A Primer on Health Insurance in Iowa: The Past, Present and Future

Iowa Insurance Division
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Acknowledgements

The information in this document was written and compiled by the staff of the Iowa Insurance Division. The following assisted directly and indirectly in the creation of the report.

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Introduction

Many of us have asked the question as to what must be done to solve the problem of high cost of health insurance, access to health care on a preventative and when needed basis as well as health insurance for those who are uninsured in Iowa. The issues are complicated and not without public policy and economic ramifications. There is no easy solution. The lowest common denominator in this entire discussion is who will be damaged. Health insurance should be affordable, meaningful and provide access to providers and hospitals when necessary. It should also contain costs. There must be a commitment of significant funds to resolve these issues. The health insurance issue cannot be solved without examining the costs of health care itself. None of us would ever consent to the repair of a vehicle without knowing what it would cost. But every day Iowans are asked to pay for services without knowing the true cost of the service. Some say that consumers must have more skin in the game. But consumers already have skin in the game. They just want to choose how that skin is being stretched. For example, Americans spend an estimate $12 billion a year on cosmetic procedures. Procedures which are not covered by insurance.

The goals in resolving these issues should be to do the least amount of harm to benefit the most vulnerable; to stop the number of uninsured and to stabilize the coverage situation. In 2004 $5.1M of uncompensated care was provided. That number increased to $7M in 2005. Losses in the number of insured or the increased number of uninsured are in obvious places; among the low income, younger employees, small employers or those who work for small employers. These segments have the least amount of disposable income and public policy should be directed toward these groups and provide greater subsidization. These groups are more uninsured than the rest of America and are more likely to become uninsured in the future.

Due to the lack of consensus on national health care policy states are attempting to address the challenge of providing affordable and accessible health care. Every state is unique in its delivery system and patient needs. Rural versus urban; special populations, i.e. Native Americans, undocumented persons; the existence of large public safety nets; managed care penetration.

The first question leaders must ask themselves is what problem do they wish to solve? Making sure all children have health insurance? Making sure that small businesses are not placed at a competitive disadvantage with the expense of health insurance premiums. If leaders want to solve the problem of the uninsured, Iowa must clearly identify who constitutes the uninsured.

This document is not a position paper on health care insurance or the insurance industry or exhaustive treatise on health care reform, but an educational tool; a compilation of what has been tried, discussed or proposed. These are items that may surface as Governor Culver and Democratic and Republican legislators grapple with solutions.

Iowa Close-up

Reform of Iowa's health care system should be a top priority to foster a healthy population, and to bring economic relief to Iowans today and economic development for our future. As is true throughout the country, signs in Iowa show that our health care system no longer meets the needs of our people:

- *Rising costs critically reduce Iowans disposable income.*
- *Iowans' access to care is jeopardized.*
- *Economic development is hindered and employers are losing their competitive edge.*
- *The problem of balancing the state budget is seriously aggravated.*
- *Quality of care is being questioned.*
- *Growing administrative burdens hamper health care providers and patients.*

The aforementioned is a quote from a report in 1992 regarding health care reform. Other than balancing the state budget, we are attempting to address identical issues in 2006. Iowa is a small rural state that is much more racially homogeneous than national averages. A greater portion of its economy is concentrated in small firms and self-employed individuals than elsewhere. Health statistics and health care spending are better than national averages, and Iowa has fewer people uninsured (9.1% versus 15.9% nationally in 2005). The census bureau recently reported that Iowa ranked 2nd in having the lowest population of uninsured. That is second in the nation to the state of Minnesota. Iowa is doing a good job according to the Council on Affordable Health Insurance. "State Health Insurance Index 2006: A 50-State Comparison of the Nation's Health Insurance Market," provides a snapshot of the health insurance environment in each state.

"The purpose of the index is to identify the states that provide a dynamic, competitive market for health insurance, where consumers have a wide range of affordable coverage options," stated CAHI Director Dr. Merrill Matthews. "Iowa is doing a good job, with several other states running a close second. The Index considers six important measures of state health insurance viability, including the regulatory environment, the number of health insurance mandates, the uninsured, access to a high risk pool and the average premiums in the individual and small group markets.

Regulation of the Marketplace

The purpose of health insurance is to spread risk, and the rationale for any insurance regulation is to protect consumers who have paid for a future benefit and are not likely able to determine an insurer's financial soundness or ability to deliver on its promises. Another objective of regulation is to improve insurance market stability.

Protection of consumers against insolvency and fraud is another objective of insurance regulation. This is accomplished by setting standards for solvency, financial reserves, rate adequacy, claims payment and accurate information disclosure.

Insurance regulation also serves the purpose of facilitating the insurance market's functioning by requiring insurers to provide information so that consumers may make appropriate decisions and by stabilizing the marketplace.

