

Research & Policy Brief

August 2006

**FINANCING MECHANISMS FOR STATE HEALTH INSURANCE COVERAGE INITIATIVES:
A REVIEW OF EXISTING STATE PROGRAMS**Introduction

One of the greatest challenges for states that seek to expand health insurance coverage is identifying a mechanism for financing the initiative and garnering the political will and support to maintain this funding over time. This brief provides state profiles that offer a summary of how other states have financed coverage expansions within different environments. By examining the experience of other states with relatively longstanding programs and comparing their experience with the Maine environment, the paper is intended to inform the discussions of Governor Baldacci's Blue Ribbon Commission to assess financing mechanisms for Maine's Dirigo health care reform effort.

The majority of states have done relatively little to expand coverage beyond the minimum Medicaid and State Children's Health Insurance Program (SCHIP) requirements.¹ For those that have, the most common approach for expanding coverage at the state-level has been to expand eligibility for Medicaid and/or SCHIP as allowed by federal rules thereby leveraging significant federal funds.² As will be discussed in more detail in a separate paper, the state of Maine has made significant use of federal funding by expanding eligibility in its Medicaid and SCHIP programs and has the highest Medicaid enrollment as a percent of the population in the country while maintaining employer-based coverage comparable to the national average.³ That is, Maine's Medicaid expansion has not "crowded out" employer coverage.⁴ Rather, Maine's high Medicaid enrollment results from the relatively high portion of the population with low income, as well as generous eligibility standards.

This brief focuses on financing strategies for experienced *state-only* initiatives to sponsor and subsidize insurance products targeted at non-Medicaid or SCHIP eligible low-income individuals and/or small businesses. The brief also discusses some recent initiatives and planned for but not yet implemented financing strategies.

While each of the states has pursued a slightly different model for expanding coverage, most were able to successfully implement health insurance expansions over time only by employing multiple and diverse funding streams. As one national policy think tank described, states have demonstrated "considerable creativity in employing diverse funding streams and have fought many political battles to achieve what they have".¹ Funding streams have generally included a combination of federal funds, state general and earmarked special revenue funds from targeted

¹ Holahan, J. & Pohl, MB. *States as Innovators in Low-Income Health Coverage*. Discussion Paper, Assessing the New Federalism. Urban Institute. June 2002.

² Federal matching rates vary by program and by state. Effective October 2006, the state of Maine's Medicaid federal matching rate is 63.27% and the enhanced federal matching rate for SCHIP is 74.29% Federal Register: November 30, 2005 (Volume 70, Number 229). *Federal Financial Participation in State Assistance Expenditures*, FY 2007.

³ *Kaiser State Health Facts*. downloaded at <http://www.statehealthfacts.org>, August 2006.

⁴ Anderson, N., Kilbreth, E. & Ziller, E. *MaineCare Non-Categorical Waiver Annual Report* Year 1: Oct. 1, 2002 – Sept. 30, 2003, Jan 28, 2005.

taxes on products, providers, and insurers, or other sources such as tobacco settlement funds. In many cases, funding for state coverage initiatives has been modified over time to take advantage of new federal monies and adjust to new realities.

Setting the Context - Who are the Uninsured in Maine?

For a state of relatively modest means, in 2004 the state of Maine had fewer uninsured than its counterparts nationally and had comparable coverage rates than in other New England states. In 2003/2004, an estimated 10 percent of all residents and 12 percent of the non-elderly were uninsured compared to 16 percent of total residents and 18 percent of non-elderly nationally. Lower than average uninsured rates are attributable to employer-based coverage comparable to the national average, but lower than other New England states, combined with relatively high Medicaid coverage.⁵

As is the case nationally, the majority of Mainers without health insurance tend to be employed and near-poor. Mainers earning between 200-300% of the federal poverty level (FPL) are three times more likely to be uninsured than those with higher incomes and those earning between 100-200% were 5 times more likely to be uninsured.⁶ Nearly 70% of uninsured Mainers had at least one family member who is employed full-time.⁷ Being employed by a small business places Maine workers at high risk of being uninsured. In 2002, nearly one-third of those working for a business of 10 employees or less were uninsured compared to only 7 percent in businesses of 50 or more.⁸ The passage of Dirigo Health and the creation of the DirigoChoice plan were intended to assist these uninsured and underinsured small businesses, sole proprietors, and low-income individuals in purchasing affordable coverage.

Financing of Other Existing State Initiatives

Described below, are seven state initiatives selected to show the range of program options and funding strategies for expanding access without federal cost sharing that states have devised.

Basic Health of Washington

Washington's Basic Health (BH) program is a state-sponsored comprehensive health insurance product with sliding scale premiums offered through private managed care plans to individuals and families with incomes below 200 percent of the federal poverty level (FPL). The program is targeted to individuals, although employers may participate, and is open to all eligible individuals regardless of their access to employment-based health insurance. Sliding scale premiums are based on income, family size, age and health plan chosen. Benefits for the program were initially limited to preventive care, hospitalization, provider visits, emergency room, and ambulance services and were later expanded to include prescriptions, limited mental health, chemical dependency, organ transplants and other services. The program was started as a pilot program in 1988 and was made permanent and statewide in 1993.⁹

⁵ Kaiser State Health Facts downloaded at <http://www.statehealthfacts.org>, August 2006.

⁶ Ziller, E. & Kilbreth, E., *Health Insurance Coverage Among Maine Residents, The Results of a Household Survey 2002*, May 2003.

