

State initiatives for the medically uninsured

by Jeffrey C. Merrill

Recently, Medicaid has changed in terms of both perception and reality. After a period of decline in entitlement, that trend has been reversed through both Federal mandates and an increasing role for Medicaid in dealing with the uninsured. As States and the Federal Government seek structural solutions, further eligibility expansions may be necessary, such as public subsidies of

private insurance or using Medicaid as a reinsurance mechanism. Currently, there is considerable State activity in identifying such solutions. These activities have given us some ideas about what is necessary to expand coverage to more of the population. Continued demonstrations and better definitions of the respective roles of the private and public sectors are needed.

Introduction

Ten years ago, most Americans assumed that the vast majority of individuals under 65 years of age had private health care coverage, and, for those too poor to afford such insurance, Medicaid filled the gap. Certainly, this was never the case, nor was Medicaid ever intended to serve that purpose. Rather, since its inception, the Medicaid program has been geared toward covering vulnerable population groups who, by virtue of low income, family status, age, and/or disability, were unable to participate in the work force and could not afford the cost of private insurance.

As we begin a new decade, both perception and reality are changing. First, as a society, we are much more aware of the fact that approximately 31 million Americans under 65 years of age, most of whom are employed, do not have health insurance. Second, expansions have already been enacted for Medicaid that potentially extend coverage to a significantly wider segment of the population.¹ Third, despite these expansions, we now recognize that Medicaid can only fill a part of the gap in covering the uninsured. Fourth, given this, consideration is being given at both the Federal and State level to other mechanisms through which the Nation might address the larger problem of the uninsured and, within that context, what expanded role, if any, Medicaid might play.

In the minds of a growing constituency (including segments of business and organized medicine), the nineties will be the decade when such a solution will emerge. It remains to be seen whether this is correct and, if so, whether the necessary changes will be incremental building onto the current system or represent dramatic restructuring. Nevertheless, some progress has already occurred. In the eighties, States began the process of examining how to alter their systems to increase coverage for the uninsured. In addition, some of the impetus for a climate of change originated with Congress enacting incentives and mandates under Medicaid for States to

expand eligibility significantly, particularly as it related to pregnant mothers and young children.

Congress, particularly through the Omnibus Reconciliation Acts (OBRA) of 1986 and 1987, significantly expanded eligibility under Medicaid for women and young children. More recent OBRA (1988 and 1989) legislation extended those provisions and made mandatory some of the options that had previously been enacted, as did the Medicare Catastrophic Coverage Act of 1988.

An expanding Medicaid program

What changes have occurred that directly enhanced Medicaid's role in dealing with the problems of the uninsured? Clearly the most direct way of addressing this issue is through eligibility expansion. States can do this by:

- Increasing income standards for the Aid to Families with Dependent Children (AFDC) program which, in turn, expands eligibility under Medicaid.
- Implementing the recent OBRA changes eliminating categorical requirements for selected vulnerable populations as well as increasing income thresholds.
- Making other eligibility requirements more flexible, such as covering people in the home and community who would otherwise only be covered in an institution.

Over the last few years, a number of States have, in fact, raised their AFDC eligibility standards (and, thus, Medicaid entitlement). For example, in 1988, about 20 States increased their AFDC benefit (Lipson et al., 1988). In addition, by the end of 1989, most States had taken advantage of the Medicaid eligibility expansions for pregnant women and children made possible under the various Reconciliation acts. By the end of last year, 15 States had increased eligibility up to 185 percent of poverty for women and infants (children under 1 year of age). Another eight States had exceeded 100 percent of poverty, but had not yet reached the 185-percent level. In sum, all but five States had reached at least the 100-percent poverty level for these groups. Also, at the end of 1989, 33 States had established eligibility standards for children 1 year of age and over at a level at least 100 percent of poverty. Some of these States, such as West Virginia and Minnesota, extended this to children up to 8 years of age. Effective April 1990, all States were required to meet the 133-percent level for pregnant women and children under 6 years of age. In addition, a

¹Between the mid-seventies and the eighties, the percent of those under the poverty level that were eligible for Medicaid dropped from about 60 percent to 45 percent. More recently, that trend has reversed and, in 1989, about one-half were covered. That rate should continue to increase as all the recent changes are implemented.

