HJR 48 BRIEFING PAPER

OTHER STATES' HEALTH FINANCING REFORMS:
Are there approaches that Montana wants to adopt?

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As Montana considers how to expand coverage of the estimated 19% of its population that lacks health insurance, other states' experiences or proposals can offer inspiration or a cautionary tale. The various state-based approaches also require attention to differences between states in their laws and insurance or health care industry regulations and conditions.

Directed by House Joint Resolution No. 48 to study "the creation of a system of universal, portable, affordable health insurance coverage" involving private health insurance and existing public programs, the Economic Affairs Interim Committee is looking at the steps taken in selected other states. In addition to the health reforms in Massachusetts, which were reviewed at a November 2007 meeting in Miles City, the committee has before it reforms in Vermont, Indiana. Also included here are proposals that either are being offered or have been offered in Colorado, California, Pennsylvania, and Wisconsin.

A Brief History of Health Care Reform Efforts

This is not the first time that Montana has sought to expand health care coverage and address affordability. Efforts in the past have included legislative appointment of a Montana Health Care Authority in 1993 that was to look a statewide universal health care access plan based on a single payor system and a recommendation for a statewide universal access plan based on a regulated multiple payor system. One result was a state health care policy, 50-5-104, that urges effective and efficient delivery of care, a central role for health promotion, preventative services, and public health services, and market-based approaches "whenever possible".[1] Also implemented in 1995 was HB 405, allowing formation of voluntary purchasing pools (of at least 1,000 eligible employees) for disability insurance.

Another study, required under Senate Joint Resolution No. 22 in 2001, involved efforts to determine causes and solutions to the rising cost of health care. Among the topics discussed were: purchasing pools for individual and small group insurance, provider reimbursement rates and cost-shifting, access to affordable prescription drugs, strategies to decrease the number of uninsured Montanans, and factors causing health insurance rates to rise faster than the rate of inflation. Among the recommendations were tax credits for low income individuals and small businesses for the purchase of health insurance, exploration of participating in a multi-state purchasing pool for pharmaceuticals, and maintenance or expansion of the Children's Health Insurance Program (CHIP). The Insure Montana program, which involved tax credits for small businesses and subsidies for individuals who obtain health insurance, was adopted in the 2005 legislature.

Building on the Past to Address Health Care Insurance Today

Montana today has the Insure Montana program, which other states are studying to see if similar programs will expand health insurance coverage of their uninsured populations. Montana also has a broad definition of a medical care savings account, implemented in 1995 under HB 560. Although not the same term as a health savings account (HSA), a medical care savings account in Montana can be used to exclude

from adjusted gross income on individual income taxes an annual contribution of up to $3,000. (The medical care savings account must be used for eligible medical expenses, defined in federal law under 26 U.S.C. 213(d). Federal law in 2007 and 2008 allowed annual contributions to a HSA of $2,900 for an eligible individual with self-only coverage and $5,800 for family coverage.)[2]

In looking at other states' reforms, it may be helpful to remember that Montana and other states may have different regulatory environments and different demographics and health provider situations. States below are included for what may be a different approach to addressing their state's lack of health insurance coverage. The committee may request that additional states be studied, but these provide some idea of what is possible. In the cases of states that have nixed health care reforms, at least for the moment, the ideas also may indicate what is not politically feasible at this time. A chart in Appendix A indicates the types of reforms that impact various goals of the study. Taken individually, they represent the "bite-sized options" promised for this study. This chart, too, can be expanded at the committee's request.

Enacted Reforms in Selected States:

Indiana

Check Up Plan, signed into law 4/30/07.

Key Features:

- POWER Accounts – combination of HSA-like accounts combined with high-deductible back-up commercial plans. The POWER Account is $1,100, funded by uninsured in Indiana (paying between 2% and 5% of their incomes on a means-tested scale. The state contributes the remainder needed to get to $1,100 and $500 worth of preventive care as well as the premiums for the back-up plans. After each year at least $500 must stay in account and participant may withdraw amounts above the $500. (NCSL summary). Back-up plans must include mental health, home health services including case management, substance abuse services, dental, and vision. Providers must be paid at Medicare rates.
- Higher income limit (200% of FPL) for pregnant women to enroll in Medicaid
- Continuous eligibility for a child for Medicaid and CHIP until age 3
- Certain small employers allowed to join together to buy group health insurance
- Qualifying employers allowed tax credit for 1st 2 years the employer makes coverage available to employees (the lesser of $2,500 or $50 for each employee enrolled in the health plan)

http://www.in.gov/legislative/bills/2007/HCCP/CC167802.001.html

Maine

Dirigo Plan enacted June 2003

Key Features:

