

# **DESCRIPTION AND ASSESSMENT OF THREE APPROACHES TO ACHIEVING UNIVERSAL HEALTH COVERAGE IN DELAWARE**

*Final Report*

*prepared for*

**DELAWARE HEALTH CARE COMMISSION  
SINGLE PAYER COMMITTEE**

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## OUTLINE OF THE REPORT

At the last meeting of the Single Payer Committee, the group decided to focus its attention on three reforms to achieve universal coverage: the single state purchasing pool approach (including the single payer and multipayer variants), the employer mandate “play or pay” approach, and the “building blocks” approach. In this paper ESRI extends its previous work by analyzing each of the approaches against criteria that help to assess the relative advantages and disadvantages of each.

We begin by identifying the criteria we used to assess the merits of each approach. The remainder of the report considers each approach in turn. For each approach, we provide a summary of the plan features and a summary of the assessment, then a detailed description of the plan features (essentially the same material provided in the first report), and finally a detailed assessment of each plan using the criteria described below.

## EVALUATION CRITERIA

When evaluating coverage expansion proposals, people typically care about certain key issues:

- *Coverage*: Who is covered and how good is the coverage?
- *Cost and Efficiency*: Is the plan efficient and economically practical?
- *Equity and Fairness*: Does the plan promote fairness and equity?
- *Choice and Autonomy*: How much choice does the plan permit?

Using these key issues as a starting point, we identify criteria for assessing expansion proposals. The four primary criteria used in this analysis are coverage, cost/efficiency, fairness/equity, and choice/autonomy.

The descriptions of each criterion in the chart below list the important factors to consider when evaluating any plan. When applying this framework, we do not always consider every single issue listed in the description, just those that seem particularly relevant.

Criteria	Sub-Criteria	Description
COVERAGE	People covered	<ul style="list-style-type: none"> <li>• How many people will be covered who previously were not.</li> <li>• Which particular populations will be newly covered and which will not (for example, most needy vs. less needy).</li> <li>• Effect on portability of coverage and continuity of care.</li> <li>• Effect on access to care (e.g., language or culture differences, geographic distance, physical barriers for people with disabilities, prohibitive cost-sharing).</li> </ul>
	Benefit package	<ul style="list-style-type: none"> <li>• Which services are covered and to what extent.</li> <li>• Effect on consumer cost-sharing and other financial limits that could affect accessibility.</li> <li>• Whether the benefit packages meet the needs of special needs populations (e.g., people with disabilities or those facing language or cultural barriers).</li> </ul>
	Quality of care/Effect on delivery system	<ul style="list-style-type: none"> <li>• Effect on quality of care.</li> <li>• Effect on the way physicians practice (for example, greater adherence to practice guidelines).</li> <li>• Whether the proposal promotes or discourages greater integration and coordination among parts of the delivery system (e.g., between primary care providers and specialists).</li> <li>• Effect on adequacy of provider supply including the safety-net system.</li> </ul>

<b>Criteria</b>	<b>Sub-Criteria</b>	<b>Description</b>
<b>COST &amp; EFFICIENCY</b>	<b>Cost</b>	<ul style="list-style-type: none"> <li>• Effect on resource cost: the value of the new additional health services and medical technology resources that are consumed as a result of the coverage expansion.</li> <li>• Effect on budgetary cost: the governmental costs associated with the expansion.</li> <li>• Effect on the balance between immediate and longer-run budget costs.</li> <li>• Effect on the balance between public- and private-sector costs.</li> <li>• Whether the approach creates entitlements, making it difficult to estimate or control the future budget cost.</li> </ul>
	<b>Cost containment</b>	<ul style="list-style-type: none"> <li>• Effect on keeping expenditures under control and ensuring sustainability.</li> <li>• Ensuring that resources are used efficiently.</li> <li>• Whether the proposal's cost control methods would produce market distortions or inefficiencies.</li> </ul>
	<b>Implementation and administration</b>	<ul style="list-style-type: none"> <li>• Degree of change from the status quo.</li> <li>• Likelihood of political opposition from those required to change.</li> <li>• Ease of initial implementation.</li> <li>• Effect on ongoing administrative costs and complexities.</li> <li>• Whether legal or regulatory changes would be required.</li> <li>• Who has accountability for ensuring good performance for quality and efficiency (insurers/health plans, employers, government, etc.).</li> </ul>
<b>FAIRNESS &amp; EQUITY</b>	<b>Access to coverage and subsidies</b>	<ul style="list-style-type: none"> <li>• Effect on who are the “winners and losers”: who is covered by government programs or eligible for subsidies, and who is not.</li> </ul>
	<b>Financing of costs</b>	<ul style="list-style-type: none"> <li>• Who receives subsidies for coverage and who does not.</li> <li>• Who pays the bill for the subsidies and how the tax burden is distributed relative to income.</li> </ul>
	<b>Sharing of risks</b>	<ul style="list-style-type: none"> <li>• Whether premium costs are based on risk of needing health resources, or whether all insured people pay the same rate (“community rating” approach).</li> </ul>
<b>CHOICE &amp; AUTONOMY</b>	<b>Consumer choice of providers and health plans</b>	<ul style="list-style-type: none"> <li>• Effect on consumers’ choices among providers and provider networks.</li> <li>• Effect on consumers’ and employers’ choices among health plans.</li> <li>• What financial consequences are attached to such choices</li> </ul>
	<b>Provider autonomy</b>	<ul style="list-style-type: none"> <li>• Effect on the prices providers charge or the reimbursement they receive (economic autonomy)</li> <li>• Degree to which providers are able to practice medicine without outside constraints or control (clinical autonomy).</li> </ul>
	<b>Government compulsion/regulation</b>	<ul style="list-style-type: none"> <li>• Degree of government intervention and control over consumers, employers, providers or health plans.</li> <li>• Whether individuals are mandated to obtain coverage; employers to pay for coverage; or health plans to participate in some purchasing arrangement.</li> </ul>