Regulation also provides access to highly valued services (such as preventive care) or coverage of disadvantaged populations by establishing minimum health benefits or coverage standards. The theory being that either consumers want these services or these services are desirable from a public health perspective and that the risk of needing them should be broadly pooled.

Lastly, regulation of health insurance assures that promised services are available, accessible and delivered.

In many instances the federal government makes the rules concerning the health care system and the states, including Iowa, must play by them. In 1974, the federal government became the primary regulator of health benefits provided by employers (ERISA). In the 1980s and 90s, Congress established minimum national standards for group health insurance (COBRA, HIPAA).

There are three primary markets for private major medical health insurance:

- The individually purchased health insurance market
- The small group market, and
- The large group market

Each market has distinct characteristics and operates under different rules. To understand the small group market and the impact of any regulatory changes, it is important to understand the other two markets as well.

Small Group

Iowa's insurance market reforms were enacted in stages from 1991 through 1997. Initial reforms were targeted to the small group market, defined at first as employers with 2-25 workers but expanded in 1992 to groups of 50. Small group portability provisions were adopted in 1991, rating restrictions in 1992, guaranteed issue of basic and standard plans in July 1994, and guaranteed issue of all small group products in 1997. Individual market reforms began in April 1996, with rating restrictions and portability provisions, which were augmented slightly in 1997 to comply with HIPAA. Iowa passed small group health care reform in 1991 in response to small businesses' growing need for health insurance.

The small employer reform law promotes the availability of health insurance coverage to small employers (2 to 50 lives). By providing for guaranteed issue basic and standard plans, employer groups unable to pass underwriting have a health care policy available to them. Insurers participating in the small group market are required to offer either their own health plans or at a minimum the basic and standard health benefit plans prescribed by statute and regulation to all applicants. Each plan includes hospitalization, outpatient care, doctor visits,

primary care and limited preventive care. The core of these reforms is to make sure that any willing small group purchaser has access to insurance and can retain that insurance through subsequent renewal periods. "Guaranteed issue" requires all insurers who participate in the small group market to accept any applicant.

Iowa follows the National Association of Insurance Commissioners' (NAIC) model by limiting year-to-year premium increases for any given small group to 15% above the insurer's "trend". Trend is defined as the increase in the insurer's rates for new business. The concept is to allow marketwide cost increases that are driven by technology advances, inflation in the medical sector and the like, but to limit those increases that reflect group-specific health risk.

The second component of the rating reform prevents any insurer from varying its prices among subscribers at any point in time more than a defined range. For small group products, rates can vary only +/-25% from the midpoint for policies with similar benefits and "case characteristics". No rate variation for health status is allowed, however, for state mandated basic and standard policies. Iowa adds another layer of complexity by allowing separate blocks or classes of business for different small group policy forms. Following the original NAIC model, Iowa applies the small group rating limits separately to each block or class of business, but to prevent circumvention of the rating limits by block gerrymandering (e.g., defining a block of business to consist of most sicker subscribers), the rating law also requires block midpoint rates to be within 20% of each other. Finally, rating differences are allowed to reflect the actuarial value of differences among benefits in different policies. As a consequence, considerable rating flexibility remains. Because each allowable factor can be added to each of the others, health risk adjustments can be as great as two fold, and additional demographic adjustments can produce rates that vary several fold more at the extreme, although these distant outliers will be rare among groups.

The law also provided for creation of a reinsurance mechanism for carriers to reinsure their basic and standard policies. This program was created to provide reinsurance as a mechanism to fairly share the risk, and to improve the efficiency and fairness of the small group accident and health insurance marketplace. However, this program was suspended as of January 1, 2004 due to the lack of carriers reinsuring claims to the program and instead opting to retain the risk. In addition, the law provided for rating reform and required disclosure of rating practices. While carriers in the small group market are not required to file their rates, they must certify on an annual basis with the Division that the rates comply with Iowa laws and regulations.

A variety of laws have been passed affecting small group health care, many of which are considered or referred to as mandates. These mandates include:

Contraceptive coverage
Dental anesthesia
External Review
Point of Service Option
Post-Delivery Care
Well-child care

Supplemental Coverage for newborns
Skilled nursing care in hospitals
Dental services by doctors
Mammography
Mail Order drugs
Fibrocystic condition
Coverage for adopted child
Physician assistants and Advanced Registered Nurse Practitioners
Optometrist
Diabetic outpatient management education
Diabetes education, supplies, training
Chiropractic
Certified registered nurse
Emergency Services
Continuity of care-terminal illness
Biologically based mental illness
Direct provider access OB-GYN
Breast Reconstructive Surgery

State law primarily governs the small group market. Small group coverage generally is "fully insured" which means that employers purchased an insurance contract from a licensed health insurer or HMO, which takes on the full financial risk of paying for claims. Operating under state law, fully insured coverage is subject to state benefit mandates, and premium taxes or assessments.