⁷ Kaiser State Health Facts downloaded at <http://www.statehealthfacts.org>, August 2006.

⁸ Ziller, E. & Kilbreth, E. May 2003.

⁹ *Washington Health Care Authority. History of Basic Health* at: <http://www.basicehealth.hca.wa.gov/history.shtml>

Financing

The cost of the BH program is supported by enrollee contributions and state subsidies. The state subsidies for the Basic Health program are supported by cigarette and tobacco products taxes and four state taxes on alcohol (liquor, liquor liter, wine, beer) which are deposited into the Health Services Account (referred to as HSA funds). Approximately 63% of tobacco tax revenues and 17% of liquor tax revenues go toward the HSA fund.¹⁰ The program is also coordinated with Medicaid through its BH Plus program which provides continuity of coverage for families. BH Plus is targeted to children under age 19 who meet Medicaid eligibility criteria, and thus are eligible for federal matching funds. BH program administrative costs which are relatively low at around 4.5% are funded about 88.5% through HSA and 11.5% in federal funds. Medical costs (premium payments to health plans) in 2006 were funded about 82% from HSA and about 18% from enrollees premiums.

Tax revenues in Washington have increased at a lower average rate than BH program costs. In response, the state has both limited enrollment and reduced the value of the benefit over time primarily by increasing enrollee cost-sharing (through increased deductibles, copayments and premium contributions). Further, Basic Health operates on a “managed competition” basis, where subsidy dollars are fixed (based on household income) enrollees select among plans with differing premium levels, but pay the additional premium if they select a higher cost plan.

In 2001, when BH enrollment had reached its funded capacity, Washington citizens approved a voter initiated referendum, that increased cigarette and tobacco product tax by 60 cents (to \$1.425/pack) to cover 20,000 additional “slots,” above the base enrollment of 125,000 in 2003 (Initiative 773). Total revenues from the tobacco tax increase were estimated at \$161 million in 2003 declining to \$155 million in 2005-2007 assuming decreased tobacco consumption due to tax-avoidance, with the majority intended for Basic Health expansions.¹¹ The Legislature appropriated \$20 million of I-773 funds to the Health Services Account, but BH was unable to enroll new members assumed under the initiative due to budget limitations. As of October 2003, more than 30,000 people were on the waiting list. Total BH funding in 2006 was \$273 M (\$12M for state administration and \$253M for benefits) to cover approximately 100,000 enrollees per month.¹²

MinnesotaCare

MinnesotaCare, which began as a state sponsored program in 1992 and switched to a Medicaid waiver program expansion in 1995 is a sliding scale state-subsidized health insurance program for uninsured families and adults with modest incomes who do not have access to affordable employer-sponsored insurance. Families with children and household income that is less than 275% of the federal poverty level (FPL) and childless adults with incomes below 175% FPL are eligible if they have been uninsured for at least 4 months and have not had access to employer subsidized coverage (defined as where the employer pays at least 50% of the premium) for 18 months.

¹⁰ *Selective Sales Tax on Tobacco and Alcohol* prepared for the Washington State Tax Structure Committee by the Washington Department of Revenue, Sept 13, 2002.

¹¹ Brown, J. Economic Opportunity Institute, *A Healthier Washington Through Increased Health Care Coverage and Reduced Tobacco Use, An Analysis of Initiative 773*, August 1, 2001.

¹² Communication with Richard Onizuka, Director, Washington Health Care Authority, July 31, 2006.

For children, MinnesotaCare benefits are identical to those available under Medicaid. For adults, the program covers all Medicaid services but personal care, case management, nursing home care, and non-preventive dental care. Enrolled parents above 175 percent FPL and all adults without children, also have an annual hospital benefit limit of \$10,000.

Financing

MinnesotaCare is financed through enrollee premiums and cost-sharing and the state's Health Care Access Fund, which is funded by 2% tax on the gross revenues of hospitals, health care providers, surgical centers, and wholesale drug distributors and a 1 percent gross premium tax on health maintenance organizations, nonprofit health service plan corporations (e.g. Blue Cross Blue Shield), and community integrated service networks.¹³ The provider tax was passed by the Minnesota Legislature in 1992 to serve as the principal source of revenue for the newly created MinnesotaCare program. Any health care provider whose occupation is regulated by the state is subject to the tax. The law allows providers to pass-through the tax to all third party payers, thereby potentially shifting the cost to private premium payers, but providers have argued that this provision of the law has not been enforced.¹⁴

Through Medicaid waivers, Minnesota also has obtained federal matching funds for children and parents enrolled in MinnesotaCare that would qualify for Medicaid. Initially, the Health Care Access Fund also received revenues from cigarette taxes, which were later phased out. Provider taxes began in 1993 at 2 percent, but due to a surplus in the Health Care Access Fund resulting from lower than expected enrollment and the availability of federal funds through the state's Medicaid waiver, were decreased to 1.5 percent in 1998, but were raised back to 2 percent in 2002 due to a projected structural deficit.¹⁵ Similarly, HMO premium taxes were suspended in 1998 due to a surplus of funds and strong opposition to the tax by employers but were resumed in 2001 to cover the projected structural deficit.