# **SINGLE STATE PURCHASING POOL APPROACH**

## **Summary of Elements**

- All non-elderly legal residents would automatically be eligible and automatically enrolled (in the single state plan, in the case of single payer, and in one of several private insurance plans offering coverage through the state pool, in the case of multiple payer).
- Benefits for people with incomes under 150% of the poverty level would be equal to current Medicaid benefits.
- Everyone else would be covered by the standard benefit package, which would be based on the most popular current small-group coverage. Anyone could buy supplemental benefit coverage from insurers.
- Under the single payer approach, people pay premiums, with subsidies graduated by income for people between 150% of the poverty level and the median income and no subsidies thereafter. Subsidies are financed with general revenues.
- Under the multiple payer approach, financing comes from an 8% payroll tax on employers and 2% on employees, with similar taxes for non-employed people. However, earnings below \$10,000 and above \$200,000 are exempt.
- Premiums would be community rated.
- The Health Care Commission would administer the program, be responsible for cost control, and negotiate with providers under the single payer approach and with insurers under the multiple payer approach.

## **Summary of Assessment**

### ***Single Payer***

- Everyone would be covered automatically—universal coverage with adequate benefits.
- Everyone would have full portability of coverage regardless of change in life circumstances.
- Real resource costs would be substantially higher because all who are now uninsured are covered and will use more health care; the additional costs will be partially offset by elimination of much duplication of administrative functions and reduction of many insurer administrative costs.
- State budget costs would be substantially higher; the state would need to raise additional general revenues, though only to subsidize those newly in Medicaid and with those with incomes up to median; others pay the full premium.
- The potential for cost and quality control would be substantially enhanced because government has access to all encounter data and great leverage as the only buyer and could set global budgets.
- Equity would be substantially increased: equal treatment of equals and financing based on ability to pay.
- Risk sharing would be very broad.
- People would have no choice of health plan but very broad choice of providers.
- Compulsion and disruption of the status quo (especially for insurers) would be high; everyone is required to have and pay for coverage; greater government control would be substantially strengthened.

### ***Multiple Payer***

- Everyone would be covered automatically—universal coverage with adequate benefits.
- Everyone would have full portability of coverage regardless of change in life circumstances.

- Real resource costs would be substantially higher because all who are now uninsured are covered and will use more health care.
- Administrative savings would be less than for the single payer approach, since insurance companies continue to offer coverage.
- The state budgetary costs are very high because state dollars substitute for private dollars, since everyone can choose a no-premium plan (though note other funding variations are possible).
- Cost control is achieved through bargaining between state pool and insurers and as result of competition among insurers offering identical coverage in the pool and competing for individual enrollees every year.
- Risk sharing would be very broad.
- Compulsion is substantially increased: coverage is required, insurers flexibility is limited, and government regulation is broadened, but disruption of the state quo is less than under the single payer option because private insurers retain a major role in the new system.

