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Expanding Health Care Coverage for the Uninsured: Lessons Learned From States

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Summary

State policymakers have been concerned about the uninsured for a number of years and have pursued many strategies to help expand health care coverage. To understand the strategies undertaken by states and their successes and failures, CRS contracted with the Institute for Health Care Research and Policy at Georgetown University to conduct a 50 state survey. The findings of that survey are presented here.

In 2002, all states subsidized comprehensive health care for at least some of their low-income residents. Medicaid and the State Children's Health Insurance Program (SCHIP) — programs which enable states to augment their resources with federal matching funds — were the principal means of subsidizing health coverage in states. In addition to Medicaid and SCHIP, a number of states used state-only funding to subsidize health insurance or pay the cost of health care services for the uninsured or low-income populations. Three states, for instance, had tax credits for small employers or individuals. Six states and the District of Columbia had other state-funded programs to either subsidize health insurance or provide direct coverage for the uninsured. Twenty nine states had established high-risk pools for individuals rejected from traditional insurance for health reasons.

The variety of approaches used by the states that have engaged in these initiatives can yield some useful information for Congress. Many have been in place for a number of years so state program officials are knowledgeable about the strengths and weaknesses of the initiatives. While many of the states' efforts are small in scale, they provide an opportunity to track their impact and any administrative challenges they pose. A caveat for the reader is that the changing fiscal conditions reflected in many states' budgets in the years since 2002 may have changed the priorities of states and impacted the size or generosity of some of the programs that were in effect at the time of the survey. Understanding how states regulated insurance markets and improved the availability of insurance for the sickest and poorest before feeling the full impact of the recent recession remains valuable, nonetheless, by providing insight into the various choices that are available and their implications for federal initiatives.

At the same time, we know that in a few states, dramatic changes in state health policies to increase coverage have occurred since 2002. This includes initiatives in Maine and California as well as several other states that have established high risk pools using funds made available under the Trade Adjustment Act of 2002. This report will not be updated.

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State policymakers have been concerned about the uninsured for a number of years and have pursued many strategies to help expand health insurance coverage in their states. Some of these initiatives have involved creating new or expanding existing state-operated and state-funded programs. Other states have increased access to health insurance coverage through the regulation of the private health insurance market. Because the states serve as 'laboratories of innovation,' their activities may give federal policymakers examining this issue some insight into how different approaches to public program expansions and private insurance initiatives may or may not work.

This report explores a range of state coverage initiatives by reviewing what states have done through public initiatives and private health insurance. It is based on data from a 50 state survey conducted in 2003 by the Institute for Health Care Research and Policy at Georgetown University under contract to CRS. More specifically, it examines the states' experience expanding health insurance to the uninsured through:

- state tax credit programs;
- state-funded public programs;
- group health insurance rules (with an emphasis on standards for small group health insurers);
- state-sponsored purchasing pools;
- individual health insurance rules; and,
- high-risk pools.

This paper does not, however, discuss Medicaid expansions in detail because of the considerable literature already available on that topic. In addition, related federal initiatives are reviewed briefly. Finally, it doesn't describe in detail programs enacted or signed into law since 2002. This includes initiatives in Maine and California as well as several other states that have established high risk pools using funds made available under the Trade Adjustment Act of 2002. California passed legislation mandating that medium and large size employers offer health insurance coverage as a benefit beginning in 2006, although the press reports that this bill may be repealed before implementation. In addition, Maine has established a universal health program called Dirigo Health. Small employers are scheduled to begin purchasing the state-sponsored coverage beginning in the summer of 2004. The final major change since 2002 is that grant funds made available under the Trade Adjustment Assistance Act of 2002 has prompted several additional states to establish high risk pools.

The report concludes with a discussion about what Members of Congress might be able to learn from the states' experiences and the key challenges states face reducing the number of uninsured in their state.

The Uninsured

In 2002, about 43.6 million Americans, or about 15.2% of the U.S. population, were uninsured.[1] The percentage of uninsured individuals among states varies widely. As illustrated in **Table 1**, in 2002, 7.9 % of the residents in Minnesota were uninsured in contrast to almost 21.1 % of the residents of New Mexico.[2]

Table 1. Number and Percentage of Uninsured Individuals by State, (2002)

	Total Population	Number of Uninsured	Percentage Uninsured
U.S.	285,934,000	43,574,000	15.2%
Alabama	4,440,000	564,000	12.7%
Alaska	635,000	119,000	18.7%
Arizona	5,442,000	916,000	16.8%
Arkansas	2,692,000	440,000	16.3%
California	35,159,000	6,398,000	18.2%
Colorado	4,476,000	720,000	16.1%
Connecticut	3,383,000	356,000	10.5%
Delaware	798,000	79,000	9.9%
District of Columbia	572,000	74,000	12.9%
Florida	16,429,000	2,843,000	17.3%
Georgia	8,426,000	1,354,000	16.1%
Hawaii	1,224,000	123,000	10.0%
Idaho	1,300,000	233,000	17.9%
Illinois	12,504,000	1,767,000	14.1%
Indiana	6,100,000	797,000	13.1%
Iowa	2,903,000	277,000	9.5%
Kansas	2,684,000	280,000	10.4%
Kentucky	4,046,000	548,000	13.5%
Louisiana	4,447,000	820,000	18.4%
Maine	1,269,000	144,000	11.3%
Maryland	5,458,000	730,000	13.4%
Massachusetts	6,471,000	644,000	10.0%
Michigan	9,910,000	1,158,000	11.7%
Minnesota	5,054,000	397,000	7.9%
Mississippi	2,787,000	465,000	16.7%
Missouri	5,585,000	646,000	11.6%
Montana	,906,000	139,000	15.3%
Nebraska	1,704,000	174,000	10.2%
Nevada	2,121,000	418,000	19.7%
New Hampshire	1,266,000	125,000	9.9%

[1] CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2002*, by Chris L. Peterson

[2] CRS Report 96-979, *Health Insurance: Uninsured by State, 2002*, by Paulette Morgan.

	Total Population	Number of Uninsured	Percentage Uninsured
New Jersey	8,605,000	1,197,000	13.9%
New Mexico	1,840,000	388,000	21.1%
New York	19,283,000	3,042,000	15.8%
North Carolina	8,162,000	1,368,000	16.8%
North Dakota	633,000	69,000	10.9%
Ohio	11,282,000	1,344,000	11.9%
Oklahoma	3,477,000	601,000	17.3%
Oregon	3,510,000	511,000	14.6%
Pennsylvania	12,189,000	1,380,000	11.3%
Rhode Island	1,056,000	104,000	9.8%
South Carolina	3,997,000	500,000	12.5%
South Dakota	744,000	85,000	11.4%
Tennessee	5,672,000	614,000	10.8%
Texas	21,529,000	5,556,000	25.8%
Utah	2,310,000	310,000	13.4%
Vermont	619,000	66,000	10.7%
Virginia	7,118,000	962,000	13.5%
Washington	6,001,000	850,000	14.2%
West Virginia	1,751,000	255,000	14.6%
Wisconsin	5,476,000	538,000	9.8%
Wyoming	488,000	86,000	17.6%

Source: Based on the March 2003 Current Population Survey; computed by the Congressional Research Service and published in CRS Report 96-979. *Health Insurance: Uninsured by State*, 2002, by Paulette Morgan.

