Options for Expanding Coverage to the Uninsured in Delaware

Before considering policy options to cover the uninsured, it is useful to consider the different categories of uninsured people. People without health coverage fall into four categories:

Those who could afford reasonably priced coverage but who have to pay premiums much higher than average because they have characteristics that make them at high risk of incurring medical expenses. (These people are typically individuals buying coverage on their own or people employed by small employers, since premiums for people employed by larger firms are normally not based on the individual employee's risk, and the groups' rate is likely to be only slightly affected by the small proportion of high-risk people in the group).

Those whose ability to pay is so limited that they could not afford to buy even reasonably priced coverage. (Many of these people will not purchase coverage unless the price *is* substantially subsidized.)

Those who could afford to purchase coverage but fail to do so, either because they feel the insurance protection is not worth the cost or because they simply don't get around to purchasing coverage.

Those who are eligible for subsidized programs but do not sign up for them, either because they are unaware that they are eligible or because they do not want to be associated with a subsidized program for one reason or another.

There is a second useful way of categorizing the uninsured-according to their employment status:

Those that are employed and are offered coverage but decline it.

Those that are employed but are *not* offered coverage and thus whose only option is to buy coverage in the individual market.

Those that are not employed and thus have only the option of buying coverage in the individual market.

In looking at the range of options available for providing coverage to the uninsured, it is useful to keep these categories in mind since not all options will address the needs of all categories of uninsured people. We will need to decide which categories of people we will target and which policies will be suitable for meeting each group's needs-that is, ultimately we will want to choose policies for the boxes (perhaps not all) in the matrix below.

Categories of Uninsured	Employed and offered coverage but decline	Employed but not offered coverage	Not employed
Could afford normally priced coverage but only-high cost coverage is available			
Could not afford without large subsidies			
Can afford but fail to buy			
Eligible for subsidized programs but don't sign up			

The Full Range of Possible Policy Options

The purpose of this project is to recommend one or more initiatives that Delaware might take to expand coverage to people who are now uninsured. There are three relevant groups that make decisions affecting insurance coverage that the state could seek to influence: individyals, employers, and insurers. We begin by looking at individuals, that it is, the people who are not insured.

It is obvious even from casual observation that for many of the uninsured, the price of coverage is the major barrier that prevents them from purchasing coverage. Conceptually, policies that lower prices sufficiently can have the affect of ensuring that virtually everyone buys coverage. Therefore, when considering policy options to extend coverage, it is useful to think in terms of the way various groups of uninsured would respond to price changes (The relevant price for this analysis is the net price that the uninsured would pay out of pocket.)

As previously noted, some uninsured individuals face unusually high prices because they represent high risks to insurers because of some present or recent medical condition or personal characteristic that is thought to be a good predictor of higher-than-average future medical expenses. For most of these people, a policy that lowered the net price to that paid by people of average risk would induce them to purchase coverage.

For those uninsured people who have such low incomes that they cannot afford even reasonably priced coverage, the net price would have to be reduced very substantially to induce them to voluntarily purchase coverage.

Some uninsured people can afford coverage at its current market price but choose not to purchase it because they do not think the benefits justify the expense. There may even be some people who would fail to purchase coverage even if the net price to them were close to zero. Ultimately however even these people would respond to falling prices, although for those at the extreme, the price might have to be negative; that is, they would have to be **paid** to get them to acquire covered.

The point is that all policy options except mandating coverage can be thought of as reducing the net price of acquiring coverage. Every decrease in price will cause some additional individuals to purchase coverage, because people have different threshold price

points where they will decide to buy coverage. But there are some classes of uninsured people-probably large numbers of them-that will make the decision to seek coverage only if their net price is reduced very substantially.

There are, of course, a variety of ways to reduce the net price of coverage. Some involve policies to influence individuals' decisions, others affect employers, and still others are designed to change the way insurers do business. The outline below spells out the policy options for lowering the net price of coverage. (At this point, we are considering only the range of options. Later in this document, we consider advantages and disadvantages.)

Policies to Reduce Net Price

1) Reduce the price of coverage that can be purchased through normal private markets

   a) Provide people who cannot afford the full market price of coverage with vouchers that they can use to purchase standard coverage. This is a very direct subsidy.

   b) Provide tax credits *or* deductions to lower the after-tax cost of providing coverage This is more indirect because it occurs after the purchase is made, although credits can be designed to be payable in advance, which makes them similar to vouchers.

      i) Credits or deductions to individuals lower the net cost of coverage by making their after-tax income higher than it otherwise would be.

      ii) Credits or deductions to *employers* lower the cost to individuals indirectly; the employer pays more of the premium and thus employees pay less; a portion of the employer's cost is then subsidized in the form of a lessened tax burden and higher after-tax income.

   c) Permit individuals (and perhaps small groups as well) to buy into an existing *private plan,* such as the state employees plan. Individuals and small groups may realize some cost reduction because the scale of the system makes some economies possible, primarily because administrative costs are spread over a large group, In addition, higher-risk individuals would get lower-priced coverage because their higher-risk is being spread over a large group, and the rest of the group would be indirectly "subsidizing" their cost. It would also be possible to make coverage available at a premium that is below the actual cost of providing coverage, that is, at an explicitly subsidized rate. But someone would have to make up the shortfall.