In FY 2005 enrollee premiums paid 10 percent of the program's expenditures for medical care, federal matching funds paid 35 percent, and the state paid 55 percent through the Health Care Access Fund. The state paid \$225 million out of \$409 million in total payments for health care services through MinnesotaCare, which served 135,586 individuals in September 2005 after 13 years of operation.¹⁶

Healthy New York

Healthy New York is a state-subsidized program authorized by the Health Care Reform Act of 2000. In contrast to other publicly funded programs, such as Washington Basic Health and MinnesotaCare that subsidize the participant's premium, the subsidy in New York is provided in the form of risk-sharing with participating health plans. All commercial HMOs operating in the state are required to offer the standard benefit plan to qualifying small businesses, sole

¹³ *MinnesotaCare*. Information Brief prepared by the Minnesota House of Representatives Research Department, February 2006. Note that the state of Minnesota prohibits for-profit insurance companies from operating in the state.

¹⁴ Minnesota Citizens Council on Health Care. *Distribution, Utilization and Impact of the MinnesotaCare Provider Tax*. Available: <http://www.cchconline.org/publications/providertaxsumm.php3>, January 2000

¹⁵ Minnesota Citizens Council on Health Care. *Distribution, Utilization and Impact of the MinnesotaCare provider tax*, Jan. 2000.

¹⁶ *MinnesotaCare*. Information Brief prepared by the Minnesota House of Representatives Research Department, February 2006

proprietors, and low-income individuals that have not had coverage within the prior 12 months.¹⁷ Eligibility for small business is limited to those with 50 or fewer employees, at least a third of whom are low-wage. The state assumes the risk for per person claims between \$5,000 and \$75,000, resulting in lower premiums. Subject to the state's community-rating,¹⁸ premiums vary by health plan and rating region. In 2005, the median premium for an individual was \$188 in the upstate region and \$198 downstate.¹⁹

The Healthy NY benefit package was designed to be more limited and require higher copayments than the plans currently dominant in the small group and individual market in New York. The plan includes benefits that cover essential health needs including inpatient and outpatient hospital services, physician services, maternity care, preventative health services, diagnostic and x-ray services, emergency services, but excludes some of the state's mandated benefits (e.g. coverage for inpatient mental health, substance abuse, home health care, and chiropractic services). Applicants may opt to include a limited prescription benefit as well. Benefits are provided for closed provider networks only.

Financing

Healthy New York is one component of the state's broader multi-pronged Health Care Reform Act (HCRA). HCRA 2000 programs including the Child Health Plus SCHIP program, the Family Health Plus SCHIP waiver program and the Healthy New York program were projected to cost \$8.7 billion over three and a half years and are funded through a combination of cigarette tax revenues, tobacco settlement dollars, and an existing uncompensated care fund.

An increase in the cigarette tax of 55 cents per pack was estimated to provide \$1.5 billion and state collections from the tobacco settlement contributed another \$1.3 billion. The remaining \$5.9 billion came from existing funding streams including one percent assessment on the gross inpatient revenues of general hospitals, and a payer surcharge on payments made for general hospital and freestanding clinics which vary by payer type and whether they voluntarily elect to submit surcharge payments directly to the state on behalf of providers (8.95 percent for most private payers in 2006).²⁰ These assessments on insurers and providers have been in place since the mid-1980's and were initiated as part of the state's all-payer hospital rate-setting program to help cover the costs of indigent care. The assessments are pooled into an Indigent Care Fund and a Health Care Initiatives fund and are redistributed to hospitals and community health centers according to their amounts of uncompensated care. When New York dismantled its all-payer rate-setting system under HCRA 1996 it continued its indigent care pools recognizing that

¹⁷ In 2004, small employers were considered to have provided health insurance coverage if they contributed more than \$50 per month in upstate counties or \$75 in downstate counties.

¹⁸ Community-rating means that the claims experience of everyone in an insurance pool is averaged and every one pays the same premium except for allowed variations for family size and other characteristics depending on state law. All Healthy NY plans must use community-rating and rate each enrollment tier (single, husband/wife) based on the combined experience of the three participant categories (small group, sole proprietors, and individuals) Swartz, K. & Keenan, PS. *Healthy New York: Making Insurance More Affordable for Low-Income Workers*. Commonwealth Fund, November 2001.

¹⁹ Report on the Healthy NY Program 2005, Prepared for the State of New York Insurance Department, December 31, 2005.

²⁰ Health Care Reform Act of 2000: An Overview. Available: <http://www.ibo.nyc.ny.us/newsfax/nws58healthreform.html>; www.health.state.ny.us/nysdoh/hcra/05overviewltr.htm.

competition could result in lower hospital rates reducing the ability of hospitals that serve the poor and uninsured ability to maintain free safety net services.²¹

The cigarette tax and a portion of tobacco settlement funds were put in a new Tobacco Control and Insurance Initiatives pool that fund the Family Health Plus program and the Healthy New York program; the Child Health Plus program continues to be supported by the Health Care Initiatives Fund.²² For the 30 month period from Jan 2001-June 2003, Healthy New York was allocated \$219 million. In 2005, Healthy New York generated \$95.7 million in premium payments by previously uninsured New Yorkers (enrollment level at year end was approximately 106,944 after 4 years of operation). The \$31.4 million paid by the state in stop-loss reimbursement as its contribution to claims costs represented just under 25 percent of overall program costs.²³

adultBasic Plan of Pennsylvania

AdultBasic, an initiative enacted by the Pennsylvania legislature in 2001, provides subsidized health insurance coverage to low income (under 200 percent of the federal poverty level), uninsured adults ineligible for Medicaid or Medicare. The State contracts with four insurers to provide a basic benefit package, determined by public officials and negotiates a premium. The adultBasic program provides full coverage of physician and hospital care with nominal copayments for primary care, specialists and non-admit emergency room visits. Prescription drugs and mental health care are not covered. In the most recent contract, the State placed increased emphasis on disease management, particularly for asthma, cardiac care, and diabetes.²⁴