Reprint requests: Jeffrey C. Merrill, Vice President, The Robert Wood Johnson Foundation, P.O. Box 2316, Princeton, New Jersey 08543-2316.

number of States (including Vermont, Maine, Washington, Minnesota, Rhode Island, and Connecticut) using both the expanded Federal match and State-only funds have broadened coverage for other poor, non-Medicaid eligible children (Solloway and Jensen, 1989). Recent congressional action will now allow these States to increase their Federal match for this broader child health coverage.

Among those States with a high Federal Medicaid match (e.g. three to four Federal dollars for every State dollar spent), these eligibility expansions have proven to be economically advantageous in terms of leveraging Federal funds. For example, in a State such as Mississippi, where significant eligibility expansions have taken place, an investment of one State dollar under the Medicaid program can generate a dollar in increased tax revenues. This occurs because of the increase in the Federal matching funds to the State and the multiplier effects of those funds throughout the State's economy. Further, these expansions have spurred these States to become innovative in combining other sources of funding, such as State maternal and child health funds to use as the State's share under Medicaid.

To date, these changes have primarily affected young children and pregnant women. However, they might be interpreted as the beginning of a shift in the Medicaid program away from its original notion of only covering the very poor, categorically eligible. Income levels set at 185 percent of poverty have the potential to extend coverage to more children in working families and can play a role in increasing entitlement to some segments of the working uninsured. As is already the case in Maine, Medicaid is now being seen as a source of coverage for all uninsured up to 95 percent of poverty (using State-only funds).

One note of caution: Although it is evident that much has already been accomplished through expanding eligibility, there is still room for further expansions. Many States still appear somewhat wary in how far they might go in implementing the OBRA changes. In addition, for those AFDC families that are not potentially covered under these expansions, coverage in many States, because of the linkage to welfare, is still very limited. For example, as of January 1990, four States still had an AFDC needs standard under \$5,000 for a family of four (National Governors' Association, 1990). Although the Federal poverty level was \$12,100 in 1989 for a family of four (U.S. Bureau of the Census, 1990), 47 States still maintain their needs standards below that level (National Governors' Association, 1990). Though further expansions will not solve the whole problem of the uninsured, Medicaid could potentially still play a larger direct role in making basic coverage available for those at or below the poverty level.

Going beyond Medicaid

Because Medicaid, as currently configured, can only be a contributor to addressing the problems of the uninsured, concern at the State level for seeking dramatic changes goes beyond this program and focuses on broader based

solutions involving both the private and public sectors. Currently, at least 13 States have active commissions or task forces examining health care financing and access issues. In addition, over the past year, six other States have completed the work of commissions and/or task forces. Whatever the future holds, many States are already experimenting to seek broader solutions to their uninsured problem (Campion, 1990).

These State initiatives to expand health insurance coverage can be categorized into three generic activity areas:

- Mandated coverage requiring all employers to offer insurance, e.g., "play or pay."
- Making private health insurance plans more available and affordable.
- Risk pools organized by States to provide coverage for the medically uninsurable.

These approaches are not mutually exclusive, and States may seek solutions that combine them. A combination of increased private coverage, expanded Medicaid, and other State subsidies, although not a panacea, can fill major gaps among the uninsured. In some cases, the goal is simply to determine how best to expand private coverage to small businesses by making insurance more affordable. (Nationwide, 67 percent [Short et al., 1989] of the working uninsured are employed by businesses with 25 employees or less.) In others, there is a broader concern as to how the overall system might be restructured to address the problem of the uninsured (including those who are not working and/or are high risk and, thus, uninsurable). In some of the States, Medicaid may play an important role; in others, however, it may not be a significant player.