2) Authorize the establishment or designation of private purchasing organizations that would offer subsidized coverage to target populations, such as low-wage and uninsured small firms.

3) Develop special public coverage programs for individuals who cannot afford private coverage. The net price is substantially below actual cost because government subsidizes the cost. In some cases, the cost to the individual is nearly zero. Examples include the following:

   a) Medicaid expansion

   b) CHIP expansion

   c) High-risk pools (where the premium is below cost).

   d) Some new program designed especially for the currently uninsured

e) Allow uninsured to go to public clinics and other providers established especially to provide care at a price below-cost (perhaps paying on a sliding-scale basis related to income)-the "safety net provider" approach.

f) The so-called 'single-payer or social insurance model. Under this variant of the subsidized public program, coverage is available to everybody, regardless of need, as a matter of "right" and with very little cost to the covered person (the Medicare [Part A hospital coverage] model).

4) Reduce the net price to higher-risk groups and individuals

a) Extend the size of the risk pool.

i) Pass small-group and individual market reforms that limit the range of rate variation between high-risk and low-risk people; mandate that insurers not deny coverage; and limit exclusion of coverage for prior conditions.

ii) Establish health insurance purchasing cooperatives for small employers. (Similar objectives as above but also to allow individual employee to have a choice of plans.).

iii) Require all insurers to share in the risk through some kind of risk pooling across all insurers (e.g., require all insurers to share losses in the individual market).

b) Regulate premium prices by requiring approval of price increases.

5) Reduce the cost (as contrasted with the price) of coverage

a) Induce insurers to offer policies that provide less comprehensive coverage-that is, change the insurance product.

i) Eliminate some or all mandated benefits.

ii) Define a benefit plan that covers only "catastrophic" expenses or other "bare bones" coverage.

iii) Define a benefit package that covers just primary and preventive care (on the assumption that safety-net providers will cover the cost of a catastrophic expense, or require all insurers to contribute to a pool to cover such "uncompensated" care).

b) Find ways to make existing coverage more efficient so that it can be sold at a lower price.

i) Purchasing pools (e.g., health purchasing cooperatives) to reduce administrative costs.

Mandated Purchase

There is another class of public policies that are not aimed at lowering the price but instead involve some kind of mandates to either provide or purchase coverage. To make such mandates workable from a practical standpoint, they would normally need to be accompanied by some sort of subsidies for some people.

1) Employer mandates.

   a) Require employers to offer coverage to employees and/or to pay for a portion of coverage.

   b) Implement a "play or pay" mandate: employers either provide coverage or pay some kind of tax to finance other coverage.

2) Individual mandates.

   a) Require individuals to purchase coverage.

   b) Mandate "play or pay" for individuals (above a certain income level): e.g., impose a tax that is forgiven if the individual purchases coverage or is covered by employer coverage. (Tax revenues would then go to pay for uncompensated care Note that this policy is essentially the obverse of a tax credit.)

On the following pages, we present a series of one-page descriptions of options that represent many of the ideas outlined above. Of course, if the Commission were interested in exploring any of these options, a more detailed analysis would be necessary. This list clearly does not exhaust the range of options. Many permutations and combinations of these options are possible.

1 VOUCHERS TO LOW-INCOME INDIVIDUALS

The Approach

The state could supply vouchers to individuals falling below some income level, which they could apply to the cost of individual insurance or to pay the employee portion of employer-sponsored insurance. Presumably, the state would specify what minimum benefits the insurance would need to provide.

Pros

- This is a straightforward market-based approach, requiring no new special public program for low-income people. People buy private insurance coverage in private markets.
- The approach would have less social stigma associated with it than special state programs for "poor" people, such as Medicaid; so the "take-up rate" might be higher; that is, more low-income individuals would voluntarily participate
- This approach directly targets the people who need subsidies rather than trying to help them indirectly, as when subsidies are made available through employers.

Cons

- To be effective in inducing many of the uninsured to buy coverage, the voucher would have to be large, which would make the budgetary cost high.[1]
- Establishing and administering standards for determining eligibility might be difficult. For example, the state would want to make sure that no one eligible for other subsidized programs that are funded in part by the federal government got a voucher (which presumably would be funded entirely from state funds). Likewise, safeguards would be needed to ensure the employers who employ significant numbers of people who might be eligible for vouchers did not drop employer-based coverage or, more likely, substantially reduce their employer contribution, knowing that people could qualify for the new state-funded voucher (the so-called "crowd out" problem).
- To the extent that people use the voucher to buy insurance in the individual market, the approach sends people to the portion of the insurance market where there is much risk segmentation, where rates can vary greatly depending upon risk status, where administrative costs are high, where applicants can be denied coverage, and where it is more difficult for people to get good information to ensure that they are getting a "good deal." To some extent, allowing people to use the voucher to buy into some state-administered health plan could ameliorate this problem-perhaps the Diamond State Health Plan, or the Delaware state employees plan.
- Eligible people might fail to apply for the voucher. Vigorous education and outreach efforts would be needed.

Financing

The state would have to provide sufficient revenue to cover the cost of the vouchers, probably without any sharing of costs by the federal government. Cutting the size of the voucher reduces the budgetary cost but also reduces the take-up rate.