Financing

Each enrollee pays \$32 per month (recently increased from \$30 a month) and the State pays the difference (\$273 per month). The program was initially funded with the state's tobacco settlement dollars. In 2005, Governor Rendell signed a Community Health Reinvestment agreement with the four Blue Cross/Blue Shield plans operating in the state, that voluntarily agreed to pay a premium tax (1.6 percent tax on BC/BS annual health care premiums and 1 percent of their Medicaid/Medicare premiums over the next 6 years) toward community health programs. Sixty percent of the estimated \$950 million available over the six years of the agreement, will be allocated to provide health insurance to low-income people through state-approved programs such as the adultBasic program²⁵.

In fiscal year 2005–2006, adultBasic was funded at \$160.6 million (\$74.3 from tobacco settlement and \$86.3 from the Community Health Reinvestment agreement) up from \$119 million the prior year. Enrollment in the program is capped based on available funds, and a waiting list maintained from which individuals are enrolled based on attrition from the program.

²¹ Bovberg et al, *Market Competition and Uncompensated Care Pools*. Urban Institute, Assessing the New Federalism. March 1, 2000

²² New York State Office of the Comptroller, *The Health Care Reform Act (HCRA): The need to restore accountability to state taxpayers*, April 2003.

²³ Report on the Healthy New York Program, 2005 prepared for the State of New York Insurance Department, Dec 31, 2005.

²⁴ Pennsylvania Insurance Department, *adultBasic Health Insurance for Adult Pennsylvanians*. Available: <http://www.ins.state.pa.us/ins/cwp>, August 2006

²⁵ Pryor, C. & Dunham, C. *The Pennsylvania Community Health Reinvestment Agreement: Establishing Non-Profit Insurers' Community Benefit Obligations*, State Coverage Initiatives, August 2006.

Current enrollment is 50,600. As of December, 2005, 115,590 persons were on the waiting list. Between 2003 and 2006, over 123,000 individuals were enrolled from the waiting list in part due to the infusion of money from the Community Health Reinvestment Agreement. Most had been waiting for a year or longer. Persons on the waiting list have the option of “buying in” to adultBasic at cost, which is currently about \$305 per individual per month. To do so does not prejudice standing on the waiting list and the opportunity to enroll at the subsidized rate when an opening becomes available.²⁶

Hawaii’s Prepaid Health Care Act and the State Health Insurance Program

An alternative approach to achieving greater coverage among low-income workers to the state subsidizing insurance products purchased by individuals and/or employers is to mandate that employers provide health insurance coverage to their employees. Hawaii was the first and only state to successfully pass and implement an employer mandate to date.²⁷ In 2006, the states of Massachusetts and Vermont also passed health reform legislation that includes more modest employer mandates that have yet to be implemented (discussed in more detail below).

Hawaii’s Prepaid Health Care Act (PHCA) which was passed in 1974 requires nearly all employers to provide health insurance to their employees who worked 20 hours or more a week for four consecutive weeks. Other than part-time employees, exemptions also apply to new hires (<4 weeks), low-wage employees, and certain categories of workers (e.g. seasonal, governmental, self-employed).²⁸ Employers are not required to cover dependents.

The employer and employee share the costs for health insurance premiums. The employer can withhold 50 percent of the premium cost from employees, not to exceed 1.5 percent of their monthly gross wages, with the balance of the premium paid by the employer. In practice, the latter provision typically leads employers to pay nearly the entire premium costs.²⁹ Plans must meet a minimum standard of benefits that must include inpatient and outpatient hospital care; surgical services, physician visits; diagnostic and laboratory services, x-ray and radiotherapeutic services; maternity care, and substance abuse and detoxification benefits. All health plans offered are subject to regulatory approval by the state.

The law allows any employer who employs eight or fewer employees to request state funds to cover premium costs that exceed one and a half percent of the total wages of the employee if the employer’s premium payments exceed five percent of the employer’s income before taxes. However, these subsidies have not been provided to employers.³⁰ If employers do not comply with the law, the state can fine them or enjoin them from doing business in the state and the employer is liable for any health care costs incurred by an eligible employee during the period the employer fails to provide coverage.

²⁶ Annual Report to the State Legislature, Calendar Year 2005, *adultBasic Health Insurance for Adult Pennsylvanians*, 2005.

²⁷ Employer mandates were also passed in Massachusetts (1988), Oregon (1989), Washington (1993), and California (2003) but were overturned in subsequent votes or referenda prior to implementation or voided due to conflicts with the federal Employee Retirement Insurance Security Act (ERISA).

²⁸ Hawaii Uninsured Project. *A Historical Overview of Hawaii’s Prepaid Health Care Act*. No. 04-01, July 2004. PHCA defines low-wage as those whose gross monthly income are less than 86.67 times the State’s minimum hourly wage

²⁹ Buchmueller, T. & Valletta, R. *The Effect of an Employer Health Insurance Mandate on Health Insurance Coverage and the Demand for Labor: Generalizing from Hawaii’s Experience*. May 29, 2006.

³⁰ Ibid.

