IMPROVING ACCESS TO NEEDED HEALTH CARE FOR UNINSURED AND UNDERINSURED IOWANS

FINAL REPORT

Submitted to:

The Iowa General Assembly

Submitted by:

The Health Care Expansion Task Force

Prepared by:

Health Systems Research, Inc.
Washington, D.C.

November 15, 1990

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Senator Bill Hutchins,
Co-Chairperson of the Legislative Council,
Members of the Legislative Council, and
Members of the Iowa General Assembly

Dear Senator Hutchins and Members of the General Assembly:

On behalf of the Health Care Expansion Task Force, we are pleased to submit this final report to the Legislative Council and the General Assembly. The report provides an assessment of the very real and pressing health care access problems faced by uninsured and underinsured persons in Iowa, and examines the underlying causes of these problems. It also presents a series of recommendations that are designed, in the short-term, to reduce the financial barriers currently faced by many of the State's most vulnerable populations---including the State's most precious resource, its children---and, over the long-term, to chart a course for making major improvements in the ways health care is financed and delivered in the state of Iowa.

It is not the Task Force's intention that its proposals be viewed as solely the Legislature's recommendations, separate and distinct from the positions taken by other organizations examining the issue of health care access. Indeed, through both the composition of its membership and the outreach efforts of the Task Force and its consultant, Health Systems Research, Inc., the Task Force has sought to obtain the views of interest parties throughout the state and to coordinate its activities with those of such other entities as the Governor's Blue Ribbon Commission on the Uninsured. The Task Force would like to extend its thanks to the many individuals and organizations who took the time to share their information and perspectives with the Task Force.

The Task Force also wishes to thank its consultant, Health Systems Research, Inc. and to inform you that HSR, Inc., as part of its contract, will be available to provide testimony to the General Assembly.

It is the Task Force's hope that its recommendations that seek to improve upon the states current, fragmented health care financing system and provide coverage to a small, but very vulnerable, portion of the State's uninsured population can be implemented rapidly. We also hope that our recommendation concerning long-term systemic reform will provide a context for continued discussion and action on this issue.

Sincerely,

Senator Charles Bruner
Co-Chairperson

Representative Patricia Harper
Co-Chairperson

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REPRESENTATIVE DOLORES M. MERTZ

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TABLE OF CONTENTS

	Letter of Transmittal	i
I.	Introduction	1
II.	Findings	3
III.	Guiding Principles	17
IV.	Recommendations	20
V.	Cost Summary	39
Appendix A.	Task Force Membership	A-1
Appendix B.	Individuals/Organizations Contacted by the Task Force and its Consultant	B-1
Appendix C.	Characteristics of Iowa's Uninsured Population	C-1
Appendix D.	Overview of State Options for Addressing the Problem of Health Care Access	D-1
Appendix E.	Summary of Demonstration Programs to Expand Private Sector Coverage in Other States	E-1
Appendix F.	Descriptions and Preliminary Cost Estimates of Options Examined by the Task Force	F-1
Appendix G.	Possible Standards to be Used to Assess M/CH Contractor Performance	G-1
Appendix H.	Summary of Costs Associated with Recommendations to Improve the Public Sector Service Delivery System	H-1
Appendix I.	Draft of NAIC Model Legislation Concerning Regulatory Rate Reform on the Small Group Insurance Market	I-1
Appendix J.	Analysis of "Pay or Play" Proposal	J-1
Appendix K.	Memo on ERISA and State Health Care Financing Initiatives	K-1

I. INTRODUCTION

In 1989, the Iowa General Assembly enacted Senate File 538, which created the Iowa Health Care Expansion Task Force. According to this enabling legislation, the purpose of the Task Force is to oversee the conduct of a comprehensive study of the State of Iowa's health insurance needs and an analysis of extending health care coverage and/or services to persons in the State who are uninsured or underinsured[1].

Since it was formed in May of 1989, the Task Force, with the assistance of Health Systems Research, Inc., a Washington, D.C.-based consulting firm, has explored in detail the problems of the uninsured and underinsured in Iowa, as well as the underlying causes of these problems. It also examined a broad array of program and policy options for reducing the access barriers faced by these vulnerable populations. In conducting its analysis, the Task Force and its consultant have received input from a wide range of individuals and organizations in the State.[2]

This final report presents the Task Force's assessment of the health care access problems that exist in Iowa, the principles it developed to guide the formation of public policy in this area, and its specific recommendations for legislative action on the part of the Iowa General Assembly to address these problems.

It is the Task Force's expectation that the enactment of these recommendations will alleviate many of the pressing health care access problems faced by Iowa's most vulnerable citizens. At the same time, however, the Task Force recognizes that the final

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[1] The Task Force membership is presented in Appendix A.

[2] A list of the individuals and organizations with whom the Task Force and/or Health Systems Research, Inc. have consulted can be found in Appendix B.

solution to the problems of the uninsured and underinsured will require a much more fundamental and sweeping reform of our current system of health care financing. While it is the Task Force's view that such reform must ultimately occur at the national level, it understands that the impetus for such action must spring from involvement in the issue at the state and local level. It is the Task Force's hope that its effort to address the health care access problems that exist today in Iowa will be part of a broader movement toward an improved health care financing and delivery system nationwide.

II. TASK FORCE FINDINGS

The Task Force's examination of the health care access problems faced by uninsured and underinsured persons in Iowa led to a number of important findings concerning the nature of these problems and their underlying causes. These are summarized below.

FINDING # 1

In 1989, approximately 220,000 Iowans had no health care coverage.

According to data from the Iowa portion of the 1989 Current Population Survey (CPS), about 220,000 Iowans lacked health care coverage of any type, including coverage from private insurance carriers or government programs such as Medicare or Medicaid. This represents about nine percent of the State's under-65 population.[3]

An analysis of the socio-demographic characteristics of Iowa's uninsured population revealed that:[4]

- Over a quarter of the uninsured are children, while a fifth are young adults aged 18 to 24. The vast majority of the remaining uninsured are non-elderly adults. Because of the nearly universal coverage provided to the elderly by the federal Medicare program, less than one percent of Iowa's uninsured are aged 65 or older.

- Iowa's uninsured population is predominantly a low-income one. Nearly a third of the uninsured are in households with

[3] The fact that this estimate of the size of the Iowa's uninsured population is lower than previously reported figures is due in large measure to improvements in the way the current Population Survey collects information on insurance status.

[4] See Appendix C for further detail on the characteristics of Iowa's uninsured population.

incomes that fall below the poverty line.[5] Another 40% had incomes between one and two times the poverty level, while 20% had incomes between two and three times poverty. Only ten percent had incomes greater than three times the federal poverty level.

- The uninsured population appears to be relatively evenly distributed throughout the State's urban and rural areas.

FINDING # 2

Most uninsured persons have some link to the workforce.

Analysis of the 1989 CPS data revealed that over 80% of all uninsured, non-elderly adults in Iowa were employed at some time during the year in which they were uninsured. Nearly a third reported being employed full-time during the entire year. A quarter were employed full-time during part of the year, while another quarter were part-time workers. Only 17% of these uninsured adults were unemployed the entire year.

When both uninsured adults and children are considered, the link to the workforce becomes even stronger. More than half of these uninsured persons were members of families in which the head of the household was employed full-time during the entire year. Only 14% were in families in which the head of household was unemployed.

[5] The federal definition of poverty varies according to family size and changes from year to year. For example, in 1989, the annual federal poverty level for a family of three was set at $9,690.00.

FINDING # 3

Over half of all uninsured workers in Iowa are employed by small businesses.

As is the case in most other states, the majority of uninsured workers in Iowa (53%) are employed by firms with 25 or fewer employees. This means that workers in small Iowa firms are more than twice as likely to be uninsured as workers in larger firms.

FINDING # 4

One important reason for the large number of uninsured workers in small firms is the inability of many small businesses to obtain affordable health care coverage for their employees.

While businesses of all sizes encounter problems providing adequate health care coverage for their employees at a reasonable cost, the obstacles faced by small businesses can be particularly difficult to overcome.

For example, restrictive underwriting practices by insurers can often result in certain employees of small firms or even entire categories of small businesses being refused health care coverage. Those small firms for which health care coverage is available are faced with high premiums that reflect heavy administrative costs, the possibility of double, or even triple, digit increases in premiums for one year to the next due to rapid turnover in insurers' small business rating groups, and significant gaps in coverage due to such things as exclusions of benefits for pre-existing conditions. As a result, many small businesses find that purchasing adequate health care coverage for their workers is not an affordable alternative.

FINDING # 5

The affordability of health care coverage is a problem faced not only by employers, but also by employees and other individuals.

In an effort to control employer health care costs, there has been a trend toward greater employee cost sharing in the form of increased premium contributions and/or the imposition of higher deductibles and coinsurance requirements . For many lower income families, this increased cost sharing can mean that they cannot afford coverage.

In fact, a study by the National Health Care Campaign found that Iowa families earning $24,200 with incomes at or below 200% of the federal poverty level (e.g., $24,200 per year for a family of four) have little or no disposable income. It is only when families earn more than 250% of the poverty level that they begin to accumulate the disposable income required to contribute toward a portion of their health care premium costs.[6]

One unsettling indication of the difficult decisions low-income families may be forced to make with respect to health care coverage is the finding from the analysis of 1989 CPS data that approximately one-quarter of all uninsured children in Iowa were in families in which the head of the household had health insurance. Given that most firms require higher employee premium contributions to obtain dependent coverage, this finding may reflect the fact that many working parents who receive health insurance through their employers may be unable to afford the additional cost of extending coverage to their children.

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[6] See The Affordability of Health Care for Iowa's Working Families, December, 1989, Iowa Health Care for All, Des Moines, IA.

FINDING # 6

The lack of adequate health care coverage can have a negative effect on health status and limits access to cost-effective health services.

The finding is supported by national data showing that:

- The uninsured report lower health status than the insured or "underinsured" population.
- The uninsured use fewer health services than insured persons, including cost-effective preventive services such as prenatal care.
- When the uninsured do use health services, it is more likely to be in costly institutional settings, such as hospital emergency rooms.

FINDING # 7

It is not only uninsured Iowans, but also many inadequately insured persons who encounter financial barriers to receiving needed care.

The Task Force found that many insured Iowans have health care coverage that does not provide them with access to needed care or does not adequately protect them from catastrophic expenses. Given the Task Force's interest in promoting access to cost-effective preventive care, it was particularly disturbed by the results of a survey of major health insurers in Iowa conducted for the Task Force by Health Systems Research, Inc., which indicated that less than half of all policies sold in the State included coverage of preventive services for children. This gap in coverage means that for low-income insured families with such coverage gaps, significant financial barriers may exist to their receiving preventive services.

The Task Force found the size of the problem of underinsurance to be a significant one. For example, while approximately 66,000 Iowa children were uninsured in 1989, the Task Force estimated that over 85,000 privately insured children in families under 200%

of poverty were not covered for preventive services. Thousands more with such coverage faced extremely high deductibles before their coverage took effect. This combination of limited income and gaps in coverage means that for financial reasons, many of these children may not benefit from services that could prevent health care problems or detect and treat them in their early, less costly stages.

FINDING # 8

The Iowa Medicaid program provides health care coverage for many low-income persons in the State although many persons in need are not eligible for coverage and coverage of families is fragmented.

The number of uninsured and underinsured persons in Iowa would be much higher were it not for the Iowa Medicaid program. This program, which is presently funded with federal and state dollars and administered by the Iowa Department of Human Services, provides coverage to approximately over 195,000 low-income Iowans who are either elderly, disabled, children, or the parents of disabled children.

While the Iowa Medicaid program is a relatively expansive one in that it extends coverage to nearly all of the eligibility groups allowed by federal law, federal restrictions result in many low-income persons, including many people living below poverty, being ineligible for coverage.[7] However, one small, but particularly vulnerable, eligible group that is not currently covered for the full range of benefits under the Iowa Medicaid program are aged or disabled persons who have incomes that are below the federal poverty level but too high for SSI and Medicaid. Approximately, 1,000 Iowans are estimated to fall into this category.

Another important problem with the program is that Medicaid eligibility is particularly fragmented with respect to families with children, in that, according to federal

[7] In general, among the low-income groups presently not eligible for Medicaid coverage are single adults who are not disabled, childless couples, and children aged eight and older in families with incomes greater than two-thirds of the poverty level and caretakers in such families.

requirements, income eligibility is set at a higher level for younger children than for older ones. For example, Iowa Medicaid currently covers:

- Pregnant women and infants in families with incomes up to 185% of the federal poverty level;
- children aged one through five up to 133% of poverty;
- children aged six and seven up to the poverty level; and
- children aged eight to twenty-one through up to about two-thirds of poverty.

This means that, depending upon the family's income, some children in the family may be eligible for Medicaid and others may not. The recent Federal Budget Reconciliation Act will address some of these inconsistencies by extending Medicaid coverage to children under poverty through age eighteen. This change, however, will not be an immediate one, but will be phased in on an age-specific basis through the year 2002. And even when fully phased in, it will not eliminate the problem of family coverage for families between 100% and 133% of poverty. In these households within this income range, children will be eligible for Medicaid through age five, but ineligible thereafter.

The Task Force identified several other important issues associated with the Medicaid program:

- Many persons in need of health care services and who are eligible for the program may not apply for coverage. This may be due to the fact that they are not aware that they might be eligible or because they refuse to apply because of the perceived welfare stigma associated with the program.
- While the Iowa Medicaid program provides preventive services for children under its Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program, the utilization of the benefit by Medicaid eligible children is extremely low. The combination of new federal requirements and the recognition of the importance of this benefit necessitates the program's taking steps to improve its performance in this area.

These problems must be addressed if the Iowa Medicaid program is to reach its full potential in meeting the health care needs of the State's low-income population.

Iowa's publicly-supported health care delivery programs provide important services to the State's uninsured and underinsured populations. However, they do not meet all the needs of these populations and their performance in a number of key areas could be improved.

There is a loose-knit system of public and quasi-public health care providers in the state that serves as a safety net for many uninsured Iowans. The network includes:

- 3 community health centers (CHCs) in Des Moines, Waterloo, and Davenport, funded by the Federal government under Section 330 of the Public Health Services Act, and one federally funded Migrant Health Center to serve farm workers.
- 11 Medicare-certified rural health clinics (RHCs) that are permitted to employ allied health personnel, such as Physician Assistants and Nurse Practitioners, under general physician supervision.
- 29 Maternal and/or Child Health Centers (M/CHs) funded primarily through the Iowa Department of Health that operate at least episodically in all 99 counties.
- 9 training sites of the Family Practice Residency Training Program (7 of which are under the direction of the University of Iowa) that train family physicians and receive $1.7 million in state funds.
- 4 school-based youth services programs that provide health services as part of their responsibilities were funded for FY 91 by the legislature, and which are currently under development.[8]

[8] The State funds a number of other health care-related activities. State and federal funds support dental treatment for children and pregnant women in the M/CH program. Specialized services for chronically ill and disabled children are delivered through the University of Iowa Hospitals and Clinics. Homemaker/home health aide services in all counties provide long-term care to permit children and adults to remain at home. Well elderly clinics provide health assessment, counseling, and referral to treatment for people over age 55. Public health nursing services in all counties (funded by state and local sources, but using county-employed nurses) provide counseling, health promotion, health assessment, nursing care, and referral to treatment. These programs all serve families with incomes below from 100% to 185% of the federal poverty level free or at a reduced

Only the rural health centers and community health centers function as full-service primary care clinics for the low-income uninsured. The network of Maternal and Child Health Centers serving all 99 counties receives $3.5 million in state and federal (MCH block grant) funds to provide maternity and child health services to about 18,000 clients with incomes under 185% of the federal poverty level. The Maternal Health Centers provide or arrange for both prenatal and delivery services for low-income women. The Child Health Centers offer only preventive care, such as immunizations and well-child check-ups. However, they can refer sick children to community physicians for primary care for problems other than chronic illnesses or injuries under a $400,000 voucher program established by the legislature in 1989. As many as half of the children served by the centers do have some form of health insurance, but no coverage for preventive care.

The Task Force's specific findings with respect to the State's network of ambulatory care providers are as follows:

- <u>The Maternal and Child Health Centers provide an important foundation for the delivery of ambulatory care services to Iowa's uninsured and underinsured populations. However, they do not meet all the needs of these populations</u>.
  This network of centers is unique and forms the framework for a public and quasi-public delivery system where private providers are not available or willing to serve the uninsured. However, these centers do not meet all the needs of these populations, particularly with respect to preventive services for children. It is estimated that in 1989 there were about 50,000 uninsured children in Iowa under 200% of the federal poverty level and 85,000 privately insured

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charge and generally cover higher income persons for a higher fee.

In addition, a survey of Iowa counties conducted by Health Systems Research, Inc. with the cooperation of the Iowa State Association of Counties found that county expenditures on personal health services for low-income persons exceeded $10 million in 1989.

See Appendix F for Health Systems Research, Inc.'s August, 1990 report to the Task Force which provides additional information on Iowa's service delivery activities and a map showing the locations of publicly supported health centers.

children in this income category without preventive care coverage. Of these 135,000 children, about 11,000 uninsured children were served by Child Health Centers and about 11,000 other uninsured children were served by Community Health Centers.

- There is great variety among the M/CH centers in terms of structure and orientation.
  Some are traditional local public health nursing agencies, while others are local community service groups (Community Action Programs or family service agencies), or hospitals. Some of these agencies view their mission narrowly to provide specific services on request, while others seek to provide a broad range of services and promote them in the community. The programs that appear to work best combine or at least co-locate maternal and child centers (just over half the programs are combined) and have a good sense of the health care needs and resources of the communities in which they function.

- Relationships with local physicians, critically important to the centers' success, vary across the state.
  Child Health Center staffs have found the voucher program very useful. Physicians, who are paid Medicaid rates for a limited number of visits, have generally responded well to the program and are willing to participate. Other relationships between the centers and physicians seem to depend upon the local medical marketplace. The general shortage of physicians willing to deliver babies makes it difficult for some Maternal Centers to find contracting physicians.

- Coordination between M/CH Centers and Medicaid is vital but inadequate.
  Maternal Health Centers have seen their funding change from mostly federal MCH Block grant to almost exclusively Medicaid, as Medicaid eligibility for pregnant women and infants has expanded up to 185% of the federal poverty line. Nevertheless, some staff noted that their clients have difficulty completing the Medicaid application process. Even with presumptive eligibility, the follow-up Medicaid application is cumbersome and confusing. M/CH center staff do not always see their job as assisting clients to apply for Medicaid, and local social services staff are not always helpful in their attitudes.

- Even for eligible children, the sick care voucher program is limited.
  The Child Health Center voucher program pays for acute rather than chronic care or care for accident or injury. Such a limitation can

impede continuity of care and discourage providers from addressing the full health needs of the child.

- Adolescent health care is an unmet need.
  Adolescents are reluctant to attend child health clinics, due both to attitude and to the physical locations of many of these clinics. Most temporary and some permanent sites are in church basements and other settings in which limitations on privacy make them inappropriate for older children. Special education and outreach efforts also necessary to attract these youth to preventive health clinics.

- On the whole, M/CH centers appear to have the flexibility to meet local community needs, but the state has not established guidelines for their performance or rigorously evaluated their effectiveness.
  M/CH contracts have apparently been awarded based on historical patterns of local service delivery, and changes in contractors is rare. The new revenues from expanded Medicaid eligibility for pregnant women and young children may free up federal and state maternal and child health care funds and offer the opportunity to review M/CH center goals and performance. The contract process can strike a balance between identifying and addressing unique local needs and meeting state standards to improve accountability. Most centers have unsophisticated patient tracking systems that would need improvement to monitor their performance and compliance with state standards.

- Preventive and primary care for uninsured adults is limited and many communities are not served by a full-service ambulatory clinic.
  Community Health Centers provided preventive and primary care to about 37,000 patients in 1989 but exist in only three communities in the state. The University of Iowa's $27 million "state papers" program provides primary and acute care in Iowa City to about 550 obstetric/newborn and 800 orthopedic patients (non-quota patients) and 3,900 patients referred under the county quota system.

- The Department of Public Health will be undertaking new needs assessment and data collection duties under recent federal law changes.
  In the 1989 Omnibus Budget Reconciliation Act, Congress imposed new responsibilities upon state Maternal and Child Health agencies. These agencies will be required to submit to the Federal government statewide needs assessment data on services to women and children and to outline a plan to meet various national MCH goals.

States must also report health status indicators, such as perinatal and maternal mortality, immunization status, low birth weight rates, and rates of early prenatal care.

- There is the opportunity for improved coordination of multiple initiatives targeted to vulnerable children.
  A number of federally-supported initiatives dealing with particularly vulnerable children need to be integrated with one another and with other state activities to develop a coherent systems for these children. The State should seek to combine resources in planning and implementing the provisions of such federal initiatives as the CASSP program, M/CH services for children with special health care needs, Public Law 99-457 Part H, and Public Law 99-661.

- Although not well quantified, it is certain that there are shortages of primary care providers in many areas of the state. These shortages increase the problems the State's uninsured and underinsured populations face in accessing both the private and public sector delivery systems.
  Research by the University of Iowa, the Iowa Medical Society, health professional licensing boards, and the Health Professionals Shortage Committee and Governor's Task Force on Rural Health have all documented shortages of personnel such as obstetricians, family practitioners, physician assistants, pediatric nurse practitioners, nurse midwives, and registered dieticians. However, despite many independent studies of the health personnel shortage issues, there is no single focal point within State government to conduct or coordinate data collection, analysis, and solution development for this overarching health care delivery problem in the state.

FINDING # 10

The current health care financing system is neither an efficient nor an equitable structure for providing health care coverage for all.

Perhaps the most sweeping and significant conclusion reached by the Task Force is that the current health care financing system in operation in Iowa and in the nation as a whole represents a very inefficient and inequitable mechanism for providing appropriate health care for all.

The inequities of the current financing arrangements were often discussed during the course of the Task Force's deliberations. Among the specific examples cited by the Task Force were:

- "Cost-shifting" which finances the cost of providing hospital care and other services to uninsured individuals by increasing charges to persons with health care coverage. Private health care purchasers' bills also are increased due to "cost shifting" that results from inadequate reimbursement rates being paid by public programs such as Medicare and Medicaid.

- Inequitable tax policies that provide corporations a 100% tax deduction for the cost of providing health care benefits to their employees but allow self-employed persons to deduct only 25% of the cost of similar coverage.

- Inequitable eligibility requirements for public health care financing programs that can result in (a) one family receiving Medicaid benefits while a second family with only a few dollars more a month in income being denied coverage; or (b) the young children in a low-income family being covered by Medicaid while the older children are ineligible, even if these older children have serious health problems.

- The movement of insurance carriers away from community-rating that has made health care coverage extremely expensive for many segments of the population.

- The inability of some small or even mid-sized firms to obtain any type of health insurance coverage because of the nature of their business or the presence of even one employee with high health care needs.

The Task Force was equally distressed by the failure of the current system to provide for the health care needs of all citizens in an efficient and effective manner. Among the factors that the Task Force cited as evidence of the current system's inadequate performance in this area were:

- An inadequate focus on prevention and early intervention to detect and treat health care problems before they worsen and require more expensive treatment, including inpatient care.

- High administrative costs associated with the marketing and provision of health care coverage to individuals and small groups. One recent national survey found that administrative expenses for coverage of firms with four or fewer employees equaled about 40% of the amount paid out in claims, compared to 5.5% for very large businesses (i.e., more than 10,000 employees).

- The failure of the current financing system to effectively control spiralling health care costs.

Finally, the Task Force noted that the current pluralistic systems of health care coverage makes it difficult to direct public programs toward one uninsured group without the private sector's incentives for coverage of these and other populations. Among the Task Force's concerns in this area are that:

- A move to provide public sector coverage of one group (e.g., uninsured low-income working families) may cause some businesses to drop their own coverage of other low-income workers and their families.

- Incentives aimed at getting employers to cover uninsured workers raises equity issues with respect to the treatment of businesses that had already assumed the responsibility of providing such coverage to their employees.

These findings, along with a set of principles used by the Task Force to guide it in its policymaking process, provided the foundation upon which the Task Force developed its recommendations. Those guiding principles are described in the following section of this report.

III. GUIDING PRINCIPLES

As it began its review of different approaches to improve access to needed care for Iowa's uninsured and underinsured populations, the Task Force identified a set of twelve principles that it believed should be used to guide the development of both short-term and long-term public policy in this area. These principles are as follows:

Access

1. *All Iowans should have access to adequate, effective, appropriate, and quality health care services without regard to financial barriers.*

2. *A basic level of health care should be defined to which everyone has access, with priority on effective, appropriate, and quality care, especially preventive and primary care, early diagnosis and treatment, and incentives for healthy lifestyles.*

Financing

3. *All Iowans share a responsibility to obtain adequate coverage for themselves and their dependents, but the government should participate in financing care for those unable to pay.*

4. *Responsibility for the financing of options should be equitably distributed among payers.*

5. *Options for improving access should minimize the negative impacts on businesses and on current employer health benefits plans. In addition, disincentives should not be adopted which would cause employers currently offering health benefits to drop or reduce this coverage.*

Cost Containment

6. *Health care expenditure controls should be essential elements of approaches to expand access to care for the uninsured and to ensure continued adequate coverage for those currently insured.*

7. *Use of cost sharing may be considered to control excessive utilization but should take into account ability to pay.*

8. *Approaches should include incentives to seek and provide care in the most efficient and cost effective manner and location, including contractual arrangements for patient management and utilization controls.*

9. *Provider reimbursement should be set at reasonable levels and should promote efficient service delivery and constrain unnecessary expenditures.*

10. *Individuals should have reasonable choice in selecting health care providers, although they may be restricted to certain providers in cases where these arrangements significantly increase the cost-effectiveness of this care.*

General

11. *Approaches to expand access to care for the uninsured should be as simple to administer as possible and avoid duplication of resources. Special attention should be given to minimizing the administrative burden on small businesses, providers and consumers.*

12. *Program policy design should be sensitive to problems of provider availability and accessibility, especially in rural areas.*

The principles developed by the Task Force concerning cost containment reflect a balanced view that any coverage extended to the currently uninsured population should not be considered exempt from any and all cost management provisions, nor should it be considered an experimental setting in which highly restrictive cost containment features not seen in other private or public programs are tested. Instead, state of the art cost management features, such as utilization reviews based upon the development of appropriate practice guidelines, should be incorporated in this coverage in a manner that is consistent with both the health needs and low income status of this population and the practices of the other health care coverage plans.

Having agreed on these principles, the Task Force then made several additional decisions concerning the way in which several of these principles should be operationalized. These decisions focused on the definition of the population for which the government should provide assistance in financing health care coverage and the identification of population groups and health care benefits to which priority should be

given. These decisions, which were included in the Task Force's interim report to the General Assembly, are as follows:

- Individuals and families with incomes at or below the federal poverty line cannot afford to contribute to their health care coverage. It is appropriate for government to assume these individuals' portions of their health care coverage costs.

- Individuals and families with incomes above poverty but still considered low-income (e.g., below 200% of the poverty level) can be expected to assume some, but not necessarily all, of the cost of their health care coverage. Government should assist in financing coverage for this group on an income-related sliding scale basis.

- These income guidelines may be increased to allow either full or partial government subsidization of health care coverage costs associated with certain high priority populations. Pregnant women and children are considered as high priority populations because of the positive health effects associated with the provision of adequate prenatal care and preventive services to these groups. The next level of priority was given to disabled adults.

- With respect to health care benefits, highest priority was assigned to the provision of preventive care, followed by primary care services.

The Task Force's recommendations that draw upon these principles are described in the following section.

IV. RECOMMENDATIONS

Over the past year, the Task Force has reviewed a wide range of options for addressing the needs of Iowa's uninsured and underinsured populations.[9] These options included a number of different approaches to address the problem, including:

- The expansion of existing public health care financing programs and/or the establishment of new financing programs;
- improvements in the public sector health care service delivery system;
- efforts to make private health care coverage more affordable; and
- major reform of the Iowa health care financing and delivery system.

Based upon its analysis of this broad range of policy alternatives and their appropriateness to the Iowa environment, the Task Force developed the following recommendations for action by the Iowa General Assembly.

RECOMMENDATION # 1

Establish a new public financing program to provide coverage to non-Medicaid eligible children below 133% of the federal poverty level.

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[9] A further discussion of the range of approaches other states have taken to address the health care access problem can be found in Appendix D. A summary of other states' demonstration projects designed to expand private sector health care coverage, which was prepared by Health Systems Research, Inc. and provided to the Task Force at its June 12, 1990 meeting is presented in Appendix E. Finally, descriptions and preliminary cost estimates of specific options examined by the Task Force are included in Appendix F.

As described earlier under Finding # 8, Medicaid coverage in Iowa is available to children on a staggered age and income-related basis, as follows:

- Pregnant women and children under 185% of the federal poverty level;
- children aged one through five up to 133% of poverty;
- children aged six and seven to 100% of poverty; and
- children to age 21 up to about 67% of poverty.

The gaps in Medicaid coverage of low-income children and the fragmentation in coverage that occurs in some low-income families with children of different ages will be reduced substantially as the state implements the new federal requirements extending Medicaid to all children below the age of 19 in families below the poverty level. However, this expanded coverage will not be immediate, but must be phased over an 11 year period. In addition, it will not extend coverage to older children in families with incomes between 100% and 133% of poverty.

Given (1) the long implementation time-frames and the gaps that will remain even after these Medicaid expansions are fully implemented, and (2) the importance attributed by the Task Force to providing adequate health care -- including preventive services -- to all children in the State, the Task Force recommends the establishment of a new state-sponsored program that would provide health care coverage to all non-Medicaid eligible children under the age of 18 in families with incomes below 133% of the federal poverty level. In 1990, this income limit would be equal to an annual income of approximately $14,045 for a family of three.

Two alternative benefit packages were considered by the Task Force. Given the availability of state funds, it recommends the provision of a benefit package similar to that provided to other low-income children under the Iowa Medicaid program. However, if sufficient funds are not available to support this full benefit package, the Task Force then

recommends the provision of an ambulatory services-only package similar to that offered under state programs in Minnesota and New York.

Under this program, coverage of children under poverty would be fully subsidized by the state, while an annual enrollment fee of $50 per child would be charged for the Medicaid benefit package and $25 per child for the ambulatory benefit package. Some switching of coverage is expected to occur as some children covered by more expensive private coverage shift over to the public program. Different participation rates in the program are assumed, depending upon current coverage status of the children and the scope of benefits covered under the program.

Assuming the program becomes operational in late 1991, it is estimated that enrollment will grow over a three year period until it peaks at approximately 9,200 children in late 1994/early 1995. From that point on, enrollment is expected to decline gradually as the phase-in of the new Medicaid coverage requirements reduce the number of children eligible for the program. By the year 2002, assuming no new Medicaid expansions or other changes in health care coverage status of children, enrollment is projected to level-off at approximately 6,700 children aged eight through eighteen in the 100%-133% of poverty income range.

Assuming constant dollars, program costs are projected to increase from less than $1 million in 1991 (including start-up costs) to approximately $6.3 million in state expenditures in 1995 for the program covering Medicaid-like benefits ($2.6 million in state funds for coverage of ambulatory services only). In subsequent years, enrollment in the program is projected to decline as the phased-in Medicaid expansions will cover an increasing number of this program's target population.

RECOMMENDATION # 2

Strengthen the public sector primary and preventive service delivery system.

Even with the phased-in implementation of expanded Medicaid coverage of children and the establishment of a new public health care financing program for non-Medicaid eligible children under 133% of poverty, the services provided by Child Health Centers and Community Health Centers will continue to play a very important role in meeting the ambulatory care needs of low-income children throughout the State. This is expected to be the case because there are an estimated 30,000 uninsured children throughout the state are in households with incomes about 133% of poverty who would be unaffected by these program expansions. In addition, many low-income insured children will rely on these public clinics because their insurance coverage does not include preventive services and/or provider shortages restrict their access to other sources of care.