Large Group Market

"Large groups" are typically those with more than 50 employees, although the number may vary depending upon state law. Many large employers choose to "self-fund", so that they bear the ultimate risk for claims costs. These self-funded arrangements may be administered by a third party administrator (TPA) or insurance company. Other large groups provide coverage to their employees through "fully insured" coverage from an insurance carrier. Operating under federal law (the Employee Retirement Income Security Act or "ERISA"), self-funded group benefit plans are not subject to state benefit mandate requirements or premium rating rules.

Individual Market

The individual health insurance market is regulated by the states, which set rules for benefits and premium rating. Because individual coverage is not subsidized by employers, each consumer pays the full premium. As a result, consumers in the individual market tend to be very price sensitive, deciding whether the potential benefits justify the premiums.

Taken as a whole, these reforms have had a positive effect including not creating major market disruptions; a competitive market in price, product diversity and number of insurers although the small group market remains highly concentrated in a few large competitors.

Operational Solutions

Efforts to expand coverage to the citizens of Iowa have been on-going despite the lack of a national health care policy. Several programs exist currently to address the health care needs of Iowans.

hawk-i (Healthy and Well Kids in Iowa)

The hawk-i program is part of Iowa's State Child Health Insurance Program (also known as SCHIP or Title XXI), which is designed to provide health insurance coverage for uninsured children in Iowa whose incomes fall between 133% and 200% of the poverty level. The Iowa legislature authorized the creation of a two-part 'combination' SCHIP program. The first part is a Medicaid expansion (M-SCHIP) for children and family incomes up to 133 percent of the federal poverty level (FPL). The second component is hawk-i, the separate state child health insurance program (S-SCHIP). hawk-i provides health insurance for children with family incomes from 134 to 200 percent of the FPL. In this program, the State of Iowa contracts with private health plans to provide covered services to enrolled children. In hawk-i, families with incomes from 134 to 150 percent of the FPL have no premiums or copayments, while those with household incomes from 151 to 200 percent of the FPL pay of premium of $10 per month up to a maximum of $20 per family per month. For those above 150 percent of the FPL, there is also a $25 fee for non-emergent care provided in an emergency room. The first recipients were enrolled in hawk-i in January 1999. As of September 2006, there were 36,226 children covered with 20,748 children enrolled in hawk-i and 15,478 in M-SCHIP.

The program is administered by the Department of Human Services and Maximus, a third party administrator. The premiums written by insurers providing hawk-i coverage are exempt from premium tax in Iowa.

Expansion of hawk-i surfaces as a possible solution to address the number of uninsured. Several states have opened up SCHIP coverage to parents and in some cases childless adults. Specific states include New Jersey, Arizona, Illinois and Rhode Island. An expansion could target low-income adults or parents of children covered by hawk-i. It would be necessary to obtain a waiver from the Centers for Medicare and Medicaid Services (CMS) through a SCHIP 1115 waiver.

Recently, the health insurance industry proposed expansion of coverage. AHIP (America's Health Insurance Plan) urged expansion of coverage with the goal of guaranteeing coverage for all children in three years and virtually all adults within 10 years. The industry proposed the following steps, estimated to cost $300 billion over 10 years:

- The federal government and the states should expand Medicaid to cover all adults with annual incomes under the poverty level, including single adults who cannot now

qualify. The poverty level is $16,600 for a family of three and $9,800 for an individual.

- The Children's Health Insurance Program, financed jointly by the federal government and the states, should at a minimum, cover all children in families with incomes less than twice the poverty level.
- Congress should create incentives for people to establish "universal health accounts." People could take tax deductions for amounts contributed to such accounts. They could use accounts to pay premiums for any type of health insurance. The federal government would help pay premiums for people with incomes below certain levels.
- Congress should establish a tax credit for individuals and families who buy health insurance for their children. The credit would be $200 a child, up to a maximum of $500 for a family. It would be available to families with incomes up to three times the poverty level—up to $60,000 for a family of four.

HIPIowa (Health Insurance Plan of Iowa)

The Iowa legislature created the Iowa Comprehensive Health Association (ICHA), also known as Health Insurance Plan of Iowa (HIPIowa), in 1986 to offer residents of the state, through participation of health insurance companies, a program of health insurance. The program is designed to provide health insurance to Iowa residents who are unable to find adequate health insurance coverage in the private market due to their mental or physical condition. The Iowa Legislature passed legislation in 2004 amending the enabling legislation for ICHA or HIPIowa. On January 1, 2005, the revised Pool became effective. The new law required that the benefit plans resemble policies available in the individual market. The new benefit packages are all network based. The pool no longer offers straight indemnity plans.

The plan is the HIPAA individual market portability alternative for the state of Iowa. As of August 2006 the total number of participants was 1,973. The average monthly premium is approximately $478.