State Coverage Initiatives

States have pursued different coverage initiatives to varying degrees to make health insurance more affordable and/or accessible. All states subsidize health insurance for at least some of their low-income residents. Medicaid and the State Children's Health Insurance Program (SCHIP) — programs which enable states to augment their resources with federal matching funds — are the principal means of subsidizing health insurance in states. As **Table 2** illustrates, few states have used state-only funding to go beyond Medicaid and SCHIP to establish initiatives that subsidize health insurance or provide coverage directly to the uninsured. In 2002, three states, for instance, used tax credits for small employers or individuals and six states and the District of Columbia had established state-only funded programs to subsidize health insurance or provide direct coverage for the uninsured.

States have also tried to make health insurance more available to employers and individuals by setting rules for private health insurers. These rules seek to stabilize coverage for those who have it, such as when people change jobs or family circumstances change. Many states' rules minimize the number of uninsured by removing barriers people face in obtaining and keeping health insurance, and place limits on how much insurers can charge for insurance. All states have comprehensive rules for insurers that sell health insurance to small firms with two to 50 employees — called small group health insurers. These rules are a product of state efforts in the early 1990s and a federal law (the Health Insurance Portability and

Accountability Act (HIPAA) of 1996, P.L. 104-191) that made these state reform efforts more uniform. To a lesser degree, states have used other strategies. A few states have tried to enhance the availability and accessibility of health insurance for small employers through purchasing pools. For individuals without job-based health insurance, some states have pursued market reforms affecting individuals seeking to purchase coverage independently intended to make coverage more accessible and stable. Many more states have opted against individual market reforms, instead pursuing another option — high-risk pools — for individuals whom insurers will not cover. The following sections elaborate on this landscape of states' efforts to expand coverage options for employers and individuals, how they have done so, and what has been learned from their activities. **Table 2** reflects a snapshot of their activities in 2002.

Table 2. Number of States with Selected Program Initiatives in 2002

State initiative	Number of states and D.C.
Tax credit programs	3
State-only funded public programs	7
Comprehensive[a] small group health insurance rules	51
State-sponsored purchasing pools	3
Comprehensive individual health insurance rules	5
High-risk pools	29

Source: Georgetown University Institute for Health Care Research and Policy 2002.

a. Comprehensive reform of the small group health insurance market includes reforms aimed at improving access to health insurance products (guaranteed issue, limits on pre-existing condition exclusion periods, and credit for prior coverage) *and* rules regarding the setting of premiums (rating rules).

Public Initiatives to Subsidize Health Coverage

A few states have established public programs outside of Medicaid or SCHIP with state-only funds. These programs usually provide insurance directly to program participants or provide enrollees with subsidies for work-based insurance. Fewer states yet have enacted tax credits toward the cost of privately sponsored insurance.

Tax Credits. State experience with tax credit programs has been very limited. In the late 1980s and early 1990s, at least four states — California, Kentucky, Massachusetts and Oregon — introduced tax credit programs for small employers.[3] Each of these programs has been discontinued. As noted in a study of such state initiatives, they appeared to have had very little impact on the number of small employers offering benefits to their employees. The study authors noted that the small size of the credits may have provided an insufficient incentive to the relatively

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[3] Debra J. Lipson, Daniel M. Campion and Michael Birnbaum, *Approaches for Providing/Financing Health Care Financing for the Uninsured: An Assessment of State Options and Experiences*, Alpha Center, Aug. 1997, p. 31. (Hereafter cited as Lipson, *Approaches for Providing*.)

few small employers who qualified and were not already offering coverage.[4] In 2002, two states had tax credits for small employers — Kansas and Maine.[5] As with the aforementioned programs, both had strict eligibility criteria and low participation rates. Kansas' program was implemented in December 1999. By the beginning of 2002, 175 companies had applied for certification but the state received only 50 claims from employers for coverage. Maine's program is newer (it began in 2001) and smaller. It's benefits are limited to employers with fewer than five employees who offer dependent coverage. As of 2002, 14 small employers were participating.

Colorado was the only state that had an individual health insurance tax credit in place in 2002. Individuals who meet certain income eligibility limits can claim a $500 credit for group or individual health insurance. The program was implemented in 2000 and had 7,544 participants for tax year 2000 at a program cost of $2.7 million. North Carolina had an individual tax credit for child health insurance that was repealed in 2001 to devote greater resources to another public coverage program. The later repealed tax credit was passed by the state's legislature in 1998 and was provided to 125,199 people in 2001 at a program cost of $21.1 million. Interestingly, this program was not limited to the low-income. Households with adjusted gross income under 225% of the federal poverty level (FPL) (just under $41,000 for a family of three in 2001) received a $300 credit. Those with income over that amount and up to $100,000 (for a family of three or about five times the 2001 FPL) were eligible to receive a $100 credit.

Public Programs. Public programs are another way to offer subsidized coverage to the uninsured.[6] **Tables 4, 5**, and **6** describe the various public programs in place by states in 2002. The number of states that have funded public coverage initiatives without federal support is small. In 2002, six states — Arizona, Massachusetts, Minnesota, New York, Pennsylvania and Washington — and the District of Columbia, had programs in place to reach the uninsured that were funded outside of Medicaid and SCHIP.

These programs differ dramatically both in terms of who is eligible and how coverage is provided, reflecting a number of factors including the availability of funding and the availability of a safety net system in each state. For example, Washington's Basic Health Plan was by far the largest program in terms of enrollment and financial support with a 2002 monthly average of about 122,250 enrollees and an appropriation of $499 million for FY2002-2003. It uses two strategies to reach low-income residents with income below 200% of the federal poverty level. For those without access to employer-sponsored coverage, the state arranges for access to health services directly. For those with access to employer-sponsored coverage, it provides premium support for the worker's share of the premium. In either case, participants are responsible for a share of the premium

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[4] Lipson, *Approaches for Providing*, p. 31.

[5] There are a few states such as CO, NC and UT that have tax credit programs for business enterprise zones and emerging businesses. They are extremely limited in scope and were not reviewed for this report.

[6] As previously noted, because there are many other reports on state initiatives under Medicaid and SCHIP this report will largely focus on initiatives funded only by the states.

according to a sliding scale. Arizona's Premium Sharing Program, on the other hand, offered direct coverage only to uninsured residents with income below 275% of the federal poverty level or to people who have one of 19 chronic conditions whose incomes are below 400% of the federal poverty level. The demonstration program, now dismantled, paid up to 97% of the premium based on a sliding scale for coverage provided through contracts with three health insurers for enrollment that reached just over 3,600 people in 2002.