Summary of State efforts

Although the following approaches represent innovative and promising mechanisms, it is too early to assess whether they might provide a more generic answer to the problem of the uninsured. What they do represent is an effort to combine the public and private sectors as partners in solving this problem, demonstrate that lower cost insurance products may be possible, gain some experience on the uninsured in terms of utilization and costs, and provide models for how State subsidies could be used to ensure the existence of more affordable products.

Strategies for extending private insurance to the uninsured include:

- Employer mandates.
Play or pay.
- Reducing the costs of benefits.
Limited or targeted benefits,
e.g., waiving State mandated benefits.
Preferred provider arrangements.
Managed care.
- Subsidizing the cost.
Waive premium tax.
Tax credits to employees.
Buy down premium directly.
Subsidize dependent coverage.
Subsidize administration and marketing.
Offer reinsurance.

- High-risk pools.
 - Create separate high-risk pools.
 - Separately cover high-risk procedures, e.g., high-risk babies; transplants.
 - Provide stop-loss coverage to private insurers.

Mandated coverage

An increasingly popular approach to address the issue of the uninsured is the potential use of employer mandates. As currently proposed, this might involve requiring that the employer either offer insurance or pay the State some fee or penalty that, in turn, could be used to cover those employees (play or pay). The oldest example of an employer mandate is in Hawaii. The Hawaii Prepaid Health Care Act of 1974 mandated that all employers offer health insurance to eligible employees (defined as those working more than 20 hours per week). Under that program, the employer paid one-half the premium, and the employee share was limited to 1½ percent of monthly gross earnings. More recently, Hawaii has expanded that notion to cover what they call the “gap group.” This would involve those part-time workers who still lack insurance and represent about 5 to 10 percent of the working population. Although it does appear that the Hawaiian program has been successful in significantly reducing the number of uninsured (from about 15 percent prior to 1974 to a low of 5 percent), that experience may not be applicable today to other States. Hawaii’s program was instituted in 1974 at a time of considerably lower health insurance premiums (even lower in Hawaii than mainland States) and may not accurately reflect the impact that mandates might have today on small employers (Wong, 1989).

A program currently receiving attention is that of Massachusetts. That program represents an effort to meld private and public sector activities using the “play-or-pay” approach, combined with Medicaid expansions and public subsidies. Despite major budgetary problems in the State, the Massachusetts program continues to move forward, albeit on a slower timetable. Expanded coverage for the disabled and new coverage for college students is in place. In January of this year, some small employers began to offer health insurance under the program that would offer them tax credits for 2 years. In addition, using community health centers as the provider, lower cost coverage is being offered to the uninsured. Nevertheless, it remains to be seen whether, if and when the actual mandates are in place, the program is workable. Over the last year, other States (Alaska, California, Illinois, Indiana, Michigan, and Minnesota) have also considered some form of this strategy.

The mandated coverage strategy has considerable appeal because 77 percent (Short et al., 1989) of the uninsured are employed (or their dependents). Yet, it remains to be seen whether this approach will, in fact, be a solution or create new problems. Opponents of mandating benefits argue that it will be inflationary, create unemployment, push employers to use more part-time or contract workers, and discriminate against high-risk or disabled individuals. Whatever the reality is, State demonstrations of this approach might be helpful in getting better answers to these questions.

Private insurance: Reducing the cost

Although the “play-or-pay” notion is appealing to some of the State task forces and legislators, the reality is that despite the mandates, it would not be financially feasible for many employers and employees to participate. Health insurance premiums have risen dramatically over the last few years. For small businesses, the costs are even higher as a result of a number of additional concerns: First, the administrative costs involved in marketing and administering small group policies is considerably greater. Second, according to insurers, the problems of risk increase as the size of the group decreases because of both the potential for adverse selection and the larger impact of a single catastrophic event in a small group. Third, some insurers argue that the experience of small groups is not as good as that of large groups. Because the costs are higher to these employers who are often least able to afford health insurance, this remains a major impediment to mandating coverage or solely using the private sector as a means of solving the problem of the uninsured among small employers.

