

Options under consideration for universal health insurance coverage in Connecticut

Draft for discussion, April 25, 2008

Introduction

Guiding principles (IOM)

Universal, continuous, affordable for individuals/families, affordable and sustainable for society, enhance health and well-being

Rationale for expansion

- Individual: rising health care costs, uncertainty about continued access to coverage, rising premium and out-of-pocket expenses, job lock
- State: unacceptably high share of residents without insurance, burden of uncompensated care on providers, burden of rising insurance costs on business, reduced labor mobility
- Business: rising insurance costs, unpredictability of future increases, differential effect on small business, skews investment away from labor

Coordination with health system reform

To avoid a mismatch between effective demand for care and availability of care. To assure attention to access and quality in tandem with coverage. To assist with cost containment.

Overview

The HealthFirst Connecticut Authority is currently considering five interventions designed to bring universal health insurance coverage to the residents of Connecticut. Two represent fairly substantial departures from the status quo. Of these, one is some version of a single-payer plan or state self-insurance. The other offers a novel approach to coverage by putting all primary care into some form of pre-paid health plan leaving only non-primary care to be covered by insurance. The other three interventions under consideration build in varying ways on the existing employer-based system. In addition to these fundamental structural reforms, the Authority is also considering complementary initiatives that would cut across all initiatives and so would apply to whichever intervention is chosen or could be implemented within the current system while awaiting reform.

In this document, we first present issues that cut across all of the interventions. Then, the five interventions are presented in a way that allows comparisons to be made easily across them. For each intervention under consideration, we present a brief summary of its components followed by an examination of its potential advantages and possible concerns that it raises.

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Cross-cutting design decisions

- * Benefit package
- * Requirements for information technology
- * Promotion of quality
- * Promotion of efficiency
- * Definition of affordable
- * Cost-control mechanisms
- * Balance of individual responsibility with societal responsibility
- * Financing

Proposed Universal Coverage Interventions

1. *Universal entitlement to publicly financed coverage*

Examples: single payer/single plan, state self-insurance with plan choice

Target: all residents or all resident citizens

Experience: none in this country but universal coverage is the norm in other highly developed countries

Design questions: single plan vs choice of plans, public administration or ASO arrangement, mechanism for enrollment, response to non-enrollment, eligibility of non-citizens, benefits, how to address any remaining uncompensated care by non-eligibles

Potentially positive aspects

- * Coverage
 - Automatic coverage is only way to assure truly universal coverage
 - “Mainstream” coverage for all
 - Eliminates issues of transitions in coverage with change in employment, income, family status
 - Single plan would be seen as egalitarian, while multiple plans would allow consumers to exercise choice
- * Providers
 - Universal coverage would end most uncompensated care for providers
- * Employers
 - Eliminates risk of job lock associated with ESI
 - Reduces search costs for individuals and businesses

Possible concerns

- * Coverage
 - if politically feasible and legal, full coverage is possible
 - could attract sick residents but motivate healthy residents to leave the state
 - since all are covered, adverse selection is not an issue
- * Providers
 - single plan could bring departures by medical services providers that fear monopsony power
 - both single plan and plan choice could be viewed by providers and possibly consumers as threat to status quo
- * Employers
 - Relief from health benefits administration
- * Cost
 - universal coverage will likely bring higher demand. Increased costs of higher demand may not be fully balanced by any cost savings or efficiency gains.
 - Distribution of any new costs will depend on financing mechanism.

* Cost

- Savings in administrative costs likely with one payer
- If single plan, savings in medical costs possible through purchasing power.
- If multiple plans, competition may lead to savings and/or quality improvement

* Administration

- start up administrative costs could be large
- on-going administrative costs are likely lower than total administrative costs of current coverage arrangement but may fall or appear to fall more heavily on state

* Crowd-out

- by design, crowds out private funding although plan choice option would allow continuation of private plans
- Some private coverage could remain, as in Canada

2. Bolstered employment-based system

- Examples: employer mandate, state subsidies for low income and/or high risk, liability/regulatory reform, mandatory reinsurance with or without state financial participation, tax incentives for employers.
- Target: employed residents and (possibly) their dependents
- Experience: Hawaii for mandate. Regulatory reform alone has shown little impact on coverage in other states.
- Design questions: what qualifies as coverage, who qualifies as employer, offer vs take-up, dependent coverage

Potentially positive aspects

- * Coverage
 - o Market approach
 - o “Mainstream” coverage
 - o Would allow residents to maintain current coverage, if desired
 - o Could directly address affordability of premiums
- * Employers
 - o Levels playing field for businesses
 - o May increase perception of fairness for employees
 - o Reinsurance and regulatory change could help moderate premium increases and volatility
- * Cost
 - o Keeps existing employer contributions to coverage
- * Administration
 - o No new bureaucracy

Possible concerns

- * Coverage
 - o Does not address the non-working uninsured
 - o Would likely not achieve universal coverage as employees are free to decline offers
 - o Benefit design would be important to avoid under-insurance
- * Providers
 - o Because universal coverage not likely to be achieved, some uncompensated care would remain
- * Employers
 - o Mandates could be seen as burdensome governmental intervention, could affect attractiveness of CT as place to locate business, could result in some business departures
 - o Cost may affect hiring decisions or reduce wages
 - o Burden could be heaviest on small businesses who have higher share of uninsured
 - o Tax incentives for employers could reduce employer costs
- * Cost
 - o cost of mandate falls on businesses who, it is generally accepted, pass it on to workers. Subsidies could shift this cost to state.
 - o Cost of reinsurance/tax incentives could fall on state
 - o Cost of regulatory reform would be specific to the reform

