State Health Reform Strategies

Bernadette Fernandez
Analyst in Health Care Financing

April 14, 2009

Congressional Research Service
7-5700
www.crs.gov
R40513

CRS Report for Congress
Prepared for Members and Committees of Congress

Summary

States have taken the initiative to propose and enact health care reforms to address perceived problems related to health insurance coverage, health care costs, and other issues. These reform efforts vary in scope, intent, and target demographic group. While not all members of Congress agree in the need to reform health care, many have expressed interest in learning about these state efforts to inform ongoing debate at the national level.

Each state has implemented a unique set of reform strategies to address concerns about health insurance and the health care delivery system. However, most health reform discussions, at both the state and federal level, focus primarily on insurance. Under this broad policy area, coverage and cost concerns are paramount.

The primary objective related to coverage is reducing the number of uninsured persons. Related reforms may target a specific group, or address the uninsured population as a whole. Cost reforms primarily address concerns about the affordability of health insurance for individuals, families, and employers. This typically results in policies that invest public resources to assist consumers and firms with the cost of health insurance.

This report identifies general approaches proposed at the state level to reform health insurance, and describes selected reform strategies. These descriptions are intended to be illustrative, not exhaustive. They include examples of both common and innovative initiatives to reflect the diversity of reform approaches, in terms of scope, policy levers used, and populations affected. The reform strategies have been identified according to targeted stakeholder groups: consumers, employers, purchasers of health coverage, and health plans. In addition, the report explores key design and implementation challenges related to coverage and cost, and provides a succinct state example for each reform strategy.

This report will be updated as circumstances warrant.

Contents

Contacts

Introduction

Although the most recent figures for 2007 indicate a drop,[1] the number of uninsured persons generally has grown during the past several years,[2] as health care costs to consumers, employers, and the government have also grown.[3] State legislators and policymakers have responded to these trends by proposing a spectrum of reforms to address concerns regarding coverage, cost, and other issues.

State governments are in a unique position to impact the availability and affordability of health insurance. They are the primary regulators of this industry, and provide funding toward the coverage of millions of residents.[4] States can be receptive to local economic, labor, and other conditions, and adopt policies tailored to their own needs. Given this, health reforms vary greatly from state to state. For instance, some states may pursue comprehensive reform,[5] while others may design reform initiatives that are more narrow in scope. These more limited reform efforts may focus on a particular component of the health care system, such as the availability of private health insurance options, the delivery of health care, or public financing for health coverage. Reform strategies also vary in terms of the target stakeholder group (e.g., children) and policy lever used (e.g., tax code).

[1] See CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2007*, by Chris L. Peterson and April Grady.

[2] "The Uninsured: A Primer," Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, October 2008, at http://www.kff.org/uninsured/upload/7451-04.pdf.

[3] For consumer spending data, see Consumer Expenditure Survey Annual Reports, Bureau of Labor Statistics, at http://www.bls.gov/cex/csxreport.htm#annual. For employer spending data, see Employer Health Benefits Annual Survey Reports, Kaiser Family Foundation and Health Research and Education Trust, at http://www.kff.org/insurance/ehbs-archives.cfm. For government spending data, see Table 16.1, *Budget of the United States Government, Fiscal Year 2009*, Office of Management and Budget, 2008, at http://www.whitehouse.gov/omb/budget/fy2009/pdf/hist.pdf.

[4] While health insurance regulation is primarily a state responsibility, there are federal requirements that have a significant impact on how and to whom health insurance coverage is provided, and what that coverage looks like. Two key federal laws are the Employee Retirement Income Security Act of 1974 (ERISA, P.L. 93-406), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191). ERISA outlines minimum federal standards for private-sector employer-sponsored benefits. It requires that funds be handled prudently and in the best interest of beneficiaries, participants be informed of their rights, and there be adequate disclosure of a plan's financial activities. ERISA preempts state laws that "relate to" employee benefit plans. This "preemption clause" was designed to ensure that plans would be subject to the same benefit laws across all states, partly in consideration of firms that operate in multiple states. For more information about ERISA, see CRS Report RS22643, *Regulation of Health Benefits Under ERISA: An Outline*. HIPAA's health insurance provisions were designed to address the concern that health insurance coverage does not stay with an insured person if that person switches jobs or changes health plans (lack of "portability"). The Act established federal requirements on private and public employer-sponsored health plans and carriers to ensure the availability and renewability of coverage for certain employees and other persons under specified circumstances. HIPAA limits the amount of time that coverage for pre-existing medical conditions can be excluded, and prohibits discrimination on the basis of health status-related factors. For more information about HIPAA, see FAQs about Portability of Health Coverage and HIPAA, Employee Benefits Security Administration, U.S. Department of Labor, at http://www.dol.gov/ebsa/faqs/faq_consumer_hipaa.html.