While these programs have helped expand coverage to people without affordable alternatives, enrollment is limited relative to demand primarily because of funding constraints. The Massachusetts Children's Medical Security Plan, which began in 1994, had to close enrollment temporarily in its first year because of high demand. At the end of June 2002, it had 25,680 children enrolled who were not eligible for Medicaid/SCHIP. Enrollment rises by almost 650 new people each month. Pennsylvania began its new direct coverage program in July 2002 using tobacco settlement dollars. AdultBasic, which provides direct coverage through four Blue Cross and Blue Shield plans, ended its first month with over 6,000 enrollees. By the next month enrollment had nearly doubled. In 2002, the state estimated that it has enough funding for about 40,000 enrollees, taking into account the $30 per month contribution by each enrollee. Enrollment, however, reached this threshold quickly, and the state was required to later institute a waiting list[7]. New Jersey had a program for childless adults with incomes under 50% of the federal poverty level but discontinued enrollment in September 2001. Within a few months of its operation, the program's enrollment exceeded estimates and funding.[8]

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[7] Pennsylvania Department of Insurance, adultBasic website at[http://www.ins.state.pa.us/ins/cwp/view.asp?a=1336&Q=543301&PM=1.]

[8] John Holahan and Mary Beth Pohl, *States as Innovators in Low-Income Health Coverage*, Assessing the New Federalist Project, Urban Institute, June 2002, p. 16.

Table 3. Key Features of State Tax Credit Programs (2002)

State	Year began	Target population	Eligibility standards	Size of credit	Number of participants	Program costs
Colorado	2000	Individual	Income may not exceed $25,000, $30,000 or $35,000 depending on marital and parental status. Credit can be claimed for an unlimited number of years.	$500 (non-refundable)	7,544 individuals (tax year 2000)	$2.7 million tax year 2000)
Kansas	1999	Small employers	Employer could not have provided insurance within past two years (or less than two years in case of new employee) and can claim credit for employees who work at least 30 hours per week. Credit can be claimed for five years.	Range from the lesser of $35 per month per eligible covered employee or 50% of total amount paid by employer (refundable)	50 small employers (tax year 2000 and 2001)	$79,000 (2000 and 2001)
Maine	2001	Small employers with under five employees	Employer can claim credit for employees who work at least 30 hours per week or 1,000 hours per year and must meet contribution requirements. Credit only available if employer provides health insurance for dependents (under the age of 19) of low-income employees. Credit can be claimed for two years.	The lesser of 20% of coverage or $125/person (nonrefundable)	14 small employers (tax year 2001)	$5,774 (tax year 2001)

Source: Georgetown University Institute for Health Care Research and Policy, 2002. Information gathered through survey of state program officials.

Table 4. State-Funded Programs (2002)

State	Program	Year began	Type of program	Eligibility categories
Arizona	Premium-Sharing Program	1997	Direct Coverage/ Subsidy Program	Uninsured residents with incomes below 275% of the federal poverty level (FPL). Chronically ill with one of 19 specific conditions.
District of Columbia	Healthcare Alliance	2001	Direct Coverage Program	Uninsured residents with incomes below 200% FPL.
Massachusetts	Children's Medical Security Program	1994	Direct Coverage Program	Uninsured children not eligible for MassHealth (the state's Medicaid program).
	Healthy Start	1985	Direct Coverage Program	Uninsured pregnant women with incomes below 225% FPL.
	Center Care	1989	Direct Coverage Program	Uninsured low-income adult residents with incomes below 200% FPL.
Minnesota	MinnesotaCare[a]	1992	Direct Coverage Program	Childless adults with incomes below 175% FPL.
New York	Healthy NY	2001	Stop-Loss Program	Working uninsured residents and sole proprietors with incomes below 250% FPL. Small employers with 1/3 employees making less than $31,000.
Pennsylvania	AdultBasic	2002	Direct Coverage Program	Nonelderly adults with incomes below 200% FPL.
Washington	Basic Health Plan	1993	Direct Coverage/Employer Buy-In Program	Low-income residents with incomes below 200% FPL.

Source: Georgetown University Institute for Health Care Research and Policy, 2002. Information gathered through survey of state program officials.

a. MinnesotaCare has several populations eligible for coverage. Childless adults with incomes under the specified federal poverty level are covered exclusively through state funding. The other eligibility categories are supported through Medicaid funds.

Table 5. Key Features of State-Funded Programs (2002)

State	Pre-existing exclusion period allowed	Minimum benefit standards	Participants pay share of premium	Basis of premium share	Co-insurance
Arizona Premium Sharing Program	No	Yes	Yes	Sliding scale	Yes
DC Healthcare Alliance	No	Yes	No	Not applicable	Not applicable
Massachusetts Children's Medical Security Plan	No	Yes	Yes (except for participants under 200% FPL)	Sliding scale	Yes
MinnesotaCare	No	Yes	Yes	Sliding scale	Yes
Healthy New York[a]	Yes	Yes	Yes (100%)	Premium amount	Yes
Pennsylvania AdultBasic	No	Yes	Yes	$30 per member per month	Yes
Washington Basic Health Plan	Yes	Yes	Yes	Sliding scale	No

Source: Georgetown University Institute for Health Care Research and Policy, 2002. Information gathered through survey of state program officials.

a. Healthy New York is a stop-loss program. The state does not contribute to any individual participant or small employer's premium. It reimburses the health plan for the cost of care for participants in excess of a specified amount.

Table 6. Selected State Coverage Programs: Enrollment and Appropriations

	Number of enrollees	Program appropriations
Arizona Premium Sharing Program	3,623 (10/02)	$10.5 million (FY2002)[a]
Massachusetts Children's Medical Security Plan	25,680 (6/02)	$15.3 million (FY2002)
Washington Basic Health Plan	122,250 (6/02)	$499 million (FY2002-03)

Source: Georgetown University Institute for Health Care Research and Policy, 2002. Information gathered through survey of state program officials.

a. Arizona PSP's enrollment figures do not include those reimbursed by the Arizona Health Care Cost Containment System, the state's Medicaid-type program. Its appropriation is supplemented by funds remaining from the previous fiscal years' appropriations.