## THE SINGLE STATE POOL APPROACH—DETAILS OF ELEMENTS

	Single Payer	Multiple Payer
<b>GENERAL DESCRIPTION</b>	Under this approach, all legal residents would be automatically covered in a single state plan that could be thought of as extending the state employees’ plan to all residents. It is also similar to the Part B (physician) portion of Medicare. Funding would come from a combination of income-related premiums and general state revenues. Anyone could buy supplemental coverage from insurers to have more comprehensive coverage, but only the state itself would offer the standard benefits package.	This approach ensures universal coverage by making coverage automatic, with coverage available through a state purchasing pool that contracts with multiple health plans. The plan is financed primarily by a payroll tax on employers and employees, but coverage is not linked to employment. People can choose health plans from any one of a number available under contract to the state. The approach has many similarities to the Federal Employees Health Benefits Plan (FEHBP).
<b>Eligibility</b>	All legal residents of the state (other than those over 65, who would continue to be covered by Medicare) would be automatically covered in the state plan/pool. Even if people did not enroll and showed up for care, they would be enrolled at that time and the cost of the care would be covered.	Same except that everyone would enroll in a health plan participating in the state pool, but if they failed to do so for whatever reason by a given date (or at the first time they sought services), they would be automatically (and randomly) assigned to the least expensive plan(s).
<b>Source of coverage</b>	A new Delaware Health Protection Plan Pool administered by the Health Care Commission would be the only source of coverage (for the standard plan).	<i>Multiple plan offerings through the state.</i> The state plan pool would contract with a number of health plans to provide a standard package of benefits offered on a community-rated guaranteed-issue basis. Health plans could offer more generous coverage, but this supplemental coverage would be separately priced.  <i>Plan choice.</i> At least one plan would be available at no cost to all eligible individuals. However, people could choose any plan under contract to the state. If they choose other than the least expensive (no cost) plan(s), they would pay any additional premium out of pocket.
<b>Standard benefit package</b>	A standard benefits package (including consumer cost sharing provisions) would be defined by the Delaware Health Care Commission and would initially be based on a review of the most popular plans sold by the state’s major insurers to small businesses. This would be the benefit package available to everyone with incomes in excess of 150% of the federal poverty level. The Commission would be responsible for updating the benefit package based on an annual review (perhaps with a restriction that the increase in the premium should be limited by being linked to some measure of affordability or cost increase).	Same
<b>Benefits for low-income people</b>	Benefits for people with incomes below 150% of FPL would be based on current Medicaid benefits (with possible minor modifications), with the expectation that federal matching funds would be available for most of these people. (A waiver would be required.)	Same

<b>Supplemental coverage</b>	<p>Anyone—individuals or employers—could buy supplemental coverage from insurers to expand the benefits available under the standard plan. Policies covering these supplemental benefits would be subject to the insurance rating restrictions and coverage guarantees that currently apply. Employers could choose to pay for supplemental coverage (as well as any portion of the premium for the standard benefit coverage).</p>	<p>Same</p>
<b>Financing</b>	<ol style="list-style-type: none"> <li>1. The system would be financed by a combination of premiums and state general revenues.</li> <li>2. The premiums would be graduated by income. People with incomes below 150% of the federal poverty level (FPL) would pay no premiums. Those with incomes above the median income (by family size) would pay a premium sufficient to cover the full costs. Those between 150% of FPL and the median income would pay a gradually increasing premium. (Alternatively, people above the poverty level could be required to pay some percent of income.)</li> <li>3. The premium each household would pay would be based on the previous year’s reported income on the state income tax forms. If a household anticipates a substantial change in income, they would submit a form to modify the premium liability (just as is done now to modify the amount employers withhold for FICA taxes). Any discrepancy between the amount paid in and the amount due (based on current year income) would be reconciled when state income tax filing is made. Likewise, anyone who for whatever reasons failed to pay the applicable premium during the year would have the shortfall as a tax liability on his or her state income tax.</li> <li>4. For employed people, employers would be required to withhold the premium amount and forward the amount to the state. All employers would be required to perform this function even if they contribute nothing toward the premium. People not employed would be required to pay quarterly payments.</li> <li>5. Employers could pay any portion of the premium for their employees and their dependents but would not be required to do so. (Federal tax laws would still provide incentives for employers to pay premiums because the employer payment would not be taxable as income to the employee.)</li> <li>6. State general fund revenues would be used to finance the premium subsidies for those between 150% of FPL and the median income and to provide the state match for people newly covered under Medicaid.</li> </ol> <p><i>Note that the funding mechanisms proposed for the two state purchasing pool approaches could be interchanged, although the amount of revenue that would need to be raised might differ and some elements would need alteration. Other funding mechanisms are also possible.</i></p>	<ol style="list-style-type: none"> <li>1. The system would be financed primarily by a payroll tax on employers and employees.</li> <li>2. Employers would pay a payroll tax of 8% except that no tax would be levied on the first \$20,000 of aggregate payroll or on individual wage or salary income in excess of \$200,000.</li> <li>3. Employees would pay a payroll tax of 2% except that the first \$10,000 of payroll income would not be subject to tax, and payroll beyond \$200,000 would be exempt.</li> <li>4. Self-employed people with income in excess of 150% of the federal poverty level would pay 8% on income between 150% and 250% of FPL and 10% on income between 250% of FPL and \$200,000.</li> <li>5. Non-employed people with income in excess of 150% of the federal poverty level would pay 8% on income between 150% and 250% of FPL and 10% on income between 250% of FPL and \$200,000.</li> </ol> <p><i>Note that the funding mechanisms proposed for the two state purchasing pool approaches could be interchanged, although the amount of revenue that would have to be raised might differ, and some elements would need alteration (see variation at end of this section). Other funding mechanisms are also possible.</i></p>
<b>Insurance Market Rules</b>	<p>Premiums for other than new residents of the state would be community rated. That is, the basic premium (before the subsidies for those below the median income) would not be risk rated.</p>	<p>Essentially the same, but a risk-adjustment mechanism would be required to compensate insurers enrolling a disproportionate number of higher-risk enrollees.</p>