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[1] Research suggests that for people whose income is below 300 percent of the federal poverty level, subsidies of from one-third to one-half the premium would be necessary to induce many of them to purchase coverage. Mark Pauly and Bradley Herring, "Cutting Taxes of Insuring. Options and Effects of Tax Credits for Health Insurance,' *Using* Tax *Policy to Reduce the Number of Uninsured,* Council on the Economic Impact of Health System Change conference, Dec. 17, 1999, p 26

2 TAX CREDITS FOR INDIVIDUALS TO COMPENSATE THEM FOR PURCHASING COVERAGE

The Approach

Individuals whose income is below a specified level would be allowed a tax credit-that is, a subtraction from their state tax liability-equal to some portion of the amount they pay toward their health insurance premium. The voucher could be used to pay for either individual or for the employer portion of the premium for employer-based coverage. The effect is to lower the net price of coverage.

Pros

- As contrasted with an approach that involves setting up separate subsidy programs for the uninsured, this approach depends on market forces, allowing people to buy "mainstream" coverage.
- It uses existing administrative procedures of the tax system and does not require a separate administrative process or a specially tailored new government program government.
- For both reasons, this approach tends to be more acceptable to people who are wary of government bureaucracies.

Cons

- Many of the uninsured have such low incomes that their tax liability is so small that a tax credit, even if equal to the full amount of their tax liability, would not be large enough to induce them to buy coverage. (This disadvantage might be overcome by establishing "refundable" tax credits so that people whose tax liability is less than the maximum credit would receive a net *payment* from the state as a tax refund.)
- The tax credits would have to be large in order to induce most of the uninsured to buy coverage. Even then, some would choose not to purchase coverage for fear that something would "go wrong." Further, credits that are available only at the time of tax filing would not make insurance coverage affordable for people who have insufficient monthly income to pay the insurance premiums during the year, (This disadvantage might be overcome by making the credits payable in advance.)
- Because tax credits would need to be large to be effective, this approach would have a significant budgetary impact in the form of forgone tax revenues. Of course, the budgetary impact could be reduced by making the tax credit smaller or by limiting eligibility to people with very low incomes but the consequence would be that fewer of the uninsured would be covered.
- Many well-off small employers newly offer coverage every year, for example relatively new businesses. Much of the tax credit could readily go to subsidize such employers., and not to reduce the uninsured rate. There is also a possibility that some people who are already buying coverage on their own would be eligible for the subsidy Unless the reforms prohibited subsidies to people already covered-which creates equity problems-some of the cost would go to aid people who do not need the inducement of a subsidy to buy coverage.

Financing

The state would have to provide sufficient revenue to cover the tax subsidies

3 TAX CREDITS FOR EMPLOYERS TO ENCOURAGE THEM TO OFFER COVERAGE

The Approach

The state would extend a tax credit to employers who newly offer health coverage to employees. The expectation is that some employers, now able to subtract a portion of coverage costs from their state tax liability, would be induced to offer and pay for a portion of coverage for their employees. To make the approach efficient, the subsidy would need to be limited to employers employing low-wage workers, and employers would need to be required to pay some reasonable portion of the premium. The state might also need to specify some minimum benefits that the insurance would cover.

Pros

- As contrasted with an approach that involves setting up separate subsidy programs for the uninsured, this approach builds on the employer-based insurance systems and depends on market forces, creating incentives for employer to make "mainstream" coverage available to employees.
- It uses existing administrative procedures of the tax system and does not require a separate administrative process or a specially tailored new government program government.
- For both reasons, this approach tends to be more acceptable to people who are wary of government bureaucracies.

Cons

- Many employers not now offering coverage are likely to be small, marginal firms, hiring low-wage employees. They may not generate significant profits and thus may not incur much of tax liability: so unless the tax credit was "refundable" and quite large, they might not get much benefit from a tax credit and thus would not participate
- These employers would still have to pay a significant portion of the premium from their own funds, which may be more than marginal firms can afford. Moreover, low-wage employees might prefer to have any increased compensation in the form of higher money wages. So the approach might have little impact on covering the uninsured
- Credits that are available only at the time of tax filing would not make insurance coverage affordable for employers who have insufficient monthly income to pay the insurance premiums during the year.
- Because tax credits would need to be large to be effective, this approach would have a significant budgetary impact in the form of forgone tax revenues.
- There is a possibility that some employers already providing coverage would take advantage of the tax subsidy and cut back on their contribution. (To prevent this, the credit could be limited to firms not previously providing coverage, though this creates equity problems among employers.)

Financing

The state would have to provide sufficient revenue to cover the tax subsidies,

4 SUBSIDIZED BUY-IN TO STATE EMPLOYEES' PLAN

The Approach

The state would allow eligible low-income working people to buy-into the state employees plan at a price below the full premium cost. The amount enrollees pay out of pocket for their portion of the premium would be based on their income level and thus their ability to pay. Since the state employees' insurance plan is self-funded, the state could simply absorb the premium shortfall, and it would be reflected in a larger appropriation to fund the enlarged state employees' plan. Low-income people enrolled would be eligible for the same covered benefits and the same choice of health plans as are offered to state employees. (It would be possible to have less comprehensive coverage for this population, but that would add to administration complexity.)