Obtaining the resources needed for these programs to reach a large number of people presents significant challenges for states. Further, in the recent budget environment, states were concerned about their ability to maintain these programs at their existing levels, prompting many to look for ways to maximize resources from the federal government. Minnesota, for example, developed a broad state-only funded program in the early 1990s. With the exception of coverage for childless

adults, the cost of MinnesotaCare is now shared with the federal government. Not long before the completion of the survey, two states, Oregon and Illinois, had received approval of Medicaid research and federal demonstration waivers that will enable the states to augment state resources with Medicaid funding for Oregon's Family Health Insurance Assistance Program and Illinois' KidCare Rebate program.[9]

Another way states leverage their resources is by encouraging employers to enroll in their programs. Since employer-sponsored group coverage tends to be more affordable than individual coverage and since most employers contribute to the cost of their workers' health insurance, states may reach more people with fewer state funds. But, as indicated by the enrollment in several state programs, they have faced challenges in doing so. Group health insurance is a major focus of programs in Washington and New York. These states' programs serve both individuals and employer groups but the majority of their enrollment is from individuals. The Washington Basic Health Plan's average monthly enrollment of 122,250 in FY2002, for instance, includes 808 enrollees from 237 employer groups. The remaining enrollees are individuals. New York also experienced an unexpected surge in individual enrollment. Unlike a number of the other public programs, New York's does not provide direct coverage or subsidies to program participants but provides stop-loss coverage to insurers whose costs fall within a specified range for individuals, sole proprietors or small employers who purchase a package of benefits under the Healthy NY program. In other words, the state does not help pay for any specific individual's coverage but reimburses the health plan if the cost of health care for a particular individual reaches a certain amount. In September 2002, this young program had about 13,430 active enrollees of which 7,400 were individuals, 3,430 were sole proprietors and 2,600 were workers covered through 835 participating small employers.[10]

Consistent with the desire to build on job-based health insurance, some states have created, or built into other existing programs ways to help subsidize health insurance offered by employers. In 2002, seven states were planning to offer, or are currently offering premium assistance through SCHIP to enroll children in their parent's job-based health insurance.[11] Medicaid also permits states to help pay the cost of employer-sponsored insurance available to those who are Medicaid-eligible (and their families) — when it is cost-effective to do so — through the Health Insurance Premium Payment Program (HIPP).

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[9] Oregon's Family Health Insurance Assistance Program (FHIAP) covered about 3,300 people and had a waiting list of approximately 27,000 residents in June 2002. With the federal waiver, it plans to ultimately cover between 20,000 and 25,000 people.

[10] For an analysis of New York's Healthy NY program and other state initiatives, see Heidi Whitmore, Kelley Dhont, et al., "Employer Health Coverage in the Empire State: An Uncertain Future," *The Commonwealth Fund*, 2001.

[11] Jennifer Ryan, *Health Insurance Family Style: Public Approaches to Reaching the Uninsured*, National Health Policy Forum, Sept. 24, 2001, p.5.

Group Health Insurance Initiatives

Because most people — two-thirds of nonelderly Americans — get health insurance through their job and most of the nonelderly uninsured are employed, group health insurance has been the cornerstone of many initiatives and proposals intended to expand coverage. While these efforts principally seek to stabilize coverage, they are also intended to reduce or prevent an increase in the number of uninsured by removing barriers to accessing health insurance and helping workers keep their health insurance.[12] Federal and state portability statutes and other market reforms created for private group health insurance have removed many of the access barriers to health insurance. For example, insurers are prohibited from denying or canceling health insurance because an employee is in poor health and, for most people, there are limits on how long insurers can deny them coverage for pre-existing conditions. A few states have gone a step further and sponsored purchasing pools for small employers to buy health insurance.

Small Group Health Insurance. Prior to the early 1990s, state regulators identified a number of problems in the small group market for health insurance. Some insurers were rejecting small employers who had an employee with poor health status. Others would accept the group but refuse to cover any employees or dependents with a history of illness. In some cases, insurers would refuse to renew health insurance or dramatically increase the price of health insurance for groups with high claims.

Access Rules. Beginning in the early 1990s, the states moved to address these barriers to health insurance by setting rules for small group health insurers. Later, in 1996, HIPAA established national standards for private health insurance based in large part on these state efforts. Although almost all of the states had small group reforms by the time HIPAA was enacted, there was inconsistency in the degree of the protections among the states. Some states, for example, required insurers to make all of their products available to small employers. But in many other states, insurers were only required to make one or two products available. These products tended to have many more sick people than healthy people and were usually very expensive.

HIPAA provided greater uniformity and breadth to these protections. It also expanded them to self-funded group health plans that state law does not reach and

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[12] Within group health insurance, there are large group and small group health plans. Large group health plans are those offered by employers with more than 50 employees. Small group health plans are those offered by employers with two to 50 employees. In about 10 states the definition of small employer has been expanded to include groups of one — that is, self-employed persons with no other employees. In 2002, in five states — CO, DE, MA, VT, WA — groups of one had guaranteed access to all products offered by a small group health insurer year-round. But some states — CO, FL, MD, NH and NC — had carved out an exception for groups of one on a limited basis. For instance, they may have guaranteed access during one month out of the year or may be limited to standardized plans. In AZ and NM groups of one have been guaranteed access to small group health insurance through state-sponsored purchasing pools.

fully-insured large group health plans, which states had not previously regulated.[13] In other words, it created a federal floor of protections for all group health plans of all sizes across all of the states.[14]

This federal floor:

- prohibits all group health plans, regardless of size and whether they are insured or self-funded, from imposing pre-existing condition exclusion periods for longer than 12 months (18 months for late enrollees);
- requires insurers to credit certain prior coverage against any new pre-existing condition exclusion period for certain individuals who change jobs;
- requires insurers to give all small employers access to all of their small group products (called guaranteed issue);
- prohibits insurers from cancelling coverage because an employee gets sick or makes claims (called guaranteed renewability);
- prohibits all group health plans from denying or limiting an employee's coverage or charging an employee more because of health status (called nondiscrimination); and
- requires group health plans to allow employees and their dependents to sign up for coverage at times other than the open enrollment period if certain changes in family status occur (called special enrollment periods).

Rating Rules. While HIPAA helps make health insurance more accessible to all small employers without regard to their employees' health status and stabilizes the market somewhat, the federal law does not address what many employers see as the major barrier to coverage for small employers — its cost.[15] Most states have tried to

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[13] Over 64% of the nonelderly U.S. population obtains private health insurance through their employers. Only 6% buy it directly from insurers. When employers provide the insurance, they do so on either an "insured" or "self-funded" basis. In other words, they either buy the insurance from a state-regulated insurer ('insured') or they pay for the cost of their employees' care out of their own general assets ('self-funded'). The Employee Retirement Income Security Act of 1974 (ERISA), a federal law, governs both insured and self-funded plans and does not allow states to regulate the employer's health plan. As a result, self-funded plans are not affected by any of the state laws we discuss in this report. States can and do, however, regulate insurers and thus indirectly affect insured health plans. For a primer on private health insurance and how it is regulated; see CRS Report RS20315, *ERISA Regulation of Health Plans: Fact Sheet*, by Hinda Chaikind; and Gary Claxton, *How Private Health Insurance Works: A Primer*, Kaiser Family Foundation, Apr. 2002.

[14] For more reading on HIPAA, see CRS Report RL31634, *The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions*, by Hinda Chaikind, Jean Hearne, Bob Lyke, Stephen Redhead and Julie Stone and Karen Pollitz, Nicole Tapay, et al., "Early Experience with 'New Federalism' in Health Insurance Regulation," *Health Affairs*, vol. 19, no. 4, July/Aug. 2000, pp. 7-22.

