coverage, hospice care and more.

CAHI and many other organizations and health policy experts have supported reducing or eliminating state mandates for years, and more than 10 other states offer some form of mandate-lite programs. What makes Healthy New York unique is that it limits access to mandate-lite policies to uninsured individuals and small businesses who meet the income criteria.

State Reinsurance Efforts. As a presidential candidate, Sen. John Kerry proposed a national reinsurance pool to reimburse 75 percent of health insurance claims losses over $50,000. While the proposal was relatively new, the concept was not. A healthy private reinsurance industry provides similar coverage to carriers across the country, and several states operate voluntary reinsurance pools funded by the insurance industry.

New York's program began by reimbursing carrier claims for individual-market losses between $30,000 and $100,000. However, covering catastrophic losses provides limited savings because very few people incur claims that exceed $30,000. New York's results were no different, and eventually the state changed the funding arrangement to cover 90 percent of claims losses between $5,000 and $75,000. According to the 2004 program report, this change resulted in a 17 percent decrease in premiums.

Does Healthy New York Really Save Money? Despite the lower premium costs and heavy promotion, Healthy New York attracted just under 107,000 people by December 2005. The program's 2005 budget of $58 million is expected to grow to about $125 million by 2007.[4]

However, the more important question is, does the program make health insurance premiums affordable?

In Albany County, the monthly rates for the Healthy New York plan vary between a low of $158 (Empire HealthChoice, Inc.) to a high of $222 (Capital District Physicians' Health Plan). The only plan available through eHealthInsurance's website for a 25-year-old male would cost more than $335 a month. Clearly, Healthy New York provides some savings, but the higher prices in the individual market are primarily because New York's 1993 health insurance reforms destroyed its individual market.

The same person applying for coverage in Lacrosse, Wisconsin — recently named the most costly health care region in the country by the U.S. Government Accountability Office — would receive quotes as low as $41 a month for a policy with a $5,000 deductible. A policy comparable to Healthy New York's would cost $160 a month. [See the table.]

Thus residents of this Wisconsin town:

- Will pay about the same as a Healthy New York participant in Albany County, but without access to mandate-lite plans, and the state doesn't subsidize their premiums.
- Have the choice of 37 benefit plans, according to eHealthInsurance, versus one choice in Albany County
- And those 37 options aren't restricted to just lower-income families.

Assessing Healthy New York. Allowing people to have access to less-expensive mandate-lite policies is a good idea. But why restrict them to low-income uninsured people? Remember, many New Yorkers who currently have coverage also have lower or moderate incomes. If mandate-lite policies increase access to affordable coverage, why not let every New Yorker have that opportunity?

The attempt to subsidize coverage for lower-income, uninsured workers could be helpful. But why do it through a reinsurance mechanism, in essence, making the state an insurer? A direct subsidy, perhaps with a tax credit applied towards one's state income tax, would be more efficient and transparent. Besides, becoming a reinsurer is a sure way to get the state micro-managing health insurance. And as New York's 1993 reforms clearly demonstrated, New York *does not* know how to regulate insurance.

Conclusion. Healthy New York is a poor way to fix the state's dysfunctional health insurance market. What the state should do is repeal its guaranteed issue and community rating laws, relax some of its mandates and regulations, and allow more choice and innovation in the health insurance market. If it did, insurers would return to the state, premiums would drop, and the state wouldn't need Healthy New York. Plus, New York would finally have a health care reform model worth imitating.

Note: Endnotes can be found at http://www.cahi.org/cahi_contents/resources/pdf/n134NY.pdf

CAHI's 2006 "Health Insurance Mandates in the States" http://www.cahi.org/cahi_contents/resources/pdf/MandatePub2006.pdf

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Prepared by JP Wieske, Director of State Affairs, Council for Affordable Health Insurance

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Council for Affordable Health Insurance
127 S. Peyton Street, Suite 210
Alexandria, VA 22314
Phone: 703/836-6200 Fax: 703/836-6550
Email: mail@cahi.org
www.cahi.org

Endnotes

1. "Most Affordable Cities for Family Health Insurance, eHealthInsurance, December 7, 2004.
2. http://www.meps.ahrq.gov/
3. Available at www.cahi.org
4. http://www.ins.state.ny.us/website2/hny/reports/hny2005.pdf


