
REPORT OF THE UNIVERSAL COVERAGE COMMITTEE

Over the last year or so, the Universal Coverage Committee of the Delaware Health Care Commission has been considering approaches to achieving universal coverage in the state. The work started with a process to determine what support there might be for a single payer approach for the state. A series of interviews with key stakeholders did not reveal a consensus for the single payer approach. The interviewed stakeholders seemed to agree that universal coverage was a desirable goal, but there was no clear agreement on how to achieve that goal.

The Committee decided that part of the difficulty in getting informed reactions to approaches to covering the uninsured is that information about several key issues is missing. Most notably, reliable estimates of the cost and coverage outcomes of adopting any particular approach to universal coverage in Delaware are not available. This gap could be filled by contracting with a firm that does micro simulation estimates of the cost and coverage outcomes of approaches to coverage expansion. With this option in mind, the Committee decided to develop the features of two approaches to universal coverage that could then be modeled through microsimulation to estimate cost and coverage effects. One, the single payer approach would entail a major overhaul of the system. The second, while still representing major change, would build more on elements of the existing financing system.

The Committee went through an exercise to develop features of these two approaches. The purpose was to outline a set of plan elements that would appear to be a reasonable way to go about putting in place these two approaches. In doing this work, the members were instructed to approach the task this way: "Assume that the state were going to adopt a single payer system. What is the best way for that system to be structured? What should it look like?" The Committee was faced with analogous assignment when they approached the building blocks approach.

No one on the Committee would contend that the specific details of either approach represent the only sensible way to structure the approach. Elements could be changed, particularly when the issue involves specifying numerical parameters for a plan element. But if modeling is to be done, the modeler has to start with detailed plan specifications. The specifications that the Committee decided upon seemed a sensible starting point for the microsimulation. The effect of altering key parameters could be determined once the first round of modeling is being done by employing "sensitivity analysis," that is, varying key parameters slightly and observing how that effects cost and coverage outcomes.

Outlined below are the decisions the Committee made regarding the two approaches.

[In a few instances, the consultant added some specificity that is necessary to do modeling. While these additions were not approved by the Committee, every effort was made to include only items that appeared to be consistent with the views the group expressed at its last meeting.]

A MASSACHUSETTS STYLE UNIVERSAL COVERAGE PLAN FOR DELAWARE

The approach to universal coverage outlined here includes elements that are similar to those adopted in the Massachusetts reform passed in 2006 and the proposal offered by Governor Schwarzenegger in California. However, various parameters of the approach are significantly different.

The approach combines several key elements:

- An individual responsibility provision that requires all residents of the state to acquire coverage.
- An employer responsibility provision that requires employers that do not offer coverage to contribute through a payroll tax.
- A tax on providers.
- A major expansion of Medicaid.
- State subsidies to make coverage affordable for low- and moderate-income families.
- A statewide insurance exchange (purchasing pool) to facilitate the purchase of economical coverage.

Plan Elements

1. Individual responsibility.

- A. Every resident of the state would be required to have coverage or pay a significant financial penalty, which would be equal to two-thirds the cost of buying the minimum coverage through the insurance exchange. The minimum coverage that would satisfy the requirement would be defined as follows:
- i. To keep the cost of state subsidies at a reasonable level, the minimum benefit package that would satisfy the mandate requirement would be relatively “lean” while still providing reasonable coverage.
 - ii. The actual covered services under the minimum benefit plan (as contrasted with the amount of insurance payment for these services) could be similar to those most commonly covered under typical corporate coverage, including large and small employers, such as the services covered under most widely sold Blue Cross and Blue Shield plan – including hospital, physician, laboratory and radiology, and prescription drugs. Not included in the minimum benefit package would be dental, vision, or long-term care.
 - iii. The benefit package would be kept affordable by including substantial consumer cost sharing. Cost sharing would be designed to create incentives for appropriate and timely utilization of preventive and primary care, would encourage cost sensitivity for other services with a substantial deductible and/or copayments, and would provide good protection against catastrophic expenses.

- B. The penalty would be enforced only if coverage were determined to be affordable. The measure of affordability would vary with family/household income and would be defined relative to the amount people would have to spend to buy the minimum benefit plan through the exchange. Any shortfall would be made up by state subsidies (as outlined below).
 - i. People with incomes above 350% of the federal poverty level (FPL) would be assumed to be able to afford coverage without any state subsidies.
 - ii. People with incomes below 100% of FPL would not be expected to pay anything toward coverage; that is, their coverage would be fully subsidized by their enrollment in Medicaid/SCHIP.
 - iii. Between 100% and 350% of FPL, the affordable family contribution would rise in small steps from 1% of family income to 10% of family income.
- C. Enforcement of the mandate and determination of eligibility for subsidies would be done through the state income tax system, usually at the time of tax filing
 - i. People who currently do not have to file state tax returns would be required to submit a short form documenting their income and their insurance status. (People would also have to submit this form to become eligible for subsidies.)
 - ii. People who have experienced a change in income before the time of their next tax filing would be able to apply at any time for a redetermination of affordability or a change in their subsidy amount if they can show proof of income change.
 - iii. Insurers would be required to provide each enrollee with the equivalent of a W-2 form that shows which months during the year the person was enrolled in an insurance plan. This would be filed with state income taxes to show proof of coverage.
 - iv. People who have not been enrolled in a health coverage plan would be assessed the penalty outlined above for each month they were not enrolled, which would become a tax liability payable at the time taxes are due. Any liability would be reduced by the amount of the subsidy for which the person was eligible (To avoid undue burdens for people just moving to the state or those between jobs, any person would be allowed to be uninsured for a maximum of 60 days during the year without penalty.)