Given this scenario and the assessment of the strengths and weaknesses of Iowa's current public sector system for delivering primary and preventive services presented in Finding #9, the Task Force recommends that a number of measures be taken to improve the ability of the State's ambulatory care clinics to meet the needs of its low-income population. These measures include:

A. Expansion of preventive and acute care services for low-income children.

The Task Force recommends a series of measures to expand the services provided by child health centers throughout the State[10]. They are as follows:

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[10] A summary of the State costs associated with these and other recommendations is presented in the next chapter. A more detailed breakdown of the costs for the recommendations to improve the public service delivery system can be found in Appendix G.

1. Expand the provision of preventive care to low-income children

As noted in Finding #9, in 1989 only about 22,000 of the State's 135,000 uninsured children and low-income children without coverage of well child care received preventive services through the child health centers and community health centers. This recommendation would provide the additional funding required to provide preventive services to an additional 15,000 predominantly school-aged and adolescent low-income children who are not eligible for Medicaid. Coverage of these new children would be phased in over a four year period at a current year cost of $110 per child, or $1.65 million for a fully implemented program.

2. Expand the State's current voucher program to provide acute care services to additional low-income children

To assure follow-up care for sick children, the state should expand its current voucher program (appropriated at the level of $450,000 for FY 1991) to cover the additional 15,000 children receiving preventive care under the previous recommendation. Only about 70% of these newly eligible children are expected to be uninsured (the others would have private coverage for acute care), so the additional costs of covering 15,000 new children would be $462,000 ($88 per case for the 5,250 uninsured children estimated to be referred to follow-up care) at full implementation in year four.

3. Expand the voucher program to cover injuries and chronic illness

The state's current voucher program excludes payment for injuries and chronic illness. To add injury services for current uninsured clients of Child Health Centers would cost about $225,000 ($100 per case for the 2,250 children estimated to need treatment for injuries). To provide them to the newly eligible groups of uninsured children would cost about $236,250 ($150 per case for 1,575 children) when the program is fully operational in the fourth year.

Treatment of chronic illness for currently uninsured CHC clients would cost about $22,500 ($300 per case to cover an estimated 750 chronically ill children). To cover chronic illness among the newly eligible groups of uninsured children would cost about $157,500 ($300 per case for 52 children).

4. Increase operational support for the expanded voucher program

The Department of Public Health staff have also estimated the need for approximately $90,000 in additional funds to administer the expanded voucher program, $30,000 to process claims for the current program, $30,000 as the program expands to cover additional services for injury and chronic illness, and $30,000 to cover 15,000 new children. Administrative costs include the processing of thousands of small claims. These funds would support administration for the entire program ($450,000 for the FY 91 program plus the $1.3 million expansion) and would represent about 5% of total care costs.

It should be noted that enhancing efforts to assure that all children eligible for Medicaid are enrolled should bring new federal revenues into the state. It is estimated that about 15% of the newly eligible children (primarily older children not now served by the centers) may become eligible for Medicaid. Child Health Centers receiving these new Medicaid funds would then be able to expand coverage to several hundred more low income, uninsured children.

On the other hand, it also must be noted that there are several impediments to significantly increasing Child Health Center capacity: the shortage of pediatric nurse practitioners and dieticians in many areas of the state; the physical space in which many child health clinics are located; the need to upgrade tracking systems to meet additional capacity and new case management responsibilities; and the potential resistance of the medical community to Child Health Center expansion. To address these problems, the Department of Public Health should assist centers in locating personnel and upgrading tracking and referral systems.

B. Actively pursue additional federal funding for one or more ambulatory community health centers in underserved areas of the state. Although federal funds for Community Health Centers have been limited in recent years, the Department of Public Health and other officials have discussed a possible grant application with the U.S. Public Health Service (PHS). There is optimism that the PHS may entertain an application for a new Community Health Center, possibly in western Iowa or in conjunction with a rural hospital. Additional state resources would be needed to develop such an application. A successful grant application requires coordinating local support among a core group of community leaders; some community needs assessment and health personnel assessment; strategic planning for primary care delivery; and development of the application with detailed administrative and programmatic description. Such an application could be expected to take about

two years and cost $50,000 per year, some of which might potentially be raised from the private sector, but some of which might need to be state resources.[11]

C. Improve coordination and integration of public programs. To obtain maximum Federal matching funds and assure that as many persons eligible for Medicaid as possible are enrolled in the program, the Department of Human Services should:

1. Expand Medicaid outreach activities to identify more eligible individuals, including eligibility coordination with Maternal and Child Health Centers, Rural Health Clinics, and Community Health Centers, preparation of a video on eligibility processing (for use by M/CH enters and other interested agencies), and the development of brochures for consumers and providers on Medicaid;

2. Outstation eligibility workers in selected public clinics, hospitals, community health centers and Maternal and Child Health Centers;

3. Consider changing Medicaid's name to lessen its welfare connotations;

4. Develop a public media campaign for the expanded Medicaid program; and

5. Increase efforts to enroll eligible children in Medicaid's preventive program for children, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, including the distribution of information on the program through the school system.

A first-year budget of approximately $300,000 is assumed for these efforts, of which half could be financed with federal Medicaid matching funds. As has been the experience in other states, this estimate assumes substantial contributors from the private sector in the form of donated TV and radio air time for public service messages, etc.

D. Simplify the Medicaid application process. Medicaid currently uses an integrated application form that collects information needed to determine an applicant's eligibility not only for Medicaid, but also for a number of other publicly supported programs, including WIC and Food Stamps. However, an often-cited barrier to getting people through the Medicaid enrollment process is the length and complexity of this form.

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[11] A recently successful CHC grant application in metropolitan Denver cost over $100,000 to develop.

The Department of Human Services should consider assessing the relative benefits of using this comprehensive form compared to a streamlined one that might increase overall Medicaid enrollment and allow new recipients to apply for other benefits once they are in the system. The possibility of designing a demonstration that would examine the effectiveness of alternative approaches in several different sites should be considered. Federal support for such a demonstration should also be explored.

E. Review the state's process of contracting with M/CH Centers. The Department of Public Health should consider the following:

1. Improving the coordination of related services (WIC, prenatal care, child health care) through mechanisms such as a single contract for such services, co-location, or other means of coordination. WIC contracts are combined with existing M/CH contracts, and this strategy should continue. While state contracts for these services evolved due to traditional patterns of community interest and service, they may not today represent the best means of delivering related services to the target population. The Department should closely examine its contracting agencies and determine how care can be delivered in the most efficient and effective manner to meet local needs.

2. Require applicants for M/CH contracts to identify and propose means to address community needs. The Department should take a more active role in helping communities, including its M/CH contractors and other interested agencies, to assess community health needs and develop plans for meeting them with both private sector and public sector strategies. This is consistent with its new responsibilities under OBRA 1989 and with a new federal grant the Department has received to conduct community needs assessments in two areas of the state in order to develop primary care systems there. The objective of these needs assessments is to identify services, personnel, and providers currently available, capacity for expansion, and training needs. Rather than duplicating current activities, the Department could assist counties already undertaking health needs assessments to include a focus of maternal and child health by developing protocols to assure standardized and high quality analyses and by full or partial funding of such activities. It could also assist local agencies by coordinating current assessment activities and planning processes.

The Department estimates the costs for this needs assessment to be about $110,000 per year for two years, during which time all 22 M/CH Center services areas would undergo needs assessments resulting in a plan to care for all low income children in each area using private and public sector resources.

3. Enhance M/CH Center participation in Medicaid outreach. The Departments of Public Health and Human Services are currently undertaking a pilot to train M/CH center staff in Medicaid outreach activities. The results of this project should be monitored and an appropriate strategy replicated throughout the state.

4. Enhance Child Health Center outreach. Children under age six have been the primary client population of Child Health Centers. To encourage more use of these centers by school-age children and adolescents will require new kinds of outreach activities aimed at these hard-to-reach groups. Activities could promote the need for preventive care and health risk reduction as well as care for acute conditions. Promotion campaigns could use media popular to children and youth and their families, particularly television, and could also include printed materials, radio, PSA's and community events. Department of Public Health staff estimate that such an outreach program would cost about $60,000 per year.

F. Require M/CH contractors to meet performance standards. Consistent with its new data collection responsibilities under OBRA 1989, the Department of Public Health should consider requiring that M/CH Centers meet specific standards for contract renewal. These standards would be developed during the process of community needs assessments discussed above and could include such elements as:

1. Identification of women and children potentially eligible for Medicaid;

2. Actively providing assistance in completing Medicaid applications;

3. Follow up to determine numbers of clients who were potentially eligible for Medicaid, who were assisted, who actually applied, and who were ultimately enrolled; and

4. Community needs assessment, problem identification, and attempted problem resolution.

A more detailed listing of potential standards prepared by Department of Public Health staff can be found in Appendix G.

The costs of training M/CH staff in these new responsibilities is estimated to be about $50,000 per year in the first two years, with that amount declining in later years. Department responsibilities to monitor contract performance and track M/CH clients are estimated to cost $100,000 in the first year, increasing to $150,000 in the second year and $200,000 in the third and fourth years.

G. Improve the integration of multiple initiatives targeted to vulnerable children.

Given its finding that there is a need to strengthen the coordination of multiple initiatives and programs targeted to particularly vulnerable children (see Finding #9), the Task Force recommends that the Iowa Department of Public Health, Human Services, Education, and other involved entities should seek to improve the coordination of their resources and activities in the planning and implementation of the following initiatives: the CASSP program, M/CH services for children with special health needs, the provisions of P.L. 99-457 Part H and P.L. 99-661, child welfare efforts, and the state's Medicaid EPSDT program.

H. Further examine the health personnel shortage issue. Although a number of state and private agencies are studying various aspects of the health personnel shortage problem, there is no central coordinating agency that can conduct targeted studies of personnel need, pull together the efforts of these various agencies, collate and analyze data, and propose solutions to the problem. Department of Public Health staff estimate the cost for this activity to be about $63,000 in the first year, declining to about $42,000 in the fourth and subsequent years.

A summary of state expenditures associated with the specific measures included in this recommendation can be found in Appendix H. However, the Task Force further recommends that prior to the expenditure of any funds appropriated as a result of this recommendations, the Department of Public Health (and, as appropriate, the Department of Human Services) develop a detailed workplan of the specific activities to be carried out with such funds (including timeframes and milestones to be reached) and submit these workplans to the appropriate committees within the General Assembly.

RECOMMENDATION # 3

Authorize Medicaid to contribute toward the premium for employment-based coverage of otherwise eligible persons, including dependents, when such arrangements prove cost-effective.

As noted earlier in this report (See Finding # 5), the Task Force found evidence that a significant number of uninsured low-income children might live in households in which their parents had access to employer-based dependent health care coverage, but were unable to purchase it because they could not afford their portion of the premium.

The Task Force considers it appropriate public policy to assist low-income families to obtain employment-based dependent coverage when it is available. This position was reflected in its earlier endorsement of an application submitted by the Iowa Department of Human Services to the U.S. Health Care Financing Administration that would have allowed the State to conduct a special pilot program to extend Medicaid to children above its current eligibility levels and to use Medicaid funds, when appropriate, to cover the employee portion of the premium cost of employment-based dependent health care coverage. (Authorization for these pilot programs was subsequently awarded on a competitive basis to only three states. Iowa was not one of the awardees.)

The issue of coordinating Medicaid with available employment-based coverage was also addressed in the recently passed federal Omnibus Budget Reconciliation Act of 1990. A provision of that statute requires that state Medicaid programs begin purchasing employment-based group health insurance for Medicaid recipients when such arrangements prove to be cost-effective.

The Task Force encourages the Iowa Department of Human Services to implement this new requirement as expeditiously as possible, while at the same time encouraging the Department to develop mechanisms for coordinating these coverages that adhere to

the Task Force's principle of designing approaches that minimize the administrative burden imposed on employers, employees and their families, and the State.

The Task Force further encourages the Department to use this new federal requirement as an opportunity to design mechanisms to coordinate not only Medicaid and employment-based coverage, but also to:

- Coordinate between available employment-based dependent coverage and other public program coverage, including the state program for low-income children proposed under Recommendation # 2; and
- explore the possibility of developing a cost-effective mechanism for providing other forms of assistance, including direct subsidies, to non-Medicaid eligible low-income workers unable to afford dependent coverage.

RECOMMENDATION #4

Extend Medicaid coverage to aged, blind, and disabled persons with incomes at or below the federal poverty level and above the income eligibility level for the federal Supplemental Security Income (SSI) program.

Covering this optional eligibility group would extend Medicaid coverage to approximately 1,000 poor persons with high health care needs who are not currently covered for the full range of Medicaid benefits. It would also provide categorical Medicaid coverage to approximately 4,200 persons currently being covered under the program's medically needy "spend down" provisions. The annual cost of these new eligibles is estimated to be $3.2 million, of which approximately $1.2 million would be state dollars and the remainder federal matching dollars.

RECOMMENDATION # 5

Enact regulatory reform measures to correct problems in premium setting practices in the small group health insurance market.

As described earlier under Finding # 4, a number of problems in the current small group health insurance market make health care coverage unattractive to many small businesses. These problems include:

- Premium levels charged by the same insurer that may vary widely across firms with similar employee characteristics and utilization experience.

- Premium setting practices that result in many small businesses being offered very attractive first year rates, but then being hit by double -- or even triple -- digit increases in their premium costs in the following years. These staggering increases cause many businesses to not enter the market in the first place, drop their coverage, or switch to another carrier. The switching or "churning" that occurs only leads to further instability in the small group market and increases in premium costs because of the administrative expense associated with constantly re-enrolling these businesses.

- Insurers dropping some small businesses without notice or refusing to renew their coverage because of their claims experience.

A number of organizations, including the National Association of Insurance Commissioners (NAIC), have been working to develop a package of regulatory reform measures that would enable states to address these problems. At its September, 1990 meeting, NAIC approved an "exposure draft" of model state legislation concerning regulatory reform of premium rating practices. (A copy of this exposure draft is presented in Appendix I.) It is expected that NAIC will vote to adopt this draft regulatory reform

proposal, with perhaps minor modifications, as its official model legislation at its December 1990 meeting.

The content of this draft is consistent with provisions identified earlier by the Task Force at its June Meeting for addressing inappropriate rating practices in Iowa and reducing the volatility of health care premiums paid by small businesses. Specifically, the draft legislation being finalized by NAIC, which will apply to insurance sold to businesses of 25 or fewer employees, includes provisions in the following areas:

- Rating restrictions that:
  - limit annual premium increases faced by individual small businesses; and
  - limit the variation in premium rates charged to different types or classes of small businesses.
- Guaranteed renewability requirements that prohibit insurers from dropping specific small firms because of their claims experience.
- A requirement that insurers disclose their premium rating practices and renewability provisions to small businesses.
- A requirement that insurers maintain their records in proper order and submit an annual statement certifying that the rates they charge small businesses are actually sound and comply with all the above requirements.

Therefore, the Task Force:

- Endorses the provisions of the NAIC exposure draft; and
- Recommends that the Iowa General Assembly enact legislation implementing the NAIC model legislation. Should the final model legislation (which will not be available until after the Task Force's final meeting) differ significantly from the exposure draft, the Task Force further recommends that the Iowa Insurance Commissioner submit a brief report to the General Assembly that (a) identifies these differences, (b) assesses the potential impact of these changes in

Iowa, and (c) recommends whether these new changes should be adopted.

The adoption of the provisions of the proposed NAIC model legislation would have a negligible cost impact on the State of Iowa but could be expected to improve the affordability and stability of health care coverage for many small businesses within the state.

RECOMMENDATION # 6

Establish a state reinsurance program to ensure the availability of health care coverage to all small businesses and their employees.

Although the regulatory reform measures included in the previous recommendation can be expected to improve the small group market, they cannot ensure that all small businesses interested in obtaining coverage for their employees will find such coverage available to them. As was found in Health Systems Research, Inc.'s survey of health insurers operating in Iowa, most, if not all insurers, engage in medical underwriting to assess the risks associated with each small business. Many small businesses that may have one or more employees with high medical needs may find themselves unable to purchase coverage for that employee or perhaps for all of their workers. In some cases, insurers may consider all businesses within particular categories (e.g., barbers or health care institutions) to be unacceptable risks and refuse to sell coverage to any business in these categories.

To address this problem, the Task Force considered the option of a state-established reinsurance pool through which all small businesses would be able to purchase coverage and in which all insurers selling to small businesses would be required to participate. In general, under this reinsurance pool approach, insurers selling to small businesses would not be permitted to refuse to cover certain types of small businesses or specific firms with one or more high risk employees. Furthermore, the additional cost

of insuring high cost individuals is not borne solely by firms that employ these individuals, but is spread across a larger number of businesses. The establishment of such a reinsurance mechanism can be expected to increase the availability of health care coverage to small businesses with one or more employees with high health care needs.

The National Association of Insurance Commissioners is currently involved in developing model legislation to guide states in developing such a pool. NAIC has not yet completed work on its recommended specifications for a reinsurance mechanism, but is expected to have an initial report on the subject prepared for its December, 1990 meeting, with model legislation drafted by mid-summer of 1991.

Given the complexity of the issues involved in the development of a state reinsurance pool for small businesses and the significant resources that are being devoted to the development of the NAIC proposal, the Task Force recommends: (1) endorsing certain principles to be included in a state-authorized reinsurance mechanism, and (2) supporting the enactment of the NAIC model legislation when it is completed, assuming that it adheres to these principles.

More specifically, the Task Force's position on this issue includes:

- Support of state legislation that will:
  - eliminate multiple waiting periods for pre-existing conditions for persons switching carriers without a break in their coverage;
  - prohibit insurers selling to small businesses from blacklisting certain industries or refusing to offer coverage to high risk employees; and
  - establish a state reinsurance pool for small businesses that will:

- -- place a limit on the premiums that can be charged small businesses with one or more high risk employees; and

- -- spread any additional costs associated with this coverage across broader base of businesses.

- Recommend that the NAIC model legislation be used as the legislative vehicle for these new requirements, assuming that the model legislation includes all of the above provisions and pending the review and comment on the final NAIC model by the Iowa State Insurance Commissioner.

RECOMMENDATION #7

Keep the focus on health care reform until universal coverage becomes a reality.

As noted earlier in this report, one of the most important conclusions reached by the Task Force is that significant systemic changes must be made to our current fragmented health care financing structure if access to needed care is to be provided in a rational and affordable manner (see Finding #10).

Indeed, it is the Task Force's view that we must move toward a universal system of health coverage because the current mixture of public, employer, and individual financing, by its very nature, almost inevitably creates coverage gaps for some people, particularly when employment status changes. It is the Task Force's further view that, while ultimate responsibility for enactment and implementation of policies creating universal access to needed health care must rest at the federal level, the pressure for change, and perhaps the first steps toward major system reform, must spring up from the state and local level.

The Task Force recognizes that the fundamental restructuring of our current health care financing system into one that is more equitable, efficient, and rational represents a

task of heroic proportions. It is not a matter of dollars in the absolute sense, since it is the Task Force's belief that there are sufficient inefficiencies in the current system which, if corrected, could in large measure offset the additional expenditures associated with providing universal access to needed care. Rather, it is more a matter of major shifts in the distribution of the responsibility for financing health services. For example, the establishment of a publicly administered health care financing system would relieve employers of the significant costs associated with providing employee health benefits but would require a substantial increase in public tax revenues to finance such a system[12].

The Task Force recognizes that the challenges to be faced in making universal health care a reality are certainly daunting, but not unsurmountable. It also understands that overcoming these challenges may take significant time and effort. In fact, it was in recognition of the time required to achieve consensus on major health care reform that the Task Force adopted the first six of its recommendations. While these recommendations seek to improve upon the current fragmented system rather than establish a major new approach to health care financing, it is hoped that they represent measures around which political consensus can be developed rapidly and which will address the very real and pressing needs of vulnerable and underinsured persons in Iowa today. One other possible recommendation on which the Task Force focused considerable attention, but around which it was unable to reach consensus, involved a "pay or play" proposal which, beginning in 1994, would require Iowa businesses with ten or more workers to either provide health care coverage to their employees or contribute

[12] It is estimated that the costs of providing health care coverage to the 220,000 uninsured persons in Iowa would be approximately $147 million. This represents less than a 4% increase in the estimated $3.9 billion being spent in 1990 for Iowa's non-elderly population. If health care spending for all Iowans is considered, including the State's elderly population, the estimate of 1990 spending is $6.6 billion. The incremental cost of covering the State's uninsured figure represent approximately 2% of this amount.

to a new payroll tax. (More detailed information on the "pay or play" proposal considered by the Task Force is presented in Appendix J.)[13]

Nonetheless, perhaps the Task Force's most significant long-term contribution to the improvement in the health care system, in Iowa and across the country, is the adding of its voice to the call for the enactment of a system of universal health care access. The Task Force strongly encourages a continuing and significant dialogue among citizens, policymakers, and health care providers in Iowa to discuss and identify the preferred form of a universal system and, in the absence of a successful initiative at the federal level, to push for enactment of such a system at the state level.

The Task Force believes that the results of its deliberations found in this report, including its findings, guiding principles, and recommendations, provide a context within which the dialogue in Iowa can be framed. However, they represent only a starting point. Only with continued discussion of the issues and strong grassroots involvement will the goal of universal health access become a reality for all Iowans.

The Task Force recommends that the State take responsibility for continuing this dialogue through the establishment of a broad-based "Universal Health Care Access Commission" that would remain in operation until its goals are attained and that seeks grassroots community involvement at all stages of its deliberations.

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[13] An analysis of th implications of the provisions of the federal Employee Retirement and Income Security Act of 1974 (ERISA) with respect to state "pay or play" strategies can be found in Appendix K.

IV. COST SUMMARY

Presented in the table on the following page are estimates of the cost to the State of Iowa to implement the Task Force's recommendations. These estimates cover a four year period beginning in 1991 and ending in 1994 and are presented in constant dollars.

TABLE V-1.
SUMMARY OF STATE OF IOWA COSTS ASSOCIATED WITH IMPLEMENTATION OF TASK FORCE RECOMMENDATIONS
(In Constant Dollars)

RECOMMENDATION	1991	1992	1993	1994
1. Public Program Covering Non-Medicaid Children <133% Poverty low - ambulatory services only high - Medicaid-like benefits	$500,000 - $750,000	$1,030,000 - $2,140,000	$1,560,000 - $3,530,000	$2,090,000 - $4,920,000
2. Delivery System Improvements (for further details see Appendix H)				
a. Expanded preventive services	$110,000	$550,000	$1,100,000	$1,650,000
b. Expanded Voucher Program	$554,000	$795,250	$1,110,500	$1,395,750
c. Medicaid Outreach*	$111,000	$111,000	$111,000	$111,000
d. Community Assessment	$315,000	$365,000	$285,000	$280,000
e. CHC Application	$50,000	$50,000	-	-
f. Personnel Shortage Coordination	$63,000	$48,000	$43,000	$42,000
Subtotal, Recommendation 2	$1,203,000	$1,919,250	$2,649,500	$3,478,750
3. Examine Potential for expanding Medicaid/Private Sector Coordination	Minimal Additional Cost to State			
4. Regulatory Reform of Insurance Rating Practices for Small Groups	Minimal Additional Cost to State			
5. State-sponsored Reinsurance Program for Small Businesses	Minimal Additional Cost to State			
6. Continued Activities Regarding Health Care Reform	$200,000	$200,000	$200,000	$200,000
Total, all Recommendations	$1,903,000 - $2,153,000	$3,419,250 - $4,259,250	$4,409,500 - $6,379,500	$5,768,750 - $8,598,750

* State Match Only

Appendix A .

TASK FORCE MEMBERSHIP

MEMBERSHIP
OF
HEALTH CARE EXPANSION TASK FORCE

Senator Charles Bruner
Ames, Iowa
Co-Chairperson

Senator Joy Corning
Cedar Falls, Iowa

Senator William Dieleman
Pella, Iowa

Senator Jean Lloyd Jones
(Member May 1989 - June 1990)

Senator Elaine Szymoniak
Des Moines, Iowa

Senator Maggie Tinsman
Bettendorf, Iowa

Mary Bergstrom
Des Moines, Iowa

Vivian Bovenmyer
Garner, Iowa

Janet Burch
Urbandale, Iowa

Steve Gleason, D.O.
West Des Moines, Iowa

Representative Tom Fey
Davenport, Iowa
(Member and Co-Chairperson,
May 1989 - October 1990)

Representative Patricia M. Harper
Waterloo, Iowa
Co-Chairperson
(October - November 1990)

Representative Dolores M. Mertz
Ottosen, Iowa

Representative Lee Plasier
Sioux Center, Iowa

Representative Bill Trent
Muscatine, Iowa

Myron Linn
Pella, Iowa

Dave Neil
Waterloo, Iowa

Mary Noland
Adair, Iowa

Robert Richard
Independence, Iowa

Appendix B .

INDIVIDUALS/ORGANIZATIONS CONTACTED BY THE TASK FORCE AND ITS CONSULTANT

ORGANIZATIONS CONTACTED BY THE TASK FORCE AND ITS CONSULTANT

Allen Women's Health Center, Waterloo

American Home Finding Association, Ottumwa

Broadlawns Hospital

Child Health Center, Blackhawk County Board of Health

Governor's Blue Ribbon Commission on the Uninsured

Health Policy Corporation of Iowa

Iowa Blue Cross and Blue Shield

Iowa Department of Social Services

Iowa Department of Employment Services

Iowa Department of Management

Iowa Department of Public Health

Iowa Department of Revenue

Iowa Farm Bureau

Iowa Governor's Office

Iowa Hospital Association

Iowa Insurance Commissioner's Office

Iowa Medical Society

Iowa State Association of Counties

National Federation of Independent Businesses/Iowa

North Iowa Community Action Organization, Mason City

Peoples Community Health Center, Waterloo

Polk County Health Department

Polk County Health Services

Principal Financial Group

University of Iowa Hospitals and Clinics

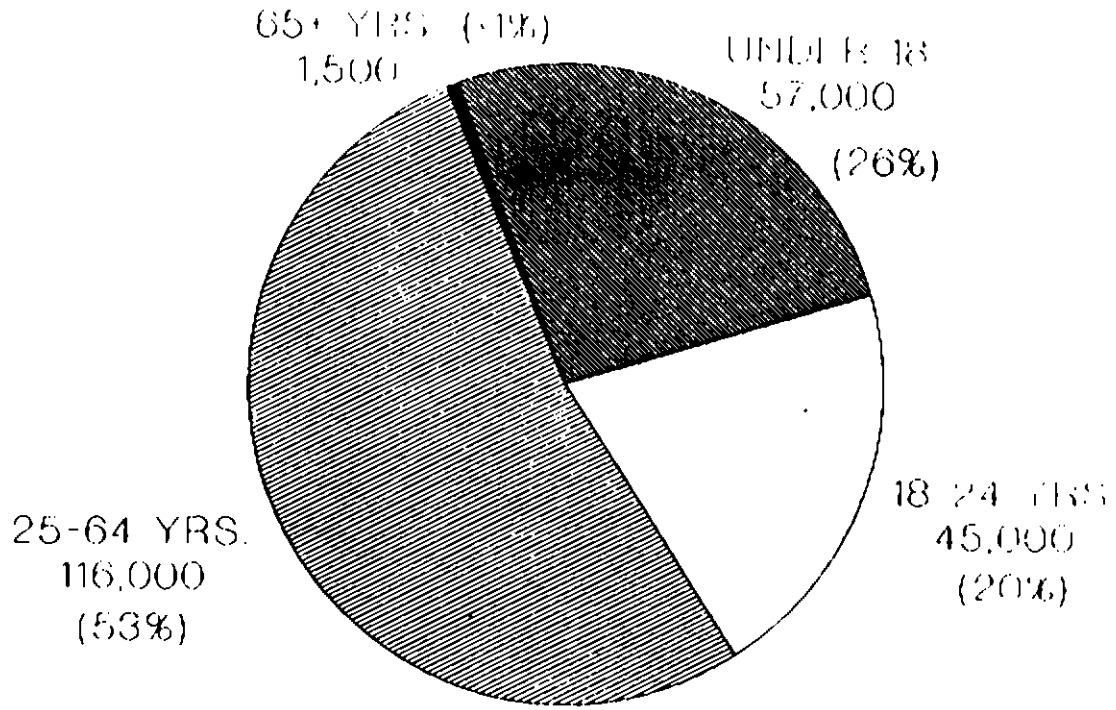
Warren County Health Department

Webster County Public Health Nursing Service, Fort Dodge

Appendix C .