<b>New residents</b>	<p>Premiums for people newly moving to the state with incomes in excess of 150% of FPL would be risk-rated, that is, medically underwritten based on age and prior medical conditions for a period of 5 years after they establish residency, after which time they would be covered as other residents. The maximum premium would be no higher than 200 percent of the statewide community rate. The minimum premium would be the state average rate. No subsidies would be available until the person had been a resident for 5 years (except for those with incomes below 150% of FPL). As an alternative to being covered under the Delaware Health Protection Plan, new residents could choose to retain previous coverage but would be required to show proof of coverage when they file state tax returns. Without proof of coverage, they would be assessed the maximum premium (that is, 200% of the state average rate) for every month they lacked other coverage; the assessment would be due when state income taxes are due.</p>	Same
<b>Administration</b>	<p>The state could choose to contract with one or more insurance carriers to administer the Delaware Health Protection Plan.</p>	<p>The state would administer the pool; the plans would administer the plan for people choosing their plan.</p>
<b>Cost control</b>	<p>The Health Care Commission would set a global budget and would then have responsibility (but could delegate parts of the task) for negotiating payment rates with providers that would be consistent with that budget. In redefining the benefits package each year, they would need to consider affordability.</p>	<p>The Health Care Commission would have responsibility for negotiating contracts with health plans so that at least one major health plan offered coverage at no cost to enrollees and so that the total cost for all enrollees was no more than the revenue collected through the payroll tax. The Commission might be required to alter the benefit structure to ensure that no-cost coverage is available.</p> <p>Health plans could be expected to compete vigorously for enrollees, which would be expected to provide cost discipline as well.</p>
<b>Variations</b>	<p>The funding for this approach could be a payroll tax instead of premiums and general revenues, or premiums could be combined with payroll tax instead of general revenues.</p>	<p>Adapting the funding mechanism for the single-payer approach to the multiple payer approach could substantially reduce the cost to the state budget of this multiple payer approach. One way to do this would be to require people to pay premiums scaled to income, as with the single payer financing. The subsidies in the system would be financing by a payroll tax. However, any premiums paid by employers and employees would count as a credit against their payroll tax obligation. It would probably be desirable to allow the credit to be refundable.</p>

## DETAILED ASSESSMENT OF SINGLE STATE POOL APPROACHES

Coverage	
<b>People covered</b>	This approach would achieve universal coverage. Access to care would obviously be improved for people who now lack coverage and for those who are “underinsured.” Financial barriers would be removed, but some people still might still face other barriers in getting access to care from high-quality providers. Problems related to portability of care caused by job changes or other changes in life circumstances would be eliminated. Except when people move from one area to another, continuity of care would be greatly improved because people could maintain provider relationship because they would not have to change health plans.
<b>Benefit package</b>	The standard benefit package would be comprehensive but not as comprehensive as some now in force. However, people and employers could purchase more comprehensive coverage at their own expense.
<b>Quality/effect on delivery system</b>	Implementation would not, by itself, have an obvious effect on the nature of delivery system or on quality. However, under the single payer approach, the state would have access to encounter data for virtually all care provided to the non-elderly. This could be a valuable tool for profiling practice patterns and identifying low quality care. Similar data could be made available under the multiple-payer option, but the state would have to require health plans to adopt standard data collection methods and release the data to the state.
Cost and Efficiency	
<b>Cost</b>	<p><b>Resource cost</b> refers to the value of the new additional labor and medical technology resources that are consumed as a result of the coverage expansion. Uninsured people now consume some care, but they would consume substantially more when insured and thus use more medical resources (but, of course, that is the intention). Because the health of the population would improve, some real savings would be realized in the form of greater worker productivity and lowered social service costs.</p> <p><i>Single payer option.</i> Substantial resource savings should be realized. Because the state would assume administrative responsibility for the standard benefit package (replacing insurers), many administrative inefficiencies due to duplication of functions by insurers and associated diseconomies of small scale should be reduced. There would be much less need for coordination of benefits, determination of eligibility, etc. However, because health plans would continue to sell supplemental coverage, administrative costs of each health plan would continue, but these costs would not be reflected in the cost of the standard benefit plan.</p> <p><i>Multiple payer option.</i> Some administrative savings would be realized because the pool would realize economies of scale in collecting premiums, providing plan information to citizens, etc. On the other hand, administering the risk-adjustment mechanism would involve some new administrative costs.</p> <p><b>Governmental budgetary cost</b></p> <p><i>Note that the funding mechanisms proposed for the two state purchasing pool approaches could be interchanged, although the amount of revenue that would need to be raised might differ and some elements would need alteration. Other funding mechanisms are also possible (see variations in previous section).</i></p> <p><i>Single payer.</i> The budgetary cost to state government is relatively high. The state would pay to subsidize premiums for those between 150% of the federal poverty level and the median income. Some of these new state dollars would go to subsidize people who are already insured, and thus some state dollars would be replacing dollars now paid by employers or individuals. In addition, the state would pay 50% of the costs for the substantial number of people newly</p>