2. Employer responsibility: Employers who do not offer coverage would pay an assessment in lieu of offering coverage.

- A. The state would assess *all* employers a percentage of total payroll (including part-time workers) equal to 75% of the average percentage that employers in the state who offer coverage now contribute to coverage. (However, see C below.)
- B. Employers would be given a credit against the tax for the amount they contribute to employee coverage, so that employers that offer coverage and spend as much as or more than the specified percentage would not have any net tax liability. (Legal experts think this approach would be allowable under ERISA, since it specifies nothing about the nature of an employer's health benefits.)

- C. This requirement would be modified for low-wage employers, defined as those that employ a workforce 70% of whom make less than 125% of the minimum wage. For such employers, the required assessment would be phased in over five years, with the assessment rising in equal amounts each year. (Assume the assessment is 7.5% of payroll. In year 1, low-wage employers would pay 1.5% of payroll, 3% in year 2, 4.5% in year 3, etc.)
- D. All employers, even those not providing coverage, would be required to withhold from employee wages the amount that employees pay toward premiums and then forward this amount to the employee's insurer or to the insurance exchange. To allow employees to pay the premiums on a before-tax basis (thereby realizing a federal "subsidy"), all employers would be required to establish a Section 125 (cafeteria) plan.

3. Provider tax: (Please see attached paper for the justification for this provision.)

- A. Physicians and hospitals would be assessed a fee on revenues they receive for providing medical service. The hospital fee would be 4%, and the fee for physicians would be 2%.
- B. Revenue generated from the provider tax would be allocated to a dedicated fund that would be used to fund subsidies.
- C. The provider tax would supplement the tax on employers who do not offer coverage. Some additional funding from other sources could also be necessary.

4. Medicaid expansion

- A. Medicaid and/or SCHIP would be expanded for children in families with incomes up to 300% of FPL and for all adults (parents and childless adults) with incomes up to 200% of FPL. People with incomes between 100% and 200% of FPL would pay premiums that rise with income (as noted above) (This is probably the least expensive way for the state to finance the needed subsidies for these people [see next point], many of whom do not have access to employer coverage, because the approach allows the state to realize the federal subsidy through the federal matching amount).
- B. To leverage employer contributions, Medicaid recipients who are employed by an employer that offers coverage would be required to accept that coverage, with the state providing "wrap around" coverage to bring that coverage up to the Medicaid/SCHIP standard.

5. State subsidies to low- and moderate-income individuals

- A. To ensure that coverage is affordable, the state would finance subsidies to low- and moderate-income individuals, in the form of a refundable, advanceable tax credit (essentially a voucher) against the cost of coverage.
- B. The tax credit would be available to people with incomes up to 350% of FPL, structured to make coverage affordable as defined above—which ensures that the family expense will not exceed a percentage of income.

6. State insurance exchange

- A. The state would establish an insurance exchange/purchasing pool—which would be a quasi-government entity—to facilitate the purchase of coverage by individuals not covered by employer plans, by all small employers, and by any other employers wishing to

purchase coverage in this manner. All small-group and individual policies would be sold only through the exchange. (This provision is compatible with the continued use of agents and brokers, who would be paid a commission for selling coverage, as they are now.)

- B. The exchange would contract with all insurers willing to offer a small number of standardized plans on an adjusted community-rated, guaranteed-issue basis to individuals and small groups. The exchange would simply be a “price taker” and would not negotiate with insurers
- C. The only factor insurers would be permitted to use in varying rates would be age, and the maximum rate variation could not exceed a ratio of 2.5:1. (In essence, the individual and small-group markets would be merged.)
- D. Individual employees, not employers, would select the plan that was most suitable for them (similar to the approach used in the Federal Employees Health Benefit Plan).
- E. A risk-adjustment mechanism would be established to ensure that insurers that get a disproportionate number of higher-risk enrollees are not disadvantaged. Money would be transferred from insurers that enroll a disproportionate number of low-risk people to insurers that enroll a disproportionate number of high-risk people.

A SINGLE PAYER TYPE PLAN

The approach outlined below is a stereotypical single payer type plan, with automatic coverage for everyone in a government program.