TAA (Trade Act Assistance)

The Trade Act of 2002 included important provisions to assist certain displaced workers in paying for qualified health insurance. This population includes those who have lost their job due to the effects of international trade as well as certain individuals whose pension is trusteed by the Pension Benefit Guaranty Corporation (PBGC). The mechanism for assistance is a federal income tax credit, the Health Coverage Tax Credit (HCTC), which will pay 65 percent of the health insurance premium amount paid by eligible individuals. Since inception August 1, 2003 through September 30, 2006 approximately 3,839 Iowans are eligible to participate in the HCTC Program and approximately 204 Iowans are enrolled in the program. The HCTC is administered at the federal level with Iowa Workforce Development acting as a state partner.

HSAs (Health Savings Accounts)

HSAs are tax advantaged trust or custodial accounts designed to encourage saving money for current and future medical expenses. HSAs allow consumers to invest money and withdraw it tax-free to cover health care costs. The incentive behind HSAs is to provide consumers more control over their health care spending, leading to better treatment at lower costs. HSAs are portable and unused funds can accumulate for future use.

In order to contribute to an HSA, a consumer must be enrolled in a high deductible plan. In 2007, the maximum contribution that can be made to health savings accounts for employees with single coverage will increase to $2,850, up from $2,700, while the cap for those with family coverage will rise to $5,650, up from $5,540 this year. Additionally, the maximum out-of-pocket expense (including deductibles) that employees with single coverage can be required to pay will rise to $5,500 from $5,250, and to $11,000 from $10,500 for those with family coverage. The minimum deductible of the high deductible health insurance plan to which HSAs must be linked will increase to $1,100 from $1,050 for employees with single coverage and $2,200 from $2,100 for family coverage.

It is questionable whether HSAs and high deductible plans help reduce the number of uninsured. It may be useful for the younger, healthier employee making a decent income. HSAs may also be useful depending upon lifestyle and outlook, e.g. certain classes of workers are used to high deductible policies already given their line of work.

Concepts for Consideration

At the heart of many reforms is the tenet that by reducing the number of uninsured, less bad debt and charity care will be created and the extent of cost shifting to the insured and self-funded market will be reduced. Expansion of insurance coverage itself is not likely to address the crippling cost of coverage and health care generally.

Cost Drivers

Why is healthcare so expensive? Oftentimes the answer lies in that is better than ever, a party other than the patient usually pays the majority of expenses and the patients are not the ones choosing more services. Many medical procedures that were unthinkable thirty years ago are incredibly ordinary today. People are successfully being treated for life-threatening illnesses that were once fatal maladies: organ transplants, traumatic brain injuries, strokes, cancers, and infectious diseases. Included in the 2005 Small Employer Health Insurance Study is a chart with examples of cost drivers, the effect on costs and possible cost containment strategies.

Transparency

To spend their health care dollars wisely, Iowans need to know their options in advance, know the quality of doctors and hospitals in their area, and know what procedures will cost. When consumers purchase new vehicles, they have access to consumer research on safety, reliability, price and performance. Purchasers of health care should have an identical expectation.

President Bush signed an Executive Order promoting quality and efficient health care in federal government administered or sponsored health care programs. The Executive Order directs federal agencies that administer or sponsor federal health insurance programs to:

- Increase transparency in pricing by sharing information about the prices paid to health care providers for procedures
- Increase transparency in quality by disclosing information on the quality of services provided by doctors, hospitals and other health care providers
- Encourage adoption of health information technology standards to facilitate the rapid exchange of health information
- Provide options that promote quality and efficiency in health care by developing and identifying approaches that facilitate high quality and efficient care

Reinsurance

State-funded reinsurance is a mechanism for reducing the price of private health insurance by having the state cover (i.e. reinsure) a portion of health insurers' high-cost claims. Under this approach, a state may cover all mid-level claims (e.g. amounts between $30,000 and $100,000 per claim) or all claims above a certain threshold (e.g. exceeding $25,000). Because the state picks up a portion of the cost of catastrophic claims, the price that insurers charge for plans with state-funded reinsurance is lower. Generally, the availability of state-funded reinsurance is linked to state-approved plans targeted at low-income, uninsured individuals and small employers. The intent of state-funded reinsurance is to expand coverage by making insurance more affordable.

Reinsurance reduces insurers overhead, therefore, the underlying concept behind reinsurance is to spend money on the "sickest of the sick" or the catastrophic claim. Catastrophic claims do not occur with regular frequency; however, front end items like co-pays are cost drivers and are unpredictable. The chronic, cyclical health care user is problematic. For example, an insured might have a heart transplant one year and have high health care costs. However, the diabetic who is stable for years one and two and then requires significant care years three through five is unpredictable and that is the risk for which insurers would want to reinsure.

While state resources are involved only in the relatively small percentage of cases that involve catastrophic claims, it appears that very substantial subsidies may be needed to significantly affect uninsured rates and substantial marketing efforts are needed to advertise the reinsurance program.