	<p>covered under Medicaid. The state would realize some offsetting savings because it would no longer need to subsidize safety net systems that serve the uninsured. The new costs would be funded through general revenue, but the proposal does not include any specific new funding mechanism. New tax revenue would be required.</p> <p><i>Multiple payer.</i> The budgetary cost for this approach would be higher than for the single payer approach (as proposed) because in addition to paying 50% of the cost of people newly covered by Medicaid, the state would guarantee that everyone else could enroll in at least one health plan at no cost to the enrollee, that is, without paying a premium. Thus the cost is borne by the state. However, this approach includes a new funding mechanism to pay all of these costs—the employer/employee payroll tax. Although this would put “on budget” many costs that were previously private costs, the revenue would come from employers and employees, who would have offsetting reductions in health insurance premium payments.</p>
<p><b>Cost containment</b></p>	<p><i>Single payer.</i> Because the state is the only payer, it would have substantial power in negotiating with medical providers to keep costs down. It could require various cost containment mechanisms to be put in place, influence the rate at which new technology is introduced, and set provider payment rates (as Medicare does at the federal level). The fact that increases in medical costs would normally require an increase in premiums and in tax revenues would help to impose discipline on the state as it determines what cost increases to permit. On the other hand, state authorities would likely find it politically difficult to limit introduction of new technologies or place other restrictions on utilization to such an extent that access in Delaware differed substantially from that in other states. If provider reimbursement rates were appreciably lower than those in other states, recruiting and retaining providers could be a problem.</p> <p><i>Multiple payer.</i> The state would presumably not administer provider payment rates, but it could negotiate with health plans to ensure reasonable premium levels. It would have a de-facto budget cap, set by the amount of expenditures generated from payroll taxes. This would be a constraint that the state would always have to consider in establishing the standard benefit package and in negotiating with health plans. Insurers would be in direct head-to-head competition with one another for customers in a situation where <i>each enrolled individual</i> could every year make a decision to change health plans during open enrollment. As a result, insurers would have strong incentives to keep costs down, since the state would pay the full cost for only the least expensive plan, with individual enrollees paying any difference for choosing more expensive plans.</p>
<p><b>Implementation and administration</b></p>	<p><i>Single Payer</i></p> <p>Initially, this approach would involve major administrative changes. For the non-low-income population, the state would become the only insurer, which would require the state to perform functions it now does for state employees for all the state’s non-Medicare population. In effect, it would be similar to having the state employees’ health plan serve the whole population. Administering the carve-out program for people newly moving to the state would require a process for risk rating them, separately collecting premiums, and tracking them for five years.</p> <p>This approach would obviously represent a major departure from the status quo. Insurers’ role would be limited to selling supplemental coverage policies, and the agents and others involved in the sale and marketing of health coverage would face major role changes. Employers would no longer have responsibility for providing health coverage. Their influence on the system in terms of helping to contain costs and promote higher quality would be largely eliminated.</p> <p>Negotiating with CMS and OMB to get approval for the expansion and alteration of Medicaid coverage could be difficult.</p> <p>Once the system for administering the new system was in place, many aspects could be expected to continue to operate smoothly. But the state would annually be involved in negoti-</p>