[5] For additional information on state efforts toward comprehensive health reform, see "States Moving Toward Comprehensive Health Care Reform," Kaiser Family Foundation, at http://www.kff.org/uninsured/kcmu_statehealthreform.cfm.

This report identifies general approaches proposed at the state level to reform health insurance, and describes specific strategies to illustrate the breadth of possible reform options.[6] It discusses a selection of current reform strategies; it is not meant to be inclusive of all health reforms.

Selection of State Health Insurance Reforms

While the states have implemented a wide range of reforms to address concerns about both coverage and the health care delivery system, most health reform discussions focus primarily on health insurance. Under this broad policy area, coverage and cost concerns are paramount.

The primary objective related to coverage is reducing the number of uninsured persons. Reforms may target a specific group (e.g., small businesses), or address the uninsured population as a whole. Cost reforms primarily address concerns about the affordability of health insurance for individuals, families, and employers. This typically results in policies that invest public resources to assist consumers and firms with the cost of health insurance.

Below are general descriptions of select reform strategies that have been proposed or implemented at the state level. Since an all-inclusive analysis of state reforms is beyond the scope of this report, these descriptions include examples of both common and innovative initiatives to illustrate the breadth of reforms. The selected strategies reflect the current diversity of reform approaches, in terms of scope of reforms, policy levers used, and populations affected. The reform strategies have been identified according to targeted stakeholder groups: consumers, employers, purchasers of health coverage, and health plans. In addition, the report explores key design and implementation challenges related to coverage and cost, and provides a succinct state example for each reform strategy.

Consumer Reforms

State reforms that focus on consumers generally target vulnerable populations that make up a disproportionate share of the uninsured, such as low-income individuals and young adults. However, reform in this area may also be very broad and include all consumers, regardless of health status, family income, or other characteristic.

Individual Mandate

An individual mandate is a requirement that all persons have health insurance coverage. Such a mandate may specify the source of that coverage, such as a government program or through an employer. Only Massachusetts currently has an individual mandate, but other states have included such a requirement in their reform proposals.

[6] State-centered resources include CRS in-house database of state health insurance reforms, state coverage profiles developed by the State Coverage Initiatives, and studies published by state-based associations, health care foundations, and policy think tanks.

For states that intend to achieve universal coverage, an individual mandate lends itself to such a goal. However, implementation of a mandate requires policies to address compliance and enforcement issues that are integral to the success of this reform strategy. Also, the effectiveness of this approach depends on the availability of insurance options to all persons who must meet this requirement. For example, unemployed adults with poor health status currently may not have any coverage options available to them, because they cannot get employment-based insurance, are ineligible for public programs, and private insurers deny them coverage based on pre-existing health conditions.

Massachusetts

In 2006, Massachusetts passed comprehensive health reform, which includes a requirement that all state residents have health insurance coverage, or be subject to a financial penalty. Residents confirm that they have coverage on their state income tax forms. Individuals can file hardship exemptions from the mandate. In addition, persons for whom there are no affordable insurance options available will not be subject to the mandate. Affordability is determined by a statutorily established board.

Complying with an individual mandate may be difficult for low-income persons who find insurance unaffordable. States that have proposed an individual mandate usually also include subsides and/or exemptions for poor individuals. In the former situation, the cost to the government would increase to finance those subsidies. In the latter situation, exemptions defeat the intent of an individual mandate.