Group Purchasing Arrangements

Group purchasing arrangements bring different employers or individuals together for the purpose of purchasing health insurance or negotiating provider discounts on behalf of their members. Examples of group purchasing arrangements include purchasing cooperatives, multiple employer welfare arrangements (MEWAs), and association health plans (AHPs). Such arrangements need to be legally recognized by the state or federal government because, under traditional insurance regulation, multiple employers and individuals are prohibited from forming a group solely for the purpose of buying group insurance. Most group purchasing arrangements are designed to allow small employers to band together so that they can gain the same administrative efficiencies and exercise the same purchasing clout as large employers. Group purchasing arrangements may offer the further advantage of giving employees a choice of health plans that they might not otherwise have. Proponents of group purchasing arrangements believe that such arrangements can lead to more people having coverage by reducing premiums and increasing choice.

HIPCs (Health Insurance Purchasing Cooperatives) (IAC 191-73)

HIPCs are one component of health reform plans. HIPCs build upon the concept of pooled buying power by securing insurance coverage for the workers of all member employers and by making that coverage more affordable by spreading risks over a larger population. The most attractive feature of HIPCs was the ability of employers to offer their employees a choice of plans; a feature that is typically not available for small groups.

In 1994 the only HPIC to operate within the state of Iowa was formed. The Independent Insurance Agents of Iowa formed the Independent Health Alliance of Iowa (IHAI). Enrollment was brisk in the initial stages of operation but IHAI could not sustain its operations once the use of unisex rating was eliminated. While the availability of several plans and uniformity among the different plans offered were attractive to employers and employees, the lack of competition and the lack of profitability also led IHAI to cease doing business after a short period of time.

ODS (Organized Delivery Systems) (IAC 641-201)

ODSs are a type of managed health plan. ODSs are owned and organized by providers who are accountable to consumers and government for accessibility of their services. Patient risk is assumed directly by providers instead of third-party payers. This gives health professionals an opportunity to establish their own ground rules. The ODS form of organization allows affiliated providers to deliver, for a per-person fee, a comprehensive package of health care services to individuals enrolled in the program. The accountability of ODSs includes a measure of the ODS's performance in relation to community health needs.

Since the inception of the statutory authorization of ODSs, only two ODSs have been formed in Iowa: SecureCare of Iowa (which no longer exists) and Keokuk Area Hospital (which

serves Lee and Van Buren counties). An ODS is dually regulated by the Iowa Department of Public Health and the Iowa Insurance Division. The Department of Public health licenses the ODS and the Iowa Insurance Division oversees the form review and financial solvency of the ODS.

Any future formation of ODSs must address the ability of an ODS to attract the critical mass necessary to ensure an ongoing, viable concern. Some view the dual regulation by two state agencies as less than successful. Formation as an HMO may be encouraged as opposed to the ODS form of organization.

Association Health Plans (AHPs)

AHPs allow small business owners to form a membership in legitimate trade or professional association in order to purchase health insurance for employees or their own families. The large numbers of employers may be able to wield the kind of purchasing clout that large employers enjoy. Federal proposals would allow small businesses and civic and community groups to form AHPs, which would allow these groups to join together across state boundaries to purchase health insurance. This would give small businesses the same advantages, administrative efficiencies, and negotiating clout enjoyed by big companies and labor unions. The Insurance Division has concerns regarding such federal proposals and the impact upon Iowa's health care market. The primary concern is that the bill supersedes state small group rating rules. On the state level, the Insurance Division has suggested language that would provide greater flexibility in rating regulations in the area of small employer health insurance. The proposed language would allow for flexibility in rating groups including association plans. The language would also provide for the use of credits and incentives for small employers and their employees through the voluntary use of wellness and other disease management programs.

Promotion of Healthy Lifestyles

Recent discussions about containment of health care costs include incentives to improve or maintain good health. Recognizing that many pervasive health care risks are self-imposed through lifestyle choices, both insurers and employers are embracing chronic disease management and wellness programs to generate savings along with creating a healthier worker. Some of the dialogue during the 2006 Iowa Legislative session focused on modifying existing laws to allow premium credits or discounts based on cost reductions derived from participation in wellness programs (e.g. tobacco cessation, disease prevention, obesity reduction, and good health promotion).

Tax Credit/Premium Assistance

The use of premium tax credits and premium assistance programs are often mentioned as options in assisting purchasers with the cost of health insurance premiums. Premium tax credits are incentives that reduce an individual's or employer's tax burden. The structure of any tax credits may be capped, limited to certain categories of tax filers, refundable or non-refundable, credits might be a percentage of the insurance premiums versus a flat rate. Some

question the usefulness of tax credits to individual workers versus tax credits offered to small businesses because a low income individual may not have enough tax liability to utilize the credit or may lack steady employment.