CHARACTERISTICS OF IOWA'S UNINSURED POPULATION

UNINSURED IOWANS:
By Age

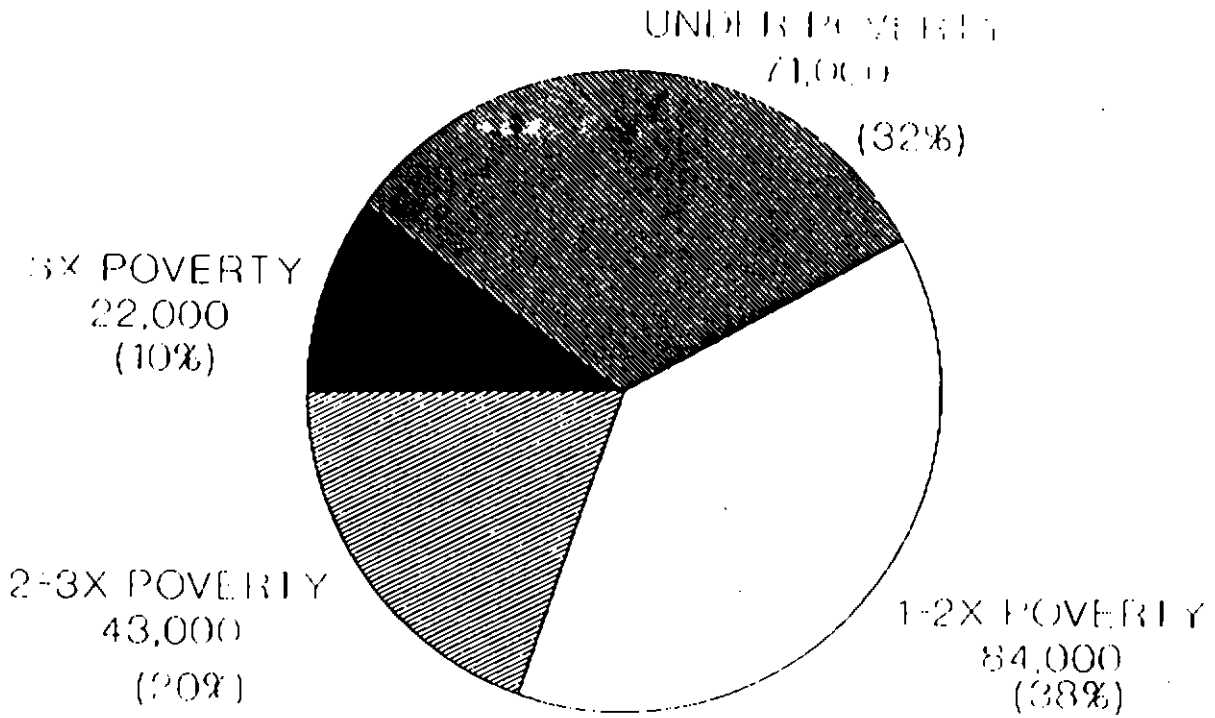


Source: Health Systems Research, Inc.
Analysis of March, 1989 CPS

1988 FEDERAL POVERTY GUIDELINES

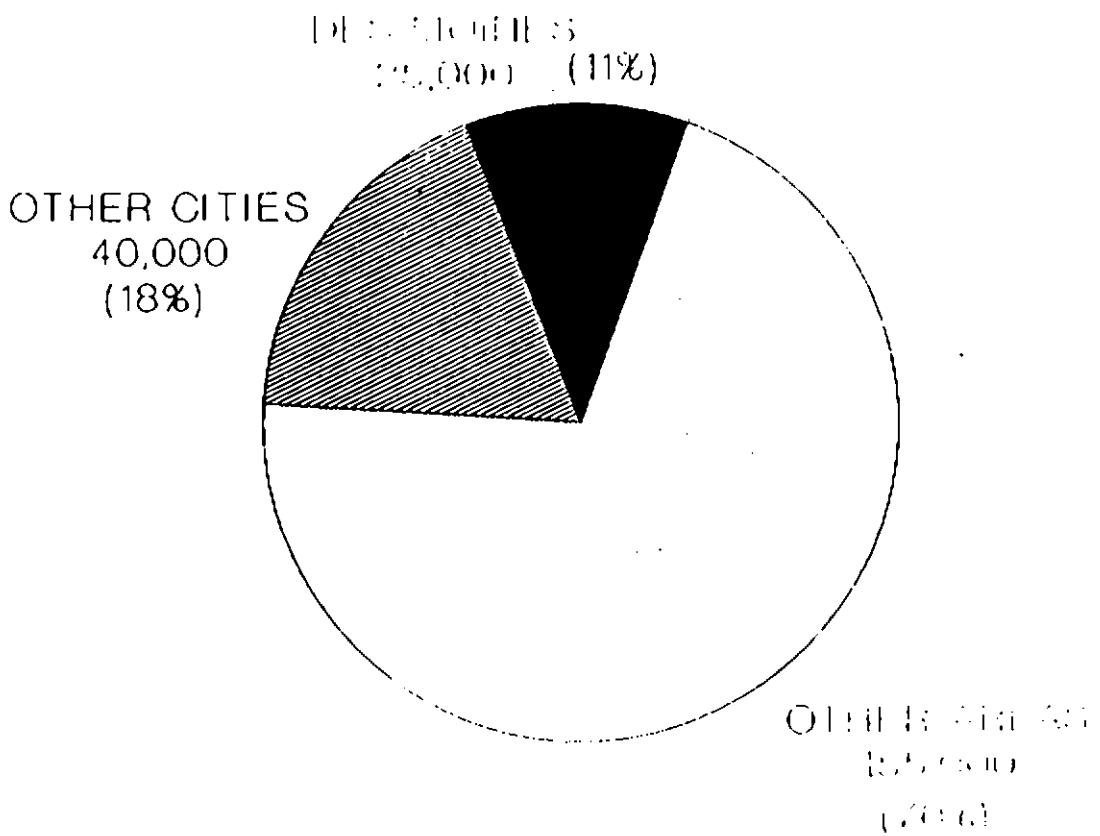
HOUSEHOLD SIZE	ANNUAL INCOME
1	$ 5,770
2	$ 7,730
3	$ 9,690
4	$11,650

UNINSURED IOWANS:
By Poverty Status



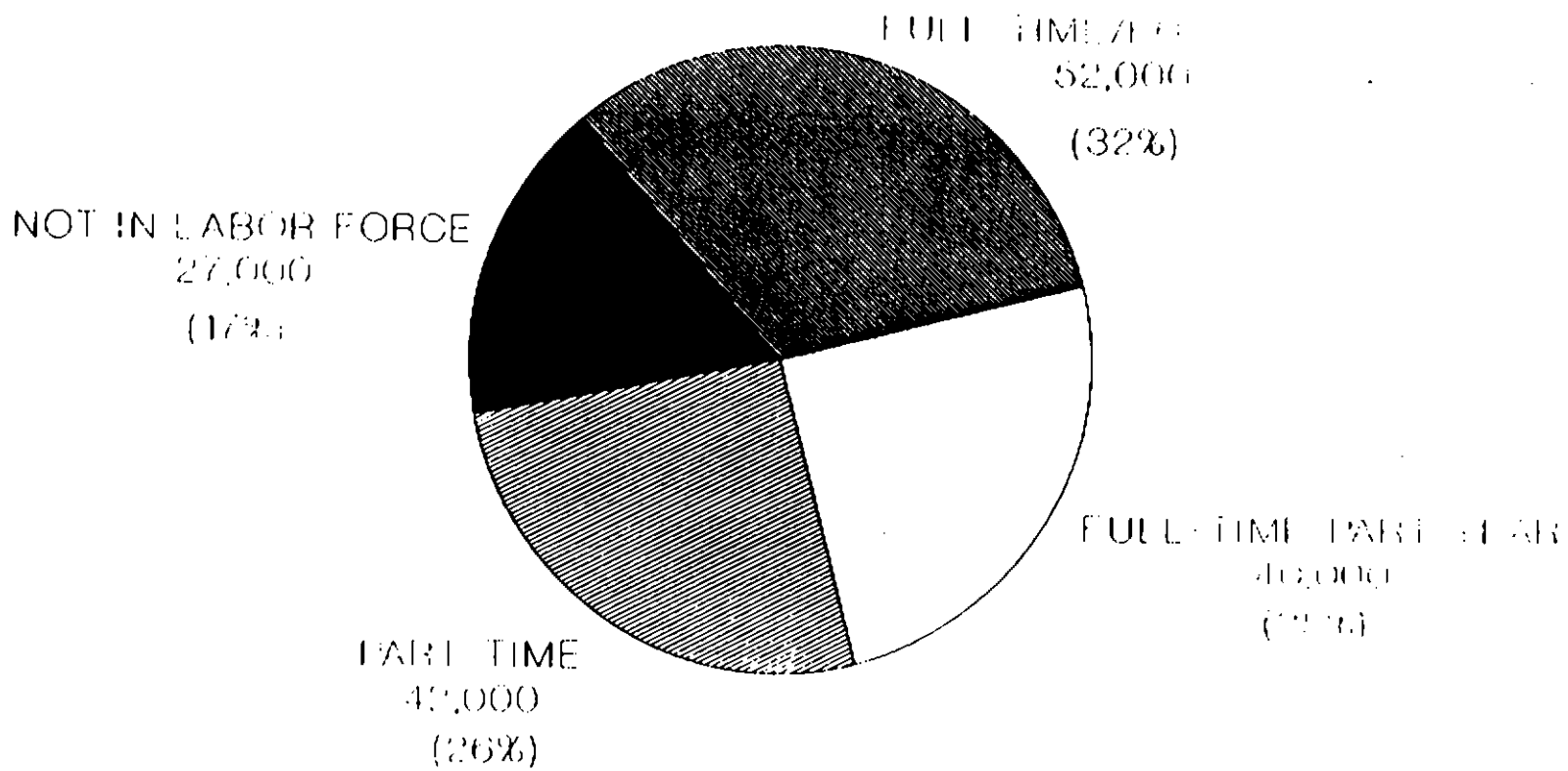
Source: Health Systems Research, Inc.
Analysis of March, 1989 CPS

UNINSURED IOWANS:
By Place of Residence



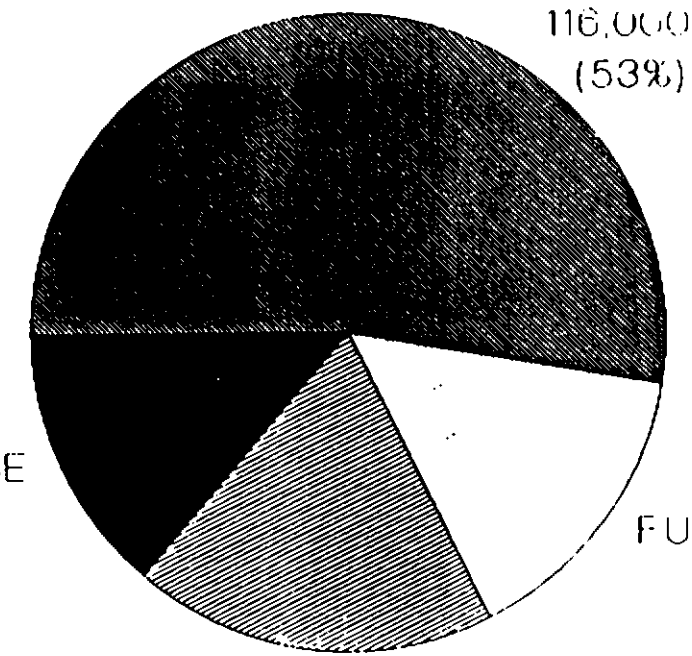
Source: Health Systems Research, Inc.
Analysis of March, 1989 CPS

EMPLOYMENT STATUS OF UNINSURED IOWANS:
Ages 18-64
(N=161,000)



Source: Health Systems Research, Inc.
Analysis of March, 1989 CPS

DISTRIBUTION OF UNINSURED IOWANS:
By Employment Status of Family Head
(N=220,000)



FULL-TIME/PART-YEAR
116,000
(53%)

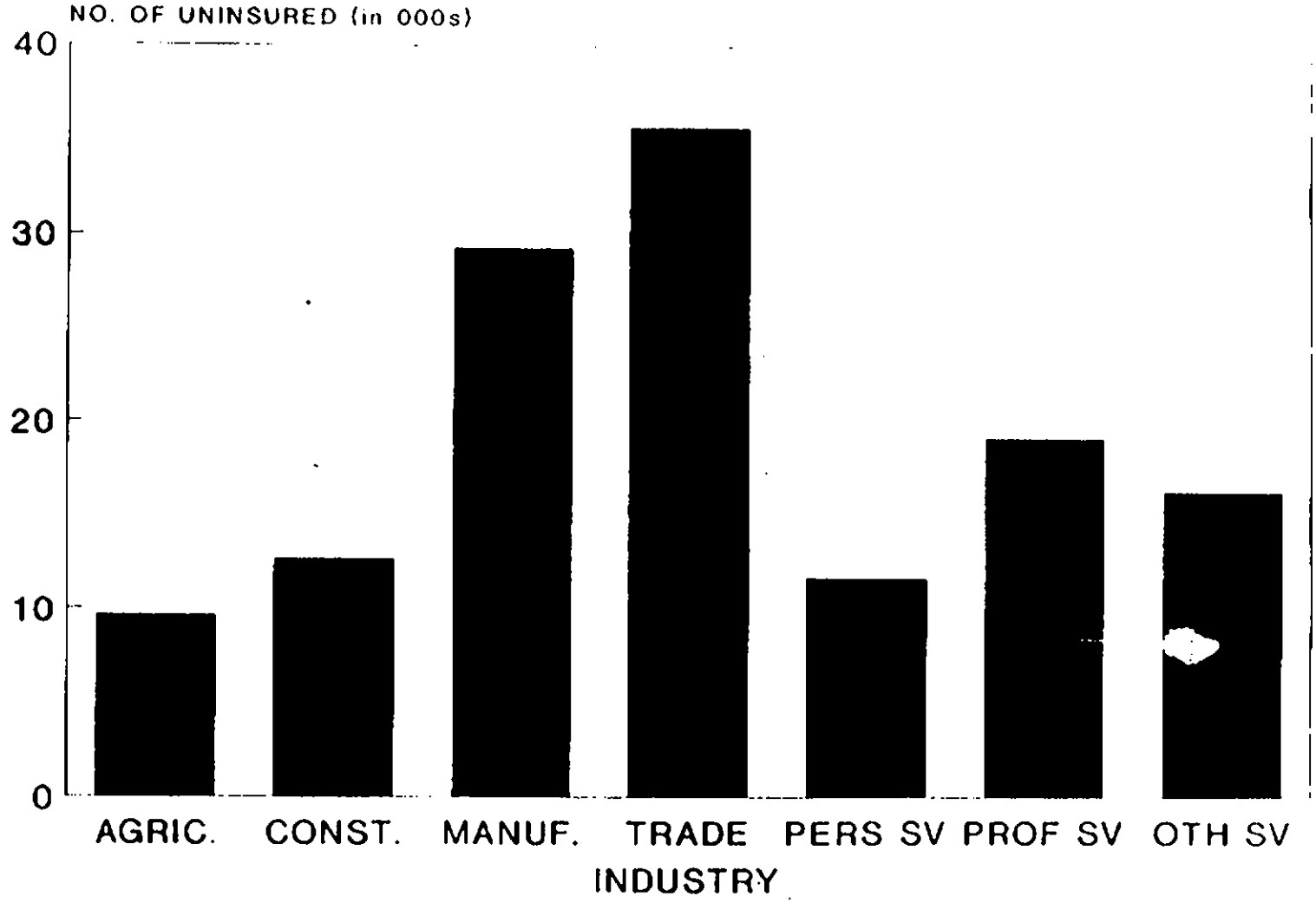
NOT IN LABOR FORCE
30,000
(14%)

FULL-TIME/PART-YEAR
33,000
(15%)

PART-TIME
41,000
(19%)

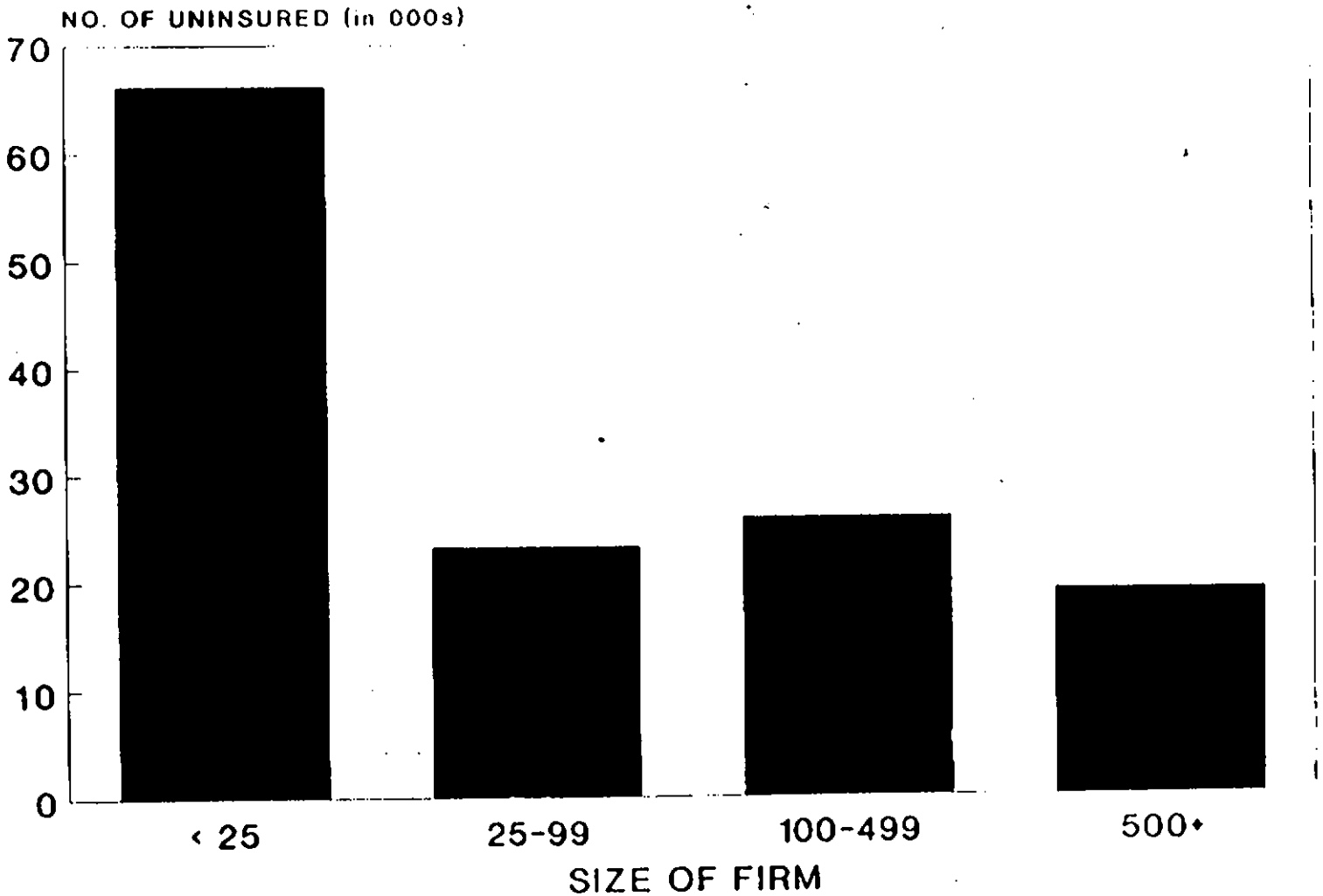
Source: Health Systems Research, Inc.
Analysis of March, 1989 CPS

UNINSURED WORKERS IN IOWA:
By Industry



Source: Health Systems Research Inc.
Analysis of March, 1989 CPS

UNINSURED WORKERS IN IOWA:
By Size of Firm



Source: Health Systems Research, Inc.
Analysis of March, 1989 CPS

Appendix D .

OVERVIEW OF STATE OPTIONS FOR ADDRESSING THE PROBLEM OF HEALTH CARE ACCESS

Prepared by

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Health Systems Research, Inc.

INNOVATIVE PUBLIC AND PRIVATE SECTOR OPTIONS TO FINANCE HEALTH CARE

Most state and/or local governments have traditionally funded health care for various low income populations not eligible for Medicaid and several states are developing innovative public and public-private sector programs for the uninsured. These new strategies can be divided into purely public sector programs and those sharing the health care financing responsibility with the private sector, particularly employers. In addition to health care financing, states are also considering health insurance regulation to redress some of the aberrations in the small group health insurance market.

A. Public Programs

In the past decade, as the number of uninsured Americans has grown, most states have studied their uninsured populations. Rather than expand their traditional indigent health care programs, many states have developed new public or public-private programs sector to serve the uninsured.

1. Medicaid Expansion

Using Medicaid to expand health care financing for certain low income groups has the advantage of sharing the expense with the federal government. Between 1981 and 1987, three dozen states, including Iowa, expanded Medicaid eligibility by adopting optional eligibility groups, particularly pregnant women and children. Several states added "Medically Needy" programs to cover people with the family, age, or disability characteristics of AFDC or SSI recipients but with higher incomes. The medically needy include people whose net income, after deducting high medical bills, falls below the medically needy eligibility level.

2. Medicaid Buy-In

A few states have enacted programs administered by their Medicaid agencies that permit low income people to "buy-in" to Medicaid through an income-related premium. Since they are funded exclusively with state funds, these programs can be designed flexibly to cover certain services or target populations (such as children or pregnant women). They also have the advantage of using the existing Medicaid administrative systems for processing client eligibility and provider claims. Programs targeting the working poor may, however, be more costly than sharing costs with employers through programs such as those described below.

- Minnesota covers children up to age 18 (and up to age 18 beginning in January 1991)with incomes below 185% of the federal

poverty line with a package of outpatient services; families pay $25/child/year to enroll.

- Vermont plans to provide a Medicaid package of services to pregnant women with incomes between 185% and 200% of the federal poverty line and children under age 6 with incomes between 133% and 225% of the poverty line.

- Maine will cover children in families with incomes under 125% of the poverty level and adults with incomes under 95% of the poverty level for Medicaid services other than nursing home or pregnancy care.

- Massachusetts, Maine, and Wisconsin cover low-income disabled workers needing insurance benefits not offered through the workplace or a supplement to workplace insurance for their special needs.

3. Public Subsidies for Private Insurance

Rather than use their existing Medicaid administrative systems, a few states have chosen to purchase health insurance for low income individuals through private sector insurers. Maine's buy-in program, described above, for instance, is designed to pay an employee's share of any workplace insurance plan that the state deems adequate. The other programs are piloting the feasibility of public subsidies for individual insurance coverage purchased from Health Maintenance Organizations (HMOs) or other managed care options. (For an outline of the features of these public programs, see appendix.)

- The Washington Basic Health Plan is a demonstration project based in seven sites designed to enroll up to 25,000 people with incomes under 200% of the federal poverty level into HMOs (or other managed care plans in rural areas). It is not employment-based; individuals can enroll and there is no mechanism for employer contributions. State premium subsidies vary by income. Because most enrollees have very low incomes, the state pays about 80% of the premiums.

- One of the Ohio insurance pilots covers people with incomes below 300% of the federal poverty level who leave AFDC for work; the state subsidizes on a sliding scale the cost of enrolling in an HMO and will pay up to 97% of the family premium.

- Three of the New York pilot projects subsidize HMO premiums for up to 9500 individuals with incomes under 200% of the federal poverty level; individual premium contributions cannot exceed 2% to 4% of gross income, so state subsidies will be 62% to 91% of premiums.

- One of the Massachusetts pilot programs subsidizes insurance for individuals if they have been without coverage for at least a year and have income under 300% of the federal poverty level.

- Connecticut has recently enacted a new program to subsidize the cost of private health insurance for children under 250% of the poverty level, pregnant women under 200% of poverty, and low income disabled individuals.

B. Innovative Indigent Health Care Programs: Public-Private Sector Programs

1. "Caring Foundation" Plans

Blue Cross Associations in several states have developed private sector programs to subsidize insurance covering outpatient services for low income children. Following the 1985 example of Blue Cross of Western Pennsylvania, Associations in Alabama, Iowa, Maryland, Missouri, North Carolina, Ohio, and Wyoming created Caring Foundation programs. These programs are usually funded by Blue Cross and private donations by corporations, civic groups, and individuals. Sometimes they require a small family contribution, but often they are free to families with incomes that range from 100% to 250% of the federal poverty line. They cover outpatient well and sick child physician visits and sometimes outpatient surgery but no inpatient care. Costs are kept low by negotiated discounts with physicians and other providers.

These programs generally involve no public funds. But Iowa's legislature appropriated $300,000 into a fund to match private donations at the rate of one state dollar for every two private dollars in FY 90, declining to 1:3 ratio in FY 91 and 1:4 ratio in FY 92.

A similar concept is under development in Colorado, where the legislature appropriated $650,000 of the state's indigent health care funds to match an equal private sector contribution that will fund outpatient services for children up to age 9 in families with incomes up to 150% of the federal poverty line. Families must pay an enrollment fee of $25/year/child.

These programs are too new to evaluate. However, public support for a "Caring Foundation" type program could enhance cost effective services to children, while

encouraging private contributions to an organized and reasonably comprehensive system of ambulatory care.

2. Positive Employer Incentives

Because over three-quarters of the uninsured are workers (most of them full-time) or their dependents, many states have considered expanding workplace insurance opportunities as a means to insure a large segment of the medically indigent population. This approach builds upon the existing tradition of obtaining insurance through the workplace and shares the cost of insurance among employers, employees, and state government. States can reduce an employer's insurance premium through tax credits, direct subsidies, aggregate premium reductions, sharing risk with insurers, buying innovative benefits and administrative assistance in plan development and marketing. Over a dozen states have undertaken such employer insurance incentive programs, most under the auspices of the Robert Wood Johnson Foundation's 3-year initiative on health care for the uninsured.[1] The programs generally focus on the full-time workers of small, uninsured firms. Most of these projects developed new insurance products with more liberal underwriting standards or preferred benefits than standard insurance in the marketplace. (For an outline of the features of each of these public programs, see appendix.)

- Employer Income Tax Credits. Six states (California, Kentucky, Massachusetts, Oklahoma, and Oregon) have enacted income tax credits for employers who offer and pay part of the premium for employee health insurance. The credits range from a lower of $15 to $25 per month or 20% to 50% of the premium. For fiscal reasons, all but Oklahoma's law limits the credits to firms that have not offered insurance for a specified period (12 to 36 months) and are of limited duration (2 to 5 years). Most of the laws also limit the credit to firms under 25 employees. Some require employers to contribute a specified percentage (25% to 75%) of the employee premium. The laws in Oregon and Oklahoma require that employers must buy insurance from the public pool in order to receive the tax credit. In all states but Oklahoma (where the credit it refundable), employers must have taxable income in order to take advantage of the credit. Only Oregon's credit has been in existence long enough to evaluate. In its first year

[1] Several of them are private sector efforts without public subsidies but with benefit design, managed care, or low cost providers to lower insurance premiums, which will be discussed below).

of operation it enrolled only about 1000 firms and 3800 employees and dependents into the state pool. It is thus hard to estimate whether such credits will induce a significant number of employers to offer health insurance compared to other more explicit premium subsidy strategies.

- Employer Insurance Premium Subsidies. The states of Michigan, Maine, Massachusetts, New York, Ohio, and Wisconsin have developed explicit premium subsidy demonstration programs. While each varies in detail, they are all designed to share in the cost of the premium for small employers, usually firms with under 25 employees, who pay a given percentage of the employee's premium. The programs in Michigan, Maine, Ohio, and Wisconsin target lower wage workers, usually those with family incomes below 200% of the federal poverty level. But those in Massachusetts and New York target the uninsured firm and subsidize premiums regardless of a worker's income. Because these are pilots with limited funding, all the programs restrict eligibility to firms without insurance for six to 18 months. Subsidy levels vary from as low as 5% of the premium in Massachusetts to 50% in New York (where employees pay no premium).

Explicit premium subsidies, particularly if targeted to low income workers, do involve administrative costs of processing income eligibility, a potentially time-consuming and costly endeavor. To avoid the eligibility determination process, Florida's small firm health insurance project reduces employer premiums by an aggregate payment to its HMO insurance partner and reinsurance to share risk of high cost cases. Together, these strategies lower premiums about 30% from market rates. This subsidy is applied to reduce family premiums more than individual premiums in order to encourage the purchase of family coverage. Arizona, Maine, and Massachusetts have also negotiated with their insurance partners risk sharing such as reinsurance or stop loss protection against high cost claims in order to lower aggregate premiums and make insurers more comfortable to enter the unknown territory of the small group market. Connecticut plans to lower small group premiums by waiving premium taxes on these products and pooling high risk cases through a state-sponsored reinsurance mechanism. These approaches lower premiums about 20% to 30% below standard market rates. While less costly to administer, they do not permit targeting subsidies to only lower income individuals and may therefore subsidize with public funds firms and individuals that could afford to pay more for insurance.

Another approach that many small firm insurance demonstrations are using to make insurance more affordable and available is assistance with the substantial administrative costs associated with selling small group insurance. Most of the projects have undertaken administrative chores, such as developing new insurance products, creating provider networks for managed care, paying for extensive marketing campaigns, processing employer and/or employee enrollment, and billing for premiums. Marke 'g to reach the small group market is especially costly, averaging $80 to $150 per enrollee in the first few years of program operation.

- Benefit Design. The small employer demonstration programs generally use HMOs, where available, but those using indemnity carriers prefer managed care systems that can control utilization and therefore expenditures. In some cases these projects have assisted insurers to develop managed care networks in rural areas where they have not previously existed. The projects also generally include outpatient and early preventive services (prenatal care, well child visits, immunizations) that are cost effective.

To encourage use of appropriate care while discouraging use of high cost or inappropriate care, some of the projects place high copayments on emergency room use. A few also place high cost sharing on hospital and sick care but waive copayments for preventive care. Because the enrollment target for these programs tends to be lower income families, cost sharing, if used at all, must be designed carefully so as not to deter use of necessary care, since even modest copayments can discourage low income families from using appropriate outpatient services.

Most states mandate that insurers provide or offer certain benefits to employee groups. Recognizing that some of these benefits may be costly and push insurance premiums over the brink of affordability for small groups, a few states have enacted laws to waive the mandated benefits if insurers participate in a small employer pool or otherwise provide approved coverage in the small group market. Kentucky, Minnesota, New York, Oklahoma, Oregon, Rhode Island, Virginia, and Washington have recently enacted such legislation. It is too early to evaluate whether waiving mandated benefits will lower premiums sufficiently to attract small employers. And depending upon the coverage changes, such policies may actually leave enrollees underinsured for needed services.

- Insurance Buying Pools. Small group health insurance can cost from 10% to 40% more than that for large groups. The extra costs are due to medical care use, insurers' medical underwriting expenses, marketing costs, employee turnover, customer service, and enrollee education. It is often assumed that aggregating many small employers into a

large group will approximate the same risk distribution as a large employee group. Unfortunately, as long as insurance enrollment is voluntary, insurers face the real threat of "adverse selection," the likelihood that people enrolling in a plan will need to use it. Experience suggests that merely pooling many small employers does not necessarily reduce premiums significantly. Pooling can reduce some administrative costs, such as marketing and enrollment processing, and thus may save 10% to 20% of premiums. But it cannot assure the same risk distribution of a large group.

Small group pools may, however, use the leverage of several thousand potential enrollees to bargain with insurers for innovative benefit design and managed care features. Many trade and business associations offer small group insurance products. Traditional association insurance pools have not tended to develop or negotiate innovative products, but most of the RWJF projects are attempting to do so.

- Experience with small group incentive programs. Despite high hopes that employer incentives would significantly decrease the number of uninsured workers and dependents, in the dozen projects under way for six to twenty-four months, enrollment so far has been modest. Consultants to the Task Force have estimated, for instance, that after two years of active enrollment, the subsidy programs will enroll between 3% and 10% of the target population (uninsured employers of small business) in the area where the pilots are operating. While this penetration rate is considered very good by health insurer standards, and over three to five years may increase somewhat, these incentives seem unlikely to solve the problem of the working uninsured to a significant extent.

Of the half dozen projects in operation long enough to evaluate, it appears that an employer's net aggregate premium (the total amount the employer pays for all employee and dependent coverage, not counting any amounts paid by employees or the state) must be reduced at least 30% below what the employer would pay in the general market for comparable coverage to attract employers. Thus, if a subsidy is targeted to low income employees only, the total amount of premium the employer pays for subsidized and non-subsidized employees must be substantially reduced by benefit design and/or indirect subsidies in order to be affordable.

Even to achieve such a penetration rate, a state must incur substantial marketing and development costs. Enrollment in the demonstrations has tended to be

very small groups (under 5 employees), perhaps because innovative insurance plans have been unavailable to them at any price. Reaching such tiny firms, however, is expensive and time-consuming.

Although employers may express a preference for choice among insurance plans, it appears that some prefer not to have to undertake the costs of such a search. The projects that offer a choice ' insurance from plans in the market have not so far been as successful as those that have contracted with a single insurer and have been able to negotiate benefit design features to lower premiums.

While employers have generally been the target of the initiatives for the uninsured, experience under Washington's Basic Health Plan suggests that marketing directly to individuals is much less costly ($1.50/enrollee) than marketing to employers ($80 to $150/enrollee). The very large public subsidy for low income enrollees may account for the enthusiastic reception that BHP has enjoyed. But it is clear that the price for having employers share one-half to one-third of the cost of insurance is the expensive and time-consuming process of marketing to the employer, for whom myriad factors contribute to the insurance purchasing decision, rather than directly to low income individuals. Besides its higher price tag, another disadvantage to the individual insurance approach is that it may provide a disincentive for employers to offer insurance. Washington is monitoring this issue as it evaluates its program over the next year.

Program costs of the demonstrations appear to be better than expected. Utilization of medical care has been equal to or better than that of larger groups of the insurance partners. While it is too early to be confident in these results, experience thus far seems to refute the insurance industry's conventional wisdom that small groups are poor risks. Administrative costs include marketing, which is substantial, and the costs of processing eligibility for premium subsidies in addition to modifying insurer billing systems to accommodate variable premiums.

Thus far, these pilot programs demonstrate that lowering the price of health insurance is necessary but not sufficient to increase insurance in the small group market significantly. Many firms eligible for the subsidies or low-cost products are still deterred by their cost. Employer surveys show that some proportion (probably 25% to 35%) of small employers would not participate in a voluntary program because they do not believe that health care financing is an employer's responsibility.

Furthermore, employer-based approaches are not likely to reach all uninsured workers. Omitted from these small group insurance projects are part-time and seasonal employees, who are generally either disqualified by insurer policy or unable to pay the larger employee share of premium for coverage. The substantial number of uninsured Iowans who work in large firms and who may be unable to afford their share of the employee or family premium are also not assisted by initiatives that target

small groups. Finally, these programs do not address the needs of those out of the workforce.

3. Negative Employer Incentives

Three states have enacted broad health care financing programs that are theoretically designed to make insurance available to most state residents. These programs include a mix of public and private sector participation.

Since 1974 Hawaii has required[2] all employers to cover employees working at least 20 hours/week with a defined (typical major medical) insurance program for which the employer pays at least 50% of the premium. The law reduced the uninsured population from 5% to 1.8%. Since the number has recently risen, however, the state has recently developed a publicly-subsidized insurance pool for uninsured Hawaiians below 300% of the federal poverty line. The will provide income-based subsidies for residents to buy private insurance through the pool.