- Created Dirigo Health Agency to administer a DirigoChoice insurance option for small (2 to 50 employee) businesses, the self-employed, and eligible individuals without access to employer-sponsored insurance. Sliding scale premium subsidy for those eligible who earn up to 300% of FPL plus limits on out-of-pocket costs and deductibles. Funding from a combination of employer (60% of employee only cost) and individual contributions, the

general fund, Medicaid, and inputs from hospitals related to bad debt and charity care. Dirigo Health Agency also established Maine Quality Forum, which obtains quality data, including nursing care quality.
http://www.dirigohealth.com/2006%20Fact%20Book%20Final%20020607.pdf

- Required determination of savings offsets (from having more insureds so that uncompensated care decreased). Dirigo Board to file with the Superintendent of Insurance a report on aggregate measurable cost savings, which determined ratio assessed on paid claims. In 2005, for example, the assessment was 2.408% for health insurance carriers on annual paid claims, for third-party administrators on annual paid claims for residents, and on employee benefit excess insurance carriers. The ratio was lowered to 1.85% in 2006. Offset cannot exceed 4% of paid claims.
- Coordinated payments for Maine's Medicaid program from various sources to increase federal to state funding input.
- Hospital profit limit of 3%. 2005 report indicated that "many hospitals did not feel profit constraints at the hospital entity level due to the voluntary profit limit of 3% in the Dirigo Act." Of 8 hospitals that earned operating profits below baseline levels, 4 were at or below 3% and 4 were between 3.6 and 4%. http://www.maine.gov/pfr/insurance/dirigo/pdf/Health_Witness_Designation.pdf

Massachusetts

Health care reform passed in April 2006, portions implemented over time
Key Features:

- Individual mandate to have insurance.
  --Enforced initially by disallowing personal income tax exemption if no documented insurance.
  --Later penalty to up to half the monthly cost of lowest-cost plan within a region for each month without coverage. Connector Board to determine if lowest-cost plan affordable, and if not the penalty does not apply.
- Creation of a Commonwealth Connector, a quasi-public entity designed to:
  --reduce health insurance administrative costs for small businesses;
  --review and approve affordable policies offered through the Connector;
  --serve as a Section 125 entity that allows individuals to buy insurance with pre-tax dollars;
  --allows part-time and seasonal employees to combine employer contributions
  --allows employees to keep same insurance if they change jobs
  --Connector requires nonsubsidized policies to cover all statutory mandated benefits.
  --Deductibles and cost-sharing of Connector-offered policies must be approved by Connector and Massachusetts Commissioner of Insurance (from Health Affairs article 9/14/06)
- Subsidized health insurance available through connector for those eligible under 100% FPL
- Employers with 11 or more workers who do not make "fair and reasonable" contribution to employees' health insurance required to contribut up to $295 a year for each uncovered full-time worker. Health Affairs article of 9/2006 says, "This amount is the estimated private sector share of the average per worker cost of free care provided to workers whose employers do not provide health insurance."(p. 425)
- All employers required to establish Section 125 cafeteria plans but not required to contribute to premiums.
- Establishes "free rider surcharge" on employers with 11 or more full-time employees who do not offer insurers or set up Section 125 plans and who have uninsured employees

that use more than $50,000 worth of care covered by the Uncompensated Care Pool.
- Children's eligibility increased to 300% of FPL from 200% for children's health insurance
- Institutes pay for performance standards and establishes a Health Disparities Council.
- Provides rate increases for hospitals, but requires them to meet improved quality or pay for performance standards.
- Quality and Cost Council established. Duties include providing cost information on web for consumers.
- Funded $5 million for computerized physician order entry systems in hospitals.
- Built on existing uncompensated care pool, which is financed by federal, state, hospital, and third-party payers.
- Expected to cost $1.3 billion in FY 2007 up to $1,4 billion in FY 2009, which includes $125 million each year in general fund money, $160 million in third-party payer assessments and $160 million in hospital assessments and less than $100 million from "Fair Share" and "Free Rider" assessments combined.