Iowa implemented an employer-sponsored health plan premium credit in the early 1990's (formerly Iowa Code section 514H.12). The credit was equal to twenty-five dollars per month, per participating eligible employee. This credit was specifically directed towards those small employers that had not previously provided health insurance coverage to its employees. The credit was repealed in 2001 because so few employers claimed the credit.

Premium assistance program assist eligible individuals purchase coverage by subsidizing part of the premium. Premium assistance programs offer opportunities to expand health coverage to working families particularly those working for small businesses.

Massachusetts Plan

The Massachusetts Plan, signed into law by Governor Mitt Romney, is a complex mixture of specific policy initiatives aimed at providing residents with access to affordable, quality, and accountable health care. The new law:

- Creates a single consumer-driven marketplace for health insurance for small businesses, their employees, and individuals;
- Promotes defined contributions rather than the defined benefit systems in employer based health insurance that does not disrupt the current tax treatment of health insurance;
- Redirects public health care subsidies from hospital systems that serve the uninsured to low income individuals to assist them in purchasing private health coverage;
- Expands Medicaid eligibility for children;
- Changes the rules governing health insurance markets; and
- Imposes a mandate on individuals to buy coverage and penalties on employers who do not provide and subsidize coverage for their employees.

How the Massachusetts Plan works:

Individuals

- As of July 1, 2007, all individuals must have coverage.
- Those below 300% of the federal poverty level (about $38,500 for a family of three), but not eligible for Medicaid, will have their private insurance plans subsidized at a sliding scale rate.
- Children whose families earn below 300% of the federal poverty level will receive free coverage through Medicaid.
- Individuals with incomes below the federal poverty level of $9,600 will have premiums waived on private insurance.
- Those who can afford insurance will be increasingly penalized for not buying coverage. In the first year, they will lose their stated personal income tax exemption.

- Family coverage will be extended to cover young adults up to the age of 25.
- Allows the use of health savings accounts with cheaper high-deductible catastrophic coverage plans.

Businesses

- All employers with more than 10 employees must contribute to health care costs.
- Employers who do not provide insurance will pay an annual fee of $295 per full-time employee.
- Creates a "health insurance connector" office to help individuals and businesses connect with carriers to find affordable private coverage.

Closing

There is no federal proposal to address health insurance in America. How risk is spread in the marketplace is very complicated and rating policies impact those that are healthy and those with chronic medical conditions. Iowa, like several other states are diligently working to remove roadblocks, facilitate innovation and direct health care reform for their vulnerable populations. While many options are available, the most innovative and creative solutions to address access and affordability of health insurance is not one single course of action but the pursuit of several initiatives to ensure success.

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H. Chapter 514H (repealed), Basic Benefit Health Coverage
I. Iowa Health Reform Council Problem Statement and Statement of Principles
J. Iowa Health Reform Transition Team Final Report, April 1996
K. School Health Insurance Reform Study, Senate File 386, Final Report, January 2004

Health care and the states

The federalist prescription

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From The Economist print edition

Extending health care to the uncovered, one state at a time

WITH his leg injured in a recent skiing accident, Arnold Schwarzenegger, California's governor, this week announced a plan that could change the terms of America's health-care debate. The Republican in charge of the country's most populous state, where 6.5m people, almost one resident in five, lack medical insurance, said he wants to introduce universal health-care coverage.

His recipe is a combination of insurance-market reform, government subsidies and—most important—compulsion. "Everyone in California must have insurance," Mr Schwarzenegger argued. "If you can't afford it, the state will help you buy it, but you must be insured."

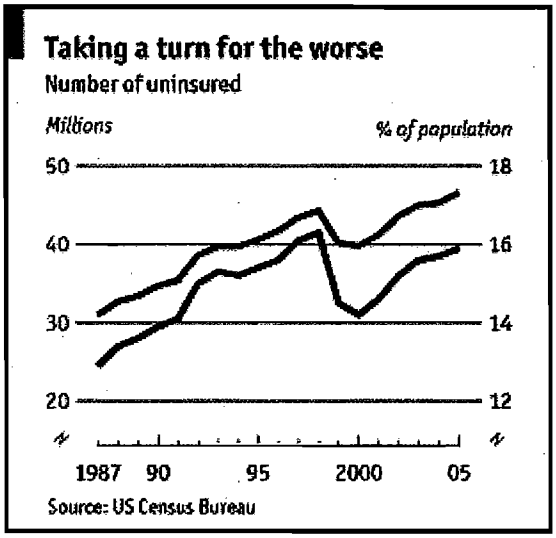
Although the details are still sketchy, Mr Schwarzenegger's plan is very like another pioneering health-care reform that was successfully championed by another Republican governor in a strongly Democratic state. In April 2006 Mitt Romney, then the governor of Massachusetts and now a leading Republican presidential candidate, agreed on a plan for universal health-care coverage with the state's Democratic legislature. It too made health insurance mandatory, and it also included insurance reform and subsidies.