Young Adult Coverage

Young adults make up a disproportionate share of the uninsured, compared to their representation in the overall population. Nearly half of all states have sought to address this issue by enacting laws to increase young adults' access to health coverage. Such laws typically require private health insurers to allow adult dependents to continue to be eligible for coverage under their family's health insurance policy, up to a specified age and under certain conditions, such as being unmarried or attending college.[7]

South Dakota

In 2005, South Dakota passed H.B. 1045, which prohibits insurers who provide dependent coverage from terminating such coverage before age 19. For dependents who are full-time college students, insurers are required to extend coverage until age 24.

This reform approach could apply to a moderate share of the uninsured. However, its reach is limited given that the family would also have to have coverage in order for the dependent to benefit. Moreover, this is a temporary solution since the individuals would eventually age out of this benefit, regardless of their educational, marital, or other personal circumstances.

Since the premium for a family policy typically does not vary with the number of dependents covered, this reform strategy would not affect the family's costs when purchasing insurance. However, if the cumulative impact of this reform results in more individuals with health coverage, that would likely lead to an increase in overall health care spending.

[7] For additional information about state efforts to increase coverage among young adults, see "The Changing Definition of 'Dependent': Who is Insured and For How Long?," National Conference of State Legislatures, at http://www.ncsl.org/programs/health/dependentstatus.htm.

Employment-based Reforms

Given that a majority of Americans obtain health insurance through the workplace,[8] many states target employers in their coverage expansion efforts. Some states focus their work-based reforms on small firms, given the disadvantages that small firms face in obtaining private health coverage, compared with large firms. These disadvantages include limited ability to spread insurance risk, limited ability to leverage size to negotiate better benefits and lower premiums, no economies of scale, and a more transient, lower-wage workforce.

Cafeteria/Section 125 Plans

Cafeteria plans are employer-established benefit plans under which employees may choose between receiving cash (typically additional take-home pay) and certain benefits (such as health insurance) without being taxed on the value of the benefits if they select the latter. Essentially, section 125 of the Internal Revenue Code provides a tax incentive to workers to obtain health coverage or other benefits.[9] While this benefit is through the federal tax code, states have used cafeteria plans as a vehicle for making health insurance more affordable for workers. A handful of states require employers to establish section 125 plans to allow employees to buy insurance using pre-tax dollars. However, these states do not necessarily require employers to fund these plans once they have been established. Small firms typically are exempt from requirements to establish cafeteria plans.

This reform strategy benefits only individuals who are employed and whose employer establishes cafeteria plans. Therefore, cafeteria plans have limited reach as a coverage strategy.

Rhode Island

By July 2009, firms with more than 25 employees are required to establish a cafeteria plan. Employers are not required to contribute toward the cost of health insurance, nor give employees the opportunity to buy insurance at the group rate.

Cafeteria plans allow individuals to buy coverage using pre-tax dollars. Because consumers are using money that is not taxed to buy insurance, they are in effect receiving a discount on the price of that insurance. On the flip side, the government "loses" tax revenue that it would have collected if those funds were in the form of take-home pay as opposed to benefits.

Employer Mandate

An employer mandate typically refers to a requirement that employers provide health benefits to their employees and those employees' dependents. Such a mandate may allow exemptions for small firms, who find it more difficult to provide health benefits than large firms. Employer mandates may also encompass "pay or play" policies (also referred to as "fair share" laws), which require employers either to contribute to a fund to finance coverage provided through a public program, or provide health benefits to their workers. Currently, only Hawaii and Massachusetts have employer mandates in place, but several other states have proposed such a requirement in the recent legislative sessions.

[8] For additional information, see CRS Report RL32237, *Health Insurance: A Primer*, by Bernadette Fernandez.

[9] For additional information about cafeteria plans and other tax-advantaged health benefits, see CRS Report RL33505, *Tax Benefits for Health Insurance and Expenses: Overview of Current Law and Legislation* , by Bob Lyke and Julie M. Whittaker.