In 1988 Massachusetts enacted a "pay or play" law designed to insure all residents while attempting to avoid the problem of the federal pension law (ERISA), which prohibits states from mandating that employers provide certain employee benefits.[3] The state requires that in January 1992 employers of six or more employees pay a tax of 12% of payroll up to $14,000/year ($1680/year) to fund a state health insurance program. An employer that offers insurance may credit its cost against the tax. Thus the employer must "pay" the tax or "play" in the insurance market. In addition to this program, the state has undertaken a series of new and expanded public programs for the poor (people leaving welfare for work, disabled workers, disabled children), covering 17,000 new people at a cost of $120 million. An additional employer tax of 0.12% of payroll will fund insurance for people receiving unemployment compensation. Colleges are required to insure their students. Small employers may participate in a state insurance pool that will be developed and receive income tax credits for health insurance. Special provisions are designed to protect new and marginally profitable firms. The programs are funded primarily with revenues from the state's hospital uncompensated care pool established by its rate-setting system. Due to controversy about public and private funding, the employer tax is likely to be delayed by at least one year.

In 1989 Oregon enacted a three-part health care financing system to offer health care financing to its residents. In its most notorious action, the state assumed

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[2] This mandate was invalidated by the U.S. Supreme Court in 1978 as pre-empted by ERISA, the federal Employees' Retirement Income Security Act. In 1983 Congress enacted an explicit exemption from ERISA for the Hawaii health insurance mandate.

[3] Id.

responsibility for funding residents under the federal poverty line by expanding the Medicaid income eligibility level. Covered services are to be defined by a process of setting priorities according to costs and benefits of services, a procedure that has generated much controversy. The actual definition of covered services will then be left to the legislature, which may choose to limit benefits to fewer than those now covered. To include non-categorical individuals with federal money and potentially cover fewer than the federally mandated Medicaid services requires a federal Medicaid waiver, which has not yet been granted.

The second piece of Oregon's program is a state purchasing pool that must offer low cost insurance to small employers, for which they receive an income tax credit. If by October 1993 the pool and credit do not enroll a specified number of people, a "pay or play" approach takes effect: the state will impose a tax on all employers of 75% of the cost of covering employees and 50% of the cost of covering dependents with a basic benefits package (defined under the Medicaid priority-setting process). The tax revenues will fund a state pool for the uninsured. Employers offering insurance can credit its cost against the tax. The law offers special provisions for new and marginally profitable firms. The third prong of the program is of a high risk pool for uninsurables.

Although the Massachusetts and Oregon programs purport to cover most state residents, they are voluntary for unemployed individuals, and if unaffordable may not cover them. They also will not cover many part-time employees or dependents or full-time and part-time workers. Although these laws are designed with some care to circumvent ERISA, it is not clear whether these laws will do so. The U.S. Supreme Court will ultimately have to resolve this issue. It is also unclear whether the 12% Massachusetts payroll tax rate will suffice to fund insurance for the remaining uninsured. If employers are paying much more than that amount for coverage when the program takes effect, it may be cheaper for them to pay the tax and drop coverage, leaving the state with a potentially large and uncontrollable insurance obligation.

4. Uninsurable Risk Pools

People with medical conditions (such as AIDS, heart disease, diabetes, cancer, or stroke) are often denied health insurance at any price. If part of a large employee group, such people can usually be covered, but if they seek individual or small group insurance, the condition, the individual, or sometimes the entire small group is denied coverage. About one percent of the U.S. population has been estimated to be uninsurable. To address this potentially growing need, as of 1990, 21 states, including Iowa, have enacted laws that provide access to health insurance for "medically uninsurable" individuals through insurance pools. Insurance under these pools is available regardless of medical condition and premiums are capped, usually at approximately 150% of the premium for a standard risk individual of the same age and

sex. The pool plans generally prohibit coverage of pre-existing conditions for six to twelve 12 months.

Pool premiums are generally affordable to higher income people but not to low or middle income families. Only the states of Maine and Wisconsin explicitly subsidize risk pool premiums for low income enrollees. Despite the high premiums, because of the great medical needs of their enrollees, the pools lose money. These excess costs over premium revenues are generally spread among all indemnity insurers and HMOs doing business in the state, and often permitted as a credit against insurance premium taxes (a general fund tax expenditure). Unfortunately, since states cannot compel self-insured employers to participate in funding these pools, this financing mechanism tends to drive larger employers into self-insurance and erode the base over which to spread the excess pool costs. In a few states, pool costs are financed through general fund appropriations (Illinois), an individual income tax surcharge (Colorado), or a hospital revenue tax (Maine).

High risk pools do not solve all the problems of the medically indigent. They can, however, assist small employers (who may be disqualified from coverage due to the medical condition of a single employee) to purchase insurance for healthier employees by moving those with medical conditions into the pool.

C. Health Insurance Market Reform

Although the objective of the public programs described is not to change the health insurance industry, it is increasingly obvious that to encourage employers to provide health insurance compels a re-examination of the small group health insurance market. Small firms face numerous barriers to obtaining health insurance, some of which can be ameliorated through regulatory strategies.

1. Obstacles to Small Employer Health Insurance

Small firms face particular obstacles in purchasing health insurance not experienced by larger groups. Premiums are higher initially due to the administrative costs of marketing to, processing eligibility for, and maintaining small groups. Marketing is especially expensive. Small employers make purchasing decisions based on individual preferences, employee circumstances, and firm profitability. They buy insurance from agents and brokers, who must spend many hours discussing options. Determining eligibility for coverage is also more costly. Medical underwriting[4], applied

[4] Medical underwriting is the detailed review of medical histories of all members of a group. It is done in small groups to permit insurers to control for adverse selection. It may result in eliminating the particular condition from coverage for a fixed or perpetual period

to small groups to correct for the problem of adverse selection, is expensive. Even with underwriting to eliminate higher risk enrollees, however, insurers charge higher premiums due to the concern that small groups will experience above average risk. Premiums are also higher for small than for larger groups because few small group policies offer managed care strategies for cost containment. Finally, servicing and maintaining accounts, including processing eligibility for employees leaving and entering the firm, is performed by large employers' personnel managers but is an insurer or broker responsibility for small groups.

Searching for health insurance is also costly for the small business owner. A National Federation of Independent Business survey found that on average small firms spend four hours per year searching for health insurance, but those that buy it spend about eight hours while those that do not spend on average only one hour per year. Their limited time to devote to this exercise explains small firms' reliance on insurance agents and brokers. Yet these agents may have incomplete information about the range of private plans or public sector options (such as high risk pools) to assist small firms.

Even when small employers find an affordable health insurance policy, they may face significant premium increases at annual renewal due to: medical care expenditure inflation (running about twice the rate of general price inflation for many years), the completion of 6-12 month exclusions on coverage for medical conditions that existed before the policy began ("pre-existing condition exclusions"), and the natural aging of the group, which will use more medical care as its members grow older. Annual rate increases may cause small firms to seek cheaper coverage, leading to group turnover, which contributes to higher insurer administrative costs. As the better risks, which can obtain cheaper coverage elsewhere, leave the group, higher risks, which may be unable to buy other coverage at any price, tend to remain, making the group more expensive to cover over time.

2. The Small Employer Health Insurance Marketplace

The market for small group coverage is different for small than for large groups, primarily because of insurers' concerns about adverse selection. To attempt to create groups of actuarially normal risk, insurers generally medically underwrite groups under ten, but increasingly are using this screening device for groups as large as 50. Some medical conditions such as AIDS, cancer, epilepsy, and hemophilia, will generally result in rejecting an insurance applicant entirely. Some insurers will not even cover the other members of a group in which such an applicant works. For conditions such as chronic allergy, asthma, sciatica, or hypertension, some insurers will cover the individual but not services needed for that particular condition. Most indemnity

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of time or in rejecting the individual or the entire group.

insurance also excludes other pre-existing conditions from treatment for anywhere from three to twenty-four months; pre-existing condition exclusion clauses have been lengthening in recent years.

Insurers also exclude certain industries from coverage entirely, regardless of the health status of their members. Industry exclusions vary widely among insurers but generally derive from bad claims experience (physician offices), risky businesses (pesticide applicators, construction firms), high employee turnover (restaurants, hotels), instability of revenues (non-profit organizations), and the potential that the group is not "real" but constituted just to obtain insurance (social clubs, family businesses).

The concept of spreading risk originally led health insurers to set "community" rates, common to all enrollees in a geographic area. With increasing competition among health insurers, community rating has deteriorated. Large firms are generally charged rates based on their own experience. Small firms' rates are based on the experience of other small groups holding policies with the insurer, but the insurer may establish several rating tiers, based on varying levels of small group experience. Federally-qualified Health Maintenance Organizations are required by federal law to use community rating, although they can adjust rates based on enrollee age and sex.

3. Strategies to Address Small Group Insurance Market Problems

The small group health insurance market has deteriorated from one where the basic insurance principle of spreading risk has turned to the competitive imperative to avoid risk. The health insurance industry itself, through the Health Insurance Association of America, and its regulators, through the National Association of Insurance Commissioners, have acknowledged weaknesses in this market and are proposing regulatory solutions to make insurers compete by efficiency and care management rather than risk avoidance. One or both of these organizations and some state legislatures are considering the following strategies: regulating rating practices, limiting underwriting and pre-existing condition exclusions, permitting insurers to sell limited benefit packages (described above), regulating participation requirements, prohibiting part-time worker exclusions, and regulating Multiple Employer Trusts (METs). Connecticut and Maine have recently enacted several of these requirements.

- Regulating Rating Practices. The NAIC is proposing that insurers disclose their rating practices, particularly how they adjust renewal rates. Many carriers aggregate small groups for internal accounting purposes based on the groups' collective claims experience. Insurers may use three different tiers of experience, aggregating the best risks, whose premium increases are lowest, the medium risks, with average rate increases, and the worst risks, with

highest rate increases. This "tier rating" discourages good risks from leaving the insurer to seek better rates, but it disadvantages the worse risks who face significant rate increases.

It would be possible, of course, to require that insurers use community rating, to retain all small groups in the pool. While more equitable, insurers fear that the best risks might tend to self-insure in order to avoid state regulation and leave the worst risks in the insurers' pool. As a less onerous solution, HIAA proposes limiting rate differentials among groups that are similar in plan design, location, industry and demography, in other words, prohibiting rate differences based on claims experience. A less broad-sweeping proposal would be to limit the difference in rate increases among all tiers. Connecticut recently enacted a law limited premium increases to 20% plus an inflation adjustment factor. Maine's new law limits rate increases to 10% annually.

- Regulating Underwriting and Pre-Existing Exclusion Practices. To cover employees with existing medical conditions who are excluded from coverage, HIAA proposes prohibiting denial of coverage due to medical condition. In exchange for accepting greater risks, the association also proposes that states establish a reinsurance mechanism funded by insurers and the public to spread the risk of high cost cases. Such a reinsurance program would be different from high risk pools (to which individuals may subscribe) because individuals remain enrolled in their employer plans, rather than being shunted into a separate insurance pool and policy. Connecticut recently enacted legislation that prohibits denying coverage to groups under 25 due to medical conditions and will also create a state reinsurance pool to spread the costs of high cost cases over all insurers.

A state could also prohibit insurers from denying coverage of individuals with certain conditions (pregnancy is generally a prohibited exclusion for larger firms under federal civil rights laws and some state constitutions). States that have enacted such prohibitions, for instance prohibiting discrimination against persons with AIDS, have found the insurance industry less willing to do business in the state, but required coverage of newborns, which can include costly premature infants, has not provoked that reaction. States with high risk pools can also require insurers and agents to refer rejected applicants to the pool.

People who are insured but develop medical conditions face a revolving door of pre-existing condition exclusions whenever they change jobs or their employers

change insurers. To remedy this problem, HIAA proposes prohibiting insurers from imposing pre-existing condition exclusions on people who have satisfied one such clause in one group policy. States could completely prohibit pre-existing condition exclusion clauses, but such limitations may discourage insurers from writing coverage in the state. Maine's law prohibits medical underwriting for employers changing carriers and limits pre-existing condition exclusions for individuals previously insured through a group or indiv · ial plan or public program who change employers.

Some insurers drop small groups with high claims experience. This makes it very difficult for such an employer to buy insurance from other carriers. HIAA proposes prohibiting any termination of a group or member due to claims history or deteriorating health status.

- Regulating Participation Requirements. Insurers often impose two types of "participation" requirements: that employers pay a certain share of the premium and that a certain percentage of employees must enroll in order to cover the group. While some employer premium participation may be appropriate to assure that the employer is committed to the insurance plan and to assure that enrollees are real, rather than fictional, employees, high percentage participation requirements may make coverage unavailable to employees who could afford to share more of the cost. And requiring that 75% or more of employees enroll in the plan is complicated when employees are covered by a spouse's plan in another business. While insurers deserve the best risk distribution they can achieve, these participation requirements also make very difficult enrolling very small firms, some of whose employees often do have coverage elsewhere that they may prefer, particularly if they have medical conditions that might not be covered by switching to the primary employer's program. No states have regulated these insurer practices. But the state of New Hampshire has prohibited insurers from refusing to cover part-time workers (under 15 hrs/week). While these part-time employees may have to pay a larger share of their insurance, some may be willing to do so and this may help cover more part-time workers and their families.

- Regulating Multiple Employer Trusts. Multiple employer trusts (METs) or multiple employer welfare arrangements are organizations of several employers that negotiate and administer employee benefit plans, including health

insurance. Popular in the mid-70s, METs often were self-insured (rather than using health insurers) and some were undercapitalized and mismanaged. Because of ambiguity of the federal ERISA law, however, states were generally unable to regulate METs. Clarifications to ERISA now permit states to regulate certain aspects of these multiple employer organizations, such as levels of reserves and contributions and other insurance laws consistent with ERISA. Several states have done so.

Appendix E .

SUMMARY OF DEMONSTRATION PROGRAMS TO EXPAND PRIVATE SECTOR COVERAGE IN OTHER STATES

Expanding Private Sector Health Care Coverage

Summaries of State Demonstration Projects

Prepared for the

Health Care Expansion Task Force
of the
Iowa General Assembly

Prepared by

Patricia A. Butler, J.D.
Health Systems Research, Inc.

June 12, 1990

Alabama's BasiCare

A private sector coalition has developed an insurance product for small business in the Birmingham area, underwritten by an HMO, that offers the alternatives of medium-priced coverage through private physicians and hospitals or low-priced coverage through public health department clinics and hospitals.

Date Begun: 4/90

Enrollment is just beginning

Benefits

- limited benefits: 6 MD visits/yr, 10 hospital days/yr
- $8 copayment for outpatient visits
- covers prescription drugs with $3 copayment

Eligibility

- any firm that did not offer insurance within previous 12 months and with 3 or more employees
- firms offering insurance to some workers can enroll if fewer than half their workers participate
- employee participation requirements vary with firm size
- no medical underwriting, but excludes people denied insurance within previous 2 years and pre-existing conditions for 12 months
- employers must contribute at least 50% toward employee premiums

Subsidy

- no public subsidy

Plan Cost Containment Features

- managed care
- use of low cost providers
- limited benefits

Rates

- private option: $74/indiv, $186/family
- public option: $45/indiv, $111/family

Marketing

- mail, radio
- HMO uses salaried sales staff

Health Care Group of Arizona

Using the state's network of Medicaid HMOs, HCG offers to small firms four insurance plans through two different HMOs in two urban and several rural counties.

Date begun: 1/88

Enrollment as of 4/1/90: 1076 people in 273 firms
average firm size: 2.1

Benefits

- employers can enroll in any of 4 plans offered by the HMO, ranging from a catastrophic plan and a first dollar plan with no stop loss to a comprehensive plan with minimal copayments

Eligibility

- any firm that did not offer insurance within previous 6 months with under 25 F-T workers
- no medical underwriting; pre-existing conditions excluded for inpatient care 1 yr

Subsidy

- no explicit state subsidy, but state negotiated reinsurance arrangements for plans, provides marketing assistance and collects premiums

Plan Cost Containment Feature

- managed care

Rates

- average premiums range from: $55 - $93/indiv(35), $180 - 298/family of 3+

Marketing

- mail, radio, TV, newspaper ads
- both in-house sales staff and independent brokers

Lessons

- despite Medicaid experience, plans were reluctant to participate because of unknown risk
- good utilization experience is encouraging more plans to consider participation program does not address needs of lower income workers
- marketing to small businesses is difficult

Colorado's SCOPE

SCOPE is a low premium, managed care indemnity plan for small firms, first available in Denver metro area and now marketed in several other urban areas.

Date begun: August 1989

Enrollment as of 4/25/90: 382 firms, 3710 people (about 60% previously uninsured)
penetration rate: about 1% of the estimated 242,000 uninsured workers and dependents in small firms in Denver area
average firm size : 4 employees

Local Economic Conditions: state's economy has been weak but is recovering

Benefits
- typical indemnity benefits with no cost sharing for preventive services, $15 copayment for MD visits, $250 deductible + 50% coinsurance for hospitalization, 50% coinsurance for tests, outpatient surgery
- stop-loss - $2750

Eligibility
- employers under 50 (including groups of 1), even if previously insured, who pay at least 25% of premium
- employees working at least 30 hrs/wk
- 75% of all workers must enroll
- fairly typical medical underwriting criteria and 6 month pre-existing condition exclusion
- somewhat more lenient excluded industry list

Subsidy
- no public subsidy (but low income enrollees would be eligible for partial write-off of their cost sharing through state's indigent care program)

Plan Cost Containment Features
- managed care plan with negotiated fees for Exclusive Provider network

Rates
- $52(35-yr old male), $72(35-yr old female), $149/family
- about 40% of market rates for other typical indemnity plans
- surcharge on groups of 1

Marketing
- mail, TV, radio ads
- brokers trained by project and referred leads (directed first to uninsured firms, the main SCOPE target)
- costs about $60/enrollee

Lessons
- price is critical factor
- limited benefits are attractive when price is critical
- insurance industry underwriting and exclusion practices limit insurance availability in this market

Florida Small Business Health Access Corporation

A public non-profit corporation is a purchasing group that negotiated rates with an HMO and acts as a third-party administrator/intermediary between small employers and a health care plan.

Date Begun: 5/89

Enrollment as of 4/1/90: 2237 people in 435 firms
average firm size: 2.9

Benefits
- 2 options offered by HMO: standard ($10 copayment) or high option ($5 copayment)
- typical HMO benefits; prescription drug option may be purchased in addition

Eligibility
- firms in business at least 1 year, not offering insurance in last 6 months, and with under 20 employees working at least 17.5 hrs/wk
- employers must pay at least 50% of employee coverage
- all eligible employees must enroll in plan
- state conducts underwriting using liberal criteria; refers uninsurables to state high risk pool; no pre-existing condition exclusions

Subsidy
- state has negotiated lower rates by limiting HMO's risk through reinsurance, paying to lower family premiums
- state also performs marketing, eligibility, and billing functions

Plan Cost Containment Feature
- managed care

Rates
- $72 - $82/indiv(35), $199 - $226/family

Marketing
- TV, radio ads
- state marketing staff oversees agent network

Lessons
- government sponsorship is credible
- a subsidy was necessary to attract the insurance partner
- state should share risk with insurer but not bear entire risk
- local markets differ; local pilots are valuable
- creating and owning a buying group gives state considerable leverage to negotiate rates, underwriting criteria, industry coverage
- voluntary efforts have limited impact, but mandatory approaches must include insurance industry reform

MaineCare

The state has negotiated with an HMO to offer small group insurance in one urban site and is developing a managed care product for a rural site.

Date Begun: 12/1/99

Enrollment as of 4/1/90: 704 people in 220 firms
average firm size 1.9

Benefits

- standard comprehensive HMO benefits

Eligibility

- any firm that did not offer insurance within previous 12 months with under 16 F-T employees
- employer must contribute at least 50% to employee and dependent coverage
- all employees must participate unless insured elsewhere
- coordination with state high risk pool; 90 day pre-existing condition exclusion

Subsidy

- state pays employee's share of employees under FPL
- state subsidy declines from 100% to 200% FPL
- state also subsidizes up to 20% of employer's share for marginally profitable firms
- subsidy costs state $54/mo; state pays 40% of overall bill; 60% of enrollees are subsidized

Plan Cost Containment Features

- managed care HMO
- state negotiated substantial hospital discounts

Rates

- community-rated without age or sex tiers
- $92/indiv, $274/family of 3+

Marketing

- no paid ads

Lessons

- good utilization experience
- lower wage workers are willing to contribute something toward coverage
- sliding scale premiums are important
- price is still a deterrent to some firms

Massachusetts "Phase-In" Health Insurance Pilots

Under Massachusetts Universal Health Care law, the state was required to develop pools for small employers to buy insurance. But the state decided that such pools are already available and instead developed pilots to improve affordability by premium subsidies, subsidizing administrative and marketing costs, and state risk sharing with plans.

Date begun: January 1990

Enrollment just beginning in spring 1990
enrollment capped at 7750 among 5 plans

Benefits

- comprehensive HMO benefits and standard PPO benefits

Eligibility

- differs among 5 pilots
- generally firms under 25 employees, in business 1 yr, without insurance in previous 12 months, and paying a minimum share of premium
- employees working fewer than 20 hrs/wk generally not eligible
- individuals in 1 pilot eligible if uninsured 12 months and income under 300% FPL no medical underwriting or exclusions (state finances costs of uninsurables)

Subsidy

- employer premium subsidies range from 5% to 14% of premium
- individual plan subsidies range from 80% to 100% of premium
- state reinsurers certain claims (e.g., between $10,000 and $100,000 or over $15,000) in certain pilots
- state pays for excess costs of uninsurables in certain plans
- no premium subsidy to PPO, but funds marketing, claims processing, administrative and case management services

Plan Cost Containment Features

- managed care in all plans and risk sharing with HMOs

Rates

- $124-140/individual, $293-380/family
- approximately market rates for large groups (15% to 25% below small group rates)

Marketing

- plans develop their own marketing strategies, including direct mail

Michigan's Health Care Access Project
One-Third Share Plan

Michigan's "1/3 Share Plan" was a 2-site demonstration program to subsidize health insurance premiums for small firms. Originally designed for firms that hired former AFDC recipients, but this condition was eventually dropped.

Date begun: May 1988

Enrollment as of 4/1/90: 1124 people in 202 firms
average firm size: 5 (3 enrollees)

Local Economic Conditions: recovering in rural Marquette County; poor in Flint

Benefits
- firms could choose among 12 plan in market, but subsidy was based on cost of HMO in Flint and Blue Cross plan in Marquette County

Eligibility
- firms not insuring in previous 2 years with some employees with low incomes (<200% FPL in Flint, <185% FPL in Marquette) - no firm size limitation
- part-time and seasonal workers generally not covered
- plans use standard underwriting, 6 month pre-existing condition exclusion for some groups

Subsidy
- state would pay 2/3 of maximum premium for employees with incomes under 100% FPL and 1/3 for those between FPL and maximum income level (employer to pay 1/3 plus extra cost if chose higher cost plan)
- subsidy dropped to 25% after 12 months of enrollment
- 83% of enrollees are subsidized
- average cost to state: $27.50/subsidized enrollee, $20/enrollee

Rates
- $118/mo/indiv(35); $248/mo/family of 3+
- subsidy brings average premium down to about 85% of market rates

Marketing
- mail, PSA, personal contacts by local staff

Special Features
- state negotiated hospital discount for Flint HMO that helped to lower rates premiums 84% of market rate

Lessons
- despite low enrollment, projects are viewed locally as successful
- most employees offered enrollment did enroll
- Flint HMO utilization experience has been good - normal risks
- despite subsidy, 1/3 of firms that contact Flint office did not enroll due to cost (firms under 5 yrs old less likely to offer coverage)
- indemnity coverage in Marquette seen as expensive; underwriting disqualified many potential enrollees or made coverage unaffordable
- welfare recipient connection was difficult in Flint and dropped; this feature of program created a welfare stigma in Flint

New York State Health Insurance Pilot Programs

New York is testing health insurance subsidies for individuals and businesses in 5 geographic areas. Insurers process eligibility, determine premiums, contract with providers

Date begun: from May 1989 through January 1990

Enrollment: 2500 as of March 1990
penetration rate: 17% of maximum 14,500 enrollees

Benefits
- 4 HMOs and 1 EPO
- comprehensive benefits (do not include some state mandates, e.g. number of outpatient mental health benefits)

Eligibility
- individuals uninsured since 1/1/88 with incomes under 200% FPL
- employers of under 20 employees without insurance since 1/1/88
- no excluded industries or medical underwriting (but some pre-existing conditions excluded)

Subsidy
- for individuals state pays 62% - 91% of premiums (individuals need not spend more than 2-4% of incomes on premium)
- for employers, state pays 50% of premium (regardless of employee income) and employer pays 50%

Plan Cost Containment Features
- managed care in all plans and risk sharing with HMOs

Rates
- $52 - $153/individual; $244 - $459/family (varies by pilot site)
- approximately market rates
- subsidy decreases individual rates up to 90% and employer rates 50%

Marketing
- mailings by plans
- outreach by community groups and non-profit agencies in one site

Lessons
- marketing much more demanding and costly than plans anticipated
- prohibiting participation of firms insured since January 1988 is too long a waiting period

Ohio Health Care for the Working Uninsured

Ohio is pilot testing insurance models for low wage workers in 4 sites, 3 subsidized plans and 1 low cost catastrophic plan.

Date begun: January to June 1990

Enrollment was 150 people as of April 1990
capped at 1000 in the subsidized plans and projected to be 1000 in the catastrophic plan.

Benefits
- 2 HMOs with comprehensive benefits
- rural PPO with $200 deductible and 80/20 coverage
- catastrophic plan: $5000 deductible for major medical plan; choice of $175 or $250 "medical spending account" for routine medical and dental care and prescription drugs

Eligibility
- 1 pilot = individual coverage for post-AFDC families without workplace insurance
- 2 pilots cover firms without insurance for 18 months with workers with incomes under 200% FPL
- catastrophic pilot covers firms under 100 employees without insurance for 18 months

Subsidy
- former AFDC families pay premiums for individual plan on sliding scale; state pays up to 97% of premium
- HMO pilot: state, employee, employer each pay 1/3 premium
- PPO pilot: employer pays 1/2 premium, employee and state pay 1/4

Plan Cost Containment Features
- managed care in HMOs and PPO, risk sharing with HMOs
- high cost sharing for hospitalization in catastrophic plan; medical spending account not spent one year expands benefits the next year

Rates
- HMO and PPO plans: $100/individual, $300/family
- catastrophic plan: $54/individual (under 30), $142/family (estimated average employer premiums: $90-120/employee)

Special Features of Catastrophic Plan
- primary care spending account is expected to cover 90% of needed medical and dental care
- although IRS rules prohibit refunding the unspent account, residual in accounts are expected to be used to improve benefit design in later years
  for expenses between the $250 and $5000, plan administrator will help enrollees obtain low interest loans from providers to pay off medical debts

Tulsa Health Option

Tulsa Health Option is a project of the Tulsa Chamber of Commerce that aggregated large and small businesses into a health insurance buying group to purchase PPO and HMO coverage at community rate regardless of firm size.

Date begun: October 1986

Enrollment as of January 1990: 34,000 to 40,000 enrollees, 4,000 - 10,000 of whom are in small employer groups
penetration rate: 7 - 17%

Benefits

- both plans had comprehensive benefits and limited cost sharing

Eligibility

- firms of any size, but target was small firms
- medical underwriting of firms under 10

Plan Cost Containment Features

- managed care for both plans; risk sharing for HMO

Rates

- $75-$85 /individual, $185/family
- 70-80% of market rates

Marketing

- mail, newspaper, radio campaign
- trained brokers staffed Chamber phones

Special Features

- community rate among all firms regardless of size provides a cross-subsidy from large to small firms

Lessons

- in this community, large firms are willing to subsidize smaller ones by aggregating experience of all businesses into one large group
- large business was convinced that it would save money otherwise spent on cost-shift
- THO brought to very small groups HMO coverage that was not sold at all before despite THO, 1990 Chamber survey found that 29% of firms not insuring reported price as reason

Oregon Small Employer Health Insurance Pool Plan

In 1989 Oregon established its health insurance pool for small employers, which offers 6 plans, including 5 PPOs and 1 HMO. By law, the monthly premium is capped at $53/individual employee.

Date begun: April 1989

Enrollment as of 6/1/90: 1000 firms with 2200 employees plus 1800 dependents

Benefits

- standard HMO and indemnity plan benefits
- to keep premiums within statutory $53 cap, plans adjust benefits, primarily by raising copayments and deductibles for older persons

Eligibility

- firms under 25 employees without insurance for 2 yrs that pay up to $40/employee/month

Subsidy

- firms in pool are entitled to tax credit of lower of $25/employee or 50% of premium for first 2 yrs; credit declines and terminates after 5 yrs.

Plan Cost Containment Features

- high cost sharing
- managed care for all plans, risk sharing with HMOs

Rates

- $53/mo/employee
- $28/mo net of tax credit

Marketing

- state has distributed information through small employer trade associations
- state plans direct mail campaign in spring 1990

Lessons

- low enrollment since not actively marketed in first year
- employers generally supplement the basic $53 benefit, paying on average $68/employee

Tennessee MedTrust

A private sector community health center-based HMO with deep hospital discounts offers coverage to uninsured employers in Memphis.

Date Begun: 3/20/89

Enrollment as of 4/1/90: 647 people in 163 firms
average firm size: 2.1

Benefits

- standard comprehensive HMO benefits with $5 MD copayment

Eligibility

- firms of any size that did not offer insurance within previous 3 months
- employee participation requirements vary by firm size

Subsidy

- no public subsidy
- substantial hospital discounts lower rates to 55% of market rates

Rates

- $49/indiv, $131/family

Marketing

- radio

Utah Community Health Plan

A private hospital-based HMO that includes community health centers and private physicians and discounted hospital rates is offering coverage to small employers.

Date Begun: 9/12/89

Enrollment as of 4/1/90: 836 people in 154 firms
average firm size: 6

Benefits

- standard HMO benefits with $10 MD visit copayment
- $150/day hospital copayment
- pre-existing conditions covered at 50% first year

Eligibility

- firms that did not offer insurance for 12 months with under 20 F-T workers.
- medical underwriting and industry exclusions

Subsidy

- no state subsidy
- provider rate discounts bring price down to 40% of market price in area

Rates

- $64/35-yr old male, $74/35-yr old female, $187/family of 4

Marketing

- direct mail
- staff salespersons

Lessons

- insurers in state fought HMO license for this project
- providers are willing to participate at substantial discounts, but only if plan's marketing efforts are not too successful

Washington's Basic Health Plan

The state subsidizes premiums for individuals to purchase care from contracting HMOs and PPOs in six sites. Enrollment does not come through the workforce.