Massachusetts, and now California, have the boldest plans. But they are not the only states concerned with reducing the ranks of the uninsured. Illinois, Tennessee and Pennsylvania have pledged to insure all children. Half a dozen other states have official commissions charged with producing comprehensive reform plans this year. Could the states jump-start American health-care reform?

America has 47m people without medical insurance, around one sixth of its population. No one doubts that this is both morally vexing and economically inefficient. The uninsured get too little preventive medicine, but hospitals are, by law, obliged to offer them (expensive) emergency care, thus raising costs for everyone else. And as health-care costs have risen, and premiums with them, the ranks of the uninsured have grown (see chart).

Unfortunately, America's national debate about health-care reform has been stalled for more than a decade by a combination of ideology and political cowardice. The left argues that the solution is more government intervention; the right espouses deregulation and consumer choice to slow cost increases and so make insurance more affordable. Both sides are cowed by the memory of Hillary Clinton's disastrous failure to rewrite the rules of American medicine in 1994.

State governors have less ideological baggage. States have often been America's policy laboratories, pioneering changes that become national models. In the late 1980s and early 1990s, for instance, Wisconsin led the revolution in welfare, the system of government handouts aimed mostly at poor single mothers.



But health care has proved trickier. Massachusetts tried and failed to force employers to provide health insurance two decades ago. One problem is that the federal government controls most of the money. Medicare, the giant health scheme for the elderly, is federally financed and run. Medicaid, the scheme for the poor, is organised at the state level but co-financed with Uncle Sam. All told, state governments pay for only about 13% of America's medical spending. If you include the huge tax subsidies for employer-provided insurance, the federal government's share is almost 40%.

Nonetheless, three things suggest that state-led innovation has greater promise now than in the past. The first is the Schwarzenegger-Romney effect. Now that America's biggest state has put universal coverage at the top of its political agenda, the feds will have to take notice. Mr Romney will also ensure that health-care reform looms large in the presidential race that is already under way.

Second, the big federally-funded State Children's Health Insurance Programme (SCHIP) is up for renewal this year. Introduced a decade ago, it gives the states $5 billion in grants a year to help children whose families are just above the poverty line (and hence ineligible for Medicaid) get access to health care. The money comes from Washington, DC, but states can spend it as they wish. Many Democrats want to expand SCHIP. And third, several congressmen are now pushing laws that would explicitly encourage state experimentation by making it easier for states to innovate using federal money and, in some cases, by offering more money.

Bay State experimenting

A lot depends on whether the states' reforms actually appear to work. All eyes are on Massachusetts, since it is the first state actually to enact (rather than merely propose) comprehensive reform, particularly the mandatory purchase of insurance. From July 2007 every resident must have health insurance, or face a $1,000 fine. People with incomes up to three times the federal poverty threshold (almost $60,000 for a family of four) will get subsidies to buy insurance. Firms with more than ten workers must offer employees a health plan or pay the state a "contribution" of up to $295 per employee.

Massachusetts has also revamped the insurance market for individuals and small businesses. A new clearing house, the "Commonwealth Connector", is designed to offer more choice and cheaper plans for those outside big firms. People in this "Connector" will be able to offset their health insurance against tax, a perk until now available only to employers.

Forcing everyone to buy insurance is probably the only way to avoid the "adverse selection" problem that plagues health-insurance markets. Younger workers in good health avoid buying coverage, leaving higher-risk people in the insurance pool, thus driving up premiums. And if the uninsured workers fall really ill, they become free-riders on the others, since hospitals are required to treat them at public expense: had they been treated earlier, they might have been cured more cheaply.