Pros

- Other than a system for determining eligibility and calculating the subsidy amount (which is common to virtually all approaches), this approach involves little new administrative structure and takes advantage of existing economies of scale and risk pooling.
- This approach puts uninsured people into an already existing, mainstream coverage system, thereby removing nearly the entire stigma associated with accepting subsidized coverage. Enrollees would have a card just like the ones state employees have, and providers would not be able to distinguish the subsidized people from state employees. Subsidized enrollees would have no more trouble gaining access to providers than do state employees. These features should increase the take-up rate
- Even though this is mainstream coverage, the state still has the ability to implement cost-control features and otherwise influence the nature of the system.
- The increase in volume of enrollees in the state employees' plan would enhance the state's bargaining power in negotiating with health plans regarding rates and other features.

Cons

- There is the potential of "crowd out." Employers now providing coverage to a workforce that includes substantial number of eligible people might be tempted to drop coverage, knowing that employees could enroll in the state's plan. A similar danger is that individuals now covered by their employer's plan would switch to the state plan because their out-of-pocket cost would be lower or the benefits would be better. (There are ways to reduce the crowd-out effect.)
- Because the providers serving these people would be doing so on the same terms as for state employees, the budgetary cost would be higher than if the people were enrolled in a program in which providers accept Medicaid rates.
- State employees might strongly object to the inclusion of this group, for fear that their inclusion would result in unfavorable changes in the state's benefits, or that the risk profile would worsen and costs per enrollee would rise, etc. The resistance might be less than expected, however, because most enrollees would be low-income *working* families that do not qualify for welfare or other typical forms of public assistance.
- Assuming many of the eligible people would have children in CHIP, the adults and children would be in separate health plans.

Financing

The state would have to appropriate sufficient funds to cover the additional cost to the state employees insurance plan of covering the additional enrollees,

5 EXTENDING MEDICAID COVERAGE TO PARENTS FOR FAMILIES WITH INCOMES BEYOND THE CURRENT 100 PERCENT OF POVERTY – WITHOUT CHANGING THE CURRENT 1115 WAIVER

The Approach

Delaware has a current 1115 waiver under which Medicaid coverage is extended to all individuals with incomes below 100% of the federal poverty level. This includes single individuals and childless couples that are not part of traditional Medicaid categories.

Federal welfare reform legislation allows states greater flexibility in treatment of the income and assets of low-income families under section 1931(b) of the Social Security Act.[2] While the states cannot increase the TANF-related income threshold for Medicaid eligibility by more than the increase in the Consumer Price Index, the State can change the way it counts income and/or assets, or increase the threshold for allowable assets. Delaware could, for example, disregard the first $1,500 of monthly earned income for a Low Income Family of three, thereby indirectly increasing the income level at which parents would be covered by Medicaid to around 150% of the poverty level for applicants and 200% of the poverty level for recipients. Section 1931 (b) also allows States to cover low-income two-parent families that would not meet the prior unemployed-parent (AFDC-U) test.

While implementation of this strategy would be extremely complex, given the existing 1115 waiver, it may not be impossible.

Pros

- The federal government would pay 50% of the cost of coverage.
- Use of an existing system would reduce the administrative burden on the State.
- For low-income individuals, Medicaid expansion can supplement existing private sector coverage that is less than comprehensive.
- The state's financial obligation can be limited. States have the flexibility to "roll-back" their 1931 (b) disregards for new applicants or for both applicants and enrollees.

Cons

- To the extent that Medicaid program retains any "welfare" stigma, the new program would similarly be stigmatized.
- Expansion of Medicaid may be politically undesirable within Delaware.
- While State's can limit their financial obligations under 1931 (b), the Medicaid expansion rules do not allow states to impose any "crowd-out" provisions.

Financing

The federal share of Delaware Medicaid funding for FY 2001 is 50%. The State would need to finance the other 50% share.

[2] However, this flexibility does not extend to low-income uninsured adults that are not part of a family with children.

6 EXTENDING MEDICAID COVERAGE TO PARENTS IN FAMILIES WITH INCOMES BEYOND THE CURRENT 100 PERCENT OF POVERTY – WITH AN 1115 WAIVER MODIFICATION

The Approach

Delaware's current 1115 waiver extends Medicaid coverage through the Diamond State Health Plan to all individuals with incomes less than 100% of the federal poverty level. The standards for budget neutrality for Medicaid 1115 waivers have become more restrictive since the point at which Delaware secured its current 1115 waiver. However, budget neutrality can be documented by indicating that Delaware could accomplish the same thing using the 1931(b) option without any requirement of budget neutrality. Alternatively, Delaware could seek a CHIP 1115 waiver to extend coverage to parents of CHIP kids (families with incomes between 100% and 200% of the poverty level,

Pros

- The federal government would pay 50% of the cost of coverage (or 65% under a CHIP waiver, to the extent Delaware has any unused CHIP allocation).
- Use of an existing system would reduce the administrative burden on the State.
- For low-income individuals, Medicaid expansion can supplement existing private sector coverage that is less than comprehensive.
- Under an 1115 waiver the state's financial obligation can be limited. States can "close enrollment" for optional expansion groups.
- States (such as Wisconsin) with 1115 waivers are able to cover parents of Medicaid and CHIP children under employer-sponsored options using both Medicaid and CHIP funds

Cons

- To the extent that Medicaid and/or CHIP retain any "welfare" stigma, the new program would similarly be stigmatized.
- Expansion of Medicaid may be politically undesirable within Delaware.
- While State's can limit their financial obligations under an 1115 waiver, HCFA has been reluctant to allow states to impose "crowd-out" provisions. The availability of heavily subsidized family coverage to significant numbers of full-time working parents and children would create greater incentives (than child only coverage) for employers and workers to drop existing private coverage (depending on what income levels are chosen and what the state does to coordinate coverage with employers.