[15] Jon Gabel, Larry Levitt, et al., "Job-Based Health Benefits in 2002: Some Important Trends," *Health Affairs*, vol. 21, no. 5, Sept./Oct. 2002, pp. 143-151. (Here after cited as (continued...)

address this issue through rating rules but the extent to which they have done so varies.

Table 7. Approaches to Rating Reform for Small Group Health Insurers

Pure Community Rating: Insurers cannot set premiums for policies sold to a small group based on the health status or case characteristics (demographics) such as age, gender, or industry of the group's membership. Those buying the same benefits are charged the same premium.

Adjusted Community Rating: Insurers cannot set premiums based on health status. The state might allow insurers to vary premiums based on factors such as age, gender or industry.

Rate Bands: Insurers can set premiums based on factors such as health status, age, gender or industry but the state limits how much the premium can vary among those receiving the same benefits based on some or all of these factors.

Health status and claims experience are the primary factors influencing rates and the focus of most state rating rules. Most states place some limits on their use in setting premiums by group insurers but in 2002, only 13 states prohibited their use altogether as rating factors. For small group health insurance, the most stringent form of rating restriction — pure community rating (see **Table 7**) — can be found only in the states of New York and Vermont.[16] In those states, small group insurers cannot charge more because of the health status, age, gender or occupation of members of the group. As a result, the cost of health insurance is spread more broadly across the entire market and premium variations are based only on benefits and not health status or demographics (called 'case characteristics'). This makes the cost of health insurance more predictable for small employers. It also spreads the cost of health insurance among all groups making it more affordable for groups with sicker employees and dependents. As a result, groups that have more employees with poor health status may pay less than they otherwise would while healthier groups are likely to pay more. In some states, pure community rating requirements may apply to certain insurers. For instance, in 2002, Blue Cross/Blue Shield was required to use pure community rating in Michigan. Another 11 states (California, Colorado, Connecticut, Florida, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, Oregon, and Washington) required that small group insurers use a method called adjusted community rating which prohibits them from charging groups more due to health status. They are able, however, to charge more for other factors such as age or gender. One of these states, Oregon, applied this rule to products purchased by groups of two to 25 instead of more common small group size of two to 50 workers. Most of the remaining states place looser limits on the use of health status and/or

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[15] (...continued)
Gabel, Job-Based Health)

[16] In VT, insurers other than Blue Cross/Blue Shield may deviate from the community rate for small group plans issued before Jan. 1, 2000 to a limited extent for age and gender. However, as of Jan. 1, 2003, all small group health insurance policies in the state will be community-rated.

case characteristics such as age, gender or occupation allowing for much greater variation in premiums.

Almost all of the remaining states had some form of rate bands required under small group market laws or regulations. When states restrict premiums by setting rate bands, premiums are allowed to vary by demographic factors, but only by a limited amount. For example, a state may allow premiums for an insurance product to vary based on the health status of the employer groups purchasing the insurance, but the amounts can vary by no more than a 2 to 1 ratio.

Purchasing Pools. In 2002, two states — Arizona, New Mexico — and New York City operated health insurance purchasing arrangements, also known as purchasing pools.[17] Purchasing pools allow small businesses to band together to purchase health insurance. Some argue that they expand access to health insurance for small businesses by offering health insurance at a lower cost than would otherwise be available to a small firm purchasing coverage independently in the private market. It is argued that the cost savings is achieved through volume purchasing and discounts negotiated with insurers.[18] Cost savings may also be achieved through favorable selection of purchasing pool members who are healthier than average. Such savings, however, may be directly offset by increases in the cost of health insurance for sicker groups who are left outside of the pool. Although achieved costs savings are debatable, pools can improve choice for small businesses and their workers. Generally, employees of participating small businesses choose among different insurance companies, health insurance policies, and benefit levels. Such choices are not typically available to employees of small businesses outside the purchasing pool.[19] Additionally, purchasing pools may fill an unmet need by serving a population that has limited access to health insurance. For example, as discussed earlier, it is more difficult for small businesses with fewer than 10 employees to buy health insurance directly from private health insurers.

For state-sponsored purchasing pools, states establish eligibility rules, design benefit offerings, sometimes regulate the premium that may be charged, and negotiate with insurers. The existing state-sponsored purchasing pools are subsidized by state

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[17] There are several states that have created state-sponsored purchasing pools. Some of them have been discontinued, such as those created in FL, NC, and TX. The flagship state-operated purchasing pool and the pool attaining the largest size, California's Health Insurance Plan, was established in 1989. The now privately operated, Pacific Health Advantage (PacAdvantage) has enrollment of more than 11,000 small businesses and almost 150,000 individuals. It was established by the state but its authorizing legislation provided for its administration to be taken over by a private entity after three full years of operations. It is currently operated by the Pacific Business Group on Health, a coalition of large employers, [http://www.PacAdvantage.org]. The three purchasing pools discussed in this report continue to be state arrangements. Over 20 states also have laws enabling private entities to form purchasing pools.

[18] Eliot K. Wicks, Mark Hall and Jack A. Meyer, "Barriers to Small-Group Purchasing Cooperatives," *Economic and Social Research Institute*, Mar. 2000, p. 10.

[19] Stephen H. Long and M. Susan Marquis, "Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?" *Health Affairs*, vol. 20, no. 1, Jan./Feb. 2001, pp. 154-163.

taxes (general or specific appropriations) and/or assessments on insurers. Key features of such programs include offering a choice of health plans on a guaranteed issue basis, not basing premiums on health status, and not excluding existing health conditions from coverage when an individual has had other health insurance.

Table 8. State-Sponsored Purchasing Pools, 2002

	Implementation date	Number of participating employers	Number of covered lives	Number of participating plans
Arizona	1998	3,859 (4/02)	11,985	2
New Mexico	1995	1,036 (7/02)	5,200	11
New York City	1999	810 (6/02)	7,290	4

Source: Georgetown University Institute for Health Care Research and Policy, 2002. Information gathered through survey of state program officials.

These key features — guaranteed issue, adjusted or community rating, and portability — are designed to make it easier for small businesses to participate by eliminating hurdles that some small businesses may face in the private market outside the purchasing pools. The Healthcare Group of Arizona, in existence since 1988, offers coverage to nearly 4,000 small businesses and self-employed individuals covering nearly 12,000 people. The New Mexico Health Insurance program established in 1995 covers over 5,200 people and over 1,000 employers. New York City's HealthPass, established in December of 1999, insures over 7, 200 individuals (over 3,200 were previously uninsured) and over 800 employers.