Date Begun: 1/1/89

Enrollment as of 4/1/90: 8468 people

Benefits

- comprehensive HMO benefits with $5 copayment for MD visits, no copayment for preventive services
- no drug or mental health benefits

Eligibility

- any resident with income under 200% FPL
- no medical underwriting, but pre-existing conditions excluded 1 yr

Subsidy

- state pays full premium for persons under 75% FPL; all others contribute on a sliding scale up to 75% of the premium at 175% FPL
- subsidy scale favors lower income persons
- state pays average of 82% of premium

Plan Cost Containment Feature

- managed care through HMOs, PPO

Rates

- $95/indiv (35), $295/family 3+

Marketing

- low key marketing campaign

Lessons

- individuals are willing to contribute to premiums
- plan to study whether businesses are dropping coverage, but no evidence so far
- program development took time
- subsidies are costly

Wisconsin Health Insurance Pilots

Subsidizing lower wage workers in small firms is one of Wisconsin's 3 insurance pilots (others: subsidize premiums for low wage workers in large firms offering insurance unaffordable to the low wage worker and allows disabled workers to buy into Medicaid)

Date begun: Noninsuring firm pilot: 2/89

Enrollment:

Noninsuring firm pilot: 22 firms/98 subsidized enrollees (4/25/90)

Benefits

- employers can enroll in any of 4 indemnity plans or 1 HMO approved by Insurance Commissioner as "comprehensive" (e.g. stop loss no greater than $1000/$2500)

Eligibility

- any firm that did not offer insurance within previous 12 months with under 20 F-T workers and at least one employee under 175% of FPL
- employer need not contribute to premium for employees to receive subsidy

Subsidy

- up to 75% of premium on income-based sliding scale
- subsidy favors buying family coverage
- average cost to state: $41/individual, $168/family, $147/enrollee

Rates

- average premiums: $73/indiv., $265/family (market rates)
- net of subsidy: $32/indiv., $97/family

Marketing

- mail

Lessons

- employers have taken a long time to return applications
- some employers haven't applied because they don't realize they are eligible for subsidy or aren't interested in applying since they see subsidy as helping employees not the firm or feel insurance rates too high, despite subsidy (which only assists some of their employees)
- state and insurer time to process applications has been lengthy
- need a local presence for local pilots

Appendix F

DESCRIPTIONS AND PRELIMINARY COST ESTIMATES OF OPTIONS EXAMINED BY THE TASK FORCE

PRELIMINARY COST ESTIMATES OF OPTIONS TO IMPROVE ACCESS FOR IOWA'S UNINSURED AND UNDERINSURED POPULATIONS

Prepared for:
The Health Care Expansion Task Force
of the Iowa General Assembly

Prepared by:
Health Systems Research, Inc.
Washington, D.C.

July 17, 1990

Introduction

This report provides preliminary information on the costs associated with a range of options for improving access to care for Iowa's uninsured and underinsured populations. For most options, these estimates are accompanied by brief descriptions of each option that identify the important design features (e.g. eligibility criteria, subsidy levels, etc.) and the assumptions upon which the estimates are based. Costs associated with several options involving administrative changes to existing state programs have been omitted pending further discussions with responsible state agency officials.

The options discussed in this document are the following:

Public Sector-Oriented Approaches

A. Medicaid expansions

B. Public sector service delivery expansions

C. Improve public program coordination and integration

D. Efforts to increase the availability of health care practitioners

E. Establishment of new public programs for certain low-income persons

F. Establishment of a Canadian-like system for all Iowans

Private Sector-Oriented Approaches

A. Insurance regulation reform

B. Increased tax deductibility of health coverage for the self-employed

C. State tax credits for small businesses

D. Subsidized coverage for small businesses

E. "Pay or Play" requirements

It is expected that at its July 17 meeting the Task Force will identify a subset of these options that it believes are most appropriate for implementation in Iowa. Health Systems Research, Inc. (HSR) will then proceed to develop more detailed final cost estimates for these preferred options. These estimates will include assessments of the

impact of these options in hospital uncompensated care levels and on county health care expenditures.

It should be noted that in constructing its cost estimation model for this project, HSR has developed or updated premium cost estimates for six alternative benefit packages, ranging from a comprehensive Medicaid-like benefit package to coverage of ambulatory services only for children. The costs for these different packages are estimated to range from $165 to $66 per month for adults and $90 to $30 for children's coverage. Descriptions of these alternative packages can be found in Appendix A to this document.

However, in an attempt to simplify the presentation of preliminary cost estimates in the body of this document, unless otherwise specified in the description of a specific option, the projected costs presented for new public or private sector coverage are based upon a mid-priced plan with a monthly premium of $125 for an adult and $60 for a child.* The issue of what is the appropriate benefit package for these options will be discussed at the July 17 meeting with the Task Force's recommendations reflected in HSR's final cost estimates. In the interim, Table A-1 in Appendix A provides information on the percentage differences in the cost of different packages that can be useful in quickly calculating differences in the costs of individual options if a different benefit package is assumed.

I. Public Sector-Oriented Approaches

A. Medicaid Expansions

1. Extend Medicaid coverage to currently ineligible aged, blind and disabled persons with incomes below the federal poverty level

This option, which was included in the Task Force's interim report, would provide Medicaid coverage to a small group of aged, blind, and/or disabled persons whose incomes are currently too high to be eligible for the Medicaid and the federal SSI program but are below the federal poverty level.

*To provide a reference point for the cost estimates presented in this document, it should be noted that the cost of covering all 223,000 uninsured Iowans with this benefit package would equal approximately $284 million.

- o Number of new Medicaid recipients: 1,000
- o Costs - Total: $2.7 million
  State: $1 million
  Federal: $1.7 million

2. Apply for the new Medicaid demonstration program authorized by OBRA 89

   Participation in the demonstration would enable Iowa to extend Medicaid coverage (or an alternative benefit package) to currently ineligible children under 20 in household with incomes below 185% of poverty. The State is currently working with Blue Cross/Blue Shield to prepare a demonstration application which must be received by the federal government by July 26, 1990. Proposed design features and cost estimates should be available to the Task Force at its July 17 meeting.

B. Public Sector Service Delivery Expansions

Iowa currently has a network of maternal and child health centers located in 29 counties. In addition, within the State, there are:

- o 11 rural health centers;
- o 3 community health centers; and
- o 6 family practice residency training program sites.

(See Appendix B for a summary of the major State programs supporting the local delivery of personal health services and Appendix C for a map showing the locations of the public delivery centers listed above.)

Presented below are preliminary costs associated with expanding the child preventive and referral activities of these centers.

1. Expanding public sector preventive care programs for children

- o In Iowa, there are approximately:
  - 32,000 uninsured children under 200% of poverty; and
  - 70,000 privately insured children under 200% of poverty who are not covered for preventive care.
- o The number of potentially eligible children is about 102,000.
- o About 11,000 currently uninsured children are served by the State's Child Health Centers.
- o An additional 91,000 low-income children are uncovered for preventive care.
- o Assuming a 50% participation rate and an annual cost per child of $100, the total cost of the expanding services to this population would be $4.55 million (state).
- o This expansion would increase the number of children served by more than fourfold.

2. Expanding pediatric referrals from these centers for diagnosis and treatment

This would represent an expansion of the State's current $400,000 program.

Assuming one-quarter of newly participating children would be referred at a cost of $50 per child, the total annual cost of these referrals would be approximately $580,000.

It should be noted that the approach of expanding current service delivery activities raises a number of issues:

- o Physical space limitations exist in many centers. This is particularly a problem for older children.

- o Personnel shortages exist, including those of pediatric nurse practitioners and dieticians.

- o There is a need for more sophisticated follow-up systems to track referred children.

- o Relationships with private physicians for diagnosis and treatment are important.

  - These are generally good for referral arrangements.

  - In some communities, physicians see Child Health Centers as competition.

  - Some physicians oppose splitting preventive and primary care (the issue of continuity).

- o The potential exists to use Family Practice Residency Training Programs.

  - They are currently located at 6 sites.

  - They generally do not serve low-income uninsured persons.

C. Improved Coordination and Integration of Public Programs

A number of opportunities exist for increasing the effectiveness of programs currently operating in Iowa. One major emphasis of these efforts could be on making maximum use of federal Medicaid funds by increasing the enrollment of eligible persons who are currently using state-supported services.

The activities to be pursued in this area include:

- o Expanded Medicaid outreach activities to identify more eligible individuals, including increased Medicaid eligibility determinations for persons using maternal and child health centers;

- o Increased efforts to enroll eligible children in EPSDT, Medicaid's preventive care program; and

- o Greater coordination and integration of Medicaid eligibility and service delivery at the local level.

Cost estimates for these activities are currently being developed in collaboration with the responsible state agencies.

D. Efforts to Increase the Availability of Health Care Practitioners, Particularly in Rural and Underserved Areas

Efforts to improve the delivery of services to the uninsured and underinsured must recognize the shortages of key health practitioners that exist in many areas of the State. Several groups have examined or are examining this issue in Iowa. Drawing upon the work of these and other groups, specific proposals in this area will be brought to the Task Force at a later date.

E. Establishment of New Public Programs for Low-Income Persons

Two illustrative programs are presented in this section: one extending coverage for all low-income persons below a certain level of poverty, the second extending coverage only to children.

1. Program for persons below 200% of poverty

Under this program, persons with incomes below the federal poverty level would not be required to contribute to premium costs. Persons between 100% and 200% of poverty would contribute on a sliding scale basis. This is similar in design to the State of Washington's Basic Health Plan. Cost estimates assume some switching of coverage by previously insured persons.

- Participation Rates**:
  - Previously uninsured: 50%
  - Previously insured/non-group: 25%
  - Previously insured/group: 10%
- Number of Enrollees: 100,000
- Costs - Total: $123.3 million
  State: $90 million
  Individual: $33.3 million

2. Program for children under 250% of poverty

This alternative would be designed to provide coverage for uninsured children under 250% of poverty. No premium contribution is assumed for children under poverty, while a $25 enrollment fee is required for other children. Some switching of coverage is anticipated. Two benefit packages are costed out: the first is the mid-priced package described in Appendix A which includes inpatient and outpatient care. The second package is similar to that provided under the Minnesota Child Health Plan or the Caring Foundation Plan in that it does not cover inpatient care.

- Participation Rates:
  - Previously uninsured: 60%
  - Previously insured/non-group: 15%
  - Previously insured/group: 5%
- Estimated Enrollees: 38,000

**Participation rates refer to the percent of a given population expected to enroll in the program.

- o Costs/Medicaid Benefits:

  Total: $34.2 million

  State: $33.4 million

  Individual: $758,000

- o Costs/Ambulatory Care Benefits:

  Total: $13.7 million

  State: $12.9 million

  Individual: $758,000

F. Establishment of a Canadian-Like System for All Iowans

At least one Task Force member has asked that preliminary cost estimates be developed for a universal health care plan which would replace current public and private sector coverage with a single, publicly financed statewide insurance plan covering all Iowans.

An order of estimates of the cost of such a plan can be developed by applying annual per capita cost estimates of $720/child, $1500/non-elderly adult, and $3,500/elderly adult to Iowa's population of 2.81 million. This results in total annual program costs of approximately $4.5 billion. If this amount were reduced by 15% to reflect increased efficiencies resulting from moving to a single paper system, total annual program costs would be reduced to $3.8 billion.

Should this option be identified by the Task Force as a high priority alternative, HSR's final cost estimates will assess the distributional cost impacts of this option on current health care programs and payers.

II. Private Sector-Oriented Approaches

A. Regulatory Reform in the Small Group Health Insurance Market

The recommendations in this area developed by the National Association of Insurance Commissioners are expected to address:

- o Disclosure and certification of underwriting practices;
- o Elimination of multiple waiting periods for pre-existing conditions; and
- o Limitations on year-to-year increases in premium costs.

Adoption of these recommendations will have a negligible cost impact on the State of Iowa but are expected to improve the affordability and stability of health care coverage for certain small businesses within the state.

B. Increasing the State Tax Deduction for Health Care Coverage Purchased by Self-Employed Persons

Federal tax laws permit incorporated businesses to claim a tax deduction for 100% of the cost of employee health benefits. However, self-employed individuals can claim a deduction for only 25% of such costs. Because the State of Iowa in general follows federal policy concerning the definitions of deductions, this same difference exists with respect to state income tax.

If the State of Iowa were to amend its tax laws to allow 100% deductibility of health care coverage purchased by self-employed persons, assuming a marginal tax rate of 8%, this would result in an annual tax savings of $90 for each of the estimated 178,000 self-employed persons in the state currently purchasing health care coverage for themselves and $59 for each of their more than 300,000 covered dependents. This would reduce the effective price of adult coverage considered in our model from $1500 per year to $1410, a reduction of 6%. We estimate that this change in policy would cause only about 5% of the 47,000 currently uninsured self-employed workers and their dependents to obtain coverage.

An alternative design option would be to limit the expanded deductions to self-employed workers and dependents under 200% of poverty. For the purposes of estimating costs for this option, a marginal tax rate of 5% is assumed.

Increased Deductions for All Income Levels

Estimated Number of Newly Covered Individuals: 2,400

Cost to the State of Change in Tax Policy: $33.9 million

Increased Deductions for Persons Under 200% of Poverty

Estimated Number of Newly Covered Individuals: 1,100

Cost to the State of Change in Tax Policy: $5 million

C. Tax Credits to Small Businesses

Under this option, state tax credits would be provided to small businesses (under 25 workers) previously not providing health benefits to their employees that elect to do so and that contribute at least 75% toward the premium cost for individual coverage and 50% toward the cost for family coverage. The credit would be equal to $25 per month for each covered employee and would be limited to employers not previously providing coverage. This tax credit would be meant to provide transitional assistance to these employers and would be eliminated or phased out after several years.

This credit would represent about a 25% reduction in the employer's portion of premium costs. We estimate that about 10% of currently uninsured full-time/full-year workers in small firms would obtain coverage as a result of this policy, as would about 5% of the uninsured dependents of these workers. Penetration rates of about half these rates are assumed for non-full-time/full-year workers and their dependents.

Estimated Number of Workers/Dependents Obtaining Coverage: 7,000

- Annual Costs - State (tax credits): $1.5 million
- Employer Premium Contributions: $4.6 million
- Employee Contributions: $2.4 million

D. Subsidized Coverage for Low-Income Employees in Small Businesses

This option would provide state subsidies for health care coverage provided to previously uninsured workers in small firms (< 25 workers). For coverage of workers under the poverty level and their dependents, the state subsidy would be equal to half of the premium cost; the employer would be responsible for the other half. Subsidies for workers between one and two times the poverty level would be available on an income-related sliding scale basis. It is estimated that, on average, the state subsidy for this group would represent about 15% of premium costs with the employer contributing 50% and the employee the remaining 35%. Additional premiums for coverage of dependents in this income group would be financed by a 30% state subsidy, a 50% employer and 20% employee contributions. There would be no state subsidies for workers with incomes greater than 200% of poverty. It is assumed that only full-time workers are eligible and that 15% of eligible employees and dependents would participate.

- Estimated Number of Newly Covered Workers/Dependents: 6,400
- Costs - Total: $7.6 million
  State: $2.6 million
  Employer: $3.1 million
  Employee: $1.9 million

E. "Pay or Play" Requirement

Under this option, all employers would be required to pay a new payroll tax equal to $1300 per year for each full-time employee. Employers providing health care benefits to employees would be able to credit the cost of these benefits toward this new tax and revenues generated by this new tax would be used to provide health coverage for uninsured persons. We estimate that approximately 72,000 currently uninsured workers would be covered if employers elect to provide coverage rather than pay the tax. In addition, it also is estimated that approximately half of currently uninsured dependents of these workers would be insured through family coverage.

- Estimated number of newly covered workers: 72,000
- Estimated number of newly covered dependents: 33,000
- Annual Costs - Total: $140.4 million
  Employer: $ 93.6 million
  Individual: $ 46.8 million

APPENDIX A

APPENDIX A

DESCRIPTION OF ALTERNATIVE BENEFIT PACKAGES

This appendix provides brief descriptions and the estimated premium costs of the six alternative benefit packages developed for use in HSR's cost estimation model.

Package 1.

The benefits under this package are similar to those available to state employees under what is known as the Blue Cross/Blue Shield Program II option. The benefits include coverage of inpatient hospital care (after a deductible equal to the two day rate for a semi-private room), physician office visits (90% coverage, no deductibles), immunizations and prescription drugs. Annual out of pocket expenses are limited to $500 per person/family.

The majority of State of Iowa employees in a BC/BS plan are enrolled in this plan. The enrollees have an age distribution similar to the state's uninsured population.

Premium Estimates

Adult: $165/month
Child: $ 50/month

Package 2.

This package is a relatively broad one similar to that provided under the state Medicaid program. Coverage includes inpatient care, physician services, well-child care, prescription drugs and a variety of other services. Estimates are based upon Medicaid reimbursement levels.

Premium Estimates:

Adult: $140/month
Child: $ 75/month

Package 3.

This alternative is based upon "Plan 1" developed by the Governor's Blue Ribbon Committee on the Uninsured. This package would include inpatient care and physician services. Prescription drugs are not covered. All benefits would be subject to a $250/person deductible and then 80/20 coinsurance payments. Annual out-of-pocket payments would be capped at $750/person. Premium estimates developed by the Blue Ribbon Committee have been updated to reflect inflation and administrative costs.

Premium Estimates:

Adult: $125/month
Child: $ 60/month

Package 4.

The services available under this alternative are modeled after the benefit package offered under the Denver SCOPE plan, a Robert Wood Johnson Foundation-supported demonstration program. The SCOPE plan has a unique benefit package that combines strong front-end coverage for preventive care with sizable cost-sharing requirements for inpatient hospital use. The plan covers 100% of the cost for well-child care and mammography screenings and charges a $15 copayment for visits to physicians for other preventive services. Persons entering a hospital are required to pay a $250 deductible and 50% coinsurance payments for the first $5,000 in charges. Out-of-pocket expenses above $2,750 per person per year are covered in full. SCOPE's premium levels also reflect the use of selected hospital facilities providing significant discounts.

Premium Estimates:

Adult: $ 68/month
Child: $ 50/month

Package 5.

This alternative is modeled after "Plan 3" included in the Governor's Blue Ribbon Committee report and is similar to a Basic health plan currently being marketed by Blue Cross/Blue Shield. It covers inpatient hospital care, outpatient surgery, emergency and accident care, and several other services. It does not cover major medical benefits (e.g. non-emergency physician office visits, prescription drugs, or maternity care). The plan includes selective contracting with hospitals and physicians

and copayments of $200-600 per hospital admission, $50-150 for outpatient surgery and non-emergent hospital emergency room use, and $10-30 for emergency and ambulatory surgery services. There is no out-of-pocket maximum.

Premium Estimates:

Adult: $ 66/month
Child: $ 46/month

Package 6.

This package covers non-inpatient services for children, including well-child visits, immunizations, and prescription drugs.

Premium Estimates:

Child: $ 30

Table A-1 on the following page presents the estimated monthly premiums for adults and children for the six benefit packages described above. As noted in the body of the document, unless otherwise specified, the cost estimates of most of the options were developed using mid-level premium estimates similar to that of Package Three. The last two columns of the table identify the percentage differences between this index premium and the projected premiums for other options.

TABLE A-1

ESTIMATED MONTHLY PREMIUM/COVERAGE COSTS FOR VARIOUS BENEFIT PACKAGES

BENEFIT PACKAGES		ADULT	CHILD	PERCENT ABOVE/BELOW INDEX PREMIUM (OPTION 3) ADULT	PERCENT ABOVE/BELOW INDEX PREMIUM (OPTION 3) CHILD
1.	State Employee Program (BC/BS Plan 2)	$ 165	$ 90	+ 32%	+ 50%
2.	Medicaid	$ 140	$ 75	+ 12%	+ 25%
3.	Governor's Commission Proposal (Plan 1)	$ 125	$ 60	0	0
4.	Denver SCOPE	$ 68	$ 50	- 46%	- 17%
5.	Governor's Commission Proposal (Plan 3 - BC/BS BASIC)	$ 66	$ 46	- 47%	- 23%
6.	Ambulatory Services Only for Children	--	$ 30	--	- 58%

APPENDIX B

TABLE B-1

IOWA DEPARTMENT OF HEALTH CONTRACTS FOR PERSONAL HEALTH CARE SERVICE PROGRAMS*

Program	Services Provided	Funding State/Federal	Income Eligibility	Contracting Agencies & Subcontractors	No. of Counties Served	No. of Clients
Public Health Nursing	Counseling, health promotion, health assessment, nursing care, referral to treatment	S/F $2.2 m.	Under 100% FPL w/ no charge; above FPL w/ sliding scale, by county	Boards of health	99	?
Child Health**	Health & dental assessment, lab, nutrition counseling psycho-social care for children 0-21	S/F $3.5 (for both child & maternal health)	Up to 185% FPL; sliding scale above	PH nurses, VNA, CAP, hospitals (25 contractors)	94 (99**)	15,100 (FY 88)
Maternal Health**	Health & dental assessment, lab, nutrition counseling psycho-social care, prenatal/postnatal care for pregnant women 15-44	S/F $3.5 (for both child & maternal health)	Up to 185% FPL; sliding scale above	PH nurses, VNA, CAP, hospitals (23 contractors) subcontract with rural MDs	96 (99**)	3440 (FY 87)
Dental Care	Dental treatment for children and women in MCH programs	S/F $164,000	Up to 150% FPL; no charge <FPL; sliding scale above	Des Moines Health Center St. Luke's Hospital	5	1950 (FY 88)
	Dental treatment for handicapped children	S/F $55,000	Up to 150% FPL	Univ. Iowa Hosp/Clinics	Statewide	200 (FY 88)
WIC	Nutrition counseling & food supplements to pregnant/lactating women and children 0-5	S/F 3.5 m.	Up to 185% FPL; no charge <FPL; sliding scale above	Boards of Health, CAP hospitals subcontracts w/ PHN & VNA	99	38,000/mo (FY 88)

* Data from Division of Family and Community Health, Iowa Department of Health, Overview, 1989 and Description of Intended Expenditures, 1989-90.

** Maternal and child health services are also provided at 5 other centers funded by other state, local, or private funds.

TABLE B-1 (continued)

IOWA DEPARTMENT OF HEALTH CONTRACTS FOR PERSONAL HEALTH CARE SERVICE PROGRAMS***

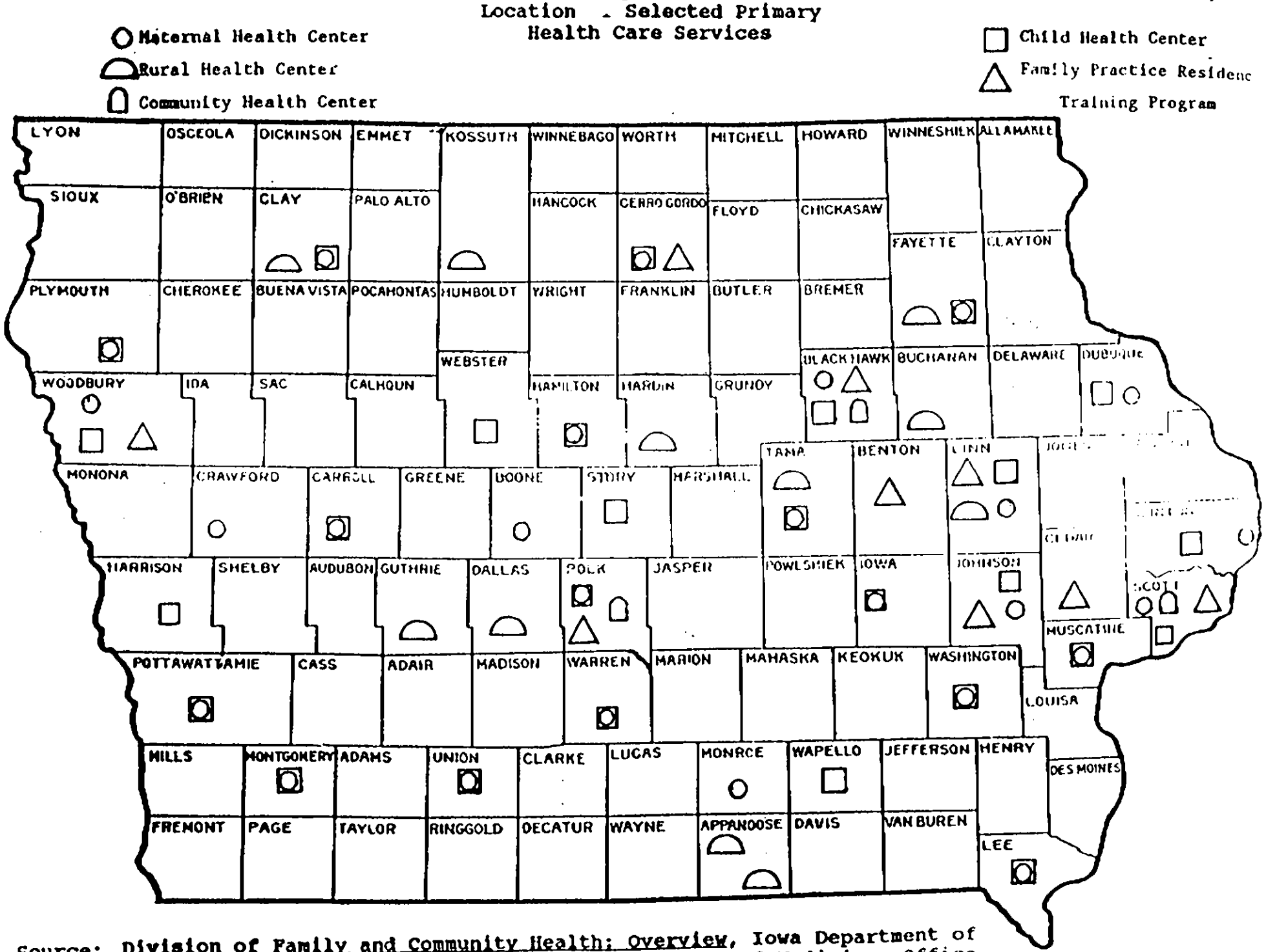
Program	Services Provided	Funding State/Federal	Income Eligibility	Contracting Agencies & Subcontractors	No. of Counties Served	No. of Clients
Family Planning	Counseling and contraceptive supplies	S/F $400,000	Up to 100% FPL w/ no charge; plus sliding scale above	Department of Health, FP Program, FP Council of Iowa, (Planned Parenthood affiliate)	99	12,300 (FY 87)
Homemaker/ Home Health Aide & Chore Services	Long term care to permit children and adults to remain at home	S $7.9 m.	SSI standards plus $10,000 of resources	Board of Supervisors, Board of Health, Subcontract w/ VNA hospitals, NFP corps	99	??
Well Elderly	Health assessment, counseling to persons over 55, referral to sources of treatment	S $492,000	Up to 100% FPL, and in some counties above FPL	Boards of Health	65	??
Substance Abuse****	Screening, evaluation, assessment, treatment, aftercare for alcohol and substance abusers	S/F $10 m.	None, but higher income persons are charged on sliding scale	Treatment centers in 31 areas of state	99	25,000

*** Data from Division of Family and Community Health, Iowa Department of Health, Overview, 1989.

**** Data from Iowa Comprehensive State Plan for Substance Abuse, 1988-1989, Iowa Dept. of Public Health

APPENDIX C

Figure 1.
Location of Selected Primary
Health Care Services



Source: Division of Family and Community Health: Overview, Iowa Department of Public Health 1989 and University of Iowa College of Medicine, Office

ADDITIONAL INFORMATION ON OPTIONS TO IMPROVE ACCESS FOR IOWA'S UNINSURED AND UNDER INSURED

A Supplement to the
July 17, 1990 Report to
the Task Force

Prepared For:
The Health Care Expansion Task Force
of the Iowa General Assembly

Prepared by:
Health Systems Research, Inc.
Washington, D.C.

August 28-29, 1990

I. Introduction

At the July 17, 1990 meeting of the Iowa Health Care Expansion Task Force, Health Systems Research, Inc. presented cost estimates for a range of options designed to improve access for Iowa's uninsured and underinsured populations. Based upon the discussion at that meeting, the Task Force requested additional information on selected options. Specifically, we were asked to:

- Provide cost estimates for expanding the public delivery system to a level below that presented in our July 17 report (In the report, this is Option B under Public-Sector Oriented Approaches);
- Provide cost estimates for improving the coordination and integration of existing public financing and delivery systems (Option C);
- Identify available information concerning health care personnel shortages in the state;
- Provide cost estimates for establishing new public programs for low-income adults and children using income eligibility limits below those used in our July 17 report (Option E);
- Explore the availability of relevant data and develop estimates of current health care spending in Iowa (This information was requested to assist the Task Force in its discussion of a single payer health care financing approach - Option F);
- Provide additional information on regulatory reform options affecting small group insurance rate setting practices (Option A under Private Sector - Oriented Approaches);
- Develop an option for establishing a pool through which all businesses could purchase health care coverage; and
- Explore approaches for expanding dependent coverage in the event that the State's Medicaid demonstration program application is not approved.

This additional information is presented in the following sections.

II. Public Sector Service Delivery and Financing Enhancements

This section provides additional information concerning:

- Options to expand the current publicly supported system of delivering preventive and curative services for children;
- Options to improve the coordination and integration of publicly supported financing and delivery activities; and
- The availability of health care personnel in Iowa.

It is organized into the following three subsections:

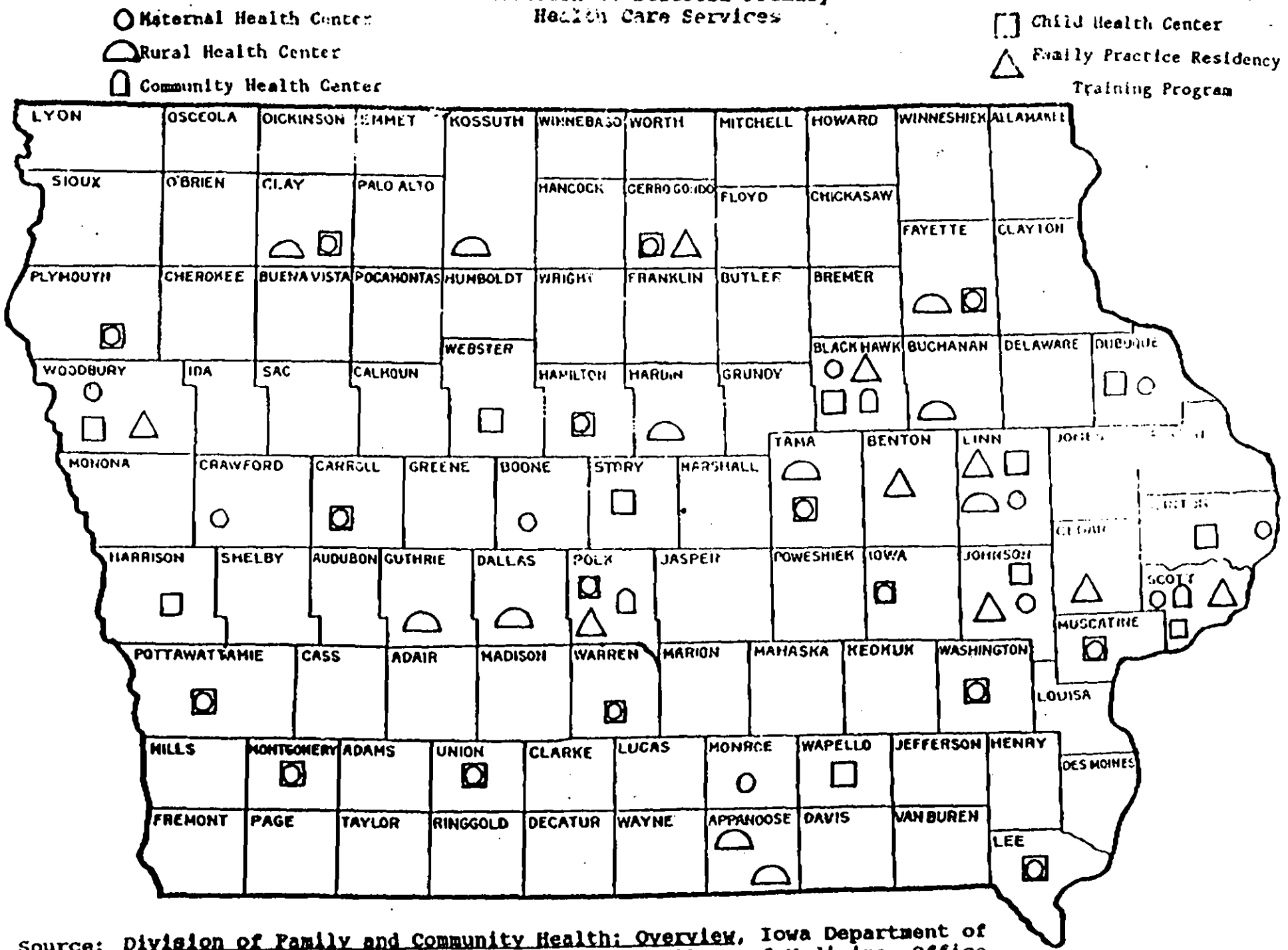
- A brief description of the publicly supported delivery system in Iowa;
- Findings from a review of this system; and
- Possible recommendations for improving the system's performance.