Vermont

Catamount Health and Health Care Affordability Acts enacted in 2006.
Key Features:

- Increased coverage through private sector insurance subsidies on a sliding scale for people under 300% FPL who have not had insurance for 12 months or who lost insurance for various specified reasons. If employed in a firm that offers insurance, employee subsidy to pay for that insurance. Subsidy funding from co-pays, tobacco taxes, Medicaid, and employer assessments. Employers who do not provide health insurance assistance or who provide insurance but an employee elects not to be insured is assessed $91.25 for each full-time equivalent employee per quarter (in excess of a specified number of employees). Enrollment dependent on availability of subsidy funds. Children not required to be covered by employer insurance program. Benefits to be similar to those of major plans covering most people in small group and association markets.
- Established Catamount Health plan targeting $250 deductible for individual in network and $500 for a family, with a 20% co-pay. Catamount Health coverage to be guaranteed and community rated, but preexisting conditions that existed up to 12 months before coverage may be excluded for 12 months (some exceptions).
- Provided for free immunizations to the extent allowed by the appropriation (state as a 2nd payer).

http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2006/acts/ACT191.HTM

- Affordability issues addressed through cost transparency including multi-payer data collection and consumer price and quality information, uniform hospital uncompensated care policies, health information technology uses, common claims administration. Required insurance commissioner to develop standard uncompensated care policy, including criteria for payment forgiveness, sliding scale payment amounts, and amount of service calculations. Also may collect data on types of patients using uncompensated care. Set uniform credentialing policy. (section 9408a)
- Established advisory committee for development system of chronic care management and chronic disease prevention, including best practices and protocols.
- Revised Medicaid provider rates upward to decrease cost-shifting to private-pay insurers or individuals.
- Created nongroup market security trust to lower costs and increase access to health

care coverage in the individual or nongroup market. Mechanism for shifting 5% of a carrier's claims costs to the trust, with insurance commissioner balancing amount paid to actual expenses.
- Approximately $5 million appropriated for subsidies and program startup costs.

Proposed Reforms in Selected States

California

Compromise Legislation ABx1 failed in Senate in late January 2008
Key Features:
- Established individual mandate for most residents, unless there was a determination insurance was not affordable (unaffordable is if the total cost is more than 6.5% of family income).
- Coverage of children and parents up to 300% of FPL. Covers single adults through California's Medicaid program up to 250% of FPL. Offers individuals with incomes between 250 and 450% of FPL with advanceable, refundable tax subsidy to help obtain coverage. For those with income below 150% of FPL there would be no premiums, co-pays, or deductibles.
- Required Managed Risk Medical Insurance Board to develop minimum benefits package.
- Affordability addressed through cost-containment measures like bulk purchases of pharmaceuticals and hospital transparency.
- Funding based on increase of $2 in tobacco tax, employer fee assessment: Employers with payroll up to $100,000 would pay at least 2% of payroll, increasing to 6.5% of payroll for employers with payrolls above $250,000. Employers would be given option of offering insurance to part-time employees or contributing to a public purchasing pool for them. Hospitals would be assessed a fee of 4% of revenue.

Colorado

Blue Ribbon Commission Recommendations to 2008 Legislature
Key Features:
- Individual mandate, with penalties for not having insurance. Affordability exceptions. Waiting period would help to avoid "crowd out" movement into public programs.
- Public subsidies to make private coverage more affordable. (e.g. Sliding scale for uninsured below 400% of FLP to help purchase employer's plan.)
- Expanded public programs. E.g. Medicaid and CHIP would be merged for parents, childless adults, and children and would be expanded to between 205% and 250% FPL. Working disabled persons would be offered buy-in. Eligibility for adults with assets up to $100,000. Automatic enrollments proposed.
- Requirement for employers to have payroll deduction/pretax plan (Section 125) to help employees buy own insurance.
- Insurance market reforms to exclude health status premium variation but allows variation by age and geography. Also would require all insurers to offer minimum benefit plan and would require guaranteed issue for individual market, if not eligible for the high-risk pool aimed at high-cost preexisting conditions.
- Provides incentives for medical homes. (e.g. through Medicaid, CHIP and high-risk pool)
- Create an Improving Value in Health Care Authority to oversee requirements for health insurers and all payers to use standardized claims, eligibility and coverage verification systems, electronic ID cards, standardized prior authorization procedures and standard insurance application forms. Develop statewide system aggregating data from all payer

plans (under Support for evidence-based medicine). Require reports from insurers on medical loss ratios, administrative costs and broker compensation. Provider price and quality information also to be made available through single entry point or website.
- Eliminate patient copayments for preventive care. Reduce patient copayments for chronic care management services.
- Allow, within federal law, reduction of health insurance premiums for healthy behaviors.
- Proposal for Connector and for Optional Continuous Coverage Portable Plan.

http://www.colorado.gov/208commission

Oregon
Healthy Oregon Act, enacted in 2007
Key Features:
- Creates Oregon Health Fund to put together by October 2008 a comprehensive plan for health care, including expansion of Medicaid, CHIP, and the Family Health Insurance Assistance Program, wellness programs, and quality, effective health care, along with a financing method.