Financing

The federal share of Delaware Medicaid funding for FY 2001 is 50%. The State would need to finance the other 50% share. To the extent that CHIP funds can be used, the federal share for Delaware for FY 2001 is 65%. The State share for CHIP is only 35%.

7 SUBSIDIZED EMPLOYER-BASED COVERAGE PROGRAMS

The Approach

Communities in several states are developing or have implemented programs of subsidized coverage targeted to employers of low-wage workers. Qualifying businesses are those that have not offered health care benefits in the past. Most of these subsidy programs cover one-third of the cost of health care services for employees and their dependents. The largest of these programs is Health Choice in Wayne County (Detroit) Michigan and currently covers around 22,000 employees and their dependents in 2,200 businesses, The Health Choice program is relatively comprehensive but does not include all of the benefits required under Michigan's insurance laws.

Some of the programs currently under development will subsidize licensed insurance products. The difference between this model and the voucher approach is that this subsidizes low-wage businesses rather than focusing on low-income individuals, and it leverages funds from employers that are not currently contributing to health coverage for their employees.

In each of the communities using this model, special Medicaid financing strategies are used to draw federal funds to enhance the available local funds. Since these programs do not depend upon Medicaid payments to government-owned health care providers, they are not adversely impacted by the recent federal regulations.

Pros

- Affordable health care is available to those that have not been able to afford it in the past.
- Employer funds that are not currently used for health care are leveraged.
- Employee contributions are used to purchase organized health care and protection from high medical costs rather than to pay for services out-of-pocket as funds allow
- If special Medicaid financing is used, federal funds pay 50% or more of the subsidy costs.

Cons

- The legal structure may be problematic if the coverage will be more restrictive than licensed insurance. Collection of "premiums" from employers may necessitate use of licensed insurance/HMO products.

Financing

It may be possible to fully fund the subsidy program from existing state and local funds in combination with federal Medicaid funds.

8 LIMITED BENEFIT COVERAGE PROGRAMS

The Approach

Communities in several states are developing or have implemented programs of minimum ambulatory services targeted to low-income individuals. While the Diamond State Health Plan covers all individuals in families with incomes less than 100% of the poverty level, many individuals with slightly higher incomes are without health coverage and struggle to pay for non-emergency services. An example of a program for this population is the Ingham Health Plan IHP in Ingham County (Lansing) Michigan. The IHP provides primary and preventive care for over 12,000 county residents with incomes less than 250% of the FPL. Members have nominal copayment amounts. Covered services include primary care (which is capitated), specialty care (which is prior authorized), laboratory and radiology (contracted with local hospitals), and prescription drugs. The formulary includes primarily generics and is restrictive. This model assumes that these are the services low-income individuals are most likely to "do without." They will seek and receive emergency and urgent care, often as charity care of a hospital system.

In each of the communities using this model, special Medicaid financing strategies are used to draw federal funds to enhance the available local funds. Since these programs do not depend, upon Medicaid payments to government-owned health care providers, they are not adversely impacted by the recent federal regulations

Pros

- Low-income individuals have new access to affordable prescriptions and primary and preventive care.
- More individuals can receive access to basic services if the benefit package is limited
- If special Medicaid financing is used, federal funds pay 50% or more of the costs.

Cons

- Approach fosters continuation of a fragmented safety-net approach to health care.
- Continues reliance on hospitals to fund, through cost shifting and disproportionate share payments, the cost of care for the uninsured.

Financing

It may be possible to fully fund the subsidy program from existing state and local funds in combination with federal Medicaid funds.

9 PREMIUM ASSISTANCE THROUGH CHIP FOR AVAILABLE EMPLOYER COVERAGE

The Approach

Establish a program to help the parents of CHIP-eligible children pay their contribution to enroll in cost-effective employer coverage when it is available to them. (These would be families with incomes between 100% and 200% of the FPL). Employers would have to contribute a minimum of 60 percent (perhaps 50 percent under some circumstances) of the premium. The employee and the state, based on family income, would share the cost of the remainder of the premium.

Pros

- Because the employer pays part of the bill for CHIP-eligible children, the state's cost to cover the children is likely to be lower than if they were enrolled in the "standard" state-based CHIP program. The savings might be used to help subsidize CHIP children's parents with federal matching funds.
- This approach can reinforce and expand employer-based coverage, and thus help avoid crowd-out caused by unintended signals that budget-wise employers and their workers should shift kids to the public program.
- National survey data indicate that particularly in the 133% to 250% of FPL range, a significant portion of uninsured children and parents are eligible for employer-based coverage.
- Children and parents would be covered under the same insurance plan with the same provider networks, thus making it more likely that both will receive regular, properly coordinated care.
- If subsidies are provided to parents to enable them to afford the employee contribution, overall take-up rates might be higher; that is, some families reluctant to enroll their children in CHIP as a separate program (with possible connotations of "welfare") might more readily enroll in their employer's plan.