	<p>ating reimbursement rates with providers and restructuring the benefit package when necessary. Keeping costs under control would likely involve difficult and contentious decisions. The state would have to balance the need to ensure access to high-quality, up-to-date services with the need to keep cost within the budget. The public would rightly expect state government to be accountable for ensuring that the delivery system is efficient and that the quality of care is high.</p> <p><i>Multiple Payer</i></p> <p>The state would be responsible for establishing the purchasing pool through which most of the population would acquire coverage. The functions of the pool would bear some similarity to those now performed by the state employees' health plan; so there is some experience with the issues and tasks, and some of the existing mechanisms could probably be adapted to this new system. Tasks would include ensuring that people had good information so that they could make wise selections among health plans. In addition, the state would have to negotiate with health plans, ensuring that at least one plan would offer coverage at a price that is sufficiently low to be available at no cost to enrollees—a price determined by the constraint of the amount of revenue generated by the new payroll taxes. The state would have to decide whether to contract with “all willing insurers” or whether to limit the number of insurers, ensuring them a larger market share in exchange for lower prices. The state would be newly collecting payroll taxes from employers and employees, which would require some new administrative and enforcement machinery. Implementing the risk-adjustment mechanism would involve a number of important decisions and tasks.</p> <p>This approach would represent a substantial departure from the status quo, though significantly less than for the single payer approach. Employers would no longer have responsibility for providing health coverage. Their influence on the system in terms of helping to contain costs and promote higher quality would be largely eliminated. At least some insurers would continue to provide coverage for the majority of the public but through the single purchasing pool. This would involve some significant changes in functions and personnel, particularly since the standard plan would be sold on a community-rated basis only.</p> <p>Negotiating with CMS AND OMB to get approval for the expansion and alteration of Medicaid coverage could be difficult.</p>
<b>Equity</b>	
<b>Access to coverage/subsidies</b>	Under this approach all legal residents would be covered, so everyone would have essentially the same financial access to (covered) services.
<b>Financing of costs</b>	<p>Under both variations of this approach, people in equal circumstances are treated equally (a condition known as “horizontal equity”). People at the same income levels have equal access to subsidized coverage, and they pay equal amounts toward the financing of coverage. Thus both approach are consistent with achieving horizontal equity.</p> <p>Under the single payer approach people would pay premiums that would increase with income up to the median income and thereafter the full premium, an approach that is consistent with the ability-to-pay principle of vertical equity. The remainder of financing would come from general revenues, which are generated from financing sources that have a progressive incidence and is thus also consistent with the vertical equity principle.</p> <p>Under the multiple-payer approach financing is based on payroll taxes, with employers paying 8% and employees 2%, and similar rates apply to self-employed and non-employed people above 150% of the federal poverty level. Economists generally agree that, at least in the long</p>

	run, employees bear essentially the full cost of payroll taxes in the form of lower money wages. <sup>11</sup> Thus the tax can be thought of as a proportional tax over the range of income to which it applies: every employee pays the same proportion of the taxable income toward the tax. But because the tax would not apply to the initial \$10,000 of individual income and to the first \$20,000 of a firm's payroll from being taxed, the tax is somewhat progressive up to \$200,000 of wage income, after which the tax does not apply—a provision which makes the tax more regressive than otherwise. But the overall impact of that exclusion is very slight, since only a very small proportion of employees have wage earnings above \$200,000. Overall, this approach is consistent with vertical equity principles.
<b>Sharing of risks</b>	Both of these approaches would produce very broad sharing of risk. Other than for people newly moving to the state, no one's contribution is in any way dependent on health status or any other risk-related characteristic. The risk is shared by everyone who pays for the system, essentially all the population above 150% of the poverty level.
<b>Choice/Autonomy</b>	
<b>Choice of providers and health plans</b>	<p>Under the single payer approach, there would be no choice of health plans: everyone would be in the single state plan. However, people could choose to supplement their standard coverage by buying coverage for additional services from any of the insurers choosing to participate in this market. Choice of providers, however, would be completely unlimited.</p> <p>Under the multiple payer plan, people could choose any of the plans under contract to the state. Choice of providers would generally be very broad. If some of the plans were HMOs or PPOs, choice of providers for people choosing those plans would be somewhat more limited, but this is the case now for people in such plans.</p>
<b>Provider autonomy</b>	<p>Under the single payer approach, providers would face greater restraints than they do now with respect to their ability to influence their fees. Payment rates would be established through negotiation with the state, which, as the only buyer, would have great bargaining power. Clinical autonomy would not necessarily be restricted in any way, but if the state determined that the need to control costs required implementing policies to constrain utilization or limit technology in some ways, clinical autonomy could be lessened.</p> <p>Under the multiple payer approach, physician fees and other provider payments rates would be determined essentially as they are now: the health plans offering coverage through the state pool would have incentives to try to bargain to get favorable prices for the services for which they pay providers. Provider autonomy would also likely not change.</p>
<b>Government compulsion/regulation</b>	<p>By most people's standards, the single payer approach embodies substantial compulsion. Everyone is automatically covered, but they are required to pay for coverage—by paying premiums and paying taxes that go to the general fund to cover subsidies. In essence, this amounts to an individual mandate to buy coverage. People with relatively low health risks (and the employers that hire them) could no longer gain any financial advantage by paying lower premiums. The bulk of health insurers business would be replaced by the state plan. Some insurers and associated businesses would be forced out of business. Government oversight and monitoring of health care financing and the quality of care would replace private oversight and monitoring. As the single buyer of health care for the non-elderly, state government would potentially have great market power, although unlike a private buyer, the state's authority would always be subject to the check of the state's elected representatives.</p> <p>The multiple payer approach involves lesser but still substantial compulsion. Everyone would be required to have coverage and pay for it in one way or another. High-income employees</p>

<sup>11</sup> The reasoning is that, in making employment decisions, employers look at *total* compensation costs. If it just pays to hire a worker at a given wage, and the employer now has to pay a new payroll tax, to continue to hire such a worker, the employer would have to lower money wages by the same amount the payroll tax increased to make continued employment of the worker profitable for the firm.