Pennsylvania
Cover All Pennsylvanians – proposed HB 700 – being addressed in discrete segments.
Key Features:
- Uses state-funded abatements to help physicians, particularly specialists, pay malpractice premiums. Surplus in account to be made available to a Health Care Provider Retention Account
- Increase in cigarette tax and tax on smokeless tobacco to help fund abatement account

Notes:
--Cost of paying for uninsureds' health care about $1.4 billion annually. About $400 milion directly paid by the state to hospitals to cover uncompensated care. Remainder paid as part of premiums – estimated to be 6.5% of every premium dollar to cover the cost of the uninsured.
http://www.state.pa.us/papower/cwp/view.asp?Q=470809&A=11

--Uncompensated Care program (set up in Chapter 11 of the Tobacco Settlement Act). HB 700 would limit amount of uncompensated care payments to the sum of uncompensated care that exceeds amount to required to provide as determined by section 5(d)(1) of the Institutions of Purely Public Charity Act, which calculates dollar amounts hospitals required to meet.

--HB 700 – Prescription for Pennsylvania
Community Benefit – Requires annual report and the estimate to be calculated as the Medicare reimbursement the hospital would otherwise receive. Excludes bad debt, heath screening and health education classes "designed to increase market share or for which a fee is charged or a referral to the hospital is made"; programs provided as an employee benefit, use of facility space to hold meetings for community groups, expenses for in-service training, continuing education, orientation, mentoring or joint appointments.
http://www.gohcr.state.pa.us/prescription-for-pennsylvania/HOUSEBILL700P_N_1011.htm

Wisconsin
Healthy Wisconsin Council, created by Gov. Jim Doyle in July 2006
Key Recommendations (from January 2007):

- Create a Healthy Wisconsin Authority to provide reinsurance on catastrophic claims for small (10 or fewer employee) businesses and cooperatives and to provide substantial premium subsidies to the smallest low-wage entities
- Expand Medicaid (through a waiver) to cover childless uninsured adults under 200% of FPL.
- Merge family Medicaid, BadgerCare, and Healthy Start programs for low-income children and families.
- Funding through a $1 increase in the tobacco tax.

Healthy Wisconsin

Proposed in 2007 by the Wisconsin Senate used a payroll tax (employees would pay 2-4% of Social Security Wages and employers would pay 9-12% of wages, up to the salary cap. Sole proprietors would pay !0% of Social Security wages and unemployed individuals not eligible for public programs would pay 10% of adjusted gross income. Also would expand eligibility for the state's Medicaid Program, BadgerCare, to 300% of FPL. The payroll tax would replace contributions to insurance premiums by employers and employees.
http://citizenactionwi.org/images/stories/Documents/healthy_wis__summary.pdf

Endnotes

1. **50-4-104. State health care policy.** (1) It is the policy of the state of Montana to continue to investigate and develop strategies that result in all residents having access to quality health services at costs that are affordable.

(2) It is further the policy of the state of Montana that:

(a) Montana's health care system should ensure that care is delivered in the most effective and efficient manner possible;

(b) health promotion, preventative health services, and public health services should play a central role in the system;

(c) the patient-provider relationship should be a fundamental component of Montana's health care system;

(d) individuals should be encouraged to play a significant role in determining their health and appropriate use of the health care system;

(e) accurate and timely health care information should play a significant role in determining the individual's health and appropriate use of the health care system;

(f) whenever possible, market-based approaches should be relied on to contain the growth in health care spending while attempting to achieve expanded access, cost containment, and improved quality; and

(g) the process of health care reform in Montana should be carried out gradually and sequentially to ensure that any undesirable impacts of the state's reform policies on other aspects of the state's economy, particularly on small businesses, are minimized.

(3) The legislature recognizes the need to increase the emphasis on the education of consumers of health care services. Consumers should be educated concerning the health care system, payment for services, ultimate costs of health care services, and the benefit to consumers generally of providing only those services to the consumer that are reasonable and necessary.

2. For more information on Montana's Medical Care Savings Account statutes, see Title 15, chapter 61, MCA.