State purchasing pools may improve access to health insurance for some small businesses by making health insurance more affordable to businesses with sick employees, when premiums are not based on health status. Such arrangements may attract a disproportionate share of businesses with high claims individuals (further taxing state budgets which help subsidize some of these programs), however, if such rules also do not apply to private health insurance outside the purchasing pool. The rules in New York are the same inside and outside of the purchasing pool. But the other pools in place in 2002 did not impose rules that were parallel to those outside of the pool, as shown in **Table 9**. If states continue to establish new purchasing pools, such arrangements may work best when subject to the same rules as the private market.

Table 9. Comparison of Rating Rules for State-Sponsored Purchasing Pools and Small Group Health Insurance, 2002

	Purchasing pools	Small group health insurance
Arizona	Adjusted community rating	Rate bands
New Mexico	Adjusted community rating	Rate bands
New York City	Pure community rating	Pure community rating

Source: Georgetown University IHCRP 2002. Interviews with program officials.

Despite these efforts, many small groups do not offer health insurance at all. In a 2002 survey, firms with fewer than 199 employees are less likely to offer coverage than medium or large-size employers. Among small firms, those with fewer than ten are even less likely to offer coverage.[20] While a number of complex factors are involved, one of the most important reasons is sensitivity to price. In the same survey, 84% of employers with between three and 199 workers cited high premiums as an important reason for why they do not offer health benefits.

Individual Health Insurance Initiatives

Individual health insurance is an alternative for some people who cannot obtain job-based insurance or who do not qualify for public programs. Others however, cannot buy individual policies either because their application is denied because of health status or other risk factors or because they cannot afford it. Many states have set up high-risk pools for those who cannot purchase private health insurance on their own.

While only 5 to 6% of the population has individual coverage at any given time, many more people move in and out of the individual market over time. A recent study found that one in four adults had been insured through individual health insurance at some point during a three-year period.[21]

Individual Health Insurance. As illustrated in **Table 10**, many of the state laws in effect in 2002 intended to preserve access to insurance apply to small employers, but did not apply to people buying individual health insurance. Although 50 states and the District of Columbia required small group health insurers to guarantee issue coverage, only five states required insurers to guarantee access to individual health insurance while another 14 states require it under limited circumstances. In other words, most states didn't require insurers to make their individual products available without regard to health status. Instead, individual health insurers were able to "medically underwrite" applicants — researching applicants' health status and health history before deciding whether to sell insurance, and if they do sell it, at what price and under what terms. In 13 states, individual health insurers were not allowed to permanently exclude coverage for a health condition, body part or body system — called an elimination rider but they are permitted to do so in 38 states.

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[20] Jon Gabel, Larry Levitt, Erin Holve, Jeremy Pickreign, et al., *Job-based Health Benefits in 2002: Some Important Trends,* Health Affairs, Sep/Oct 2002, Vol. 21, Issue 5, p. 148.

[21] Lisa Duchon and Cathy Schoen, et al., "Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk: Findings from the Commonwealth Fund 2001 Health Insurance Survey," *Commonwealth Fund,* Dec. 2001, p. 24.

Table 10. Number of States and D.C. with Selected Market Reforms (2002)

	Small group market reforms	Individual market reforms
All products guaranteed issue	51	5
Limited pre-existing condition exclusion period	51	29
Elimination riders prohibited	51	13
Credit for prior coverage applies to new plan's pre-existing condition exclusion period	51	27
Guaranteed renewability	51	51

Source: Georgetown University Institute for Health Care Research and Policy, 2002.

Access Rules. The states have taken a variety of approaches to improve access to individual health insurance. These approaches can be summarized as follows:

All Products Guaranteed Issue. Five states — Maine, Massachusetts, New York, New Jersey, and Vermont — required individual health insurers to make all of the individual products available to all comers.

The experience of the states guaranteeing access to all products has been mixed. All five states have preserved this requirement for a number of years (although not necessarily without a political struggle). Other states that used to have these rules no longer do. New Hampshire and Washington, for example, had both repealed many of their individual health insurance reforms by 2002.

Selected Guaranteed Issue. Some states required insurers to make individual health insurance available only if the applicant is 'federally eligible' as narrowly defined in HIPAA.[22] While HIPAA required guaranteed access to those individuals who are federally eligible, it allowed states to choose how to implement this guarantee. Most states used options that already existed such as high-risk pools. As a result, in most states, HIPAA protections do not change people's options for coverage when they do not have job-based health insurance or do not qualify for Medicaid.

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[22] A person is federally eligible if he meets several criteria. He has to have 18 months of continuous coverage ending with a group health plan. He must use up any COBRA or state continuous coverage for which he was eligible and he must apply for health insurance for which he was federally eligible within 63 days of losing his prior coverage. He cannot be eligible for Medicare, Medicaid or a group health plan and cannot have other health insurance. (An exception is if the other insurance is about to end, then he may apply for guaranteed issue coverage while still insured.)

There are a few states that required individual health insurers to guarantee issue coverage to non-federally eligible individuals under certain circumstances or during certain times of the year. How they structured this requirement differs considerably. Ohio, for instance, required insurers to take turns holding an open enrollment period throughout the year. Oregon required insurers to make available certain plans to those who have had six months of prior coverage. Rhode Island required insurers to guarantee issue all products to individuals who have had 12 months of prior coverage with no gap in coverage.

Insurer of Last Resort. In 2002, four states — Michigan, North Carolina, Pennsylvania, and Virginia — and the District of Columbia required certain health insurers selling plans in the individual market in their state, usually Blue Cross and Blue Shield plans, to cover individuals who cannot get insurance elsewhere.

In addition to the above protections, Congress and the states enacted laws in the 1990s to make health insurance more secure by prohibiting insurance companies from canceling policies once an individual became sick. As a result, insurers can no longer cancel individuals because of their medical claims.[23]

Rating Rules. As shown in **Table 11**, some states limited insurers' ability to base individual health insurance premiums on health status. Three states required pure community rating while four states required adjusted community rating. In another three states, some dominant insurers community rated individual health insurance as a matter of law or longstanding practice. Another 11 states relied on rate bands to temper premium rates for individual health insurance.

Table 11. State Individual Health Insurance Rating Rules Applied Market-Wide (2002)

	Number of states	
Pure community rating[a]	3	NJ, NY, VT
Adjusted community rating[a]	4	ME, MA, OR, WA
Rate bands	11	ID, IA, KY, LA, MN, NV, NH, NM, ND, SD, UT
No rating limits[b]	33	

Source: Georgetown University Institute for Health Care Research and Policy, 2002.

a. In a few states, certain insurers were required to community rate. In MI and PA, for example — Blue Cross/Blue Shield — was required to community rate individual health insurance. In HI, while there were no requirements to do so, it is our understanding that Kaiser and other large insurers community rate as a matter of practice.

b. A few states that do not apply rating limits market-wide do apply them on a very limited basis to certain products such as conversion policies.

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[23] There have been recent concerns that some insurers are charging substantially higher premiums, when the policy is renewed, to people who have been diagnosed with an illness or had medical claims. Chad Terhune, "Insurer's Tactic: If You Get Sick, the Premium Rises," *The Wall Street Journal*, Apr. 9, 2002.