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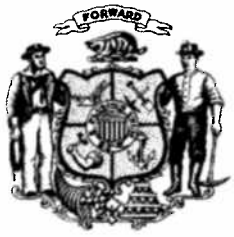
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The Council for Affordable Health Insurance's

ISSUES & ANSWERS

Solutions for Today's Health Policy Challenges

No. 132 January 2006

Maine's Dirigo Health: A String of Broken Promises

As part of his gubernatorial campaign, John Baldacci promised to create a new health care program, Dirigo Health, to address health system costs and provide health insurance to uninsured Mainers. In 2003, Governor Baldacci (D) signed the law creating the program. By reviewing the program's first-year, one can see clearly that this program has not fulfilled its goals.

What is Dirigo Health? "Dirigo Health" is an assortment of new government working groups, including: the Maine Quality Forum, Advisory Council on Health Systems Development, Task Force on Veteran's Health Services and Dirigo Health Agency, which governs DirigoChoice, the reform's insurance component. DirigoChoice is subsidized insurance that, in theory, tens of thousands of Mainers would have purchased within the program's first 12 months. Meanwhile, the other components of Dirigo Health were to "contain costs, ensure access and improve the quality of health care." Proponents claimed that The Dirigo Health Reform Act, signed into law in 2003, would enroll all uninsured state residents within five years.

What is DirigoChoice? "DirigoChoice" is the insurance component of Dirigo Health. According to the program's website, the insurance product is to provide "Maine businesses with 50 or fewer employees, the self-employed, and individuals an affordable, high-quality option for health coverage." To make policies more affordable, DirigoChoice offers premium discounts and reduced deductibles based on income. The discounts are paid by the program. DirigoChoice also includes a Medicaid expansion and many new health insurance and health care regulations.

Applicants earning less than 300 percent the federal poverty level ($28,100 for individuals and $56,500 for families) can have their DirigoChoice premiums subsidized by the program. The subsidies decrease as income increases. All policies are guaranteed issue (no applicant is denied coverage) and community rated (only slight premium variations because of age).

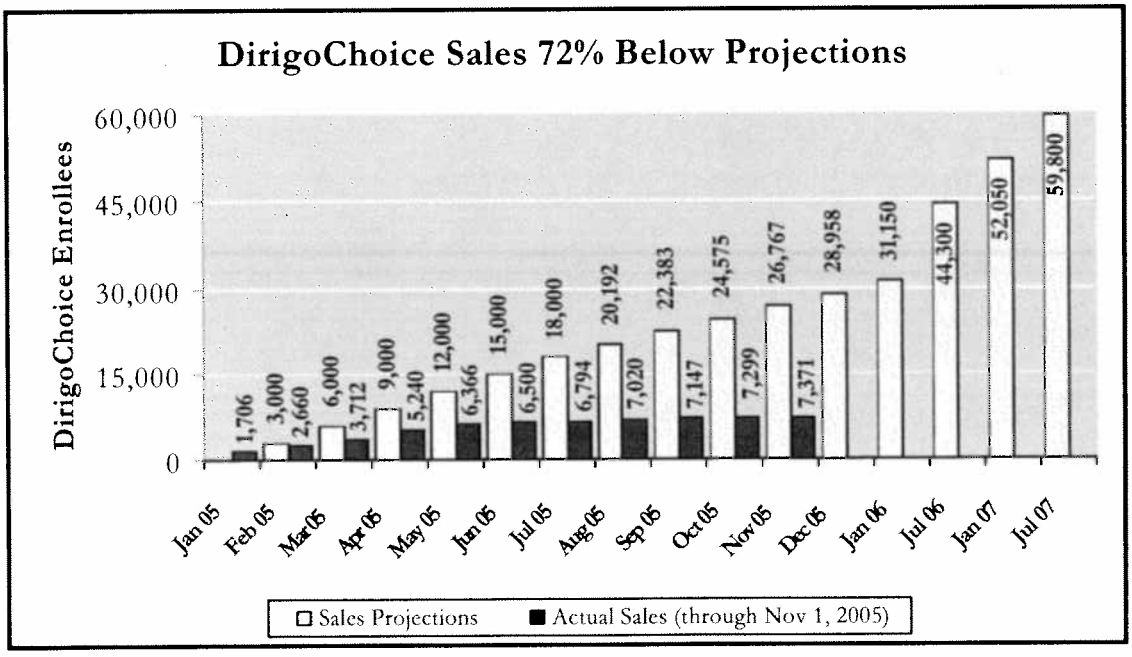
Clearly, Dirigo Health is an ambitious undertaking, but has it lived up to the governor's promises?