Cons

- There is the potential for greater crowd-out: some low-income families now paying for employer-based coverage might drop it, knowing that they are eligible for the same coverage on a subsidized basis: employers could reduce their contribution and state subsidies would fill-in for the cost employees would otherwise bear.
- Implementing such a program is complicated, partly because of all the federal requirements:
  - Programs must meet CHIP standards regarding comprehensiveness of coverage
  - Programs must meet standards regarding maximum out-of-pocket payments for CHIP families, which usually requires that states have "wrap-around" policies to make up for differences between what employer insurance covers and what the federal government requires.
  - The state must adhere to requirements to minimize crowd-out.
  - The cost of providing coverage to families must be no more than the cost of covering children alone under a "conventional" CHIP program.
- The approach does nothing for CHIP parents whose employers do not offer coverage, and it does nothing for uninsured adults who do not have children eligible for CHIP

Financing

The financing would be shared among the state, the federal government, businesses, and participating families. The federal government would match state funds at 65%, the same rate as for the regular CHIP program. Whether the state would pay more than it does now depends on many factors-the take-up rate, the proportion of premium that employers cover on average (since some would pay more than the minimum), the share of the premium required of families, average family income of participating families, etc.

10 SMALL-GROUP AND/OR INDIVIDUAL SEPARATE INSURANCE REFORMS

The Approach

This approach involves trying to broaden the risk pool to make coverage more affordable for higher-risk groups or individuals. The possibilities include restricting insurers' flexibility in setting rates based on health status and some other factors in both the individual and small-group markets and limiting insurers' ability to deny coverage to applicants in the individual market (already prohibited in the small-group market). An additional option would be to require all insurers to share in losses that health plans and insurers incur in covering high-risk individuals (and perhaps groups).

Pros

- This approach would make coverage affordable for higher-risk groups and individuals who would buy coverage if they could get it at the price available to average-risk groups and individuals.
- It would probably make people think that the insurance system is fairer.
- If small employers are assured their prices won't escalate because a worker gets sick, some may be more likely to buy. It is easier and administratively cheaper for consumers and small employers to compare health plan prices if they can be published: that is they are readily available and don't vary based on each insurer's unique assessment of current health risk presented by a given individual.

Cons

- This approach would not help to cover people who cannot afford average-priced insurance.
- The likely effect of this approach in the individual market, and if individuals (as "groups of one") are included in the small employer market, is to raise the average price somewhat because of the inclusion of more higher-risk people, which would likely cause some people to drop coverage and/or require substantial cross-subsidies of individual market coverage.
- This approach is likely to be strongly opposed by some insurers.
- Some insurers with a weak commitment to the state might decide to no longer sell individual or small-group coverage in the state.
- A guaranteed-issue requirement with such rating reforms in the individual market is likely to result in a significant influx of high-risk individuals, because individuals tend to buy coverage when they know they will need medical services. This would likely cause a significant increase in rates, which would cause some people to drop coverage.

Financing

The state would incur no significant additional costs apart from the need to enforce the changes in the law.

11 UNSUBSIDIZED HEALTH INSURANCE PURCHASING COOPERATIVES FOR SMALL EMPLOYERS

The Approach

Several states have sponsored efforts to form health-purchasing cooperatives (HPCs) so that small employers can pool their purchasing power and collectively purchase health coverage. The cooperative signs contracts with health plans that agree to offer a few standardized products to any small employer that chooses to buy through the HPC. The expectation is that with the purchasing clout of many small employers purchasing collectively, the HPC will be able to do what large employers do: bargain for better premiums and realize administrative savings, thus making coverage more affordable

Pros

- Though states (or municipalities, such as New York) normally provide start-up money, the cost is relatively small.
- This approach tends to be politically palatable to people of different philosophical perspectives, though insurers and insurance agents may oppose it.
- HPCs make it possible for an employer to allow individual employees to choose different health plans rather than forcing everyone to enroll in a single plan chosen by the employer. Hence, HPCs are an appropriate vehicle for offering subsidized coverage.

Cons

- The evidence is that few HPCs are able to offer products at prices significantly lower than those generally available already, at least in part because most cooperatives have not bee able to capture a large market share and become large enough to have clout or realize administrative economies of scale.
- Even if they were very successful, cooperatives could not produce price reductions sufficient to attract large numbers of the uninsured, many of whom would still need subsidies,
- It has been difficult to persuade health plans to continue to participate in HPCs, since they don't see them as a significant source of profits when they aren't large.
- Insurance agents and brokers may see HPCs as a threat, but success depends on their willingness to sell the HPC products.
- Coops can't be more permissive in accepting high-risk groups or in pooling risks in setting premiums than the market is generally: if they do, they will become victims of adverse selection-that is, they will end up with all the high risk and thus have to charge very high premiums.
- If a state's law limiting the amount by which insurers can vary rates between high-risk and low-risk groups (known as "rate bands") allows a wide premium variation, this poses problems for traditional coops.

Financing

A few cooperatives have been started without any government money, but most have depended upon government for start-up funds (usually $1 million to $2 million) and then support themselves from fees added to the premium once they become fully operational But lack of money for marketing has hurt HPCs' attempts to capture a large market share

12 PURCHASING COOPERATIVES OFFERING SUBSIDIZED HEALTH INSURANCE FOR LOW-WAGE SMALL FIRMS

The Approach

A health insurance purchasing pool could coordinate public subsidies and private contributions to cover low-wage uninsured small firms and their workers. For example, it could provide heavily subsidized coverage to low-wage workers and their dependents while relying on employer and employee contributions to cover higher wage co-workers.