High-Risk Pools. Most states allowed insurers to reject people with pre-existing health conditions who apply for individual health insurance and, as an alternative, set up a high-risk pool for people who are "medically uninsurable." Individuals could purchase insurance through the pool if they:

- have a chronic health condition;
- have been turned down by a private individual health insurer; and/or,
- have been charged a premium that is higher than the high-risk pool premium.

In 2002, 29 states had high-risk pools. In all but a few of the states, these programs are small and nationally, high-risk pools have enrolled a small percentage of the uninsurable population.[24] As of June 2002, these pools were estimated to have provided health insurance to fewer than 154,000.[25]

Table 12. State High-Risk Pools

(most recent year available)

State	Implementation year	Number of enrollees
Alabama[a]	1998	3,545 (6/02)
Alaska	1993	456 (6/02)
Arkansas	1996	3,167 (12/01)
California[b]	1991	16,971 (6/02)
Colorado	1991	3,886 (6/02)
Connecticut	1976	2,553 (5/02)
Florida[c]	1983	638 (12/01)
Illinois	1989	13,123 (6/02)
Indiana	1982	8,317 (12/01)
Iowa	1987	178 (6/02)
Kansas	1993	1,577 (12/01)
Kentucky	2001	1,282 (5/02)
Louisiana	1992	1,635 (12/01)
Minnesota	1976	29,385 (5/02)
Mississippi	1992	3,011 (12/01)
Missouri	1992	1,750 (6/02)
Montana	1987	2,635 (6/02)

[24] Steven Pizer, Ph.D., Austin Frakt, Ph.D., et al., "Evaluation of High Risk Pools Draft Final Report to CMS," *Abt Associates*, July 6, 2001, p. 39. (Hereafter cited as Pizer, Evaluation of High Risk.)

[25] Communicating for Agriculture, Inc., *Comprehensive Health Insurance for High-Risk Individuals: a State-by-State Analysis*, 16th ed., 2002/2003. High-risk pool enrollment has been growing over the years. In 1999-2000, there were fewer than 130,000 people covered by high-risk pools.

State	Implementation year	Number of enrollees
Nebraska	1986	6,008 (6/02)
New Hampshire	2002	25 (8/02)
New Mexico	1998	1,128 (6/02)
North Dakota	1982	1,407 (6/02)
Oklahoma	1996	2,848 (12/01)
Oregon	1990	8,762 (6/02)
South Carolina	1990	1,610 (12/01)
Texas	1998	19,822 (6/02)
Utah	1991	2,087 (6/02)
Washington	1988	2,348 (6/02)
Wisconsin	1981	12,606 (12/01)
Wyoming	1991	725 (5/02)

Sources: Communicating for Agriculture, *Comprehensive Health Insurance for High-Risk Individuals*, 16th ed. (2002/2003). New Hampshire enrollment figures obtained from conversation with state program officials.

Note: Maryland implemented a high-risk pool in 2003.

a. Alabama's high-risk pool is limited to persons who are federally-eligible under HIPAA.
b. California has a waiting list. The average wait is 12-18 months.
c. Florida closed its high-risk pool to new enrollment in 1991.

There are a number of reasons for the small enrollment numbers. The most prominent reason is that these programs have lacked funding to enroll a larger number of people.[26] States and enrollees generally share in the cost of the insurance. Funding for states' high risk pools came from a variety of sources including general revenue, tobacco settlement funds, state taxes, assessments on insurers and taxes or service charges on providers.[27] At the time of the survey, participants were also required to pay a premium for their coverage. While states often offered a variety of levels of coverage, high-risk pool coverage is still, nonetheless, expensive and unaffordable for many uninsurable individuals.[28] This may have discouraged some people from applying. Some of the features of high-risk pools may also have contributed to low enrollment levels. While individuals meeting the eligibility requirements could not be turned down, the high-risk pools could use many of the same features as private individual health insurers. For example, to protect against individuals waiting until they get sick to purchase coverage, called adverse selection, high-risk pools had pre-existing condition exclusion periods. However, these strategies, used to protect against overwhelming the pool, may also deter the seriously and chronically ill from buying coverage.

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[26] Pizer, "Evaluation of High Risk," p. 39.

[27] *Communicating for Agriculture*, pp. 29-33.

[28] Pizer, "Evaluation of High Risk," pp. 47-49.

Despite these challenges, some states have made a significant commitment to these programs reflecting their desire to offer a safety net to those residents who have nowhere to turn for coverage. A few states — Colorado, Connecticut, Montana, New Mexico, Oregon, Utah, Washington and Wisconsin — have created subsidy programs for low-income enrollees in the pool. From time to time, a few states have had to institute a waiting list. In 2002, only California was placing applicants on a waiting list because of a lack of funds.[29]/[30] Florida has been closed to new enrollment since 1991.[31]

Minnesota has the largest and one of the oldest high-risk pool programs, with an enrollment of 29,385 in May 2002.[32] Applicants can become eligible for high-risk pool coverage in Minnesota in a number of ways, including if they:

- have a condition that has been specifically determined by the pool to make one medically uninsurable;
- are federally eligible under HIPAA;
- have lost their coverage;
- have been turned down;
- were quoted a premium for a policy that was higher than the typical, standard rate for that policy; or,
- were offered a policy that had an exclusionary rider.

Once accepted into the pool, Minnesota applies a six-month pre-existing condition exclusion period but credits time spent in any prior coverage against that exclusion period. Minnesota also caps its high-risk pool premium at 125% of the standard rate in the individual health insurance market. By contrast, the premiums for most other state high-risk pool premiums are between 150 to 200% of the standard rate for individual health insurance. This makes Minnesota's high-risk pool premiums, even for an elderly enrollee, lower than many of the other states.

Related Federal Initiatives

In the 1990s, efforts to expand coverage to the uninsured largely focused on public programs in partnership with the states. The State Children's Health Insurance Program (SCHIP) is the latest major example. More recently, the Bush Administration and Congress have focused on how to use private health insurance

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[29] Communicating for Agriculture and discussions with high-risk pool program representatives.

[30] In 2002, CA passed *Assembly Bill 1401* requiring that high risk pool subscribers be disenrolled after 36 months of continuous enrollment. Implemented in 2003, this change was intended to reduce the waiting list. Disenrolled subscribers are given the opportunity to enroll into guaranteed coverage in the individual insurance market. As of 2004, there is effectively no waiting list.

[31] In Jan. 2004, the FL Governor's Task Force on Access to Affordable Health Insurance recommended re-opening enrollment. Mary Ellen Klas, "Panel Urges State Pool for Health Insurance" *Palm Beach Post*, Jan 10, 2004. pg. 1.A.

[32] *Communicating for Agriculture*, p. 23.

to expand coverage. This section highlights some of the recent federal initiatives that affect or relate to state activities.