Promise #1: Dirigo Health will provide insurance to 130,000 uninsured Mainers in five years. On May 15, 2003, the director of the Governors Office of Health Policy and Finance proclaimed that DirigoChoice would enroll 57,000 residents in its first year. Within months, expectations were lowered to 31,000, then 15,000, then finally to 8,000 first-year enrollees. Given the latest sales figure, even the 8,000 target was not realized by the end of 2005.

Promise #2: Businesses, the self-employed and individuals will buy DirigoChoice because it is affordable insurance. Small businesses have been very reluctant to buy DirigoChoice coverage. This is probably due to the fact that even with subsides, DirigoChoice is still expensive. Individual and self-employed premiums are no bargain, either.

Let's look at a self-employed individual seeking DirigoChoice for his family. In November 2005, a family (40 year-old parents with two children) ineligible for an income discount would have paid $951 monthly for Plan 1 (with a $2,500 deductible) or $880 monthly for Plan 2 ($3,500 deductible). If the same family earned $40,000 annually, its premium decreased to $570 ($1,000 deductible) and $528 ($1,600 deductible) a month, respectively; DirigoChoice paid the balance of the premium.

While Dirigo's discounts lower premiums for the insured, they do not reduce total policy costs.



In this example, the family, DirigoChoice or a combination thereof, would pay roughly $900 monthly for health insurance.

Are families paying this much nationwide? An online brokerage, eHealthInsurance, released a report November 9, 2005, showing that the average monthly premium for a four-person family plan was $394. While the average family deductible was not reported, 82 percent of family deductibles were less than $3,000 per year.

Promise #3: DirigoChoice will attract the uninsured. DirigoChoice was created to cover uninsured Mainers. However, privately insured individuals and small businesses have been DirigoChoice's best customers. In October 2005, the Dirigo Health Agency disclosed that 78 percent of DirigoChoice policyholders were privately insured before purchasing DirigoChoice coverage.

While 7,300 Mainers had enrolled by November 2005, only 1,600 (22 percent) were previously uninsured. At that rate, it will be 2070 before all uninsured Mainers purchase DirigoChoice insurance, not 2009 as once promised. And, just like any insurance market, policyholders drop coverage. About 1,200 people (14 percent of all enrollees) had disenrolled from DirigoChoice through October last year. Since most of the new enrollees dropped their private coverage for DirigoChoice, the program is exhausting its budget while doing little to help the uninsured.

Promise #4: Dirigo Health will lower costs. Determining Dirigo Health's first-year impact on Maine's entire health care system has been difficult and controversial. The Dirigo Health Agency, working with Mercer Government Services Consulting, first identified $233 million in Dirigo Health-attributable savings.

However, this initial projection was proven to be faulty. First, one could analyze 2003 Maine hospital data, the year before Dirigo Health was operational, and the Mercer model showed Dirigo Health "savings." Second, another consultant entered 2002-2003 New Hampshire hospital data in Mercer's proposed savings formula and discovered $45 million in Dirigo "savings." This could not be correct since Dirigo Health does not exist in New Hampshire.

After a several-week process, the Superintendent of Insurance certified $44 million in Dirigo Health savings. Within that $44 million figure:

- $34 million (77 percent) was attributed to Maine's 39 nonprofit hospitals voluntarily limiting their operating margins and cost increases;
- Another $7 million was credited to the state's Medicaid program paying debts and increasing physician reimbursement rates;
- Finally, DirigoChoice was estimated to have reduced bad debt and charity care by just $2.7 million.

Without the hospitals' voluntary actions, Dirigo Health's "savings" were $10 million.

Dirigo is not helping the uninsured, but it is spending a lot of money trying. In the first nine months of 2005, the Dirigo Health Agency spent $19.5 million to enroll 1,600 previously uninsured Mainers. At this low rate of reaching the uninsured, Dirigo Health would cost taxpayers $16,000 per uninsured life annually. Furthermore, reaching all uninsured Dirigo-style would cost over $2 billion annually, or more than one and half times the total raised by Maine's income tax.