A voluntary community rating system is also applied under which small businesses under 100 employees are consolidated into a larger risk pool, to leverage lower premiums. On average, for the minimum package under PHCA, employers paid \$271 per member per month in 2006.³¹ An analysis of employer premium data from 1996 to 2003, revealed that Hawaii's premiums averaged 13-15 percent below national premiums in 2003 and predicted rates for 2006 were 27 percent below the national average.³² The reason for the low costs has not been definitively determined. Hypotheses include: a healthier than average population; the market-wide impact of the Kaiser Permanente – one of the two largest insurers in the state and an HMO plan with conservative, low utilization style of practice; and the cost-reducing impact of having all young healthy workers in the insurance pool.

Financing for State Supplemental Coverage

Post implementation of the PHCA, Hawaii's rates of uninsurance fell from around 30% in the early 70s to 2-5% in the 1980's and early 1990's. To address remaining gaps in coverage (e.g. for sole proprietors, dependents, part-time workers), in 1989, Hawaii also established a subsidized insurance program emphasizing access to preventive and primary care for the uninsured known as the State Health Insurance Program (SHIP). SHIP was funded with state-only general funds and provided insurance coverage to uninsured Hawaiians based on their ability to pay. (1992 enrollment = 16,000) The state legislature allocated \$14 million for the first two years of SHIP operations, with a maximum expected enrollment of 20,000. Premium copayments were estimated to support 15% of costs. Monthly per member contributions ranged from \$10-\$60 for adults in 1990. The program also limited payment for hospital care to \$500 per day and five days per calendar year. The SHIP program was later abolished and folded into Hawaii's HealthQUEST 1115 waiver Program in 1994 to maximize federal funding and make more efficient use of the state's limited dollars.

ERISA Issues

Hawaii is unique in that it was able to grandfather-in its existing PHCA and obtain an exemption from the federal Employer Retirement Income Security Act (ERISA) that Congress passed in the same year. ERISA is a pension reform law whose preemption clause has been broadly interpreted by the courts until the mid-1990's as prohibiting any state legislation that had any impact on or referred to private sector employee plan benefits, structure or administration. Even Hawaii's ERISA exemption is specific to the Hawaii Prepaid Health Care Act as enacted in Sept 1974 and prohibits any substantive amendment to the PHCA.

While ERISA prohibits other states from mandating that employers offer health insurance as in Hawaii, more recent decisions by the courts have limited the scope of ERISA's preemption. In 1995, the Supreme Court upheld New York State's hospital rate setting law that imposed surcharges on hospital bills paid by insurers for the states uncompensated care fund even though it increased costs for ERISA health plans buying coverage from these insurers. This case and several that followed support an interpretation that ERISA preemption does not necessarily prohibit state health care legislation that may have some effect on plan costs, benefit design, or

³¹ Lewin Group, *Analysis of the Impact of an Illustrative Single-Payer System for Hawaii*. Discussion DRAFT, Prepared for Hawaii Health Care Task Force, March 2006.

³² *Health Market – Insurance Premiums*. Available: http://www.healthtrends.org/healthmarket_premiums.aspx.

administrative responsibilities so long as the law is not directed specifically at ERISA plans themselves. Some have interpreted this shift as potentially opening the door for state “pay or play” legislation,³³ so long as the objective is to establish a publicly-financed health coverage program funded partially with taxes on all types of employers and remains neutral on whether an employer pays the tax or covers its workers.³⁴

The US District Court recently ruled that ERISA pre-empted Maryland’s Fair Share Health Care Fund Act that, effective January 2007, would have required all non-governmental employers of 10,000 or more employees to expend 8% of payroll on health care or pay an equal amount to the state. Maryland’s law, commonly referred to as the Wal-Mart law because it effectively targeted only this employer, did not uniformly apply the tax to all types of providers and as noted by the court, specifically targeted an ERISA plan of a particular employer. In contrast, the recent health care coverage initiatives passed in Massachusetts and Vermont described below, may test the broader interpretation of ERISA as both impose employer taxes on broad classes of non-insuring employers. The court ruling in Maryland specifically noted that the recent Massachusetts legislation “addresses health care issues comprehensively and in a manner that arguably has only incidental effects on ERISA plans” and suggested it would be “strongly in the public interest” to permit states to “experiment” in this area.³⁵ To date, neither Massachusetts nor Vermont has been legally challenged.

Recent State Initiatives

Both Massachusetts and Vermont passed reforms after the passage of DirigoHealth that also seek to achieve universal coverage. These initiatives, both of which have yet to be implemented, have many of the same elements as DirigoHealth. While DirigoHealth is voluntary, Massachusetts initiative is mandatory and Vermont’s is voluntary with mandatory employer assessments. The following are brief summaries of the key features of these initiatives.

Massachusetts Health Reform

In April 2006, Massachusetts passed universal health insurance legislation aimed at ensuring that every state resident has health coverage. As the legislation has just been passed and will be implemented in July 2007, it is too early to fully assess the lessons or applicability of this model in the state of Maine. The key components of the law include:

- An individual mandate, that requires that everyone in the state have health insurance coverage by July 2007 and penalizes those who do not.

³³ “Pay or play” is a term for a state coverage strategy that would impose a payroll tax on employers to fund health coverage for the uninsured, but would forgive the tax for employers who were providing adequate coverage for their workforce through an employee benefit plan.

³⁴ Butler, P. *Revisiting Pay or Play: How States Could Expand Employer-based Coverage within ERISA Constraints*. National Academy for State Health Policy, May 2002.