- * Administration
 - provision would need to be made for enforcement of new requirements
 - on-going administrative costs would remain
- * Crowd-out
 - by design, favors private coverage
 - mandates could move some current Medicaid beneficiaries to private coverage (“crowd-in)

3. Insurance-choice system

Examples: Make state employees' plan available to all, other pooling mechanisms, buy-in to public programs could make Husky/Medicaid a new choice for residents

Design: Establish a new entity or use an existing entity to purchase coverage collectively on behalf of participating employers. Would negotiate contracts with a variety of health plans, as large employers do, allow individual employees to choose among all participating health plans. Many variations possible in plan of operations.

Target: Employers to increase offer rate of insurance to employees; employees to improve choice of plans.

Experience: A significant minority of states have tried pools. Health plans resist participation, which is seen as competing against their own non-pool offerings. All existing pools are small. WV has opened aspects of the state employees plan to small business.

Potentially positive aspects

- * Coverage
 - Market approach
 - "Mainstream" coverage
 - Politically acceptable generally, although often not to insurers and agents
- * Employers
 - Allows small employers to give individual employees choice of health plans
 - Simplifies enrollment, reduces search costs for private firms
- * Administration
 - Pool administration can be public or private; either could contract out to pool administrator
 - Use of state employees' plan would allow use of existing administrative structure
 - Pool could provide mechanism for subsidies, if desired

Possible concerns

- * Coverage
 - Does not address the non-working uninsured
 - Would likely not achieve universal coverage as employees are free to decline offers
 - in practice, pools have not expanded number of insureds, only choices for employees.
 - Impact on coverage overall depends in part on extent of savings achieved through pooling
- * Providers
 - Because universal coverage not likely to be achieved, some uncompensated care would remain
 - Pool may be able to negotiate lower provider rates
- * Employers
 - Increased choice could lead to increased take-up and so increase employer cost
- * Cost
 - Little additional public burden unless subsidies offered
 - Main cost advantage to enrollees would come from cross-subsidy from lower risks within pool

* Cost

- Modest budgetary cost for start-up, smaller for ongoing administration
- Likely some savings on administration for individuals and small groups

- Some adverse selection possible with impact on costs within the pool
- Possible savings on medical benefits if pool can negotiate with providers Administration
- Additional administrative burden for processing new enrollees to pool

* Crowd-out

- by design, favors private coverage
- provisions needed to avoid crowd-out of employer contribution

4. Regionally organized networks of care (possibly building on/extending Charter Oak)

Example: individuals without private insurance could buy into new coverage plan, state required to subsidize needy,
Design: new offering of affordable coverage for currently uninsured adults and children with premiums, copays, and deductibles; affordability based on sliding scale. Regional organization of care including at a minimum, an acute care facility, an FQHC, and a network of private primary providers and specialists to facilitate quality and efficiency.
Target: uninsured adults and children
Experience: Combines elements of reforms in San Francisco and North Carolina
Design questions: mandatory or voluntary participation, allowance for out of network care

Potentially positive aspects

- * Coverage
 - Broad benefits for enrollees
 - Open to non –workers and workers with no ESI offer
 - Subsidies help make coverage affordable across all incomes
 - Combined procurement for Charter Oak and HUSKY intended to aid in continuity
 - Care coordination requirements included to improve quality
- * Administration
 - could build on existing care structure such as Charter Oak
 - Uses existing administrative structure
- * Cost
 - Copays could be structured to favor primary and preventive care and discourage excess ED use

Possible concerns

- * Coverage
 - Would likely not achieve universal coverage without an individual mandate
 - Non-mandatory coverage makes adverse selection likely
- * Providers
 - Because universal coverage not likely to be achieved, some uncompensated care would remain
 - “no adverse changes” for HUSKY may stabilize provider payment rates
- * Employers
 - None likely
- * Cost
 - Subsidies for low income (<350% FPL) could generate substantial public sector costs
 - Adverse selection could affect costs within plan
- * Administration
 - state to contract out program management
- * Crowd-out
 - significant potential for crowd-out so provisions needed to address it

5. Universal entitlement to primary care or coverage, with insurance purchased for inpatient care only

Example: New program offered by the state.
Design: primary care provided by or paid for by the state. Non-primary care subject to separate traditional insurance.
Target: all state residents or legal residents; or uninsured residents only
Experience: none in this country
Design questions: what to include as primary care

Potentially positive aspects

- * Coverage
 - designed to allow greater attention to quality and efficiency in the provision of primary care with expected positive effects on quality at same or lower cost
- * Employers
 - state provision of/payment for primary care could reduce employers' insurance costs

Possible concerns

- * Coverage
 - Primary care coverage automatic for all but insurance for non-primary care would rely on existing insurance structures
- * Providers
 - Because non-primary care not explicitly covered, some uncompensated care would likely remain
 - Separation of primary and non-primary care could result in disruptions in existing practice patterns.
- * Employers
 - None expected.
- * Cost
 - Could result in substantial new public costs, depending on how it is financed
- * Administration
 - Could require substantial new state administrative burden
- * Crowd-out
 - designed to replace private coverage of primary care, so "crowd-out" is built in