Pros

- By providing coverage through the workplace, the pool could reinforce rather than undermine employer-based coverage.
- By providing a single coverage venue that harnesses various contribution sources, the cooperative could provide a stable source of coverage (facilitating continuity of care) as changes in family earnings over time affect eligibility and cause people to move among different state, federal and private sources of coverage.
- The cooperative could reduce employer administrative costs and burdens by playing such purchaser/sponsor roles as negotiating and contracting with health plans, offering worker choice of competing plans, and resolving problems. That is, it could be an efficient way to provide subsidized coverage for small low-wage employers.
- The pool could be structured to facilitate the combination of multiple financing sources including Titles XXI and XIX, tax subsidies, state and private dollars in a seamless manner that allows affordable single-source coverage for working families of small firms.

Cons

- The subsidy must be large enough to attract participation of significant numbers of uninsured small employers and employees. Otherwise, the pool cannot significantly reduce the number of uninsured, and will not have sufficient enrollment to attract the participation of the health plans on terms needed to make the pool a success (To be attractive to health plans, the pool needs to offer them access to new enrollees who cannot be reached in traditional ways.)
- Some important interests may oppose the creation of such a purchasing pool, favoring subsidies that are used to buy into existing private coverage sources.
- If the subsidy is targeted at individuals who work for small firms, not all the uninsured will be reached. (Although many uninsured individuals are small-firm workers or their dependents, many others work for larger firms or have no stable attachment to the work place.)
- The design of a viable subsidy and pricing structure, especially for partial subsidy recipients, could be complicated in a state like Delaware where health status is allowed as a small-group rating factor.

Financing

In addition to a commitment of subsidy funds sufficient to attract participation of a critical mass of, say, 15,000 enrollees (e.g., $5 million state, $10 million federal, $15 million employer and employee), start-up funds of at least $1 million to $2 million would be needed. (And this assumes the pool would contract with an administrative vendor that would capitalize the needed systems development costs.)

13 "BARE BONES" INSURANCE — CATASTROPHIC COVERAGE

The Approach

The legislature could permit insurers to sell a "bare bones" insurance package that would Cover only expenses past some relatively high level-perhaps $1,500 for an individual and $3,000 for a family, This would require that the legislature waive mandated benefits for this particular insurance package.

Pros

- Such coverage would be less expensive than comprehensive plans that cover all expenses after payment of a small deductible and minimal cost sharing.
- Such coverage would be especially useful for young, healthy, low-income adults, who make up a significant portion of the uninsured. They don't use much primary care, but they need protection against the acute episode that would leave them with a burdensome debt to pay.
- This is what insurance is supposed to be: a means for spreading the risk of expensive, unpredictable losses among a population group.

Cons

- Experience with efforts to sell this kind of "bare bones" policy-often in the form of state-defined "basic" plans-indicates that few people are willing to purchase it. They want more comprehensive coverage.
- Many would see legislation that waived the requirement for mandated benefits as setting a bad precedent.
- Many would think it inappropriate to allow sale of insurance that includes a financial disincentive to seek preventive care or early primary care for conditions that might become acute without early attention.
- Because a very high proportion of medical expenses go for acute-care episodes, the cost of such coverage might not be low enough to induce many of the insured to purchase coverage without subsidies.

Financing

The expectation would be that low-income consumers would pay the cost themselves

14 "BARE BONES" INSURANCE — PRIMARY CARE

The Approach

The legislature could permit insurers to sell a "bare bones" Insurance package that included coverage for only cost-effective primary care and preventive services and prescription drugs. This would require that the legislature waive mandated benefits for this particular insurance package. The idea would be that this insurance might appeal to lower-income people because the cost would be relatively low and they would be more likely to purchase it than catastrophic coverage because they would anticipate using the covered services. If these people needed hospitalization or other acute-care services, they would be no worse off then if they had no insurance. These expenses would most likely become uncompensated care for providers.

Pros

- Removing the financial barriers to use of primary and preventive care services would encourage early use before people get so ill that they require more expensive acute care.
- Such coverage might be especially cost-effective and useful for low-income adults who suffer from chronic conditions like hypertension and diabetes, where regular primary care can prevent onset of acute conditions.

Cons

- From an actuarial standpoint, such coverage is more pre-payment than Insurance the cost of the policy is not likely to be much lower than sum of what the typical person would pay out of pocket during a year if he or she paid for services as they are used. There is little spreading of risk of the cost of unpredictable losses, which is the purpose of insurance.
- The coverage provides no protection for those people who need really expensive care. Those who needed such care would be left with a major financial burden, and the costs would often have to be absorbed by providers.
- Allowing sale of such coverage sets what many would see as a bad precedent by allowing sale of coverage that provides inadequate protection against the kinds of expensive events that are the real purpose of the insurance.
- Insurers who sell such coverage may become victims of adverse selection people who find the coverage attractive are likely to be those who know they will need many of these services, Healthy, young adults will often see little benefit in buying such coverage.

Financing

Since the cost of coverage would be relatively small, the expectation would be that low-income consumers would pay the cost themselves.

15 EMPLOYER "PLAY OR PAY" MANDATE

The Approach

The state could require that all employers either offer coverage to their employees and pay at least some minimum proportion of the cost of the premium (the "play" option) or, alternatively, pay a tax approximately equal to the employer's portion of the cost of providing coverage had the employer chosen the play option (the "pay" option). Presumably, the state would also define a minimum benefit package. The state would use the tax money collected from "non-playing" employers to finance subsidies in the form of vouchers for those employers' workers to buy coverage on their own.