States are experimenting with a number of different approaches to lower the cost of insurance² (an estimated 30-40 percent reduction in premiums may be necessary to make these plans widely affordable for small businesses). One strategy is to permit insurers to offer small employers limited health plans, stripped of mandated benefits. Although this approach can reduce the premium costs, it does also raise the issue of how much insurance is sufficient to provide adequate protection for those covered under these plans.

Nevertheless, some States are experimenting with this approach. For example, Virginia has permitted a plan that allows a minimum annual coverage of only 30 days of hospitalization; comprehensive prenatal, obstetrical, and well-child care; and a minimum of two annual physician visits. In the State of Washington, health maintenance organizations (HMOs) can now offer limited benefit plans to employers with fewer than 25 employees. The plan must provide, at a minimum, hospital care and coverage of children from birth. Also, demonstrations in Colorado and Tennessee combine more limited benefit packages with special provider arrangements (such as deep discounts from hospitals that are already caring for the uninsured) as a means of reducing costs.

Another approach being tested is the broader utilization of managed-care plans as means to reduce costs. For example, Arizona is now offering the Medicaid Arizona Health Care Cost-Containment System program to the uninsured as a means of providing a managed-care product with significantly lower premiums than other products currently available to the small business market. A pilot in Florida, called the Small Business Health Access Corporation, is also testing a low-cost plan offered through an HMO, as is the Maine Managed Care

²Many of these are a part of a 15-State demonstration, the Health Care for the Uninsured Program, funded by the Robert Wood Johnson Foundation.

Insurance Demonstration, or Maine Care. (To date, in both Florida and Maine, these are only available in limited areas; however, both programs are in the process of expanding to other regions of the State.)

Despite those efforts to lower premiums through reduced benefits or managed care, there remains an additional need to subsidize the cost of these insurance products. For many employers and employees, even these lower cost products continue to be unaffordable. To address this problem, some States are experimenting in a variety of ways with subsidies such as tax credits to employers or employees; a direct buy-down of the cost of the premium using public funds; or indirectly subsidizing administrative or underwriting costs through, for example, payment of marketing costs or reinsurance mechanisms. A number of States, including Connecticut, Kentucky, Massachusetts, and Oregon, are providing tax credits to employers to assist in reducing the costs of insurance. California is also contemplating a similar approach. These tax credits are offered to previously uninsured small employers who contribute to their employees' premiums. For some States, they may be short term and might even be replaced over time with a "play-or-pay" mandate. In addition, other States, including New Jersey, Missouri, Nebraska, and South Dakota, have also considered, but not enacted, tax credit programs to subsidize health insurance.

Some States, such as Florida, Maine, and New York, are providing direct subsidies to reduce the cost of the premium for employees who fall below certain income standards. For example, in Maine, those under 200 percent of poverty receive such subsidies. In addition, Michigan paid one-third of the premiums for those entering the workforce, most of whom had previously received Medicaid. On the other hand, Massachusetts is proposing the inclusion of both State support for the marketing and administrative costs of insurance to reduce the cost of the small business product, as well as offering reinsurance (possibly through a bond issue) as a means of lowering the premium even further. Reinsurance is also a part of the Connecticut program, as is a waiver of the premium tax the State collects from the insurer (this is waived for firms with fewer than 25 employees).

Public subsidies, both direct and indirect, may be an important catalyst in promoting public-private partnerships intended to expand coverage to a large segment of the uninsured population. In that respect, some suggest that Medicaid funds might be used to provide such subsidies. For a State that wants to reduce an individual's reliance on Medicaid by expanding private insurance coverage to people who might otherwise be Medicaid eligible, it may be cost beneficial to subsidize private premium costs, as Michigan has done, so that Medicaid pays only a portion of an individual's health care costs, rather than being responsible for the total cost. Whether the Medicaid program is the appropriate mechanism remains an unanswered question, one that merits further experimentation. Nevertheless, with or without Medicaid, the need for the public sector to find ways of subsidizing private costs may be necessary if private insurance can be made available and affordable to

a significant portion of the population currently without health insurance.