A. Iowa's Publicly Supported Health Care Delivery Systems

There is loose-knit system of public and quasi-public health care providers in the state that serves as a safety net for many uninsured Iowans (See map in Figure 1). The network comprises:

- 3 community health centers (CHCs) in Des Moines, Waterloo, and Davenport, funded by the Federal government under Section 330 of the Public Health Services Act, and one federally funded Migrant Health Center to serve farm workers;
- 11 Medicare-certified rural health clinics (RHCs) that are permitted to employ allied health personnel, such as Physician Assistants and Nurse Practitioners, under general physician supervision;
- 29 Maternal and/or Child Health (M/CHs) Centers funded primarily through the Iowa Department of Health that operate at least episodically in all 99 counties;

Figure 1.
Location of Selected Primary Health Care Services



Source: Division of Family and Community Health: Overview, Iowa Department of Public Health 1989 and University of Iowa College of Medicine, Office

- 9 training sites of the Family Practice Residency Training Program (7 of which are under the direction of the University of Iowa) that train family physicians and receive $1.7 million in state funds; and

- 4 school-based youth services programs that provide health services as part of their responsibilities were funded for FY 91 by the legislature, and which are currently under development.***

This network of Maternal and Child Health Centers serving all 99 counties receives $3.5 million in state and federal (MCH block grant) funds to provide maternity and child health services to about 18,000 clients with incomes under 185% of the federal poverty level. As many as half of the children served by the centers have insurance but no coverage for preventive care.

In spite of this broad array of public health services, only the rural health centers and community health centers function as full-service primary care clinics for the low-income uninsured. The Maternal Health Centers generally provide or arrange for both prenatal and delivery services for low-income women, but their income guidelines now match those of Medicaid, so they do not generally subsidize care for other uninsured women. The Child Health Centers offer only preventive care, such as immunizations and well-child check-ups. Although, they can refer sick children for care other than for chronic or accidental illness or injury to community physicians under the $400,000 program established by the legislature in 1989 to pay for diagnosis and treatment of children referred through the centers.

The state funds a series of other programs (see Table 1). State and federal funds support dental treatment for children and pregnant women in the M/CH program. Specialized services for chronically ill and disabled children are delivered through the University of Iowa Hospitals and Clinics. Homemaker/home health aide services in all counties provide long-term care to permit children and adults to remain at home. Well elderly clinics provide health assessment, counseling, and referral to treatment for people over age 55. Public health nursing services in all counties (funded by state and local sources, but using county-employed nurses) provide counseling, health promotion, health assessment, nursing care, and referral to treatment. These programs all serve families with incomes below from 100% to 185% of the federal poverty level free or at a reduced charge and generally cover higher income persons for a higher fee.****

*** A task force comprising the Departments of Public Health, Human Services, and Education is currently examining school health services in general.

**** County governments also fund a variety of health services. The results of a survey of county activities is being analyzed separately.

TABLE 1

IOWA DEPARTMENT OF HEALTH CONTRACTS FOR PERSONAL HEALTH CARE SERVICE PROGRAMS*

Program	Services Provided	Funding State/Federal	Income Eligibility	Contracting Agencies & Subcontractors	No. of Counties Served	No. of Clients
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Child Health**	Health & dental assessment, lab, nutrition counseling psycho-social care for children 0-21	S/F $3.5 (for both child & maternal health)	Up to 185% FPL sliding scale above	PH nurses, VNA, CAP, hospitals (25 contractors)	94 (99**)	15,100 (FY 88)
	Referral to sick care	$ 400,000		Local MDs		
Maternal Health**	Health & dental assessment, lab, nutrition counseling psycho-social care, prenatal/postnatal care for pregnant women 15-44	S/F $3.5 (for both child & maternal health)	Up to 185% FPL sliding scale above	PH nurses, VNA, CAP, hospitals (23 contractors) subcontract with rural MDs	96 (99**)	3440 (FY 87)
Dental Care	Dental treatment for children and women in MCH programs	S/F $164,000	Up to 150% FPL no charge <FPL; sliding scale above	Des Moines Health Center St. Luke's Hospital; private DDS	99	1950 (FY 88)
	Dental treatment for handicapped children	S/F $55,000	Up to 150% FPL	Univ. Iowa Hosp/Clinics	Statewide	200 (FY 88)

* Data from Division of Family and Community Health, Iowa Department of Health, Overview, 1989 and Description of Intended Expenditures 1989-90.

** Maternal and child health services are also provided at 5 other centers funded by other state, local, or private funds.

TABLE 1 (continued)

IOWA DEPARTMENT OF HEALTH CONTRACTS FOR PERSONAL HEALTH CARE SERVICE PROGRAMS***

Program	Services Provided	Funding State/Federal	Income Eligibility	Contracting Agencies & Subcontractors	No. of Counties Served	No. of Clients
WIC	Nutrition counseling & food supplements to pregnant/lactating women and children 0-5	S/F 3.5 m.	Up to 185% FPL; no charge <FPL; sliding scale above	Boards of Health, CAP hospitals subcontracts w/ PHN & VNA	99	38,000/mo (FY 88)
Family Planning	Counseling and contraceptive supplies	S/F $400,000	Up to 100% FPL w/ no charge plus sliding scale above	Department of Health, FP Program, FP Council of Iowa, (Planned Parenthood affiliate)	99	12,300 (FY 87)
Homemaker/ Home Health Aide & Chore Services	Long term care to permit children and adults to remain at home	S $7.9 m.	SSI standards plus $10,000 of resources	Board of Supervisors, Board of Health, Subcontract w/ VNA hospitals, NFP corps	99	??
Well Elderly	Health assessment, counseling to persons over 55, referral to sources of treatment	S $492,000	Up to 100% FPL, and in some counties above FPL	Boards of Health	65	??

*** Data from Division of Family and Community Health, Iowa Department of Health, Overview, 1989.

**** Data from Iowa Comprehensive State Plan for Substance Abuse, 1988-1989, Iowa Dept. of Public Health

B. Findings

Based on review of documents, interviews with state officials, and visits to one community health center and selected maternal and/or child health (M/CH) centers around the state that represented a variety of organizational models, we make the following observations and conclusions about Iowa's public and quasi-public health care delivery system. The purpose of our visits was not detailed a M/CH Center program evaluation, which could involve its own separate study, but we did observe program strengths that could be built on and weaknesses that could be addressed.

Our comments with respect to the state's network of ambulatory providers are as follows:

- The M/CH Centers are an important foundation for ambulatory care delivery in the state. This network is unique and forms the framework for building a public and quasi-public delivery system where private providers are not available or willing to serve the uninsured.

- Nevertheless, M/CH Centers do not meet all the need for preventive care. We estimate that in Iowa there are currently about 32,000 uninsured children under 200% of the federal poverty level and 70,000 privately insured children in this income category without preventive care coverage. Of these 102,000, about 11,000 uninsured children are now served by Child Health Centers and about 11,000 other uninsured children are now served by Community Health Centers.

- There is great variety among the M/CH centers in terms of structure and orientation. Some are traditional local public health nursing agencies, while others are local community service groups (Community Action Programs or family service agencies), or hospitals. Some of these agencies view their mission narrowly to provide specific services on request, while others seek to provide a broad range of services and promote them in the community. In our limited review, the programs that seemed to work best combine or at least co-locate maternal and child centers (just over half the programs are combined) and have a good sense of the health care needs and resources of the communities in which they function.

- Relationships with local physicians, critically important to the centers' success, vary across the state. Child Health Center staffs have found the voucher program very useful. Physicians, who are paid Medicaid rates for a limited number of visits, have generally responded well to the program and are willing to participate. Other relationships between the centers and physicians seem to depend upon the local medical

marketplace. The general shortage of physicians willing to deliver babies makes it difficult for some Maternal Centers to find contracting physicians; several mentioned that physicians are generally limiting their Medicaid client loads. Furthermore, when a community is prosperous, physicians seem comfortable with a prominent role for Child Health Centers, but when the economy is stagnant, some physicians tend to view these centers as competition for even uninsured patients. In some communities, physicians send their insured patients to Child Health Centers for well-child care, while in others, doctors assert that splitting preventive and primary services impedes continuity of care, especially for chronically ill children.

- Coordination between M/CH Centers and Medicaid is vital but inadequate. Maternal Health Centers have seen their funding change from mostly MCH Block grant to almost exclusively Medicaid, as Medicaid eligibility has expanded up to 185% of the federal poverty line (the MCH eligibility standard). Nevertheless, some staff noted that their clients have difficulty completing the Medicaid application process. Even with presumptive eligibility, the follow-up Medicaid application is cumbersome and confusing. M/CH center staff do not always see their job as assisting clients to apply for Medicaid, and local social services staff are not always helpful in their attitudes.

- Even for eligible children, the sick care voucher program is limited. The Child Health Center voucher program pays for acute rather than chronic care or care for accident or injury. While some center staff attempt to stretch the definition of covered care to include acute episodes of a chronic condition, others are uncomfortable bending the rules. Such a limitation can impede continuity of care and discourage providers from treating the whole child.

- Adolescent health care is an unmet need. Adolescents are reluctant to attend child health clinics, due both to attitude and to the physical locations of many of these clinics. Most temporary and some permanent sites are in church basements and other settings inappropriate for older children. Special education and outreach is also necessary to attract these youth to preventive health clinics.

- On the whole, M/CH centers appear to have the flexibility to meet local community needs, but the state has not established guidelines for their performance or rigorously evaluated their effectiveness. M/CH contracts have apparently been awarded based on historical patterns of local service delivery, and changes in contractors is rare. The new revenues from expanded Medicaid eligibility for pregnant women and young

children may free up federal and state maternal and child health care funds and offer the opportunity to review M/CH center goals and performance. The contract process can strike a balance between identifying and addressing unique local needs and meeting state standards to improve accountability. Most centers have unsophisticated patient tracking systems that would need improvement to monitor their performance and compliance with state standards.

- The Department of Public Health will be undertaking new needs assessment and data collection duties under recent federal law changes. In the 1989 Omnibus Reconciliation Act, Congress imposed new responsibilities upon state Maternal and Child Health agencies. In an expanded application process, MCH agencies will be required to include statewide needs assessment data on services to women and children and to outline a plan to meet various national MCH goals. States must also report health status indicators, such as perinatal and maternal mortality, immunization status, low birth weight rates, and rates of early prenatal care.

- Many Medicaid eligible are not enrolled. Despite a significantly increased caseload of children and pregnant women, many Medicaid eligible families are not enrolling in the program. In 1989, an estimated 24,000 persons eligible for Medicaid were not enrolled. Among the many reasons that people do not participate in public programs are lack of information, eligibility complexity and confusion, and the program's association with the welfare system. Several states have greatly simplified their application forms and processes for pregnant women and young children, and many have developed major media campaigns to encourage these groups, in particular, to enroll. Some states have also renamed their Medicaid programs for pregnant women ("Baby Your Baby," "BabyCare," etc) to improve its image and encourage early enrollment.

  Medicaid's EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Program for children is designed to identify childhood disability and illness early in order to treat or ameliorate potentially disabling conditions. Throughout the United States, about 30% of the children screened under EPSDT are referred on to diagnosis and 27% of them are referred to treatment. In Iowa these proportions are only 9% and 10%, respectively, suggesting the need for an improved system to follow referrals from screening and diagnosis to treatment providers, an approach which has been successful in other states.

- There are many communities where low-income uninsured are not served by a full-service ambulatory clinic. The map in Figure 1 shows these areas.

- Access to prenatal care for lower income women not eligible for Medicaid is an increasing problem. Local needs vary across the state, but most M/CH centers cited an increasing problem of access to prenatal care providers, (due in part to the general physician shortage in rural areas) especially for women above Medicaid income eligibility guidelines. Some try to assist these women, but they are not funded to subsidize their care.

- Preventive and primary care for uninsured adults is limited. Community Health Centers provided preventive and primary care to about 37,000 patients in 1989 but exist in only three communities in the state. The University of Iowa's $27 million "state papers" program provides primary and acute care in Iowa City to about 550 obstetric/newborn and 800 orthopedic patients (non-quota patients) and 3,900 patients referred under the county quota system. M/CH center staffs reported difficulty in getting patients into the state papers program because County Relief directors, responsible for setting eligibility standards and certifying patient eligibility, vary in their willingness to use their quota slots. Furthermore, despite the University Hospitals' transportation network, low-income patients not certified as state papers have difficulty traveling to Iowa City due to cost and unavailability of private or public transportation. Some center staffs also noted the problems faced by residents of outlying rural counties in transporting themselves to the centers' sites for preventive care or acute care referral.

Our final finding addresses the problem of shortages of primary care providers in the states:

- Although not well quantified, it is certain that there are shortages of primary care providers in many areas of the state. Research by the University of Iowa, the Iowa Medical Society, health professional licensing boards, and the Health Professionals Shortage Committee and Governor's Task Force on Rural Health have all documented shortages of personnel such as obstetricians, family practitioners, physician assistants, pediatric nurse practitioners, nurse midwives, and registered dieticians.*****

*****See Final Report of the Health Professional Shortage Committee submitted to the Iowa College Aid Commission and Joint Education Appropriations Subcommittee

For instance, although the Board of Nursing reports 72 licensed pediatric nurse practitioners in the state, over one-third are located in Johnson County, and some are not actively practicing. Child Health Centers generally contract with PNPs on a part-time basis, so these nurses find it difficult to establish a sufficient practice, especially in rural areas where travel is an additional problem. Physicians are also in short supply in some areas of the state; 28 areas in Iowa (in all or parts of 48 counties) are designated by the U.S.P.H.S. as "health manpower shortage areas." The University of Iowa College of Medicine's Office of Community-Based Programs reports that 165 Iowa communities are seeking one or more family practitioners. The Physician Assistant training program estimates that there are 45 unfilled employment opportunities for PAs in the state. And a recent Iowa Medical Society survey revealed that over one-third of obstetricians and family practitioners report a shortage of obstetrical services for all patients, and up to half report a shortage of obstetrical services for Medicaid patients. The majority of the physicians responding report an obstetrical shortage for all patients in over one-third (35) of the state's counties.

Despite many independent studies of the health personnel shortage issue, there is no single focal point to conduct or coordinate data collection, analysis, and solution development for this overreaching health care delivery problem in the state.

See Appendix A for further information on this issue.

C. Possible Recommendations

To address the most pressing of these needs, the Task Force should consider the following recommendations:

1. Expand the preventive and acute care programs for children under 200% of the poverty line, to include the largest number of children that can be covered within the state's budget limits and expand the sick care voucher program to include chronic and accidental illness and injury.

(continued)
December 15, 1989, and Final Report of the Governor's Task Force on Rural Health, November 28, 1989.

Currently about 80,000 low-income children without preventive care coverage are not served by Child Health Centers or Community Health Centers. Assuming that half of these eligible 80,000 children would participate in expanded child health services at $100 per child per year, the cost of expanding services to 40,000 new children (12,400 currently uninsured children and 27,600 insured children) would be 4 million state dollars (it is unlikely that new federal Maternal and Child Health Block grant funds would become available to support such an expansion). By lowering the income eligibility level or capping the budget, for instance at $2 million, the state could serve a smaller group, for example, one-quarter of the eligible population (20,000).

To assure follow-up care for sick children, the state could expand its current voucher program (appropriated at the level of $450,000 for FY 1991). About 13% of the children seen in well-child clinics are referred to physicians for treatment, but this is an early estimate that might be low (one center we visited referred one-third of its children). Current per child costs are $50, but this estimate may also be low since it is based on very early program experience. Only the 12,400 currently uninsured children would require state funds for this follow-up care. Assuming a 20% participation rate among the 12,400 uninsured children and a $50 per child cost, expanding the sick care voucher program to correspond with expansion of the preventive care program would cost $124,000 in state funds.

The Department of Health staff have also estimated the need for approximately $60,000 in additional funds to properly administer the expanded voucher program. These funds would support administration for the entire program ($450,000 for the FY 91 program plus the $124,000 expansion) and would represent about 11% of total care costs.

Removing the restriction on using vouchers for chronic or accidental illness or injury would increase the cost of this program somewhat, but it is not possible to estimate the impact of this change.

It should be noted that there are several impediments to significantly increasing Child Health Center capacity: the shortage of pediatric nurse practitioners and dieticians in many areas of the state; the physical space in which many child health clinics are located; the need to upgrade tracking systems to meet additional capacity and new case management responsibilities; and the potential resistance of the medical community to Child Health Center expansion. The Department of Health could assist centers in locating personnel and upgrading tracking and referral systems.

2. Actively pursue additional federal funds for one or more ambulatory community health centers in underserved areas of the state. Although federal funds for Community Health Centers have been limited in recent years, the Department of Health and other officials have been discussing a possible grant application with the U.S. Public Health Service (PHS). There is optimism that the PHS may entertain an application for a new Community Health Center, possibly in western Iowa or in conjunction with a rural hospital. Additional state resources would be needed to develop such an application. We estimate that a successful grant application requires some community needs assessment and health personnel assessment as well as detailed administrative and programmatic description. Such an application might cost $50,000, some of which might potentially be raised from the private sector, but some of which might need to be state resources.******

3. Improve coordination and integration of public programs. To obtain maximum Federal matching funds and assure that as many persons eligible for Medicaid as possible are enrolled in the program, the Department of Human Services should:

   a. Expand Medicaid outreach activities to identify more eligible individuals, including eligibility coordination with Maternal and Child Health Centers, Rural Health Clinics, and Community Health Centers, preparation of a video on eligibility processing (for use by M/CH centers and other interested agencies), and preparation of brochures for consumers and providers on Medicaid;

   b. Outstation eligibility workers in selected public clinics, hospitals, and Maternal and Child Health Centers;

   c. Consider changing Medicaid's name to distance it from its welfare association;

   d. Develop a public media campaign for the expanded program; and

   e. Increase its efforts to enroll eligible children in Medicaid's EPSDT, including the distribution of information on the program through the school system.

******A recently successful CHC grant application in metropolitan Denver cost over $100,000 to develop.

A first-year budget of approximately $300,000 is assumed for these efforts, of which half could be financed with federal Medicaid matching funds. As has been the experience in other states, this estimate assumes substantial contributions from the private sector in the form of donated TV and radio air time for public service messages, etc.

4. Simplify the Medicaid application process. Medicaid currently uses an integrated application form that collects information needed to determine an applicant's eligibility not only for Medicaid, but also for a number of other publicly supported programs, including WIC, Food Stamps, etc. However, an often-cited barrier to getting people through the Medicaid enrollment process is the length and complexity of this form.

   The Department of Human Services should consider assessing the relative benefits of this comprehensive form compared to a streamlined one that might increase overall Medicaid enrollment and allow new recipients to apply for other benefits once they are in the system. The possibility of designing a demonstration that would examine the effectiveness of alternative approaches in several different sites should be considered. Federal support for such a demonstration should also be explored.

5. Review the state's process of contracting with M/CH Centers. The Department of Public Health should consider the following:

   a. Improve the coordination of related services (WIC, prenatal care, child health care) through mechanisms such as a single contract for such services, co-location, or other means of coordination. WIC contracts are combined with existing M/CH contracts, and this strategy should continue. While state contracts for these services evolved due to traditional patterns of community interest and service, they may not today represent the best means of delivering related services to the target population. The department should closely examine its contracting agencies and determine how care can be delivered in the most efficient and effective manner to meet local needs.

   b. Require applicants for M/CH contracts to identify and propose means to address community needs. The department should take a more active role in helping communities, including its M/CH contractors and other interested agencies, to assess community health needs and develop plans for meeting them with both private sector and public sector strategies. This is consistent with its new responsibilities under OBRA 1989. Rather than duplicating current

activities, the Department could, for instance, assist counties already undertaking health needs assessments to include a focus on maternal and child health by developing protocols and by full or partial funding of such activities. It could also assist local agencies by coordinating current assessment activities and planning processes and assuring standardized and high quality analyses.

c. Actively participate in Medicaid outreach. The Departments of Public Health and Human Services are currently undertaking a pilot to train M/CH center staff in Medicaid outreach activities. The results of this project should be monitored and an appropriate strategy replicated throughout the state.

The Department of Health estimates the annual cost of carrying out the above three activities to be $690,000.

d. Department of Health staff estimate the cost of expanding its current pilot outreach efforts to a statewide basis to be approximately $325,000 per year. It is assumed that half of this amount would be financed with Medicaid matching funds.

6. Require M/CH contractors to meet performance standards. Consistent with its new data collection responsibilities under OBRA 1989, the Department of Public Health should consider requiring that M/CH Centers meet specific standards for contract renewal, such as:

a. Identification of women and children potentially eligible for Medicaid;

b. Actively providing assistance in completing Medicaid applications;

c. Follow up to determine numbers of clients who were potentially eligible for Medicaid, who were assisted, who actually applied, and who were ultimately enrolled; and

d. Community needs assessment, problem identification, and attempted problem resolution (as discussed above).

The Department of Health estimates that requiring its M/CH contractors to actually assist and follow up on clients applying for Medicaid would involve new staff costs of approximately $15,000 per year per contractor. The total annual cost to the Department of Health to implement these activities is estimated to be $660,000.

7. Further examine the health personnel shortage issue. Although a number of state and private agencies are studying various aspects of the health personnel shortage problem, there is no central coordinating agency that can conduct targeted studies of personnel need, pull together the efforts of these various agencies, collect and analyze data, and propose solutions to the problem. Department of Health staff estimate the annual cost of this activity to be about $65,000.

III. New Public Coverage Programs for Certain Low-Income Persons

In our July 17 report to the Task Force, we provided cost estimates for two different programs that would extend publicly supported health care coverage to certain low-income persons not eligible for Medicaid. The first would extend fully subsidized coverage to adults and children below the poverty level, and partially subsidized coverage to adults and children between 100% and 200% of poverty. The second program extended coverage to children under 250% of poverty and required payment of a $25 annual enrollment fee for those children above poverty. For the latter program, two different benefit packages were costed out: a Medicaid benefits package and a package covering only ambulatory care. These cost estimates assumes some switching of coverage by previously insured persons.

The Task Force requested that alternative cost estimates be developed by varying certain design features and/or assumptions. Specifically, we were asked to explore the cost implications of:

- lowering the program's income eligibility limits;
- reducing the amount of the subsidy for the adult and child program; and
- reducing the crossover of previously insured persons into the programs.

Cost estimates were developed for five different alternatives for the adult and child program and four alternatives for the children only program. The design features/assumptions upon which these alternative scenarios are based are identified below. A summary of the enrollment and cost estimates for the alternative adult and child programs is presented in Table 2. A summary of enrollment and cost estimates for the children only program is presented in Table 3.

A. Programs for Adults and Children

Alternative 1: Coverage of Persons under 200% of Federal Poverty Level (FPL)

Assumptions:

- Full state subsidy of premium for persons below poverty
- Sliding scale premium subsidy for persons between 100 - 200% poverty
- Average state subsidy for 100 - 200% poverty group is 60%
- Average monthly premium cost equal to $125/adult and $60/child
- Participation rates by current insurance status:

uninsured	- 50%
nongroup	- 25%
group	- 10%

Alternative 2: Coverage of Persons under 150% FPL

Assumptions:

Same as Alternative 1 except:

- Sliding scale premium subsidy for persons between 100 - 150% poverty

Alternative 3: Coverage of Persons under 150% FPL

Assumptions:

Same as Alternative 2 except:

- 90% state subsidy of premium for persons below poverty
- Average state subsidy for 100 - 150% poverty is 50%
- Participation rates by insurance status:

uninsured - 40%
nongroup - 20%
group - 5%

Alternative 4: Coverage of Persons under 100% of FPL

Assumptions:

Same as Alternative 1 except:

- No sliding scale premium subsidy for persons above poverty

Alternative 5: Coverage of Uninsured Persons under 200% FPL

Assumptions:

Same as Alternative 1 except:

- Participation by insurance status:
  - uninsured - 50%
  - assumes no participation by currently insured persons

As can be seen in Table 2, enrollment in the program is estimated to range from a high of nearly 100,000 under Alternative 1 to a low of 30,800 under Alternative 4. Total annual premium costs would range from $123 million under Alternative 1 to slightly more than $40 million for Alternative 4. Annual state costs would range from a high of $90 million under Alternative 1 to approximately $40 million for Alternative 3 and 4.

B. Programs for Children Only

Alternative 1: Coverage of Children under 250% FPL

Assumptions:

- Full state subsidy of premium for children below poverty
- $25/yr enrollment for children above poverty
- Average monthly premium cost equal to $60/child for Medicaid

TABLE 2.
COST ESTIMATES FOR A STATE PROGRAM TO
COVER ADULTS AND CHILDREN BELOW CERTAIN POVERTY LEVELS

	ALTERNATIVE 1	ALTERNATIVE 2	ALTERNATIVE 3	ALTERNATIVE 4	ALTERNATIVE 5
Eligibles					
Adults	375,700	205,500	205,500	110,600	104,000
Children	169,400	71,800	71,800	29,200	31,700
Total	545,100	277,300	277,300	139,800	135,700
Enrollees					
Adults	65,900	39,700	30,700	23,200	34,700
Children	34,000	16,900	12,700	7,600	15,100
Total	99,900	56,600	43,400	30,800	49,800
Annual Costs/Total					
Adults	$98,801,200	$59,509,100	$46,110,300	$34,730,800	$51,981,300
Children	$24,465,100	$11,614,600	$9,147,700	$5,466,600	$10,905,000
Total	$123,266,300	$71,123,700	$55,258,000	$40,197,400	$62,886,300
Annual Costs/State					
Adults	$73,173,100	$49,597,800	$33,894,500	$34,730,800	40,424,900
Children	$16,865,700	$9,499,500	$6,246,700	$5,466,600	7,852,400
Total	$90,038,800	$59,097,300	$40,141,200	$40,197,400	$48,277,300

-like benefits and $25/child for ambulatory services benefits

- Participation rates by insurance status:

uninsured	- 60%
nongroup	- 15%
group	- 5%

Alternative 2: Coverage of Children under 200% FPL

Assumptions:

Same as Alternative 1 except:

- Only children under 200% of poverty are eligible

Alternative 3: Coverage of Children under 185% FPL

Assumptions:

Same as Alternative 1 except:

- Only children under 185% of poverty are eligible

Alternative 4: Coverage of Children under 133% FPL

Assumptions:

Same as Alternative 1 except:

- Only children under 133% of poverty are eligible

As can be seen in Table 3, enrollment in the program is estimated to range from a high of 38,000 under Alternative 1 to a low of 14,000 under Alternative 4. Total annual premium costs for Medicaid-like benefits range from $27.2 million under Alternative 1 to $10.2 million for Alternative 4. Annual state costs for this benefit package would range from a high of $26.5 million under Alternative 1 to $10 million under Alternative 4.

For a program covering only ambulatory care, total premium costs would range from $11.3 million (Alternative 1) to $4.3 million (Alternative 4), with state costs varying

TABLE 3

COST ESTIMATES FOR A STATE PROGRAM TO
COVER CHILDREN BELOW CERTAIN POVERTY LEVELS

	ALTERNATIVE 1	ALTERNATIVE 2	ALTERNATIVE 3	ALTERNATIVE 4
Eligibles				
Previously uninsured children	35,500	31,100	25,500	18,600
Previously insured children	224,000	130,400	98,300	33,300
Total	259,500	161,500	123,800	51,900
Enrollees				
Previously uninsured children	21,300	18,700	15,300	11,200
Previously insured children	16,500	10,700	8,400	3,000
Total	37,800	29,400	23,700	14,200
Total Costs				
Medicaid-Like Benefits:				
Previously uninsured children	$15,340,500	$13,445,100	$11,010,900	$8,042,900
Previously insured children	$11,868,900	$7,691,400	$6,032,700	$2,171,100
Total	$27,209,400	$21,136,500	$17,043,600	$10,214,000
Ambulatory Benefits:				
Previously uninsured children	$6,391,900	$5,602,100	$4,587,900	$3,351,200
Previously insured children	$4,945,400	$3,204,800	$2,513,600	$904,600
Total	$11,337,300	$8,806,900	$7,101,500	$4,255,800
Total Costs/State				
Medicaid-Like Benefits:				
Previously uninsured children	$14,944,200	$13,114,700	$10,765,000	$7,900,100
Previously insured children	$11,507,070	$7,474,300	$5,873,440	$2,145,800
Total	$26,451,270	$20,589,000	$16,638,440	$10,045,900
Ambulatory Benefits:				
Previously uninsured children	$5,995,600	$5,271,700	$4,342,000	$3,208,300
Previously insured children	$4,583,495	$2,987,600	$2,354,321	$879,400
Total	$10,579,095	$8,259,500	$6,696,321	$4,087,700

from $10.6 million under Alternative 1 to $4.1 million under Alternative 4.

IV. Estimates of Current Health Care Spending in Iowa

As part of its discussion of moving to a single payer health care financing system, the Task Force requested that Health Systems Research, Inc. explore the availability of relevant data that could be used to estimate total health care spending in Iowa.

Actual figures on total current health care spending in Iowa are not available. The latest state-specific estimates available are for 1982. However, we attempted to develop reasonable estimates for 1990 using two alternative techniques:

- Updating the 1982 Iowa per capita health care spending figures using the medical care component of the Consumer Price Index (CPI). This figure was compared to the 1990 inflated national per capita figure to ensure that the adjustment was correct. The updated Iowa per capita spending amount was then multiplied by the estimated state population to yield total health care spending.

- The second method utilizes more recent age-specific per capita health care expenditure data to arrive at total health care spending. National age-specific per capita health spending figures for 1987 were updated to 1990 using the medical care component of the CPI, and then applied to the age profile of the Iowa population. The sum of the expenditures for each age category produced an estimate of aggregate Iowa health care spending figure.

Using the first methodology, total 1990 health care spending for Iowa was estimated to be $6 billion. The second method generated an estimate of $6.6 billion.

Order of magnitude estimates of payment sources for these expenditures can be developed by applying national parameters to these Iowa-specific estimates. They are as follows:

- **Private:** $3.6 to $3.9 billion
- **Medicare:** $1.2 to $1.3 billion
- **Medicaid:** $670 to $747 million
- **Other Public:** $586 to $647 million

Finally, it should be noted that both estimates include nursing home expenditures. However, because many proposals considering single payer financing systems do not include long-term care, we also calculated total health care spending without nursing home care expenditures. This reduced our estimates to $5.4 billion to $6 billion.

V. Insurance Regulation Reform Measures

As discussed at previous meetings, significant problems currently exist in the small group health insurance market. A number of organizations, including the National Association of Insurance Commissioners (NAIC), have been working to develop a package of regulatory reform measures that would address many of these problems. The model legislation being finalized by NAIC will apply to coverage for businesses of 25 or fewer employees. It is likely to include provisions in the following areas:

- Rating restrictions
  - annual increases
  - maximum variation
  - allowable classes or blocks of business
- Guaranteed renewability requirements
- Elimination of multiple waiting periods for pre-existing conditions
- Disclosure requirements
- Actuarial certification
- Maintenance of records

As noted previously, adoption of these recommendations will have a negligible cost impact on the State of Iowa but are expected to improve the affordability and stability of health care coverage for certain small businesses within the state.

VI. Improved Availability of Small Business Coverage

Although the measures can be expected to improve the small group market, they cannot ensure that all small businesses interested in obtaining coverage for their employees will find such coverage available to them. As we found in our survey of health insurers operating in Iowa, most, if not all insurers, engage in medical underwriting to assess the risks associated with each small business. Many small businesses that may have one or more employees with high medical needs may find themselves unable to purchase coverage for that employee or even for all of their workers. In some cases, some insurers may consider all businesses within a particular category (e.g., barbers or health care institutions) and refuse to sell coverage to anyone in the category.

To address this problem, the Task Force has asked that we explore the option of establishing a pool through which all small businesses would be able to purchase coverage. The model that currently appears to be the most attractive model for such a pool is a state-established reinsurance pool in which all insurers would be required to participate. NAIC is presently involved in developing model legislation for such a pool. The acting Iowa Insurance Commissioner, who is actively involved in the NAIC efforts, is also in the process of developing a state-specific proposal for Iowa.