Hawaii

The Prepaid Health Care Act of 1974 requires nearly all employers to provide health benefits to at least some of their workers. Eligible employees are those who work a minimum of 20 hours a week and make a certain amount above the state minimum wage. The coverage offered must meet state-prescribed standards. A worker may have to cover part of the premium, although there are limits to that contribution and cost sharing requirements vary based on the type of plan chosen. Congress gave Hawaii an exemption from ERISA to allow the state's employer mandate to remain in place.

Requiring employers to insure their workforce may be the beginning steps to a universal coverage initiative, when paired with other related policies. However, there is ongoing debate whether a state may impose any kind of benefit requirement on employers. While states are the primary regulators of health insurance, the Employee Retirement Income Security Act of 1974 (ERISA) places the regulation of private-sector employee benefits (including health insurance) under federal jurisdiction.[10] This leaves open the possibility of legal challenges to any state planning to implement an employer mandate.[11]

Costs related to complying with an employer mandate would be directly borne by employers. However, economic theory would argue that the additional costs would ultimately be borne by workers in the form of lower wages.[12] Moreover, even with employer contributions toward a health care fund or health benefits to employees, individuals may still have to pay a premium to get coverage. And to the extent that the state would enforce compliance of this mandate, there are administrative costs and capacity issues related to enforcement.

Purchaser Reforms

Some state reforms target both consumers and businesses as purchasers of health insurance. These reforms may attempt to address availability and cost concerns, as well as administrative burden issues.

Connector/Exchange

A health insurance connector or exchange is a clearinghouse that provides "one-stop shopping" for purchasers of insurance, typically individual consumers and small businesses. This entity generally offers a choice of insurance options, simplifies plan administration, and provides portable coverage that allows a person to remain covered regardless of life and work changes. It may also have other responsibilities, such as negotiating with plans regarding benefits and premiums, but fundamentally it functions as a "store" or "facilitator" that brings together health insurance carriers and purchasers. Massachusetts established a connector as part of its overall

[10] For additional information about this issue, see "ERISA and State Health Reform" at http://www.allhealth.org/publications/State_health_issues/ERISA_and_State_Health_Reform_68.pdf.

[11] For additional information about fair share laws and ERISA, see CRS Report RL34637, *Legal Issues Relating to State Health Care Regulation: ERISA Preemption and Fair Share Laws*, by Jon O. Shimabukuro and Jennifer Staman.

[12] For discussions regarding the relationship between employer-provided health benefits and employee wages, see L. Summers, "Some Simple Economics of Mandated Benefits," The American Economic Review, Vol. 79, No. 2, May 1989; and J. Gruber, "The Incidence of Mandated Maternity Benefits," The American Economic Review, Vol. 84, No. 3, Jun. 1994.

health reform plan, but a few others states have proposed creating one within the context of their reform initiatives.[13]

While a connector or exchange may provide additional insurance options to any given state resident, such options do not automatically lead to increased coverage by themselves. Questions regarding the value of benefits offered and affordability of insurance still apply.

Through the clearinghouse function, a connector may reduce administrative costs, and through negotiations, it may be able to get favorable rates, but this is dependent on what other reforms and market rules have been enacted in any given state. In other words, these entities, in and of themselves, do not necessarily lead to significant reductions in premiums for those buying insurance through them.

Oregon

in June 2007, Oregon passed the Healthy Oregon Act, an act that outlines the first steps to reforming Oregon's health care system with the intent of providing universal access to coverage to all state residents. The Act creates a public board that will gather input on reform ideas, develop a comprehensive reform plan, and present legislative proposals to the state legislature in 2009. Among the issues the board may consider to achieve universal coverage is the design for and implementation of a health coverage exchange, to serve as a "central forum" for individuals and businesses to buy health insurance.

Premium Subsidies/Tax Credits

In order to make coverage more affordable, many states provide financial assistance to individuals and families for the purpose of buying health insurance, and businesses to encourage the provision of health benefits through the workplace. Assistance may be in the form of direct subsidies for premiums, or reimbursement through the tax system. For assistance to consumers, states may specify that subsidies be used to purchase only certain types of insurance, such as a policy in the nongroup market. For assistance to firms, states often focus on small businesses. Some states provide tax credits to small firms to encourage those firms to provide health benefits to their employees.