Promise #5: No new taxes will be needed for Dirigo Health. Dirigo Health was to be funded by Medicaid and its "recovered" health system savings. To determine Dirigo Health's impact, the Dirigo Health Agency Board examined all Maine health system spending. After identifying what it determined to be precise Dirigo health system savings, the Dirigo board will levy a Savings Offset Payment (SOP), a claims tax. This tax is similar to a sales tax. If individuals or businesses directly pay for health care through their insurance benefit, they now pay a new "sales" tax on these paid claims. The SOP is needed because Dirigo Health's high costs would otherwise bankrupt the program.

Since Maine's state government certified that it saved its citizens $44 million (see Promise #4), it then reasoned that it should "recover" those dollars to fund Dirigo's ongoing costs. But not everyone returns "savings" to the state. Only privately insured individual and small group policyholders and large companies using a third party administrator (TPA), an outside person or firm administering insurance claims, are assessed the Savings Offset Payment. According to the Kaiser Family Foundation, 55 percent of Mainers are privately insured and even fewer will pay the tax.

While all Mainers should have benefited from Dirigo Health's operations, the identified health system savings are extracted from less than 55 percent of the state's population. But, those paying the tax cannot have possibly received all "health system savings."

Nevertheless, on November 22, 2005, the Dirigo Health Board voted to extend the Savings Offset Payment, a new 2.4 percent claims tax on the aforementioned groups' health insurance. This tax is in addition to Maine's 2 percent premium tax. When applied, this new tax will cost an individual about $75 a year and a family about $200 a year. That is, unless they switch to DirigoChoice — like most of the program's enrollees already have.

Prepared by Adam Brackemyre, Assistant Director of Government Affairs, Council for Affordable Health Insurance, and Tarren Bragdon, Director of Health Reform Initiatives, Maine Heritage Policy Center

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Council for Affordable Health Insurance
127 S. Peyton Street, Suite 210
Alexandria, VA 22314
Phone: 703/836-6200 Fax: 703/836-6550
Email: mail@cahi.org
www.cahi.org


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ISSUES & ANSWERS

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One Solution for the Small Group Market

Health insurance is usually divided into three primary groups:

- The individual market covers only individuals and their families;
- The small group market usually means two to 50 employees covered; and
- Large group is 50 or more employees.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has harmed the small group market. It mandated guaranteed issue and other changes that have lead to insurer consolidation, rising premiums, and overall lower rates of coverage.

The individual market, by contrast, still manages to function pretty well in most states, providing lots of policies and a wide range of prices. That is, in part, due to the fact that the individual market still allows underwriting, along with riders and denial of coverage to those applying with a pre-existing medical condition.

A few states have sought to bypass these restrictions in the individual market by creating a so-called "group of one." "Groups of one" define individuals as a small group for health insurance purposes, providing them with all small group rights including guaranteed issue insurance. That approach fundamentally misunderstands insurance.

The bigger a group, the more insured people there are to spread out the cost of the few who need expensive medical care. As a result, many larger companies are able to obtain more favorable and predictable insurance rates. Large groups also have the advantage of self-funding their insurance plans, which provide both benefit flexibility and many unique pricing options. Very small groups — especially one to 10 lives — have much more volatile claims experience (leading to higher premiums) and fewer plan-design options. In essence, small employers face both higher average health insurance premiums and fewer health insurance options.

The Small Employer Dilemma. Health insurance in the small group market can be very expensive — $9,950 for a family according to a Kaiser Family Foundation survey of about 2,000 companies. Despite this significant expense, most small employers provide health insurance as a benefit for their employees. However, not all small employers have the funds available to pay that level of premiums. As a result, some are looking for a product that would not require group participation, could be issued on a voluntary basis, provides numerous plan options (to ensure affordability), and (for many of the part-time and seasonal employees) a plan that would be portable.

If employees without employer-provided coverage were given the option to obtain coverage in the less-expensive individual market — where about 16 million Americans currently are covered — many would take it.

Is there a model for that approach? Yes, "list billing," and it is something many states allow. A "list bill" solves the problem by allowing employers to make health coverage available on a voluntary basis, but in the less-expensive individual rather than the small group market.