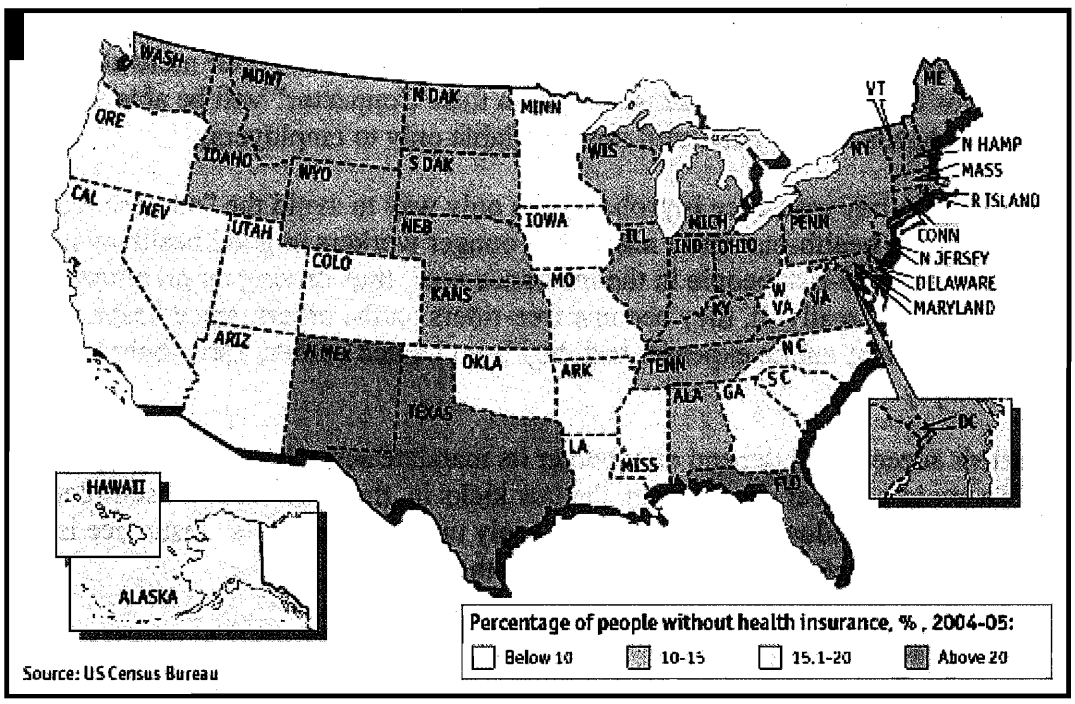
Massachusetts's success will depend on whether its mandate actually prompts people to buy insurance. To avoid political uproar when the law kicks in, the state has left itself plenty of wriggle room. The individual mandate will not apply unless "affordable" insurance is available. But the greater the wriggle room, the less effective the mandates will be.

Experiments elsewhere in New England suggest that the voluntary route to universal health-care coverage is costly and difficult. Maine and Vermont are both trying to insure all their citizens. Both have rejigged their insurance market for individuals and small businesses. Both are offering subsidies to poorer people. But neither compels anyone to buy insurance. Vermont's plan was introduced less than a year ago. But Maine's plan has been up and running since January 2005, and its results have been disappointing. According to Cristy Gallagher of the New America Foundation, a Washington, DC, think-tank, only 15,000 people have enrolled so far. The state is a long way from covering its 130,000 uninsured citizens, while the subsidies are proving costlier than expected.

Besides, although obliging everyone to have health insurance can compensate for some of the extra cost of covering the uninsured, it does not offset it entirely. Massachusetts could push for universal coverage in part because only 10% of its citizens lack health coverage. The state was also blessed with lots of money to fund its reforms: an annual $385m pot of federal Medicaid funds, as well as $600m a year that was already being used to help reimburse hospitals for treating the uninsured. Most other states have less money and greater need. Covering California's 6.5m uninsured, for instance, will cost the public purse around $12 billion a year. Mr Schwarzenegger expects $5 billion of that money to come from the federal government. He plans to raise the rest from a mish-mash of taxes on employers, doctors and hospitals.

Going for kids

The cost of expanding health coverage explains why many states have set themselves less ambitious goals than universal insurance. One popular and attainable one is to insure all children. Only about 3% of children are both uninsured and ineligible for help under either SCHIP or Medicaid. Several states are simply expanding their SCHIP schemes to cover children higher up the income scale. Illinois allows any parents to buy into SCHIP if their children have been without health insurance for more than a year. Pennsylvania offers free coverage to families who earn up to twice the official poverty rate.



Other states, however, are concentrating on the much larger problem: low-paid workers in small firms. Only 50% of small businesses now offer health insurance, down almost 10 percentage points since 2000. Several governors are trying to stem this decline by subsidising bare-bones health insurance for these people.

Arkansas, for instance, has launched a scheme in which the state subsidises the premiums of poor workers in small firms provided every worker is enrolled. To control costs, the coverage is limited to six doctor visits and seven days in hospital a year, and two prescriptions a month. New Mexico has a similar subsidised deal for small employers with a $100,000 annual limit on coverage. Tennessee has set the premium rather than the coverage, creating an insurance plan that costs $150 a month, of which it will pay $50, though just what the plan will cover is not yet clear. The hope is that people will prefer cheap, if limited, health care to none at all.

It is tempting to pour cold water on all this state activity. The most radical innovation—forcing people to buy health insurance—may prove unenforceable. Will Massachusetts's new Democratic governor, Deval Patrick, really risk levying heavy fines on low-paid workers without health insurance? And even if the idea works at first, the model will surely collapse unless the ever-growing cost of treatment can be brought under control. As the plan's architects admit, that was not the main priority.

For now, however, such cynicism is misplaced. America's governors are focusing on an important issue that Washington has ducked for too long, and, in several cases, are tackling it with bold new ideas. Now it is up to President Bush and the new Democratic Congress to respond.