	<p>and the employers who hire them would pay more for health coverage than they do now because the payroll tax is likely to be a substantially higher percentage of wages than what they currently pay for health coverage (although this is moderated by the fact that individual would pay no tax on income over \$200,000). Insurers would be required to offer coverage through the state plan as the only buyer, to offer the standard plan, to community rate, and to participate in the risk-adjustment mechanism.</p>
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# EMPLOYER PLAY OR PAY MANDATE

## Summary of Plan Elements

- Employers would be required to pay a fee, including a 20% portion collected from employees, which the state would use to finance coverage for people not covered by an employer-sponsored plan.
- The state would operate a pool which would contract with a number of insurers to offer a standard benefit package.
- The state would waive the fee for employers who provide and pay for 80% of the costs of employee plus dependent coverage. Low-wage, low-profit employers would receive a declining subsidy for five years to help pay for coverage.
- People with incomes below 150% of the poverty level would be covered by Medicaid; non-employed people would be required to purchase coverage through the pool, with premiums graduated by income.
- The only policy that insurers could sell would be one that covered the standard benefit package and required employers to pay 80% of employee and dependent coverage; they could also offer separately priced supplemental benefits coverage.

## Summary of Assessment

- Nearly everyone would be covered, with adequate benefits, but coverage sources are fragmented.
- Portability would be somewhat better than currently, but only for those continuously covered through the state pool.
- Substantially higher real resource costs would be incurred because most people now uninsured would be covered and would use more health care. There would be little reduction in system-wide administrative costs and substantial new administrative functions for the state.
- Additional state government funding requirements would be relatively small, because fees levied on employers and employees would pay costs of those in the state pool. Employer-sponsored plans would cover others now uninsured, and these costs would be "off-budget."
- Equity would be improved because of more nearly equal treatment of people in equal circumstances. Financing through employers is somewhat regressive.
- There would be some potential for better cost control through direct competition among insurers.
- Broader sharing of risk would be achieved.
- There would be greater choice of health plans for individuals in the state pool.
- Compulsion would be substantially increased because employers and individuals would be required to pay for health coverage, but disruption of the status quo would otherwise be only modest.

## DETAILS OF THE “PLAY OF PAY” EMPLOYER MANDATE ELEMENTS

<p>This approach requires employers either to pay a fee to a new state purchasing pool, which would provide coverage for their employees and dependents, or to provide such coverage themselves. (It is designed to be neutral with respect to whether employers should be encouraged to use the pool.) Individuals with incomes above 150% of the poverty level who are not employed would be required to buy coverage through the pool, with premiums graduated by income.</p>	
<p><b>The Pool</b></p>	<p>The state would establish the Delaware Health Insurance Pool, which would provide coverage to all persons not covered by employers, Medicare, or Medicaid.</p> <p>The pool would negotiate contracts with health insurers to provide a standard benefit package on a community-rated, guaranteed-issue basis, and participating individuals could choose from any plan offered through the pool.</p> <p>The standard benefit package would be established by the Health Care Commission based on an analysis of the typical plan bought by small employers.</p> <p>The pool would annually establish a fee equal to the cost of providing the standard benefit package (including all of the pool’s administrative costs) for all eligible residents of the state. All employers (except those getting a waiver by providing their own coverage) would be required to submit this fee to the pool for each employee and dependent. The employer would be required to pay at least 80% of the fee, the employee the remainder. Employers would be required to provide employees with an enrollment form to sign up with any of the plans offered through the pool. Employees who failed to enroll voluntarily would be automatically be assigned by the pool on a random basis to the least costly plan(s) offered through the pool.</p> <p>With the approval of the Health Care Commission, the pool could in subsequent years set the fee at a higher or lower percentage of the statewide average premium rate, after determining how the rate affects the risk profile of people choosing the pay option. The objective is to prevent severe adverse selection against the pool.</p>
<p><b>The Pay Option — Employers Not Offering Their Own Plan</b></p>	<p>All employers not offering coverage (including the self-employed) and their employees would be required to pay a fee to the state pool for each employee and each dependent (as outlined above). Employers would be required to pay a minimum of 80% of the fee; employees would pay the remainder.</p> <p>All employees and dependents of employers choosing this option would be covered by the state pool plan. They could choose any plan offered through the pool. At least one plan would be available at no premium. Individuals choosing more expensive plans would pay the difference out-of-pocket. (Plans could offer additional benefits to make coverage more comprehensive, but these benefits would be separately priced.)</p>
<p><b>The Play Option — Employers Sponsoring Their Own Plan</b></p>	<p>Employers offering a health insurance plan to their employees would have the fee waived. There would be no restrictions on the type of plan that employers must offer [to make the approach more likely to be accepted under ERISA]. However, the kinds of coverage that insurers could offer would be restricted.</p> <p>Insurers would only be permitted to sell coverage that required employers to pay 80% of the premium for the insured and all dependents and that covered the standard benefit package or a benefit package that is actuarially equivalent. Insurers could, however, sell <i>separately priced</i> supplemental coverage that made this benefit package more comprehensive. [This provision ensures</p>