Pros

- Rather than creating a new public coverage program, this approach builds upon the employer-based system that already covers most employees.
- The approach does not necessarily require state subsidies to employers (although without state subsidies for marginal firms, some might be forced out of business or at least find it necessary to lay off workers).
- All employees in firms affected by the policy would be offered health coverage or a voucher, and the employer or the voucher would pay a significant portion of the cost So the approach would reach many of the currently uninsured.

Cons

- The approach involves a degree of compulsion that would be politically objectionable to sectors of the business community and many others.
- The approach would certainly be challenged under ERISA, but if very carefully crafted, might survive the challenge.
- The effect of requiring employers to pay for health insurance has a similar effect on the work force as raising the minimum wage: some employers now paying at or near the minimum wage would be forced to lay-off workers, because the workers are not productive enough to justify raising their compensation by the amount represented by their employer's insurance premium.
- Unless the required employer contribution were a large proportion of the premium, some low-wage workers still might find coverage to be more than they are willing to pay. But requiring a large employer contribution would be a hardship on marginal employers and might force some out of business, unless the state provided subsidies
- Enforcement would require some new administrative apparatus.
- The added cost to employers might deter some from locating in Delaware (although this would presumably affect only employers not planning to provide health coverage)
- The approach would do nothing for uninsured non-workers (unless they were also eligible for subsidies--which would require an additional source of financing beyond the employer tax).

Financing

This approach would not necessarily require any new state monies beyond those raised by the payroll tax that is part of the idea, although see above regarding the desirability of subsidies for marginal firms.

16 MANDATE THAT INDIVIDUALS HAVE COVERAGE

The Approach

The state could pass legislation requiring everyone to acquire health coverage of one kind or another. Presumably, the state would specify some minimum benefit package: this might be "bare bones" or catastrophic coverage to keep the cost down. Individuals who failed to acquire coverage could be required to pay an amount equal to the cost of coverage as an addition to their state tax liability. (In effect, everyone could be required to pay a tax equal to the cost of coverage, and then a credit could be given for the cost of the coverage for those who purchased coverage or were otherwise covered.) Presumably, any tax revenues generated this way would go to pay for "uncompensated" care to cover the costs of treating the people who still remain uninsured.

Pros

- This approach creates strong incentives for everyone to acquire coverage; everyone would be covered or would contribute toward the cost of coverage.
- This approach would ensure inclusion of people who can afford coverage but who choose not to buy it now.

Cons

- To make this realistically workable, subsidies would still be required for low-income people: mandating that they buy coverage when they have insufficient income to cover necessities accomplishes nothing useful. If the mandate took the form of a "forgivable" tax, as suggested above, it would probably need to be forgiven for anyone whose income falls below some level where coverage is not affordable.
- This approach would be likely to face stiff political opposition.
- Enforcement would be difficult, especially for people who do no pay income tax.

Financing

The state would still need to subsidize the cost of coverage for low-income people

17 THE "SINGLE-PAYER" OR SOCIAL INSURANCE APPROACH

The Approach

The state would guarantee that all Delaware citizens are automatically covered for a defined set of health care benefits, which would be publicly financed. Similar to Pan A hospital coverage under Medicare, coverage under the system is a "right" of all citizens and is not dependent upon meeting any tests of eligibility based on need, family status, or other personal characteristics. No premium payments are required for the basic coverage benefits, This is the social insurance approach that prevails in many other countries.

Pros

- This approach guarantees universal coverage. There are, by definition, no uninsured; nobody "falls through the cracks."
- The approach is administratively much less complicated because there is a single payer, the government-no coordination of benefits, no determination of eligibility, no filing of claims by patients, etc. Administrative costs should be reduced once the new system is in place.
- There is no stigma associated with accepting subsidized coverage, since everyone is in the same system.
- There is no uncompensated care (at least for the services covered under the standard benefit package). Providers do not have to absorb the costs of unpaid bills
- There is no need for a safety-net provider system. Everyone has access to "mainstream" providers
- There is minimal "tiering" of care based on income or socio-economic status

Cons

- Because the state would now be paying for a very large proportion of health costs now covered by employer and employee premiums contributions, the cost to state government would be very high, requiring a major increase in state revenues. It is difficult to envision how money now provided by the federal government for Medicaid and CHIP (and other smaller federally subsidized programs) could be captured, given current federal law.
- The state would face difficult administrative tasks in setting up such a system-for example, establishing mechanisms to pay providers, control costs, etc. (The Medicaid program might provide a foundation on which to build.)
- A single state establishing a system alone might face a large influx from other states of people with serious medical problems who move to become eligible for publicly financed coverage. Delaware might have difficulty attracting providers, depending upon the rules for reimbursing them and the amount being paid
- Raising sufficient revenue to fund the program might put the state at a comparative disadvantage in attracting new productive people to the state if the source of revenue is tax paid by consumers and in attracting business if the tax is levied on business
- Given the current political environment and the wariness about expanding government's role, the political opposition to such a system would likely be intense, particularly from insurers and providers.

Financing

The state would have to increase revenues very substantially. Many options exist for the kinds of taxes that could be levied.