³⁵ United States District Court for the District of Maryland. *Retail Industry Leaders Association v. James D Fielder Jr.* Maryland Secretary of Labor, Licensing and Regulation. Available: <http://www.mdd.uscourts.gov/Opinions152/Opinions/Walmartopinion.pdf#search=%22Court%20decision%20-%20Maryland%20Walmart%20law%22>, August 2006.

- A limited employer mandate that imposes a \$295 annual per-employee surcharge on employers with more than 10 employees who do not offer coverage³⁶ and a “free rider” surcharge on employers whose employees use a minimum level of free care.
- Creation of a new quasi-public entity -- the Commonwealth Health Insurance Connector, that will connect individuals to commercially offered affordable, quality insurance products that it approves. Health insurance purchased through the Connector will be portable from job to job and multiple employers can contribute to the cost of a policy, so as to address problems faced by part-time and seasonal employees.
- Expanded Medicaid eligibility for children up to 300 percent of the federal poverty level. Other changes to Medicaid include a restoration of cuts in benefits that were made in 2002 and increases in Medicaid rates to hospitals and physicians.
- A new Commonwealth Care Health Insurance Program for non-Medicaid eligible persons, which will offer sliding-scale premium subsidies to individuals up to 300% FPL. Employers will be able to make contributions to the cost of the premium. Plans will not have any deductibles and will be offered by managed care organizations that participate in the Medicaid program.
- Insurance market reforms including merging the individual and small group markets that is expected to reduce premium costs for individuals by 24 percent. Also allows insurers to create insurance products specifically target 19-26 year olds and to consider tobacco use when setting group base premiums.

The individual mandate is only enforceable if affordable health plans are available and while the legislation does not define what affordable is, legislators have indicated that premiums for low-cost products should range from \$200-\$250 per month.³⁷ It is still unclear whether insurance companies will offer plans that are deemed affordable, although market reforms are intended to assist in achieving this objective.

The plan is expected to cost \$1.2 billion over three years and will be funded through a combination of redistributed existing uncompensated care and Medicaid disproportionate share funds (\$575 m),³⁸ new funding from employer contributions and general fund revenues of \$308 million over three years, with no additional state funding anticipated beyond that time. The existing uncompensated care pool on which the Massachusetts reform proposal relies heavily has been in place since the mid-1980's, established as part of the state hospital rate-setting program, and is financed through assessments on hospitals (\$157.5 m in FY 2004), insurers (\$157.5), intergovernmental transfers, state funds (\$30 million), federal matching disproportionate share (DSH) dollars (\$110 million), tobacco settlement funds and other sources for a total of \$693 million.³⁹

³⁶ The definition of what constitutes coverage is based on a “fair and reasonable contribution” to the cost of coverage, which depending how this is interpreted in the final regulations could limit the number of employers subject to the surcharge.

³⁷ Kaiser Commission on Medicaid and the Uninsured. *Massachusetts Health Care Reform Plan*. Kaiser Family Foundation, April 2006.

³⁸ Under Medicaid law, states are required to make increased payments to hospitals that serve disproportionate numbers of low-income patients with special needs and can get federal matching funds for these payments. States can use hospital taxes to fund the nonfederal share of DSH payments. Mechanic, R. *Medicaid's Disproportionate Share Hospital Program Complex Structure and National Health Policy Forum*, September 14, 2004.

³⁹ Silow-Carroll, S. & Alteras, T. *Stretching State Health Care Dollars: Innovative Use of Uncompensated Care Funds*, Commonwealth Fund, October 2004.

Vermont's Health Care Affordability Act and Catamount Health Plan

Vermont also passed legislation in 2006 intended to achieve universal access to high quality health care while reducing the rate of growth in health care costs. The goal is to accomplish universal coverage through a voluntary approach, but if 96% of coverage is not achieved by 2010, the state will consider mandating individual coverage. As with the Massachusetts reforms, the law is still to be implemented. Key features of the law include:

- Prevention and management of chronic diseases through a state-wide blueprint for chronic care infrastructure, management, reimbursement and outcome measurement that is intended to be used uniformly statewide by private insurers, third party administrators, and public programs with the goal of managing the care for individuals with or at risk for conditions in order to improve outcomes and the quality of care. The law also establishes a chronic care management program for Medicaid and Vermont Health Access clients to be administered by a private entity for individuals with one or more chronic conditions.
- Creation of a new Catamount Health state-subsidized plan voluntarily offered in the commercial market (fully insured but with option to move to self-insurance if commercial offering is not cost-effective for the state) that subsidizes premiums and cost-sharing on a sliding scale for non-Medicaid eligible persons below 300% FPL with no insurance for the past 12 months. Expected to cover 25,000 uninsured. Enrollment cap based on available funding.
- State-funded financial assistance to employed uninsured or public program eligibles who have access to employer-sponsored coverage with incomes under 300% FPL. Employer coverage must meet coverage standards including chronic condition coverage consistent with the state Blueprint.
- An assessment on employers who do not offer coverage (phasing in from employers of 8 or more FTEs in 2007/2008 to employers with 4 or more in 2010) for each full-time equivalent (including seasonal and part-time workers) uncovered employee. The assessment is \$91.25 per employee per quarter or \$365 annually.