ADVANTAGES OF LIST BILLING:

- Individual health insurance coverage provided through the workplace
- Easier to sign up
- Portable from job to job
- May provide some tax advantages
- Simplified payment process for the employee
- Allows employees to choose their own plans

What Is a List Bill? List billing is the process that allows a health insurance company to send employers a single bill for several employees' individual health insurance policies, if the employer and employee agree to payroll-deduct employee premiums.

The process usually begins with an agent identifying a company that does not offer health insurance to its employees. After obtaining an agreement from the employer, the agent offers any interested employees the opportunity to apply for the health insurance plan of their choice. Once accepted by the insurer, the employees agree to have the premiums deducted from their paychecks. The insurer, in turn, sends a single bill, listing each employee's premium — hence, "list bill" — to the employer.

However, list billing does have some restrictions common to the individual market. It is important to note that these plans are individually underwritten. That means that an older employee or one with a medical condition might have to pay higher premiums than younger and healthier employees. And in some instances, employees may be denied coverage because of a pre-existing medical condition. In those cases, the uninsured employees would have the option of entering the state's high-risk pool — similar to other applicants in the individual market.

Second, there is a debate over whether an employee is allowed a tax break for the cost of the premiums. Some believe that the situation under a list bill arrangement is no different than when a worker without employer-provided coverage buys his own policy in the individual market — there is no tax break for the insurance premiums.

Others argue that individual health insurance premiums, when paid through a list billing arrangement, are eligible to be paid on a pre-tax basis through Section 125, or cafeteria, plans. It is important to note that other types of voluntary benefits, such as short-term disability and dental plans, are allowed to be paid through cafeteria plans.

Employees Benefit from List Bill Arrangements. The large majority of the uninsured, about 83 percent, come from a household where someone is employed. These individuals may work part time, seasonally or for one of the many firms (especially small firms) that do not offer health insurance. Many of these employees could benefit from list billing.

- With no minimum participation requirements (as in the small group market), any employee who wants coverage can apply.
- The insurance policy is owned by the employee, not the employer, so the coverage will remain intact as long as the premiums are paid — even if the worker switches employers (though a new employer is not and should not be required to honor a list billing arrangement).
- The policy could cover only the worker, or it could include other family members.
- Insurers in the individual market sometimes charge a billing fee on each bill; list billing eliminates the billing fee.

If their employer takes advantage of a Section 125 plan, individuals may be able to have their premiums deducted on a pre-tax basis, which will increase their net take home pay and decrease the effective cost of their benefits.

In addition, by not having to seek out their own insurance agent, sort through numerous plan designs and companies, and keep track of their own premium payments, employees eliminate many of the transaction costs associated with buying health insurance.

Employers Benefit from a List Bill. Studies indicate that employers believe health insurance helps to attract and keep employees, leads to increased production, and may boost morale because employees believe they have a "good job," even if the employee must pay part of the premium. Many of these same advantages can be applied to list bill coverage. Although employees are paying the entire cost of the benefits, list bills allow employers to help employees find and purchase affordable health insurance.

List billing may also help employers reduce their tax liability. If employees and employers take advantage of the Section 125 plans, employees reduce their taxable income which also reduces an employer's liability for FICA tax.

What Is Needed to Make List Billing Widely Available? List billing is already allowed in many states, including Arizona, Illinois, Pennsylvania, Texas and West Virginia. However, at least two points should be made clear in federal law in order for workers and employers in every state to have a list bill option:

Congress needs to clarify that a list billing arrangement is not defined as group insurance. While this could be done for all small group policies, it is most pressing for the "micro groups" with two to 10 lives.

Second, Congress needs to clarify that any part of the premium paid by the employee through a Section 125 plan could be excluded from income — just as it is for employer-provided coverage in the small and large group market.

In other words, put coverage provided under a list bill on a level-tax field with all employer-provided coverage.

Conclusion. List billing alone will not solve the uninsured problem, nor is it a substitute for small group coverage. However, it does provide an option for an employer to help uninsured employees find affordable coverage, while reducing the costs and challenges of finding insurance.

Prepared by JP Wieske, Director of State Affairs, Council for Affordable Health Insurance

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Council for Affordable Health Insurance
127 S. Peyton Street, Suite 210
Alexandria, VA 22314
Phone: 703/836-6200 Fax: 703/836-6550
Email: mail@cahi.org
www.cahi.org