State risk pools

A third mechanism that can be used as a means of expanding coverage is through the use of State high-risk pools. Clearly, the cost of insurance to any group is greatly increased when that group includes individuals with significant health care needs. By medically underwriting those individuals out of the group and moving them to State high-risk pools, funded by pooling private insurance funds and/or public subsidies, the cost of insurance for the non-high-risk individual can be reduced. In addition, those pools often also serve as the only vehicle through which those already considered as "uninsurables" can get access to coverage.

On the other hand, opponents would argue that these high-risk pools remove too much risk from insurers and, in a sense, dilute the definition of insurance. Further, they argue that the high-risk pools do run some risk themselves of becoming, over time, an increasingly larger source of insurance coverage as more people are medically underwritten out of the basic insurance system. Some States have found this to be the case with auto insurance pools when increasing numbers of people are placed in these pools. Lastly, opponents argue that greater use of community rating would reduce the need for such segregated pools by lessening the impact of high-risk individuals in a group by spreading that experience across the much larger risk pool.

Nevertheless, the notion of high-risk pools is not a new one, and 19 States have already taken action to this area. Recently, there has been increased interest in this approach, and many proposals to address the issue of the uninsured have advocated the need for expanded use of high-risk pools. Further, for many people, Medicaid has implicitly served as a high-risk insurance mechanism (e.g., States currently have medically needy programs). Often, individuals with private insurance whose condition deteriorates wind up on Medicaid as their only source of coverage. One idea that has been discussed is to use Medicaid as a reinsurer or a stop-loss mechanism. Under this approach, individuals could maintain their private insurance but if, in a given year, they exceeded some stop-loss level, Medicaid would assume the coverage for that year. In this way, the private insurer could limit its risk, and Medicaid might get more involved earlier in the management of a patient. Although this idea has not been implemented in any States, in a different context it is being proposed in several States as a mechanism for addressing the long-term care needs of both seriously ill children and the elderly. Experimentation with this as a possible model for reinsuring acute care may be merited.

Whether or not Medicaid is an appropriate vehicle to address the high-risk population remains an issue. In addition, basic questions remain concerning the role, if any, of high-risk pools as part of an insurance system and whether they should be used only as reinsurance to limit rather than eliminate a carrier's exposure.

Some lessons learned

For the most part, the approaches being tried at the State level are still very much in the early stages of development, are limited to only few sites, or serve a small segment of the population. To date, they provide no definitive answers or generalizable models.

Nevertheless, they have begun to demonstrate some findings that may be helpful to future considerations of the problems of the uninsured:

- First, they have demonstrated that lower cost products can not only be made available but are marketable to a wide population. To date, many of these projects have exceeded their enrollment projections despite, in some cases, providing fairly limited coverage. Specific products have reduced costs, as mentioned earlier, through targeted or limited benefits, high cost sharing for some services, or preferred or exclusive provider arrangements. Some, including the author, had argued that such limited benefits or access would discourage interest in these products. Yet, experience to date in such places as Colorado have not borne out this concern.
- Second, future solutions may require greater cooperation between the private and public sectors. Whether that cooperation takes the form of better linkages between Medicaid and private insurance, reductions in some mandated benefit requirements, tax credits or other direct subsidies, or other kinds of indirect subsidies, a real solution may not be possible without the participation of both sectors. A corollary to this is the fact that the experience to date would argue that there are many forms such cooperation can take and each State may view this differently. Flexibility is important in finding the appropriate public sector role.
- Third, these demonstrations have found that, to date, the claims experience of small groups may not differ from that of larger groups. Although data is clearly preliminary and experience may change over time, none of the programs has yet experienced any problems in terms of underwriting losses with regard to the small groups they have covered. In fact, so far, their experience would indicate the contrary.³

An expanded role for Medicaid?