North Carolina

Effective for the 2007 and 2008 tax years, firms with 25 workers or less could claim a tax credit against their corporate or personal income tax or corporation franchise tax if they provided health benefits to their employees. To be eligible for the credit, an employer would have had to contribute at least 50% toward the cost of health insurance coverage. Moreover, the coverage must have met or exceeded the minimum benefit standards recommended by the Small Employer Carrier Committee. The credit may be claimed only for premiums paid for employees whose total wages from the firm do not exceed $40,000 per year. The credit amount was equal to the lesser of $250 or costs incurred.

Given that health insurance premiums have grown faster than wages and increasing numbers of people and businesses find coverage to be unaffordable,[14] premium assistance addresses a primary reason why people are uninsured. However, subsidies do have their limits if they are tied to insurance options that are not available to everyone, or in every area.

[13] For additional information about state health insurance connectors and exchanges, see http://www.statecoverage.net/pdf/healthinsurance0907.pdf.

[14] For related data, see Employer Health Benefits, 2007 Annual Survey, Kaiser Family Foundation and Health Research and Educational Trust, September 2007, at http://www.kff.org/insurance/7672/upload/76723.pdf.

States may have to provide a generous subsidy to encourage either uninsured individuals to purchase coverage or small firms to offer coverage who otherwise would not.[15] Depending on the scope of the coverage expansion, the cost to taxpayers for financing these subsidies may be large.

Market/Regulatory Reform

This set of reform strategies focuses on what private insurance carriers may offer, how plans formulate premiums, how insurers conduct their business, and other requirements that states may impose on the insurance industry. The spectrum of issues addressed may target the benefit package (e.g., minimum benefit requirements), rating rules (e.g., community rating requirement), other access provisions (e.g., guaranteed issue), and cost-sharing limits (e.g., maximum out-of-pocket costs).

Limited-Benefit Plans

In an effort to entice both small employers to offer coverage to employees and individuals to purchase insurance, many states have enacted legislation to allow insurance carriers to offer limited-benefit health plans, or established coverage programs that provide a limited set of benefits. Limited-benefit plan policies allow insurers to avoid all or some benefits mandated by the state. By decreasing the number of covered services, such policies may lead to a reduction in premiums.

States may increase insurance options through limited-benefit plan policies, but value and affordability considerations still apply. For uninsured but otherwise healthy people, these policies may be an attractive option. However, persons with pre-existing health conditions may find little to no value in limited-benefit plans. Likewise, individuals with low incomes may still find such plans unaffordable.

Kentucky

In 2005, Kentucky passed H.B. 278, which allows insurers in both the non-group and small group (2-50 employees) markets to offer basic health plans. Such plans may exclude any state-mandated benefits from coverage, with the exception of diabetes services, hospice care, chiropractic benefits, and any federal benefit mandates. Insurers must disclose that the basic plan being offered provides limited coverage.

Existing studies have found that such plans do reduce premiums, but the overall impact varies both within and across states.[16] That impact often depends on the specific mandates that no longer apply and any accompanying policies—such as premium subsidies or increased cost-sharing—which may be coupled with these plans. In the former example, a subsidy reduces the premium that a consumer pays, but there is a cost to the government. In the latter example, the consumer

[15] For discussions regarding how the size of subsidies impact the take-up of health insurance, see M. Pauly and B. Herring, "Expanding Coverage Via Tax Credits: Trade-offs and Outcomes," Health Affairs, Vol. 20, No. 1, Jan./Feb. 2001; and K. Thomas, "Are Subsidies Enough to Encourage the Uninsured to Purchase Health Insurance? An Analysis of Underlying Behavior," Inquiry, Vol. 31, No. 4, Winter 1994-95.