The new Catamount Health plan and the employer premium assistance programs will be financed through individual premiums and a special fund known as the Catamount Fund, which will include revenues from employer assessments, savings from mandating premium assistance in the Vermont Health Access program, 17.5 percent of the revenue from a new cigarette tax assessments and possible federal matching funds through an amendment to the state's Global Commitment for Health Medicaid Section 1115 waiver, which if granted will pay about 60 percent of program costs.⁴⁰ The estimated cost of the legislation net of premiums was \$145.4 million over 4 years.⁴¹

Other Sources of Funding

Some states have attempted to use other revenue sources either to pay for the state portion of their Medicaid waiver costs or to support state-funded pharmacy assistance programs that offer drug coverage only to the elderly and disabled. For example, Arkansas levied a soft drink tax of

⁴⁰ The Health Care Affordability Act H.861 Committee of Conference, May 5, 2006. Available: http://www.leg.state.vt.us/HealthCare/H861_Two_Pager.htm

⁴¹ H.861 Balance Sheet, estimated by Dr. Kenneth Thorpe and the Vermont Joint Fiscal Office, May 5, 2006. Available: <http://www.leg.state.vt.us/jfo/Healthcare/H.861%20Balance%20Sheet.pdf>

2 cents per can which brings in \$40 million annually and is used to support the state-portion of its Medicaid program.⁴² Pennsylvania set aside its lottery funds for programs for the elderly particularly its Pharmaceutical Assistance Contract with Elderly (PACE) programs.⁴³ Similarly, as a condition of allowing casinos in the state of New Jersey, the state created a casino revenue fund supported by a 8 percent assessment on casino revenues which funds many programs for the elderly including the state's Pharmaceutical Assistance for the Aged and Disabled program.

Summary of Other States and Implications for Financing DirigoChoice

States have taken a variety of approaches for extending coverage to low-income uninsured individuals and small businesses. While the mechanisms and benefit designs for expanding coverage to uninsured or underinsured individuals or employers vary by state, the vast majority of states have financed these initiatives through dedicated special revenue sources that were either preexisting (redirection of uncompensated care funds from assessments on hospitals and insurance carriers) or legislated as part of the coverage expansion initiative (i.e. increased cigarette taxes, tobacco settlement funds or imposition of assessments on hospitals and insurers in Minnesota) (Table 1).

Maine has supported its Dirigo Health Initiative through assessments on insurers that are offset by the savings resulting from the Dirigo Reform Act including voluntary hospital cost reductions, an expanded Certificate of Need review program, reduced uncompensated care and other program cost savings. Other states have not attempted to justify a savings to the insurers but have imposed assessments on insurers in at least three of the states described (Minnesota, New York, Massachusetts). Pennsylvania also relies on voluntary insurer contributions. Both Healthy New York and the Massachusetts plan, once it is implemented, rely on existing uncompensated care funds and matching federal disproportionate share dollars that are supported by assessments on providers and insurers that have been in place for many years. Minnesota imposed assessments on hospitals and insurers as part of the MinnesotaCare statute.

Both New York and Massachusetts, in creating their provider-funded uncompensated care pools and in maintaining them after dismantling the hospital regulatory structure of which they were originally a part, argued that these funds would reduce hospital bad debt and charity care and equalize the burden among hospitals. Minnesota's provider assessment was based on a similar rationale. Unlike Maine, however, the continuation of these assessments was not *contingent* on showing savings. Prior to the implementation of DirigoChoice, Maine did not have an existing uncompensated care fund in place. In addition, Maine had already redirected its unspent Medicaid Disproportionate Share Funds to a Medicaid expansion to childless adults up to 100 FPL.⁴⁴

Maine is the only state whose health reform law stated that there is sufficient funding in the system to cover the uninsured if cost containment strategies successfully lowered the rate of health care growth and invested instead in coverage. These strategies included voluntary

⁴² Jacobsen, M. & Brownwell, K. *Small Taxes on Soft Drinks and Snack Foods to Promote Health*, American Journal of Public Health, Volume 90, No. 6, June 2000.

⁴³ Pennsylvania Department of the Aging, *The Pennsylvania Lottery*. Available: <http://www.aging.state.pa.us/aging/cwp/view.asp?a=3&Q=176060>

⁴⁴ Centers for Medicare and Medicaid Services. *Medicaid Waivers and Demonstrations List: Details for MaineCare for Childless Adults*, HIFA 1115 at www.cms.hhs.gov.

hospital cost reductions, an expanded Certificate of Need review program, reduced uncompensated care and other program cost savings. The method to recapture those funds – the Savings Offset Payment - became quickly contentious and is the primary reason Governor Baldacci has convened the Blue Ribbon Commission to find alternative funding sources.

Table 1: Summary of Funding Sources for Existing State Coverage Initiatives

<i>State Health Coverage Program</i>	<i>Program Start Date</i>	<i>Program Costs*</i>	<i>Funding Sources</i>
Washington Basic Health	1993 (statewide)	\$273 M (2006)	Health Services Account from cigarette and alcohol tax revenues; federal matching funds for children.
MinnesotaCare	1992	\$409 M (FY 05) \$225 M (state share)	Health Care Access Fund supported by 2% tax on hospital gross revenues; 2% tax on medical providers gross revenues; 1% tax on HMOs and not-for-profit health plans; cigarette tax (phased out); and federal matching funds.
Healthy New York	2001	\$127 M (2005) \$ 31.4 M – state subsidy	Tobacco settlement funds; cigarette tax; uncompensated care funds from 1% tax on hospital gross revenues and surcharge on health care payers/insurers for hospital and free standing clinic payments (8.95% in 2006).
adultBasic	2001	\$160.6 M (FY 06)	Tobacco settlement funds and 1.6% premium voluntary contribution by not-for-profit insurers.
Hawaii SHIP	1989	\$14 M allocated (1992)	State general funds initially; federal matching funds through Medicaid waiver.
Massachusetts	Enacted 2006; Not yet implemented	Estimated \$1.2 billion over 3 years.	Uncompensated care funds (from existing assessments on hospitals and insurers, state funds, disproportionate share federal matching funds, tobacco settlement); general funds; employer contributions.
Vermont	Enacted 2006; Not yet implemented	Estimated \$145.4 M over 4 years	Cigarette tax and other tobacco product tax; employer assessment, possible federal funds through Medicaid waiver.