Medicaid may or may not play an expanded role in addressing the problems of the uninsured. This may be a function of how much the private sector can fill the current gaps; what other roles States might play as a partner to private insurers; and future activity at both the

³Data from three of the Robert Wood Johnson demonstrations—Arizona, Maine, and Florida—indicate that, to date, inpatient utilization for the enrollees is lower (about 250 inpatient days per 1,000 members) than that for new HMO plans in general (382 days).

Federal and State levels with regard to whether, and to what extent, Medicaid should expand its role in dealing with the uninsured.

Nevertheless, if Medicaid does become a significant player, some fundamental notions of the program's purpose and function may have to be reconsidered.

The notion of Medicaid providing a safety net for only those persons at the low end of the socioeconomic spectrum may be anachronistic—i.e., to serve a broader segment of the uninsured population, the program's roots in the welfare system may need to be altered. Some might argue that the program might be of more use if viewed as part of the public insurance system, identified with coverage expansion rather than impoverishment. One of the most shocking facts about the problem of the uninsured is the high percentage of that population that is employed or are dependents of workers. If Medicaid is to make a difference in addressing the needs of this population, some proponents of Medicaid restructuring contend the program should be decoupled from the welfare system. Further, they argue that it will require Medicaid to expand its focus and function not only as a direct insurer but, possibly, as a reinsurer or subsidizer of private insurance in order to reach those segments (e.g., some small businesses, part-time workers, uninsured) for whom coverage is not available or affordable.

Conclusion

These changes would require major philosophic and programmatic shifts in the Medicaid program. Such steps cannot be viewed lightly and would require greater experimentation before more permanent change is possible. The demonstrations to date are promising but do not yet suggest such blanket changes in Medicaid. Nevertheless, more demonstrations are needed. (More demonstrations may be possible through recent congressional authorization⁴ which, for instance, has now made it possible to test Medicaid's role as a subsidizer or reinsurer of private insurance, at least for children.) Giving the States greater flexibility to test innovative uses of Medicaid on a demonstration basis may make it possible to determine a more structural future role for Medicaid in addressing the issues of the uninsured, in leveraging private dollars, and in creating a more complementary relationship between the private and public sectors.

Whatever form such demonstrations take and what solutions to the problems of the uninsured emerge, greater cooperation between the public and private sectors is necessary. As we move towards a solution, we must find ways that Medicaid, Medicare, and private insurance can complement each other, building on each's strengths and correcting the weaknesses present in both systems. To do otherwise may only help to perpetuate the current crisis and, ultimately, serve no one's needs.

⁴These were enacted in OBRA 1989.

Acknowledgments

I would like to thank the Intergovernmental Health Policy Project for their assistance in updating States' actions with regard to OBRA implementation. In addition, my particular thanks to Dan Campion of the ALPHA Center whose help was invaluable in examining existing State initiatives to address the problems of the uninsured. Lastly, Michael Beachler of the Foundation was of great assistance in providing technical and policy information.

References

Campion, D.: Unpublished memo on State actions with regard to the uninsured. Alpha Center. Washington, D.C., May 1990.

Lipson, D.J.: *Major Changes in State Medicaid and Indigent Care Programs*. Intergovernmental Health Policy Project. Washington, D.C., 1988.

National Governors' Association: *State Coverage of Pregnant Women and Children, January 1990*. MCH Update. Washington, D.C., 1990.

Short, P. et al.: *A Profile of Uninsured Americans: National Medical Expenditure Survey, Research Findings 1*. DHHS Pub. No. DHS 89-3443, National Center for Health Services Research and Health Care Technology Assessment. Washington. U.S. Government Printing Office, 1989.

Solloway, M.R., and Jensen, R.: *Major Changes in State Medicaid and Indigent Care Programs*. Intergovernmental Health Policy Project, Washington, D.C., 1989.

U.S. Bureau of the Census: *Poverty and Wealth Statistics*. Unpublished Data. July 1990.

Wong, T.: *Health Access for the Uninsured: A Comparison of the Canadian and Selected State Programs*. Wisconsin Department of Health and Social Services. Madison, Wisconsin, 1989.