[16] Studies on state limited-benefit health plans include "Health Insurance Mandates in the States 2008," V. Bunce and J.P. Wieske, Council for Affordable Health Insurance; "State Options for Expanding Health Care Access," B. Yondorf, L. Tobler, and L. Oliver, National Conference of State Legislatures, March 2004; "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and Health Marts," Congressional Budget Office, January 2000; "Access to Health Insurance: State Efforts to Assist Small Businesses," Report HRD-92-90, U.S. General Accounting Office, 1992; and "Flesh or Bones? Early Experience of State Limited Benefit Health Insurance Laws," P. Butler, National Academy for State Health Policy, August 1992.

may pay a lower premium but at the expense of higher out-of-pocket costs once he/she uses services.

Reinsurance

Insurance carriers face the risk that the premiums they collect will not be sufficient to cover their expenses and generate profit, so they seek reinsurance to provide some protection from significant financial losses. Given that reinsurance is insurance for insurers, state reinsurance programs benefit carriers directly and consumers indirectly.

Idaho

Idaho operates reinsurance pools for its small group and individual markets. In the individual market, the state operates the Individual High-Risk Reinsurance Pool that reinsures five guaranteed-issue products and sets premiums for these products. The primary insurer is responsible for claims up to $25,000. All claims exceeding that amount are covered by the reinsurance pool, up to the lifetime maximums of the guaranteed-issue products. In the small group market, the insurer is responsible for claims up to $13,000. Above that amount, the pool pays increasing amounts in claims, depending on the plan.

The impact on coverage depends greatly on the premiums charged by carriers participating in the reinsurance program. Unless a reinsurance program requires participating insurers to reduce premiums in order to receive the reinsurance benefit, the insurer has complete discretion over what premiums will be, which directly affects the potential for coverage expansion. And because reinsurance benefits carriers directly, the subsequent impact on premiums (and consumers) varies.

States may finance reinsurance programs through assessments on all insurers in that market, as well as general revenue and the collection of premiums from participating insurers. To compensate insurers that may end up enrolling a sicker, more expensive population, the state may withhold a portion of premiums collected and distribute those withholds at a later time according to the actual risk enrolled by each participating insurer (this concept is referred to as "risk adjustment").

Implications for National Reform

The above-mentioned state reforms (and other strategies) are policy levers that are available to federal legislators and policymakers. But while state experiences provide some insight, they are not directly generalizable to the nation as a whole. The differences between state-level reform and national reform relate not only, or even primarily, to scope, but also involve fiscal and legal constraints, the regulatory environment, economic conditions, labor market supply, and other factors.

The complexity of national reform poses unique challenges and opportunities. For example, each state sets regulatory standards with which insurance carriers licensed in their state must abide, such as benefit mandates, rating rules, and solvency standards. Some states establish very strict standards, others impose less restrictive requirements, and some not at all, depending on the regulatory area and segment of the health insurance market. Given that state laws and regulations vary, any new standard imposed nationwide would place unequal burden on insurance carriers, depending on which state they already operate in. On the other hand, only federal law applies to health coverage that is self-insured. Given that self-insured plans provide coverage to

approximately half of all workers with health insurance, federal action is necessary if the objective is to apply health reforms broadly.

In addition, while individual states have achieved some measureable successes in their efforts to expand coverage or make health insurance more affordable, those successes have had their limitations and trade-offs. For example, while Massachusetts has achieved near-universal coverage two years after enactment of comprehensive health reform,[17] the costs associated with reform have exceeded initial estimates[18] and long-term financing is an ongoing concern. Moreover, the increase in newly insured residents has highlighted a common feature in health care delivery in Massachusetts and other states: severe physician labor shortages, particularly in primary care.[19] Overall, the Massachusetts experience exemplifies the eventuality that any national reform will involve consideration of trade-offs. And in the climate of limited resources, such consideration will necessitate priority setting.

Author Contact Information

Bernadette Fernandez
Analyst in Health Care Financing
bfernandez@crs.loc.gov, 7-0322

Acknowledgments

This report was completed with assistance from Lynn Sha and William Rodriguez.

[17] S. Long, "Health Insurance Coverage in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey," Urban Institute, December 18, 2008, available at http://www.urban.org/publications/411815.html.

[18] See "Health Connector Facts and Figures March 2009," at http://www.mahealthconnector.org.

[19] "Physician Workforce Study," Massachusetts Medical Society, 2008, at http://www.massmed.org.