*Based on most recent available data. Year available specified.

Another source of funds utilized by Pennsylvania, New York, and Massachusetts is tobacco settlement revenues. Through its Trust Fund for Healthy Maine, the state of Maine is one of the only states in the country that has already allotted most of these funds toward health care programs including tobacco prevention programs, Medicaid initiatives to draw down federal funding and to help support the state's Drugs for the Elderly and Maine Rx program.⁴⁵

In times of budget deficits and Medicaid shortfalls, many states including Maine have increased the excise tax on tobacco as an opportunity to generate new revenue or replace deficits. In addition to an increase in available funds, raising the excise tax on tobacco products reduces smoking rates in the general population, especially in youth and pregnant women. Maine has already used cigarette taxes toward insurance expansions. In 2001, Maine raised its cigarette tax by 26 cents to total \$1.00, some of which contributed toward expanding Medicaid coverage to single adults and couples without children along with use of state disproportionate share dollars.⁴⁶ Maine's cigarette tax is currently \$2.00 per pack and is the 4th highest cigarette excise tax in the country behind, Rhode Island, New Jersey, and Washington.⁴⁷

Like the state of Washington, Maine has also utilized alcohol taxes to help support health expansions in the past. The Maine Health Program created in 1989 extended Medicaid-like benefits to all adult residents ineligible for Medicaid with incomes under 100% FPL and was supported with state-only funds through a combination of sources including an increase in liquor taxes, an increase in cigarette and smokeless tobacco taxes, and a non-commercial watercraft excise tax.⁴⁸ The program was terminated in 1995 due to budget cuts and later replaced by federally authorized Medicaid expansions. Maine's current alcohol-related taxes, which have remained constant since the late 1980s, are at or above the average rates for beer and wine, and below average for liquor (beer 25 cents, wine 30 cents, sparkling wine \$1.00 per gallon and liquor \$1.00 per proof per gallon).⁴⁹

Only a few states have specifically dedicated taxes on other products such as soft drinks to health programs (e.g. Arkansas) but 20 states, including Maine, have had a "snack tax".⁵⁰ In 1991, Maine enacted a 5.5 percent "snack tax" on snack foods and soft drinks as a revenue source to help solve the state's fiscal crisis. The tax was repealed in 2000 in response to a popular petition initiative opposing the tax.

⁴⁵ Maine State Legislature Office of Fiscal and Program Review. *Fund for a Healthy Maine Allocation Summary*. Updated 11/01.

⁴⁶ Alteras, T. & Silow-Carroll, S. *Childless Adult Coverage in Maine*. State Report, Kaiser Family Foundation, August 2004. Available:

<http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=46180>

⁴⁷ *State Excise Tax Rates on Cigarettes*. January 1, 2006. compiled by Federation of Tax Administrators. Available: from <http://www.taxadmin.org/FTA/rate/cigarette.html>

⁴⁸ PL 1989, Chapter 588, Part A, Section 43; Part B-E.

⁴⁹ The state also imposes premium taxes per gallon of 10 cents for beer, 30 cents for wine, and 24 cents for sparkling wine. Source: Tax Policy Center (a joint venture of the Urban Institute and Brookings Institute), *State Tax Facts, Alcohol rates in 2006*. Available: www.taxpolicycenter.org, Center for Science in the Public Interest, Alcohol Policies Project. *Proposed Increases in State and Local Taxes and Fees*, 2003. Available: <http://www.cspinet.org/booze/taxguide/2003taxstateupdate.htm>.

⁵⁰ Jacobsen, M. & Brownwell, K. *Small Taxes on Soft Drinks and Snack Foods to Promote Health*, American Journal of Public Health, Volume 90, No. 6, June 2000.

Conclusion

One clear lesson from other states and from previous state-supported insurance expansions in Maine itself is that there is no magic bullet funding source for state coverage initiatives. States have used a variety of sources but have largely relied on a combination of ‘sin taxes’ (cigarettes, alcohol), tobacco settlement revenues, and/or assessments on medical providers and/or insurers either through existing uncompensated care funds or through new assessments passed as part of the expansion initiative. Several states with initiatives that were started as state-only programs subsequently have pursued federal Medicaid waivers to support a portion of program costs.

For the state portion of costs, none of these taxes has been imposed without controversy. The provider tax in Minnesota, which has remained in place for more than a decade through both Republican and Democratic administrations, has been described by provider associations as a ‘sick tax.’ Opponents to taxes on soft drinks argue that they are regressive and unfairly burdensome for the poor. Uncompensated care pool taxes were opposed by suburban hospitals that were less likely to benefit from the distribution of pool funds. Each state has had to creatively negotiate the financing of coverage initiatives and the related political dynamics both initially and over time. Maintaining successful longstanding programs has required strong political will and generally a separately dedicated funding stream to protect the programs from being subject to the annual budget cycle and review.

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