The basic features of a reinsurance pool will be discussed at the Task Force's August 28-29 meeting.

VII. Support for Expanded Dependent Coverage

Earlier in this report, we costed out alternate versions of a program providing publicly supported coverage for low-income children (See Section III. B.). In that analysis, we identified the possibility that some low-income parents facing significant premium costs for covering their children through employment-based dependent coverage might switch their children's coverage to the public program. With respect to these children, as well as uninsured low-income children whose parents have not elected to purchase dependent coverage, a more appropriate public policy objective might be to encourage low-income families to take advantage of available employment-based dependent coverage. This option seeks to do that by providing a state subsidy (perhaps in the form of a voucher) for the employee portion of dependent coverage of children.

The design features/assumptions that underlie our cost estimates of this model are as follows:

- Subsidy available to full-time/full-year workers with dependent children (under 18) and whose family income is below 200% of poverty.

- Premium cost per child is $60/month, with employee contribution normally set at 50% or $30/month.

- State subsidy equal to entire employee contribution ($30/month/child) for workers below 100% of poverty; on a sliding scale basis, with average of 60% of employee contribution or $18/child/month, for workers with family incomes between 100% and 200% of poverty.

- Participation rate assumption:

  - children in families where head of household has group coverage - 40%

  - children in families where head of household does not have group coverage but child has non-group coverage - 40%

  - all other children - 30%

Based upon the above assumptions, the following are the estimated impacts of implementing the above program:

- Number of enrollees: 50,000

- Total state subsidy costs: $12.1 million

- Total employee contributions: $6 million

MEMORANDUM

DATE: August 20, 1990
TO: Health Care Expansion Task Force
FROM: Pat Butler, Health Systems Research, Inc.
RE: Health Personnel Shortages

Health care financing strategies presume the availability of health care providers to serve additional groups of people, such as those with new purchasing power through health insurance. Proposals to expand the current public health care delivery systems also require an adequate supply of providers. After examining health personnel issues, two Iowa task forces have concluded that there are significant professional health personnel shortages in the state.[1] Unfortunately, these studies did not quantify the extent of the shortages, although they do provide current data on the location of most categories of licensed personnel in the state. We have spoken to several state agency staff familiar with these issues. There are few hard statistics on the numbers of personnel needed in he state. An outline of findings follows:

I. Physicians

A. Obstetrical services

The Iowa Medical Society (IMS) has recently surveyed obstetricians and family practitioners to determine availability of prenatal and delivery services. One-third of family practitioners and 38% of obstetricians observed that there is a shortage of obstetrical services in he county for all patients; 13% and 25% more, respectively, believe that there is a shortage of obstetrical services for Medicaid patients. Based on responses from 44% of physicians surveyed, IMS identified 35

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[1] See Final Report of the Health Professional Shortage Committee submitted to the Iowa College Aid Commission and Joint Education Appropriations Subcommittee December 15, 1989 and Final Report of the Governor's Task Force on Rural Health, November 28, 1989.

counties where a majority of physicians report a shortage of such services for all patients, another 20 where one-third to one-half of physicians reported a shortage, and 5 additional counties where Medicaid patients have problems finding obstetrical services.

B. Family Practice

According to the University of Iowa's office of Community-Based Programs, 1,175 family practitioners now practice in the state, but 165 communities in Iowa are currently seeking 279 family practitioners (FP). Comparing those who enter and those who leave practice in the state, the state has gained 1-2 FPs per year in recent years. Rural areas, however, are less likely to receive new family practitioners that are urban areas. The retention of Family Practice Residency Training graduates from Iowa dropped from 66% in 1985 to 54% in 1988.

C. Pediatrics

Pediatricians are generally not found in Iowa communities smaller than 25,000. About 60% of the state's 700 pediatricians are located in Des Moines and Iowa City, and most of the others in smaller cites. The Iowa chapter of the American Academy of Pediatrics has no precise figures but does perceive a shortage of pediatricians in the western half of the state in general, and specifically in Sioux City and Waterloo.

II. Nurses

Child Health Centers rely heavily on Pediatric nurse practitioner (PNP), but have experienced a shortage of these personnel in some areas. Since most of the centers can only employ PNPs on a part-time contractual basis, PNPs find it difficult to establish a sufficient practice in rural areas to make the travel worth their effort.

According to the Report of the Task Force on the Shortage of Nursing Personnel in 1989, in the next decade there will be a serious shortage of nurses, especially for acute and long-term care.

III. Other Personnel

A. Dieticians

Child health and WIC centers have experienced shortages of dieticians, but there are no data on the numbers of such personnel needed in the state.

B. Physician Assistants

According to the Health Professional Shortage Committee Report, half of the graduates of the Physician Assistants (PA) training program at the University remain in the state and in 1989 half were place in medically underserved areas. The University's Physician Assistant training program estimates that while about 179 PAs practice in Iowa communities (and another 25 in VA hospitals), about 45 employment opportunities in local communities are currently unfilled.

Appendix G .

POSSIBLE STANDARDS TO BE USED TO ASSESS M/CH CONTRACTOR PERFORMANCE

POSSIBLE CRITERIA TO BE USED TO MONITOR M/CH CONTRACTOR PERFORMANCE IDENTIFIED BY THE IOWA DEPARTMENT OF PUBLIC HEALTH

Activity	Monitoring Criteria
I. Administration	
A. Outreach	- Percentage of MH clients enrolled in first trimester - Percentage of population served for all programs - Percentage of school-aged and adolescent youth served in program - Mandatory evening and weekend clinics (i.e., at least one time per month) - Service area teen birth rate and births to mothers under age 15 - Quarterly reporting of CH/MH enrollment and eligibility by county

B. Fiscal Management	- Setting and enforcing minimum percentage of Medicaid reimbursement by program
	- No more than 1/12 of grant money distributed per month
	- Quarterly reporting to include:
	  - Money spent per contractor
	  - Program income collected by source and service
	  - Percentage of clients receiving assistance with Medicaid application
	- Cost of service delivery
	- Cost per participant

Activity	Monitoring Criteria
C. Coordinator Role	- Definition of minimum role and responsibilities of coordinator including minimum level of experience and education - Definition of minimum coordinator FTE - based upon the number of people served, programs, service area

D. Planning	- Annual or biannual local needs assessments - especially related to access
	- Program yearly goals and objectives stated in clearly measurable terms and related to above
	- Six month progress reports
	- Include plan for local provider outreach - six month reports to include:
	  - Number of local providers (by type) participating in program
	  - Provider concerns
	- "internal" marketing plan

II. Quality Assurance	

A. Coordination	- Mandatory linkages
	  - Written agreements
	  - Plans for ongoing communication
	  - Regular meetings
	- Post clinic team conferences
	- Use of mutlidisciplinary care plan
	- Percentage of families (by program) on WIC
	- Percentage of MH participants enrolled in CH/FP
	- Monitoring area reported cases of child abuse/neglect

Activity	Monitoring Criteria
B. Continuity of Care	- Child health drop rate - Ratio of continuing CH/new - Documentation of follow-up on all referrals in chart within 30 days
C. Clinical	- Percentage of children referred from screening (i.e., vision, dental, developmental) - Completion of training program prior to administering dev/vision/hearing screening (with regular updates) - Immunization rates by ages - Completion of training program prior to prenatal education - Percentage of population with anemia (CDC level defined)

D. Comparison to Percentage of Low Birth Weight	- Receipt of prenatal care:
	  - Adequacy of medical visits
	  - Adequacy of enhanced package
	  - Percentage of service population (from area) with dental caries
	  - Monitoring area cases of measles, tetanus, diphtheria, rubella, encephalitis

Source: Iowa Department of Public Health

Appendix H .

SUMMARY OF COSTS ASSOCIATED WITH RECOMMENDATIONS TO IMPROVE THE PUBLIC SECTOR SERVICE DELIVERY SYSTEM

BUDGET ESTIMATE FOR STRENGTHENING OF PUBLIC SECTOR PRIMARY AND PREVENTIVE CARE DELIVERY SYSTEM

COSTS - YEAR 1

1. Preventive services to 1,000 school-age children and adolescents — 1,000 children x $110	$110,0
2. Voucher Program:	
Acute services for 1,000 school-age children and adolescents — 1,000 children x $44	$44,000
Treatment of injuries — 2,250 children x $100	$225,000
Treatment of chronic conditions — 750 children x $300	$225,000
Support services (2 FTE)	$60,000
3. Medicaid Outreach (DHS)	$300,000
4. Community Assessment (1 FTE)	$55,000
Planning and implementation	$50,000
Training	$50,000
Monitoring/tracking systems (1 FTE)	$100,000
Outreach	$60,000
5. Community Health Center development	$50,000
6. Health personnel shortage coordination	$63,000
TOTAL	$1,392,0

COSTS - YEAR 2

1. Preventive services to 5,000 school-age children and adolescents — 5,000 children x $110	$550,000
2. Voucher Program:	
Acute services for 1,750 school-age children and adolescents — 1,750 children x $88	$154,000
Treatment of injuries — 2,250 young children x $100 + 525 school-age children x $150	$303,750
Treatment of chronic conditions — 925 children x $300	$277,500
Support services (2 FTE)	$60,000
3. Medicaid Outreach (DHS)	$300,000
4. Community Assessment (1 FTE)	$55,000
Planning and implementation	$50,000
Training	$50,000
Monitoring/tracking systems (2 FTE)	$150,000
Outreach	$60,000
5. Community Health Center development	$50,0
6. Health personnel shortage coordination	$48,000
TOTAL	$2,108,250

BUDGET ESTIMATE FOR STRENGTHENING OF PUBLIC SECTOR PRIMARY AND PREVENTIVE CARE DELIVERY SYSTEM

COSTS - YEAR 3

1.	Preventive services to 10,000 school-age children and adolescents -- 10,000 children x $110	$1,100,000
2.	Voucher Program:	
	Acute services for 3,500 school-age children and adolescents -- 3,500 children x $88	$308,000
	Treatment of injuries -- 2,250 young children x $100 + 1,050 school-age children x $150	$382,500
	Treatment of chronic conditions -- 1,100 children x $300	$330,000
	Support services (3 FTE)	$90,000
3.	Medicaid Outreach (DHS)	$300,000
4.	Community Assessment	$0
	Planning and implementation	$0
	Training	$25,000
	Monitoring/tracking systems (3 FTE)	$200,000
	Outreach	$60,000
5.	Community Health Center development	$0
6.	Health personnel shortage coordination	$43,000
	TOTAL	$2,838,500

COSTS - YEAR 4

1.	Preventive services to 15,000 school-age children and adolescents -- 15,000 children x $110	$1,650,000
2.	Voucher Program:	
	Acute services for 5,250 school-age children and adolescents -- 5,250 children x $88	$462,000
	Treatment of injuries -- 2,250 young children x $100 + 1,575 school-age children x $150	$461,250
	Treatment of chronic conditions -- 1,275 children x $300	$382,500
	Support services (3 FTE)	$90,000
3.	Medicaid Outreach (DHS)	$300,000
4.	Community Assessment	$0
	Planning and implementation	$0
	Training	$20,000
	Monitoring/tracking systems (3 FTE)	$200,000
	Outreach	$60,000
5.	Community Health Center development	$0
6.	Health personnel shortage coordination	$42,000
	TOTAL	$3,667,750

Source: Original estimates developed by Iowa Department of Health staff, with updates made by Health Systems Research, Inc.

Appendix I .

DRAFT OF NAIC MODEL LEGISLATION CONCERNING REGULATORY RATE REFORM ON THE SMALL GROUP INSURANCE MARKET

Exposure Draft 9-11-90

PREMIUM RATES AND RENEWABILITY OF COVERAGE FOR HEALTH INSURANCE SOLD TO SMALL GROUPS

Table of Contents

Section 1. Purpose
Section 2. Definitions
Section 3. Health Insurance Plans Subject to this Act
Section 4. Restrictions Relating to Premium Rates
Section 5. Provisions on Renewability of Coverage
Section 6. Disclosure of Rating Practices and Renewability Provisions
Section 7. Maintenance of Records
Section 8. Discretion of the Commissioner
Section 9. Effective Date

Section 1. Purpose

The intent of this Act is to promote the availability of health insurance coverage to small employers, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules for continuity of coverage for employers and covered individuals, and to improve the efficiency and fairness of the small group health insurance marketplace.

Section 2. Definitions

A. "Small employer" means any person, firm, corporation, partnership or association actively engaged in business who, on at least fifty percent (50%) of its working days during the preceding year, employed no more than twenty-five (25) eligible employees. In determining the number of eligible employees, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation shall be considered one employer.

Drafting Note: States may wish to consider a different threshold number of employees for the purposes of defining a "small employer," depending on the underwriting and marketing practices of insurers in the state and any other factors that the state finds relevant.

B. "Insurer" means any person who provides health insurance in this state. For the purposes of this Act, insurer includes a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a multiple employer welfare arrangement or any other person providing a plan of health insurance subject to state insurance regulation.

C. "Health insurance plan" or "plan" means any hospital or medical expense incurred policy or certificate, hospital or medical service

plan contract, or health maintenance organization subscriber contract. Health insurance plan does not include accident-only, credit, dental or disability income insurance; coverage issued as a supplement to liability insurance; worker's compensation or similar insurance; or automobile medical-payment insurance.

D. "Small employer insurer" means any insurer which offers health insurance plans covering the employees of a small employer.

E. "Case characteristics" mean demographic or other relevant characteristics of a small employer, as determined by a small employer insurer, which are considered by the insurer in the determination of premium rates for the small employer. Claim experience, health status and duration of coverage since issue are not case characteristics for the purposes of this Act.

F. "Commissioner" means the Commissioner of Insurance.

G. "Department" means the Department of Insurance.

H. "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business, by the small employer insurer to small employers with similar case characteristics for health insurance plans with the same or similar coverage.

I. "New business premium rate" means, for each class of business as to a rating period, the premium rate charged or offered by the small employer insurer to small employers with similar case characteristics for newly issued health insurance plans with the same or similar coverage.

J. "Index rate" means for each class of business for small employers with similar case characteristics the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

K. "Class of business" means all or a distinct grouping of small employers as shown on the records of the small employer insurer.

(1) A distinct grouping may only be established by the small employer insurer on the basis that the applicable health insurance plans:

(a) Are marketed and sold through individuals and organizations which are not participating in the marketing or sale of other distinct groupings of small employers for such small employer insurer;

(b) Have been acquired from another small employer insurer as a distinct grouping of plans;

(c) Are provided through an association with membership of not less than [insert number] small employers which has been formed for purposes other than obtaining insurance; or

(d) Are in a class of business that meets the requirements for exception to the restrictions related to premium rates provided in Subsection A(1)(a) of Section 4.

(2) A small employer insurer may establish no more than two (2) additional groupings under each of the subparagraphs in Paragraph (1) on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs.

(3) The commissioner may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer insurance marketplace.

M. "Actuarial opinion" means a written statement by a member of the American Academy of Actuaries that a small employer insurer is in compliance with the provisions of Section 4 of this Act, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the insurer in establishing premium rates for applicable health insurance plans.

N. "Rating period" means the calendar period for which premium rates established by a small employer insurer are assumed to be in effect, as determined by the small employer insurer.

Section 3. Health Insurance Plans Subject to this Act

A. Except as provided in Subsection B of this section, the provisions of this Act apply to any health insurance plan which provides coverage to one or more employees of a small employer.

B. The provisions of this Act shall not apply to individual health insurance policies which are subject to policy form and premium rate approval as provided in [insert reference to insurance code provisions for approval of individual forms and rates].

Section 4. Restrictions Relating to Premium Rates

A. Premium rates for health insurance plans subject to this Act shall be subject to the following provisions:

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%).

Paragraph (1) shall not apply to a class of business if all of the following apply:

(a) The class of business is one for which the insurer does not reject, and never has rejected, small employers included within the definition of employers eligible for the class of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon their claim experience or health status.

(b) The insurer does not involuntarily transfer, and never has involuntarily transferred, a health insurance plan into or out of the class of business.

(c) The class of business is currently available for purchase.

(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates which could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more or less than twenty-five percent (25%) of the index rate.

(3) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer insurer is not issuing new policies, the insurer shall use the percentage change in the base premium rate.

(b) An adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the insurer's rate manual for the class of business.

(c) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the insurer's rate manual for the class of business.

(4) In the case of health insurance plans issued prior to the effective date of this Act, a premium rate for a rating period may exceed the ranges described in Subsection A or B of this section for a period of five (5) years following the effective date of this Act. In such case, the percentage increase in the premium rate charged to a small employer in such a class of

business for a new rating period may not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer insurer is not issuing new policies, the insurer shall use the percentage change in the base premium rate.

(b) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the insurer's rate manual for the class of business.

B. Nothing in this section is intended to affect the use by a small employer insurer of legitimate rating factors other than claim experience, health status or duration of coverage in the determination of premium rates. Small employer insurers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

C. A small employer insurer shall not involuntarily transfer a small employer into or out of a class of business. A small employer insurer shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration since issue.

Section 5. Provisions on Renewability of Coverage

A. Except as provided in Subsection B of this section, a health insurance plan subject to this Act shall be renewable to all eligible employees and dependents at the option of the small employer, except for the following reasons:

(1) Nonpayment of required premiums;

(2) Fraud or misrepresentation of the small employer, or with respect to coverage of an insured individual, fraud or misrepresentation by the insured individual or such individual's representative;

(3) Noncompliance with plan provisions;

(4) The number of individuals covered under the plan is less than the number or percentage of eligible individuals required by percentage requirements under the plan; or

(5) The small employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan.

B. A small employer insurer may cease to renew all plans under a class of business. The insurer shall provide notice to all affected health insurance plans and to the commissioner in each state in which an affected insured individual is known to reside at least ninety (90) days prior to termination of coverage. An insurer which exercises its right to cease to renew all plans in a class of business shall not:

(1) Establish a new class of business for a period of five (5) years after the nonrenewal of the plans without prior approval of the commissioner; or

(2) Transfer or otherwise provide coverage to any of the employers from the nonrenewed class of business unless the insurer offers to transfer or provide coverage to all affected employers and eligible employees and dependents without regard to case characteristics, claim experience, health status or duration of coverage.

Section 6. Disclosure of Rating Practices and Renewability Provisions

Each small employer insurer shall make reasonable disclosure in solicitation and sales materials provided to small employers of the following:

A. The extent to which premium rates for a specific small employer are established or adjusted due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer;

B. The provisions concerning the insurer's right to change premium rates and the factors, including case characteristics, which affect changes in premium rates;

C. A description of the class of business in which the small employer is or will be included, including the applicable grouping of plans; and

D. The provisions relating to renewability of coverage.

Section 7. Maintenance of Records

A. Each small employer insurer shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation which demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

B. Each small employer insurer shall file each March with the commissioner an actuarial opinion certifying that the insurer is in compliance with this section and that the rating methods of the insurer are actuarially sound. A copy of such certification shall be retained by the insurer at its principal place of business.

C. A small employer insurer shall make the information and documentation described in Subsection A of this section available to the commissioner upon request. The information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the department except as agreed to by the insurer or as ordered by a court of competent jurisdiction.

Section 8. Discretion of the Commissioner

The commissioner may suspend all or any part of Section 4 as to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small employer insurer and a finding by the commissioner that either the suspension is reasonable in light of the financial condition of the insurer or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

Section 9. Effective Date

The provisions of this Act shall apply to each health insurance plan for a small employer that is delivered, issued for delivery, renewed, or continued in this state after the effective date of this Act. For purposes of this section, the date a plan is continued is the first rating period which commences after the effective date of this Act.

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Appendix J.

ANALYSIS OF "PAY OR PLAY" PROPOSAL

The following members of the Health Care Expansion Task Force formally endorsed this portion of the report:

Senator Charles Bruner, Co-Chairperson

Representative Patricia M. Harper, Co-Chairperson

Mary Bergstrom

Vivian Bovenmyer

Dave Neil

Mary Noland

HSR inc.

HEALTH SYSTEMS RESEARCH, INC.

DATE: November 5, 1990

TO: Health Care Expansic.. Task Force

FROM: Larry Bartlett, Health System Research, Inc.

RE: Analysis of "Pay or Play" Proposal

At its last meeting, the Health Care Expansion Task Force requested Health Systems Research, Inc. to develop cost estimates associated with the implementation of a "pay or play" option developed by a Task Force subcommittee composed of Representatives Fey and Harper and Mr. David Neil. This memo describes the subcommittee proposal and provides a cost analysis of its implementation. As requested by the Task Force, this memo also describes ways to use a state-sponsored pool to encourage businesses to provide health insurance prior to implementation of a "pay or play" requirement.

In addition, because it is essential that this proposal, if enacted, be properly designed to avoid a successful court challenge based upon the provision of the federal Employee Retirement and Income Security Act of 1974 (ERISA), we have provided you, in a separate memo, with a discussion of the implications of that statute on programs such as these.

A. Description of the Subcommittee Proposal

The principle design objective of the "pay or play" requirement developed by the subcommittee is to establish a "pay or play" requirement that provides strong incentives. The features of this proposal are as follows:

- Triggered Implementation

  The "pay or play" requirement would be implemented in July, 1994 if a specific reduction in the number of uninsured workers is not achieved. The specific reduction target is yet to be established.

- Phase-In

  In its first year, the requirement will only apply to businesses with 50 or more employees. In year two, it will apply to businesses with 40 or more

employees; and in year three, to businesses with 20 or more employees. In year four and thereafter, the requirement would apply to businesses with 10 or more employees.

- Employer Requirements

  In year one, covered employers are required to pay a new tax equal to 80 percent of the cost of covering each of its full-time workers, plus 50 percent of the cost of covering each eligible dependent through a newly established state health insurance pool. Full-time employees would be required to participate in premium sharing by paying a payroll tax equal to 20 percent of the individual pool premium and 50 percent of the dependent premium. In subsequent years, the requirement will be extended on a pro-rata basis to part-time workers employed, on average, more than 20 hours per week. Coordination of coverage applies when more than one person is employed in a household.

  Employers providing health care benefits to their employees are provided a credit for these expenses up to the amount of the tax required for each worker.

  After year one, the tax liability faced by employers for each of these classes of employees would not increase annually by more than the rate of change in the Consumer Price Index (CPI).

- State Health Insurance Pool

  The state would establish a state-sponsored health insurance pool for persons not covered by employment-based benefits or other forms of health care coverage and through which businesses could purchase coverage for their workers.

  The pool would be financed by revenues generated by the new tax, enrolled premium payments, and state general revenues.

  The benefits available under the plan would be comparable in scope to those currently available in the market, but would not be a "Cadillac" plan. The cost of purchasing coverage through the pool will reflect the following features:

- State reinsurance protection for cases where costs exceed $50,000. This reinsurance would be financed by state general revenues obtained from sources other than the new tax.

- The incorporation of vigorous managed care features(including the use of effectiveness/appropriateness research for treatment protocols) and price negotiation measures that are expected to reduce premium costs 10-15 percent below currently available comparable coverage.

The state health insurance pool will be governed by a board made up of representatives from the state government, and employee, employer, consumer, and provider communities. Employer, employee and other consumer representation shall constitute the majority of the board.

B. Cost Analysis

For the purpose of this analysis, insurance coverage comparable to that available through the state pool is estimated to have the following per capita premiums if purchased outside of the pool:

	Monthly	Annual
Adult:	$125	$1500
Child:	$ 60	$ 720

However, the description of the state pool assumes that:

- The state will finance reinsurance coverage for cases exceeding $50,000. It is estimated that the state's provision of this reinsurance will reduce premium costs by approximately 8%; and

- the incorporation of vigorous cost management features could reduce premium costs by 10%-15% below that of comparable products available in the marketplace.

Using a mid-range estimate of 12% for savings associated with the pool's cost management features, these two design elements are projected to result in pool

premiums approximately 20% below market rates, or about $1200 per adult per year and $576 per child per year. Given the features of the pool described above, this translates into the following annualized per capita costs:

- Employer tax liability

  - per full time worker
    @ 80% of premium: $960

  - per dependent
    @ 50% of premium
    - adult: $600
    - child: $288

- Full-time employee premium/tax requirement

  - worker coverage
    @ 20% of premium: $240

  - dependent coverage
    @ 50% of premium
    - adult: $600
    - child: $288

- State cost for reinsurance coverage

  - adult: $120
  - child: $ 58

As noted earlier, in the first year of the "pay or play" requirement, businesses with more than 50 employees who do not provide health benefits to their employees would be required to pay a new payroll tax equal to their portion of the pool premium. In subsequent years, the size of the firms covered by this requirement would drop down to those having 40, 20, and finally 10 or more employees. At a later date, the requirement will be phased in to cover part-time employees on a pro-rated basis.

We have estimated the impacts of a "pay or play" requirement based upon these design features and our estimates of the number and characteristics of uninsured workers and dependents in Iowa firms of different sizes. In conducting this analysis we have assumed that 90% of all previously uninsured workers and

dependents in businesses affected by the "pay or play" requirement would be enrolled in the pool and that businesses would incur a half-year liability for full-time, part-year workers. The results of this analysis are summarized in Table 1 and are discussed below.

Over the four years in which the "pay or play" requirement would be phased in, the number of previously uninsured workers and dependents enrolled in the pool is projected to climb from approximately 55,000 in year one to nearly 104,000 in year four. Similarly, the employer and employee premium contributions to the pool would rise to $59 million and $26 million, respectively.

Given the assumption of a constant 10% non-enrollment rate for eligible previously uninsured individuals, number of eligibles not enrolled will also increase, from 6,100 persons in year one to over 11,500 in year two. The State's projected revenue from the new payroll tax levied on the employers of these individuals is estimated to increase from $3.5 million in year one to $6.6 million in year four. However, the State's cost of providing reinsurance coverage to the pool population is expected to exceed the new revenues, rising from $4.5 million in year one to $8.5 million in year four.

It should be noted that the above figures only reflect the State's costs associated with providing reinsurance coverage for previously uninsured workers. However, as discussed earlier, it was the intent of the subcommittee to use the reinsurance subsidy to make the cost of pool coverage attractive to all businesses, including those already providing health benefits. Thus, depending upon the number of businesses (and individuals) that switch their source of coverage to the pool, state costs associated with the operation of the pool can be expected to increase by an average annual cost of the reinsurance subsidy, which is $100 per adult enrolled and $58 per child. Thus if 100,000 previously insured adults -- or about 5% of the more than 2 million persons in the state with private group or non-group coverage -- were to have their coverage switched to the pool, the state's cost for providing them reinsurance protection would be approximately $10 million.

There are two other possible sources of State expenditures associated with the operation of the pool. The first is the possibility that, due to adverse risk selection that causes a disproportionately large number of persons with extremely high health expenses were to enroll in the pool, the cost of the State's reinsurance protection could exceed our estimate of 8% premium costs. One way to address this problem is to coordinate coverage between the new state pool and the current statewide insurance pool for high risk individuals. Another is to integrate the State's reinsurance protection with that provided under the new reinsurance program for small businesses that the Task Force has recommended be established (See Recommendation # 5 in the Task Force's final report).

TABLE 1

ESTIMATED IMPACT OF THE PROPOSED

"PAY OR PLAY" REQUIREMENT ON UNINSURED WORKERS AND DEPENDENTS

(In Constant Dollars)

	YEAR 1	YEAR 2	YEAR 3	YEAR 4
NUMBER OF PREVIOUSLY UNINSURED WORKERS AND DEPENDENTS ENROLLED IN POOL	55,172	59,648	80,430	103,746
EMPLOYER PREMIUM PAYMENTS TO POOL	$31,515,174	$33,902,569	$45,688,382	$59,134,058
EMPLOYEE PREMIUM PAYMENTS TO POOL	$13,873,462	$14,867,791	$20,027,745	$25,989,220
NUMBER OF UNINSURED FULL-TIME/PART YEAR WORKERS AND DEPENDENTS FOR WHOM TAX IS PAID	6,130	6,628	8,937	11,527
EMPLOYER TAX LIABILITY FOR UNINSURED INDIVIDUALS	$3,501,686	$3,766,952	$5,076,487	$6,570,451
STATE COST OF REINSURANCE COVERAGE @ $120/ADULT AND $58/CHILD	$4,544,301	$4,882,834	$6,579,418	$8,522,492

A second source of state expense is the design provision that caps the annual rate of increase in pool premiums to the rate of increase in the Consumer Price Index(CPI), a measure of overall inflation. The existence of this cap is meant to make pool coverage attractive to businesses and individuals. In turn, as pool membership grows, this will increase the pool's purchasing power and improve its ability to negotiate better financial arrangements with health care providers.

However, in the event that the pools' cost management provisions and price negotiations fail to keep increases in per capita pool expenditures below this level, the State may have to absorb the difference. This point can best be illustrated with an example. In 1989, the CPI increased nationally by 4.6%. During that same year, the medical care component of the CPI(not necessarily an accurate measure of premium increases, but sufficient for the illustration), increased by 8.5%. Per capita pool expenditures increased at the same rate as the medical component of the CPI, due to a combination of higher health care inflation and adverse selection, the estimated adult premium would theoretically have increased from $1200 per year to $1302 per year, while the child premium would increase from $576 to $625. However, if the CPI increase served as a cap, premium increases would be limited to $1255 for adults and $603 for children, leaving a shortfall of $47 per enrolled adult and $22 per child to be absorbed by the State. Applying these per capita figures to projected pool enrollment in year four, the cost to the State of the gap would be $3.3 million.

C. Incentives to Enroll Individuals in the State-Sponsored Pool Prior to the Triggering of the "Pay or Play" Requirement

The Task Force also asked us to explore ways in which employers could be encouraged to enroll previously uninsured workers in the state-sponsored pool prior to the triggering of a "play or pay" requirement. The thought was that if these incentives were successful in significantly reducing the number of uninsured workers, the need to trigger the "pay or play" requirement could be avoided.

As we discussed with the Task Force at its June 1990 meeting, one of the important findings from other state-sponsored pilot programs that seek to expand the provision of employer-based health benefits is that the price of coverage is a critical factor. In general, it appears that in "successful" programs, insurance products with prices at least 30% less than market rates were able to reduce the number of uninsured workers in targeted businesses by about ten percent. Given the possibility of a "pay or play" requirement being imposed, we might assume that the prior offering of an acceptable product at 30% below market rates might result in a 15% reduction in the number of targeted uninsured workers.

As discussed earlier, the state-subsidy of the cost of reinsurance protection and the inclusion of strong cost management features in the state pool could reduce

premium costs by 20% below market. The addition of two other measures -- the elimination of the State's mandated benefit requirements and the waiver of the State's premium on pool coverage -- could reduce the cost of the pool by close to 30%, as indicated below:

	Percent reduction in Premium
▪ State reinsurance subsidy:	8%
▪ Cost management features:	12%
▪ Elimination of mandated benefit requirements:	7%
▪ Waiver of premium tax:	2%
TOTAL	29%

If these voluntary incentive packages were targeted to uninsured, full-time workers and their dependents in firms with 50 or fewer employees, a 15% increase in coverage of this population would reduce the number of uninsured persons in the State by about 15,000. If the state reinsurance subsidy and premium tax waiver applied only to previously uninsured workers or businesses, the annual cost to the state for these enrollees would only be the reinsurance subsidy, which would total approximately $1.3 million. If they applied to all pool enrollees, regardless of prior coverage status, these costs would be higher, and would include both the cost of the reinsurance subsidy plus any forgone premium tax revenues.

Appendix K.

MEMO ON ERISA AND STATE HEALTH CARE FINANCING INITIATIVES

HSR inc.
HEALTH SYSTEMS RESEARCH, INC.

DATE: November 5, 1990

TO: Health Care Expansion Task Force

FROM: Pat Butler, Health Systems Research, Inc.

RE: ERISA and State Health Insurance Financing Initiatives

Because the Task Force has expresses an interest in "pay or play" strategies to expand employer-based health insurance, we have explored the ERISA implications of such approaches. Our assessment of these implications is described below.