Tax Credits. In each of the years that President Bush has been in office, the Administration's budget proposals have included, as a central component of his health care agenda, a proposal to establish health insurance tax credits for the uninsured. In addition, various members of Congress have introduced their own health insurance tax credits bills. Some of those bills include credits for employers, but most of the national debate has focused on credits for individuals.[33] There has been much discussion among policy analysts about how large a tax credit has to be to make individual health insurance affordable and a growing consensus that it will have to be large to substantially lower the number of uninsured.[34] Analysts have struggled with the difficult question of how a tax credit could be structured so that it really reached the uninsured.[35] There has also been discussion about how a tax credit could be structured to minimize any adverse impact on job-based coverage.[36] This discussion includes, for instance, the extent to which younger and healthier workers who qualify for the tax credit will drop their job-based health insurance and make health insurance more expensive for those who remain. The impact of tax credits on people with chronic conditions or a history of illness has also been a subject of concern since as discussed above, most states currently do not have the protections in place to make individual health insurance accessible to a broad range of people.

Public Programs. The Health Insurance Flexibility and Accountability Demonstration Initiative (HIFA) gives states options to expand coverage to the uninsured by allowing them more flexibility in designing eligibility, benefit packages and cost-sharing requirements than under current Medicaid and SCHIP rules. It also encourages states to offer premium assistance through SCHIP to enroll children in their parent's job-based health insurance.[37] While this may expand coverage, some have expressed concern about the effect on Medicaid beneficiaries should states reduce benefits packages or increase cost-sharing as allowed under the initiative.[38] Other proposals have been introduced to expand coverage through public programs.

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[33] For more on tax credits see CRS Issue Brief IB98037, *Tax Benefits for Health Insurance: Current Legislation*, by Bob Lyke and Beth Fuchs, Mark Merlis and Julie James, *Expanding Health Coverage for the Uninsured: Fundamentals of the Tax Credit Option*, published by The National Health Policy Forum, Aug. 28, 2002 .

[34] Bowen Garrett, Len Nichols and Emily Greenman, *Workers Without Health Insurance: Who Are They and How Can Policy Reach Them?*, W. K. Kellogg Foundation. (Hereafter cited as Bowen, *Workers Without Health Insurance*.)

[35] Garrett, *Workers Without Health*, pp. 22-28.

[36] Institute for Health Policy Solutions (IHPS), "Individual Tax Credits and Employer Coverage: Assesing and Reducing the Downside Risks: Expert Forum," Aug. 2002.

[37] Jennifer Ryan, *Health Insurance Family Style: Public Approaches to Reaching the Uninsured*, National Health Policy Forum, Sept. 24, 2001, p.5.

[38] Jennifer Ryan, *Health Insurance Family Style: Public Approaches to Reaching the Uninsured*, pp. 6-8.

The HealthCARE Act of 2003 (H.R. 2402/S. 1030), introduced in the House by Representative Kaptur and in the Senate by Senator Bingaman, is one example.

Association Health Plans. Because small employers continue to have difficulty affording health insurance, Congress continues to debate other strategies to make insurance affordable. One strategy that has been discussed for a number of years is to change federal law so that many association-sponsored plans would not be subject to state small group health insurance rules including some benefit mandates and rating rules. The bills would establish Association Health Plans (AHPs) as legal entities that allow small employers to pool together to buy coverage that is priced below plans that must meet state regulations. This approach has been the subject of heated debate for many years. Three bills, H.R. 4281, H.R. 660 and its companion bill, S. 545, have been introduced in the 108th Congress.[39]

The Trade Act of 2002. Some of the approaches discussed in this report were incorporated into the Trade Adjustment Assistance Reform Act of 2002 (P.L. 107-210). This act included an individual tax credit that applies only to individuals who are receiving trade readjustment assistance or benefits from the Pension Benefit Guaranty Corporation. They will be able to use the credit to subsidize 65% of their cost for COBRA or other qualified health insurance. The act relies on states to establish these other qualified health insurance arrangements. It also provides some resources to states to create or expand high-risk pools. The act included seed money in the amount of $1 million for each state that had not yet started a high-risk pool and limited matching funds to help states with existing pools defray some of their costs. The matching funds available amount to a total of $40 million in each of fiscal years 2002 and 2003. Three states, New Hampshire, Maryland and South Dakota, have qualified for grants under the TAA to establish risk pools.

Implications for the Future

The federal government continues to look to the states as its laboratories of innovation. States have spent many years exploring ways to expand private health insurance and public programs to the uninsured. Medicaid and SCHIP are the primary vehicles through which they have pursued this goal. States have also made progress designing rules to better stabilize group health insurance and promoting access for those who can afford to pay. But they have been largely unable to reach those who are not eligible for public programs, or those who are declined or cannot afford private insurance. For those who lack access to group health insurance, the states have faced greater challenges. Access to and affordability of individual health insurance and alternative forms of coverage, such as high-risk pools, in particular, remains problematic. Creating stable coverage options for small employers and individuals who cannot access or afford private health insurance has proven a difficult task for states.

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[39] For more information on Association Health Plans see CRS Report RL31963, *Association Health Plans, Health Marts and the Small Group Market for Health Insurance*, by Jean Hearne.

Probably the most important lesson learned from the states' experience is that they cannot easily do this alone. The most comprehensive initiatives that states have undertaken involved significant federal involvement — federal standards and/or federal dollars. The SCHIP program and the small group health insurance rules established under HIPAA are the most recent notable examples. While states had begun to enact many of the market reforms later included in HIPAA, the federal law's passage created uniformity across states so that all small employers have the opportunity to buy group health insurance. SCHIP helped states make significant headway in reducing the uninsurance rate for children.

States have been uneven in their efforts to expand coverage to the uninsured reflecting, at least in part, the significant financial costs associated with many of these initiatives and the demands of different priorities. Only six states and the District of Columbia, for instance, had public programs in place in 2002 providing access to health insurance funded without federal dollars. Very few states have attempted to extend tax credits to subsidize the cost of health insurance coverage.

Further, with few exceptions such as Minnesota's high-risk pool or Washington's Basic Health Plan — the states have not reached appreciable numbers of uninsured through these initiatives. Even in the case of high-risk pools, which 29 states have created, states have struggled to garner sufficient resources to reach a large number of residents or to make such coverage affordable. They are further challenged by the rising number of people without insurance and the declining number covered by employer-based coverage. Given competing priorities for limited state budgets questions remain about how states can maintain their current public programs much less begin new ones.

Nevertheless, the variety of approaches used by those states that have engaged in these initiatives can yield some useful information for Congress. Many have been in place for a number of years so state program officials are knowledgeable about the strengths and weaknesses of their initiatives. Understanding how these public and private programs have been designed can provide insight into the various choices that are available and their implications. While many of the states' efforts are small in scale, they provide an opportunity to track their impact and any administrative challenges they pose.