Plan Elements

7. Eligibility: who is covered

- A. All permanent residents would be eligible automatically except Medicare eligibles, who would be covered as now. To establish permanent residence, a person would have to show proof of having resided in Delaware for at least 18 months.
- B. No agreement was reached regarding the inclusion of federal employees, military personnel, and people covered by the Veterans’ Administration.
- C. Delaware residents living outside of Delaware for a substantial portion of the year would be eligible while away, but any services provided out of state would be compensated according to the fee schedules applicable for in-state services, with the possibility that the people receiving out-of-state services would be subject to balance billing by the out-of-state providers.
- D. Undocumented immigrants would not be eligible. Legal immigrants who are residents would be eligible.
- E. People newly moving to Delaware would not be eligible for 18 months and would not pay the household premium for 18 months, but they could buy into the system on a risk-rated basis (paying a premium equal to the full actuarial value), using perhaps age and

previous medical status as rating factors, with some reasonable limit on the overall range of rate variation.

- F. People who are *fully employed* (and their dependents) would be eligible after six months of continuous residence and employment in the state. [It is not certain there was agreement on this point.]
- G. People working in Delaware but living elsewhere (non-residents) would not be covered automatically but would be allowed to buy into the system on the same basis as new residents, but their premium would be reduced to reflect the fact that their employers are paying (through the payroll tax) on their behalf. If they choose to get services from out-of-state providers, the providers would be paid in-state reimbursement rates, which could subject the service recipients to balance billing by these providers. Employers would not pay a payroll tax for those out-of-state residents who opted not to enroll in the Delaware system.
- H. Medicaid and SCHIP residents would be integrated into the program and have the same insurance card as everyone else does, but the state would separately track their eligibility for these federal programs to ensure the federal match, and the services available to them would have to be at least equivalent to the federally required benefits. There would be a separate designation on their card to ease tracking.

8. Benefits: what is covered

- A. The services covered under the uniform, standardized benefit plan would be similar to those most commonly available under typical corporate coverage, including large and small employers. An example might be the most widely sold Blue Cross and Blue Shield plan.
- B. Cost sharing provisions would be designed to create incentives for appropriate and timely utilization of preventive and primary care, would encourage cost sensitivity for other services, and would provide adequate protection against catastrophic expenses. Incentives would be included to promote healthful life styles and the use of preventive services.
- C. The system would not cover long-term care services. These services would be covered as now, by a combination of Medicaid, private insurance, and private payment.
- D. Benefits for people eligible for Medicaid and SCHIP would cover, at minimum, the federally *required* services, though not necessarily the optional services now covered.

9. Claims administration

- A. The state would put out an RFP to select a private contractor to administer claims.

10. Budgeting and financing

- A. All payers who now finance health coverage should contribute in roughly the same proportion as they do now.
- B. One source of financing would be an employer payroll tax. To protect small low-wage employers, the tax would not apply to some initial amount of aggregate payroll; for example, the first \$20,000 of aggregate payroll might be exempt. To avoid having high-wage employers pay much more than they do now, there would be a cap on the amount

of *individual* employee income subject to the tax (as with Social Security tax); for example, the tax might apply to only the first \$100,000 of individual employee payroll.

- C. A second source of financing would be households. The tax/premium would be applied to household gross income minus exemptions as calculated for state income tax purposes (which amounts to an adjustment for ability to pay). It was agreed there would be a cap on the amount of income subject to the tax/premium. There was no decision as to whether the tax/premium should be graduated by income.
- D. To avoid the loss of federal subsidy that results from the fact that employer-paid premiums are not taxable as employee income, all employers would be required to establish a Section 125 plan and to withhold the household premium/tax from employee income, so that the premium would be paid with “before-tax” income.
- E. It was agreed that efforts should be made to continue to have the federal government provide financing for the portion of the population that would otherwise be eligible for Medicaid and SCHIP. It was further agreed that eligibility for these programs should be extended up the income scale to maximize the federal contribution to the universal coverage program. (Waivers and perhaps legislation would be required.)
- F. State government (along with the federal match) would continue to finance coverage for those people who would otherwise be eligible for Medicaid and SCHIP.
- G. There was no agreement about a provider tax as a possible source of revenue.
- H. Revenue collected from all sources would be put in a dedicated fund available only for the universal coverage system.
- I. A “rainy day” stabilization fund would be established to cover two circumstances: (1) revenue shortfalls that occur as a result of cyclical economic downturns, and (2) short-term, unpredicted spikes in medical expenditures.
- J. The system will establish a global budget for overall expenditures, as well as capital expenditure budgets for health care facilities and equipment. Other policies to control the rate of proliferation of new technologies may be necessary.
- K. There was no agreement about how to cope with the high probability that over the long run rising medical costs will outpace the growth of revenue.

11. Provider Payment

- A. In establishing a provider reimbursement methodology, the new system should build on present payment systems.
- B. Decisions about changing provider payments should be done in consultation with a provider advisory panel.

12. Administration

- A. The program would be administered by a quasi-independent commission, not part of any existing state agency, somewhat protected from day-to-day political influences (somewhat analogous to the Federal Reserves System). To provide this degree of autonomy, commission members would be appointed for relatively long, staggered terms of office. Commissioners would be appointed through the political process, probably involving both the governor and the legislature.

- B. The Commission would have some controls over technology deployment and capital budgets.

13. Supplemental Insurance

- A. Household and employers could purchase supplemental insurance from private insurers to extend coverage beyond that covered under the standard program.