A. The ERISA Statute

Enacted in 1974 as a response to pension fraud and mismanagement, the federal Employees' Retirement Income Security Act, ERISA[1], sets out a comprehensive scheme to regulate employee benefit programs, including requirements for: disclosure to employees; reporting to the federal government; eligibility, participation, and vesting; funding and fiduciary and management standards; and a federal insurance system to fund insolvent plans.

The Act applies to "employee benefit plans, " which includes both "employee pension benefit plans" and "employee welfare benefit plans."[2] The latter term is defined as a plan or program established by an employer to provide, among other benefits, employees' medical care "through the purchase of insurance or otherwise."[3] The Act regulated employee benefit plans maintained by any employer engaged in commerce or in any business affecting commerce. Exempt from the Act's jurisdiction are plans operated by governments or churches or those "maintained solely for the purpose of complying with workmen's compensation, unemployment compensation, or disability insurance laws."[4]

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[1] 29 U.S.C. 1001 et seq.

[2] 29 U.S.C. 1102(1).

[3] 29 U.S.C. 1002(1), (3).

[4] 29 U.S.C. 1003(b).

Although it applies to employee health plans, ERISA does not regulate their content except to require that they provide the opportunity for continuation of group rates to former employees and dependents, the so-called "COBRA" continuation requirement of P.L. 99-272 (1985). In view of this federal regulatory vacuum, one might assume that the states could regulate health plan content and relationships among plan participants. However, ERISA's pre-emption clause (section 514(a) of the Act) provides:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in 29 U.S.C. 1003(a) of this title and not exempt under section 1003(b) of this title.[5]

Subsection 514(c)(2) defines the term "state" to include

> any state, political subdivision, or agency thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefits plans.[6]

And subsection 514(c)(1) defines "state law" to include "laws, decisions, rules, regulations, and other state action having the effect of law, of any state."[7]

Subsection 514(b) provides several exemptions from the pre-emption clause: state laws regulating insurance, banking, and securities; state criminal law; the Hawaii Prepaid Health Care Act; multiple employer welfare arrangements; Medicaid "secondary payer" laws; and domestic relations orders that, for instance, divide pension benefits among spouses.[8] Of particular relevance to state health insurance regulation, the so-called insurance "saving clause" is further modified by the "deemer" clause that prohibits an employee benefit plan or trust from being deemed an insurer in order to bring it under a state's regulatory jurisdiction.[9]

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[5] 29 U.S.C. 1144(a).

[6] 29 U.S.C. 11144(c)(2).

[7] 29 U.S.C. 1144(c)(1).

[8] 29 U.S.C. 1144(b)(2)(A).

[9] 29 U.S.C. 1144(b)(2)(B).

B. Judicial Interpretations of ERISA's Pre-emption Clause

Reading this contorted statute in an attempt to interpret its operative terms, one Court of Appeals found ERISA "convoluted and seemingly contradictory."[10] And even the U.S. Supreme Court, in a classic understatement, noted that the law is "not a model of legislative drafting."[11] Before the Supreme Court decided it first ERISA pre-emption case on the merits in 1981, a number of lower federal courts worked their way through the law's cumbersome provisions in order to determine whether it pre-empted various state attempts to regulate health and other benefit plans.

To evaluate ERISA's impact on a state law, courts should examine several questions in turn: Is the program at issue an employee benefit plan? Do any of the jurisdictional exceptions apply? Is the state law at issue one that "purports to regulate" such plans? Does the state law "relate to" such plans? Do any of the pre-emption exemptions apply? While courts have addressed each of these issues, they have rarely examined them in a logical sequence. This memo will address each question briefly, focussing particularly on the last three issues, which have the greatest relevance to state health employer health insurance incentive programs.

What is an Employee Benefit Plan?

The courts have found that virtually any program of employee benefits constitutes a "plan" for purposes of examining ERISA pre-emption. A notable exception is the Supreme Court's determination that a state law mandating employer-paid severance benefits when closing a plant did not require the employer to have "a plan" and was therefore not pre-empted by ERISA.[12] The Court looked to the language of ERISA and its legislative history (emphasizing congressional concern with uniformity of regulation to avoid conflicting state laws) to define a plan as one requiring an ongoing administrative program.[13] Since health benefits programs meet that test, it is certain that they would constitute an employee benefit plan.

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[10] Michigan United Food and Commercial Workers Union v. Baerwaldt, 767 F.2d 308 (6th Cir. 1985).

[11] Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724, 740 (1985).

[12] Fort Halifax Packing Co.Inc. v. Coyne, 107 S. Ct. 2211 (1987).

[13] Since Justice Brennan's opinion was met by a stinging dissent from Chief Justice Renquist and Justices O'Connor and Scalia, it is unclear that this decision would be reaffirmed by a future Court.

Does the Plan Come Within ERISA's Jurisdiction?

Exempt entirely from ERISA jurisdiction are employee benefit plans maintained by governments or churches or established for the purpose of compliance with state workers' compensation, unemployment compensation, or disability laws. The contention that an employer's health insurance program is exempt as disability insurance was first raised in Standard Oil of California v. Agsalud.[14] The District Court rejected this argument after analyzing the different purposes served by health compared to disability insurance. And in 1984, the Supreme Court held that to be exempt as a disability insurance program, an employer plan would have to be established "solely" to comply with state disability insurance law.[15] That is, the state could not regulate multiple-benefits plans under its disability law but could require employers to maintain separate disability programs, which would then be subject to state jurisdiction.

Does the State Law "Purport to Regulate" Employee Benefit Plans?

Although this definitional language in section 514 could have a profound impact on state attempts to encourage employer insurance, the Supreme Court has never interpreted it. Two Courts of Appeal, however, have used the language to reject ERISA pre-emption challenges. In Lane v. Goren[16], the Second Circuit held that ERISA did not pre-empt the state fair employment commission's award of damages for racial discrimination against an ERISA trust because the state policy at issue did not purport to regulate the ERISA plan even though it affected the trust's assets. The court identified three tests that a statute must meet to be pre-empted. It must relate to employee benefit plans, not be subject to the pre-emption exceptions, and purport to regulate employee plans. The court said that for a state law to purport to regulate an employee plan, it "must attempt to reach in one way or another the terms and conditions of employee benefit plans," for instance by regulating disclosure, fiduciary responsibilities, or claims resolution.[17]

In Rebaldo v. Cuomo [18] the Second Circuit held that New York's hospital rate-setting law was not pre-empted by ERISA merely because it increased an employee benefits plan's cost of doing business. "Where, as here, a state statute of

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[14] Supra note 2.

[15] Shaw v. Delta Air Lines, 463 U.S. 85 (1983).

[16] 743 F.2d 1337 (9th Cir. 1984).

[17] 743 F. 2d at 1339.

[18] 749 F.2d 133 (2d Cir. 1984), cert. den. 472 U.S. 1008 (1985).

general application does not affect the structure, administration, or type of benefits provided by an ERISA plan, the mere fact that the statute has an economic impact on the plan doesn't require that the statute be invalidated."[19] The court agreed with its colleagues in Lane that whether a state law purports to regulate employee benefit plans establishes a test separate and distinct from whether the law relates to employer plans or falls within the exceptions to pre-emption.

Both cases suggest that whether a statute purports to regulate benefit plans is an independent test of ERISA pre-emption. As a matter of statutory construction, this inquiry should precede the question of whether a law "relates to" a plan and, if so, whether pre-emption exceptions apply. As a practical matter, however, it seems that the courts will examine these issues simultaneously.

What is a State Law That "Relates to" Employee Benefit Plans?

The issue most often examined in ERISA pre-emption cases, especially those involving health plans, is whether the state law "relates to" such plans. Of particular relevance are two cases decided by California District Courts in 1977.[20] In Hewlett-Packard v. Barnes[21] the court invalidated the state's prepaid health plan law (regulating primarily HMOs) insofar as it attempted to regulate self-funded employee health plans. The court held that the pre-emption clause prohibits any state or local action that "would affect" any employee benefit plan. It also rejected application of the insurance exemption to pre-emption, citing the "deemer" clause that prohibits states from claiming that self-insured firms are traditional insurers.

The same year, another judge in the same district invalidated Hawaii's Prepaid Health Care Act in Standard Oil of California v. Agsalud[22]. The Act required that all employers offer to full-time employees a health program meeting certain standards.

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[19] 749 F. 2d at 139.

[20] An early case of little current application, Insurer's Action Council v. Heaton (423 F. Supp. 921 (D. Minn. 1976), upheld against an ERISA challenge a state requirement that employers offering health insurance make available a major medical policy with prescribed features. Denying a motion for preliminary injunction, the court held that the law was a state insurance statute, rejected application of the deemer clause, and held that ERISA's pre-emption required a more direct conflict between state and federal law. The court's reasoning clearly conflicts with subsequent decisions of the Ninth Circuit and the Supreme Court.

[21] 425 F. Supp. 1294 (N.D. Cal. 1977), aff'd 571 F. 2d 502 (9th Cir. 1978).

[22] Supra note 2.

When the state required in 1976 that employers cover a defined set of services for substance abuse, Standard Oil, which maintained a self-funded plan that did not include this coverage, challenged the state law as pre-empted by ERISA. The District Court first held that Standard Oil's plan was an "employee benefit plan" under the Act. It then rejected the state's contentions that the health insurance law was a "disability insurance law" exempt from the Act and that the law was an exercise of taxing power, since funding for health benefits was not paid to the state and since the employer contribution "does not enable the state to perform a traditional, essential public function"[23]. To be a tax, the court held that the employer's contribution must be "calculated according to a specific formula"[24].

The court next examined Hawaii's argument that the law does not "relate to" Standard Oil's plan in the same way that ERISA does (regarding vesting, disclosure, funding, and reporting). That is, the state argued that since ERISA did not regulate the content of health plans, the state could do so, effectively urging a partial pre-emption of any direct conflict between ERISA and state law but none where federal law was silent. Although criticizing the blanket pre-emption of state laws in subject areas the federal law does not regulate ("apparently without a specific discussion of the need for such a step"[25]) and quoting Justice Brandeis on the value of encouraging state social and economic experimentation, the court nevertheless read the pre-emption clause broadly. Under its plain meaning, benefits requirements "relate to" plans as much as do financial and administrative requirements.

The court also discussed the legislative history of the clause, which was narrowed in conference committee. The Senate bill would have pre-empted only matters specifically covered by ERISA, and the House version would have pre-empted only state regulation on issues of reporting, disclosure, and fiduciary duties. But the conference agreement went further than either house to pre-empt all state legislation that relates to benefit plans, even in the absence of a direct conflict. Supporters of pre-emption, such as Senators Harrison Williams and Jake Javits, argued that such broad pre-emption would eliminate "the threat of conflicting and inconsistent state and local regulation" and "endless litigation"[26].

Based on its decision in the Hewlett-Packard case, the Ninth Circuit affirmed the District Court's holding, rejecting Hawaii's additional argument that a state mandate turns the employer's private plan into an exempt government plan. The U.S. Supreme

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[23] 442 F. Supp at ---.

[24] Id.

[25] 442 F. Supp. at --.

[26] 120 Cong. Rec. 29993 (1974).

Court affirmed the case without opinion. After several years of negotiations, including attempts to authorize all state regulation of health insurance plans or, at least, the Hawaii act and other similar laws, in 1983 Congress adopted an exception to ERISA pre-emption for the Hawaii law[27] (Pfefferkorn 1989). But the exemption prohibits amendments after 1974, foreclosing, for instance, the requirement of substance abuse coverage at issue in the Standard Oil case.

With this background of activity in the lower courts, the Supreme Court decided its first ERISA pre-emption case, Alessi v. Raybestos-Manhattan, Inc.[28]. The Court held that ERISA pre-empted state law prohibiting an offset of pension benefits by a workers' compensation award even though the effect on pension benefits was indirect. The Court noted that "every action bearing on private pensions may encroach on areas of exclusive federal concern"[29]. The Court's next pre-emption case, Shaw v. Delta Air Lines,[30] involved a challenge to two New York statutes requiring pregnancy leave: the Human Rights Act (prohibiting employment discrimination on the basis of pregnancy) and the Disability Act, requiring disability leave for pregnancy. The court read the pre-emption clause broadly, stating that "relates to" means "having a connection with or referring to" an employee benefit plan[31]. Thus the Court held that ERISA pre-empted both state laws related to employee benefit plans.[32]

The Insurance Exemption

Of all the exceptions to pre-emption under section 514, such as criminal or banking law, only that for state insurance regulation would be likely to apply to health plan legislation. In 1977 the First Circuit Court of Appeals foreshadowed the Supreme Court's 1985 Metropolitan Life decision in Wadsworth v. Whalen[33]. Third party administrators sued to enjoin the state of New Hampshire from mandating that all group health insurance include mental health coverage. Most of the plaintiffs administered plans that were funded at least partially by group insurance but that

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[27] 29 U.S.C. 1144(b)(5).

[28] 451 U.S. 504 (1981).

[29] 451 U.S. at ___.

[30] Supra note 16.

[31] 463 U.S. at ___.

[32] See also, Pilot Life Ins. Co. v. Dedeaux (481 U.S. 41 (1987).

[33] 562 F. 2d 70 (1st Cir. 1977).

ultimately bore some of the underwriting risk themselves. Nevertheless, the plans claimed that they were not self-funded and the court agreed, finding that private insurers shared risk with the plans. The court held that the statute in question was a state insurance law, exempt from pre-emption, while acknowledging the apparent inconsistency of permitting states, through insurance regulation, to do indirectly what they could not do directly -- regulate employee benefits provided by self-insured firms.

The Supreme Court followed similar reasoning in interpreting the insurance law exemption to section 514 in Metropolitan Life Insurance Co. v. Massachusetts[34]. Employers and insurers challenged the state's insurance mental health benefits mandate. The Court found that the law did relate to employee benefit plans but was exempt as a statute regulating insurance. Maneuvering its way through the statutory labyrinth, the Court observed, "While Congress occasionally decides to return to the states what it has previously taken away, it does not normally do so at the same time"[35]. It noted further, "We also must presume that Congress did not intend to pre-empt areas of traditional state regulation," such as laws regulating the contents of *insurance contracts*[36]. The Court set forth three tests (derived from the McCarran-Ferguson Act) to determine whether an activity is the "business of insurance" that states may regulate: 1) the activity spreads risk, 2) the relationship between insured and insurer is an integral part of the activity, and 3) it is limited to entities in the traditional insurance industry. In Pilot Life[37], the Court added another step to insurance exception analysis: whether the common sense view of the statute in question would suggest that it was an insurance regulation law. In that case, general common law remedies for fraud and breach of contract that were not specifically directed to the insurance industry failed this test.

Met Life establishes two classes of health insurance: plans funded through traditional insurers, where states can define benefits, as most have done, and the self-funded plans not subject to the 700-odd state health insurance mandates. With as many as half of working Americans estimated to be covered through self-funded plans, some analysts express concern over whether these enrollees are adequately insured. While most self-insured firms appear to offer fairly comprehensive major medical benefits[38], self-funded plans are not subject to state continuation and conversion

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[34] Supra note 12.

[35] 471 U.S. at 740.

[36] Id.

[37] Supra note 33.

[38] Surveys of insurers in Iowa and Colorado disclosed that self-insured firms usually do offer most traditional benefits, even those alleged to be costly.

requirements (other than the 18-month federal COBRA continuation) and cannot be required to participate in state insurance pools for high risk uninsurable individuals[39].

Applying the reasoning in Met Life, the Sixth Circuit added an interesting wrinkle to the interpretation of the insurance law exemption. In Michigan United Food and Commercial Workers Union v. Baerwaldt[40], a health plan trust fund challenged the state's mandatory substance abuse coverage law. Plaintiff funds were self-insured with stop loss coverage (insurance for claims above a given level) from Occidental. Citing Met Life, the Court of Appeals held that mandatory benefits laws are insurance laws and that the stop loss nature of the insurance is irrelevant; stop loss insurers were required to cover the state's minimum benefits. The court did not discuss the indirect impact of this requirement on self-funded plans: Stop loss coverage will generally dictate the type of primary coverage a plan will offer, since they must mesh administratively.

Similarly, in General Motors Corp. v. California State Board of Equalization[41], the Ninth Circuit held that ERISA does not prohibit a state from taxing insurance premiums of stop loss insurers (although they cannot tax health benefits costs of self-insured health plans) even if the taxes are calculated based not only on the stop loss premium but also on the costs for primary coverage by the ERISA plan itself (for which the stop loss carrier is not responsible). Despite the fact that the stop loss contract required the ERISA plan to pay the carrier's actual premium taxes and that the state's premium tax law would clearly appear to "relate to" the employee benefit plans, the court upheld the tax scheme, noting that insurance taxation is generally regarded as insurance regulation reserved to the states under the McCarran-Ferguson Act.

On the other hand, in United Food and Comercial Workers v. Pacyga[42] and Moore v. Provident Life and Accident Ins. Co.[43], the Ninth Circuit held that ERISA pre-empted a state's anti-subrogation law as well as a state's common law cause of action for fraud and breach of an insurer's fiduciary duty. In both cases, ERISA plans

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[39] St. Paul Electrical Workers v. Markham, 490 F. Supp. 931 (D. Minn. 1980), General Split Corp. v. Mitchell, 523 F. Supp. 427 (D. Wis. 1981), Dawson v. Whaland, 529 F. Supp. 626 (D. N.H. 1982).

[40] Supra note 11.

[41] 815 F.2d 1305 (9th Cir. 1987).

[42] 801 F. 2d 1157 (9th Cir. 1986).

[43] 786 F.2d 922 (9th Cir. 1986).

held stop loss coverage from indemnity carriers. But the court found that the insurance exception did not apply[44].

What appears to distinguish these cases is that in Michigan and General Motors the state regulation was directed at the stop loss insurer (such as in the tax case or the minimum benefits case) whereas in Moore and United it was aimed directly at the self-funded firm.

Peripheral Effects Permitted

The pre-emption cases, especially those of the Supreme Court, illustrate a broad reading of section 514(a) and narrow interpretation of the its exceptions. Yet despite Alessi's language that pre-emption is "deliberately expansive"[45] and prohibits even indirect effects, some lower courts have preserved a few areas for state regulation by citing the dictum in Shaw that some impacts may be "too tenuous, remote, or peripheral" to be pre-empted[46].

The state employment discrimination law in Lane[47] and the hospital rate-setting law in Rebaldo[48] are examples of statutes that had a small, peripheral, and therefore permitted impact on employee benefit plans. In a case similar to Lane, the Ninth Circuit also found only a remote effect on employee benefit plans. In Martori Bros v. James-Massengale[49], the court held that an Agricultural Labor Relations Board award of pay for bad faith employer negotiations that was based in part on the rate of hourly wages set forth in an ERISA plan was not pre-empted by ERISA. This court cited four types of state laws that would be pre-empted: 1) those regulating the types of benefits or plan terms, 2) those regulating reporting, disclosure, funding, or vesting, 3) those setting forth rules to calculate the amount of benefits to be paid, and 4) common law remedies for misconduct by an ERISA plan administrator. Whereas a state cannot regulate conduct that is part of the administration of an employee benefit plan, in this case, using the plan's wage rate as a measure of damages awarded for employer misconduct is not regulating the plan administration.

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[44] See also, Minnesota Chamber of Commerce and Industry v. Hatch, 672 F. Supp. 393 (D. Minn. 1987).

[45] 451 U.S. at 523.

[46] 463 U.S. at ___.

[47] Supra note 17.

[48] Supra note 18.

[49] 781 F.2d 1349 (9th Cir. 1986).

State garnishment laws applying to pension benefits for alimony and child support and community property laws effecting distribution of pension benefits were upheld many years before the explicit domestic relations order exception to pre-emption[50] was enacted in 1983[51]. In Stone v. Stone[52], a state community property law was upheld against an ERISA challenge. The District Court said that section 514 was not intended to pre-empt any state law with "even the most tangential relationship to ERISA" and distinguished the Ninth Circuit's early health plan cases on the ground that community property laws were "more well established" than laws regulating employee health plans[53].

Similarly, a municipal income tax ordinance that did not recognize a tax deferred income plan and medical spending account as exempt from income for purposes of calculating the city's tax was upheld against an ERISA challenge in Firestone Tire & Rubber Co. v. Neusser[54]. Citing the "peripheral/tenuous" dicta in Shaw, the court found that the tax did not "directly affect the administration of benefits under the plan"[55]. It cited three factors for a state law to meet the Shaw test: 1) it is a traditional exercise of state authority, 2) it affects relations only between an outside party and either the employer, the plan, the fiduciary, or employees, rather than relations among the four parties, and 3) it has an incidental effect on the plan. The court noted that the tax in question met all three tests but that the weight given to each test might vary under other circumstances.

Although it would be comforting for states attempting to design employer health insurance incentive strategies to rely on the language in Shaw, it may be unwise. In Pilot Life the Supreme Court reiterated its position that section 514 is "not limited to state laws specifically designed to affect employee benefit plans"[56]. And some lower courts, which have crafted pre-emption exceptions using both the Shaw language and

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[50] 29 U.S.C. 1144(b)(7).

[51] See, e.g., Cody v. Reider, 594 F. 2d 314 (2d Cir. 1979) and A T & T v. Merry, 592 F. 2d 118 (2d Cir. 1979).

[52] 450 F.Supp. 919 (N.D. Cal. 1979), aff'd 632 F.2d 740 (9th Cir. 1980), cert. den. 453 U.S. 922 (1981).

[53] 450 F. Supp. at 932.

[54] 810 F.2d 550 (6th Cir. 1987).

[55] 810 F. 2d at ___.

[56] 481 U.S. at 47.

the "purport to regulate" test, have in the past interpreted ERISA's scope narrowly, for instance on issues of pregnancy discrimination laws[57], only to be later overruled.

Regulation of Multiple Employer Welfare Arrangements

After ERISA was enacted, multiple employer trusts (METs) emerged to offer health and other employee benefits without federal oversight. Some self-funded METs were undercapitalized and mismanaged, but states were unable to regulate them. In 1983, Congress added an additional exemption to section 514 to permit state regulation of "multiple employer welfare arrangements"[58] that are either insured through private insurance or self-funded but exempt by the U.S. Secretary of Labor. State regulation includes both financial reserves and other state insurance laws "not inconsistent with" ERISA. It is currently unclear how far state jurisdiction over self-funded METs and mewas actually extends (Cassidy 1987).

State Tax Laws

Because taxation is a long-standing state power, the district and circuit courts in Standard Oil[59] suggested that a specific state tax law might circumvent ERISA pre-emption. However, a Connecticut tax directly on employee benefit plans, not a generally applicable tax, was invalidated in National Carriers Conference Committee v. Heffernan[60]. And state laws attempting to assess self-funded plans for the losses of state uninsurable risk pools have also been overturned[61].

The 1983 ERISA amendment that exempts the Hawaii health insurance law specifically provides that "nothing [in this subsection] shall be construed to exempt ... any state tax law relating to employee benefit plans"[62]. Due to both its placement in the law and its lack of legislative history to the contrary, this provision appears to relate only to a Hawaii tax law (perhaps because of the language in Standard Oil). By negative inference, therefore, the statute could be constructed specifically not to prohibit another state to use a tax law of general applicability, even though it relates to

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[57] Gast v. Oregon, 585 P.2d (Or. App. 1978), Westinghouse v. Maryland Comm'n on Human Relations, 520 F. Supp. 539 (D. Md. 1981).

[58] 29 U.S.C.1144(b)(6).

[59] Supra note 2.

[60] 454 F.Supp 914 (D. Conn. 1978).

[61] See, St. Paul, supra note 40, Dawson, supra note 40, and General Split, supra note 40.

[62] 29 U.S.C. 1144(b)(5)(B).

employee benefit plans. More likely, however, a court would consider many factors, including the significance of the impact upon benefit plans, in evaluating the impact of ERISA on a state tax scheme.

Although it is difficult to chart a safe course through ERISA's treacherous waters, the following conclusions seem to derive from the statute and its judicial interpretations:

- States cannot directly regulate employee health benefit plans.
- States cannot impose premium taxes on self-funded plans or require them to participate in insurance pools for high risk or other individuals.
- States cannot mandate that employers provide health benefits or insurance.
- States can regulate insurers, including stop loss insurers, but cannot regulate self-funded plans, even those using stop loss insurance.

C. State Health Insurance Incentive Authority Under ERISA

To encourage more workplace-based insurance, states are experimenting with several types of employer incentives: premium subsidies, business income tax credit, and taxes with credits for offering insurance. This section examines each strategy and its possible ERISA implications.

Premium Subsidies

States such as Maine, Massachusetts, Michigan, New York Ohio, and Wisconsin are offering explicit health insurance premium subsidies to employers and employees in small firms that did not previously offer insurance. The projects differ in the amounts of the subsidy, whether they target assistance to lower income workers, and whether they develop new health insurance plans or use existing products. Other states, such as Florida and Arizona, have reduced the insurance partner's risk exposure through stop loss protection. Kentucky, Oregon, and Oklahoma are creating pools that firms may join; Arizona, Florida, and several other states are providing administrative and marketing assistance to insurers offering lower priced policies. These positive incentives are probably would not qualify under ERISA as "state laws" because as incentives only, they do not "purport to regulate" terms and conditions of employee benefit plans covered by ERISA. They simply offer an alternative that qualifying employers may choose. Thus, they should not be subject to section 514 at all. And if they were interpreted as purporting to regulate employee benefit plans, they should meet the Shaw test of remoteness applied in Rebaldo, Lane, Martori, and Firestone.

Income Tax Credits

Offering an employer a credit against his/her business income tax liability is also a fairly benign positive incentive. Five states (California, Kentucky, Massachusetts, Oklahoma, and Oregon) have enacted these laws[63] that provide a tax credit of $15 to $25 per employee per month for two to five years, usually for previously non-insuring small firms. To qualify for the credit four statutes (Massachusetts, Oregon; Oklahoma, and California) require employers to pay a minimum proportion of the employee and/or dependent premium. Oklahoma and Oregon also require employers to buy insurance from a state pool. In these states it may be argued that the tax credit laws do in some sense "purport to regulate" the terms and conditions of employee benefit plans. By the same logic, they can also be said to "relate to" benefit plans, and they are certainly not subject to any statutory exemptions.

Under this line of reasoning, the tax credit laws would be pre-empted by ERISA unless a court would find that their impact was "tenuous, remote, or peripheral." Such an exception is possible under the Firestone tests. It is arguable, for instance (despite contrary language in Standard Oil), that taxation and tax credits are traditional state functions (albeit pre-emptable by Congress[64]). It is also likely, for example, based on Oregon's experience thus far, that tax credits have little impact on employers' decisions to select a plan. But if, as seems likely, the purpose of the credit is to encourage employers to offer and finance employee basic health coverage, tax credit laws would seem to affect terms and conditions, benefits administration, and relationships among the various parties.

A court might accept the argument that tax credit laws do not purport to regulate health insurance but merely offer a reward for employers who meet certain standards. The outcome of a challenge to a given tax credit appears to depend upon the actual legislative purpose in enacting it, whether to influence health plan selection and employer contributions or merely to reward voluntary employer activity. But as a practical matter, the chance that such a case challenging tax credit laws would be filed is remote, since the only employers with standing or interest in the issue would be those ineligible for the credit, who are unlikely, given its small value and limited duration, to prosecute an expensive lawsuit.

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[63] California's tax credit will not become effective unless specifically funded.

[64] See Aloha Air Lines v. Director of Taxation (464 U.S 7 (1983).

Pay or Play Taxes

The strategy most likely to face an ERISA challenge is the "pay or play" tax-plus-tax-credit approach adopted in Massachusetts and, if voluntary insurance enrollment goals are not met by October 1993, Oregon. There are certain differences between these two laws. As part of its "Health Security Act" of 1988, Massachusetts will impose an employer tax of 0.12% of payroll, and its tax credit applies to any employer payment up to that amount for any health benefit plan, regardless of benefits covered or employer premium contribution. Oregon, on the other hand, describes its program as a requirement that employers offer employee health insurance or pay a tax equal to a given percentage of the cost of basic benefits for employees and dependents. Although pay or play generally presents an incentive rather than a mandate, one may argue, as courts seem to do throughout the ERISA cases, that a state cannot do indirectly what it cannot do directly.

The Massachusetts law is the more easily defended, since it is arguably not a state law that "purports to regulate" employee benefit plans. What it purports to do is establish a state-funded health program for all residents, with a payroll tax as its primary revenue source. If an employer relieves the state of this health care financing responsibility, it is logical that the employer should receive a tax credit. The credit is not conditioned upon any definition of terms or conditions, such as benefit levels or employer premium contributions. Thus, even if one argued successfully that the law does purport to regulate benefits, under the Rebaldo, Lane, Martori, and Firestone analyses its effects should be seen as too remote for pre-emption. For example, this law meets the second and third Firestone tests and could arguably meet the first (which is certainly less weighty in any event).

For these same reasons, however, the Oregon statute is somewhat harder to justify. On its face it resembles a mandate, essentially similar to the one invalidated in Standard Oil[65], and it has generally been marketed as such by its supporters. Although employers can apparently escape the tax by providing any benefits, without definition, it is harder to argue that this law does not purport to regulate employee benefits. If a court is less concerned with the structure of and public relations surrounding the Oregon law, however, it might at least apply the tests of peripheral impact. If it can be argued that the state is really only imposing a tax (against which a credit is appropriate for each business reducing the state's responsibility by insuring its employees), then the Oregon statute seems about as likely as that in Massachusetts to meet a test of remoteness, and it might similarly overcome an ERISA challenge.

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[65] "All employers who have not provided employee and dependent health care benefits ... by January 1, 1994 shall make monthly payments to the fund..." Section 7 of Oregon Senate Bill 935 (1989).

While a pay or play approach therefore has a reasonable chance of withstanding an ERISA attack, it seems likely to do so best if:

- The legislative purpose is clearly to establish a state health care financing program and any employer tax credit is justified because the employer is relieving the state of this financing burden;

- The tax is set out in the law as a fixed dollar amount or percentage of payroll (which may include inflation adjustments), not calculated specifically as the cost of a particular benefit package; and

- The tax credit is not conditioned on any definition of acceptable levels of benefits, employer contributions, or other structural or administrative features.

D. Conclusion

It is difficult to predict how a court, especially the Supreme Court, will resolve an ERISA challenge to a state health care insurance/financing incentive strategy such as a pay or play statute or tax credit. As commentators have noted, the pre-emption clause itself raises thorny policy problems, such as how states can effectively meet residents' needs for health care (Pfefferkorn 1989, Inman 1984, Mishkin 1984, Ackerman 1981). Even absent this policy concern, the statute is fraught with internal inconsistencies. For instance, the exemption from all ERISA regulation of disability insurance and workers' compensation creates for multi-state employers the very chaos that the pre-emption clause was drawn broadly to avoid. And likewise, the insurance law exemption to the pre-emption clause is inconsistent with a preeminent concern about uniformity of regulation. Nevertheless, Congress is obviously reluctant to reform this convoluted statute in any significant measure. It has thus far ignored state requests (for instance from Massachusetts, before enacting the Health Security Act, and Minnesota) for Hawaii-like exceptions to Section 514.

The courts read general ERISA jurisdiction very broadly and its exceptions to jurisdiction narrowly. Likewise, they read the pre-emption clause broadly and its exemptions narrowly. While not always logical (or dictated by the terms of the statute), traditional exercises of state regulation, such as community property and taxation, seem to be given more leeway than newer state authority, such as employment discrimination, family leave, and health care financing.

State policy that on its face does not purport to and in fact does not regulate the benefits, financing, or administrative terms of health plans is most likely to survive

judicial scrutiny. Thus, it is harder to defend a tax-plus-credit plan where the credit is conditioned on certain benefits or employer contributions.

Even a program meeting these standards, as Massachusetts' law appears to do, faces a serious ERISA battle to test the breadth of the Supreme Court's decision in Shaw and whether the Court will accept the lower courts' reasoning under both that case and section 514's "purport to regulate" language.

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