	<p>that employers who buy insurance rather than self-insure provide the standard benefit package. It does not affect employers that self-insure, primarily large employers; but they are likely to provide comprehensive coverage.]</p> <p>Stop-loss insurers would not be permitted to sell coverage to firms employing fewer than 200 workers. [This is to prevent small firms from self-insuring to avoid having to provide the standard benefit package or paying the minimum of 80%. Small firms cannot safely self-insure unless they have stop-loss coverage. This provision, therefore, makes self-insurance very risky for small firms. Of course, they could offer a very limited self-insured plan—for example, one that simply paid for the first \$500 of medical expenses and nothing more. (Whether such a scheme would meet the ERISA definition of a health benefit plan is not yet determined.) But competition for labor might make it difficult for such employers to attract workers of sufficient quality. Nearly all larger firms could be expected to provide reasonably good coverage, since they do so now.]</p>
<b>Subsidies for Low-Profit, Low-Wage Employers</b>	<p>Low-profit employers of low-wage workers—defined as those in which the FTE average wage is less than 150% of the federal minimum wage—would be eligible for subsidies that decline over time to ease the impact of having to pay for health coverage. In the first year in which they are subject to the play or pay requirement, all low-wage, low-profit employers, including those choosing the play option, would receive a subsidy equal to 25% of the fee. The subsidy would decline by 5 percentage points per year, so that after five years, there would be no further subsidy.</p>
<b>Low-Income People</b>	<p>People with incomes below 150% of the federal poverty level would be covered by Medicaid with approximately the same benefits as are currently in force. (Waivers would be required.)</p>
<b>Other People Not Employed</b>	<p>People with incomes in excess of 150% of the federal poverty level who are not employed would be required to purchase coverage through the pool. The premiums would be available on an adjusted community rating basis (<math>\pm 20\%</math> for all factors combined). Premiums would be graduated by income. For those with incomes above the median, the fee and the premium would be equal to the state average premium. It would be zero for those at 150% of FPL, and it would be graduated between those two income levels.</p>
<b>New Residents</b>	<p>People newly moving to the state who are employed would be treated as other employed people. People newly moving to the state who are not employed and have incomes in excess of 150% of FPL would be risk-rated, that is, medically underwritten based on age and prior medical conditions for a period of 5 years after they establish residency, after which time they would be covered as other residents. The maximum premium or fee would be no higher than 200% of the statewide community rate. The minimum premium would be 100% of the state average rate. As an alternative to being covered under the Delaware Health Protection Plan, new residents could choose to retain previous coverage but would be required to show proof of coverage when they file state tax returns. Without proof of coverage, they would be assessed the maximum premium (that is, 200% of the state average rate) for every month they lacked other coverage; the assessment would be due when they file their state income tax.</p>
<b>Financing</b>	<p>The primary source of financing for the pool is the employer/employee fee. However, if the pool experiences significant adverse selection, which is possible, the fee will be inadequate to cover all costs. In addition, the subsidies to low-wage small employers and people newly eligible for Medicaid will have to be financed separately from the fee. In both cases, the source of funds will be state general revenues. [This is a mechanism for spreading the cost of higher-risk people across the whole population.]</p> <p>Some employers choosing the pay option would be paying a fee toward the cost of coverage for some people who would be eligible for and covered by Medicaid. In most instances, the state</p>

	would realize a net revenue gain: the revenue from the fee would exceed any new costs the state incurs, thereby providing a source of funds that could be use to apply to any shortfalls in the pool.
<b>Insurance Market Rules</b>	The small-group market rules would be changed so that the only basis for rate variation would be age and geographic location, and the total variation could not exceed $\pm 20\%$ . {This is so that the pool does not get strong adverse selection in the small-group market. Since all employers are required to offer coverage or pay the fee, there is no danger that low-risk groups would not provide coverage, as there would be now.) A risk adjustment mechanism would be established for insurers participating in the pool to transfer funds from insurers with a disproportionate share of low-risk enrollees to those with a disproportionate share of high-risk enrollees.
<b>Variations</b>	<ul style="list-style-type: none"> <li>• Financing could be a percentage of payroll instead of fixed amount.</li> <li>• Making the fee much higher would cause nearly all employers to choose the play option.</li> <li>• Making the fee substantially lower would cause many employers to choose the public pool, but more public general fund money would be required.</li> </ul>

## “PLAY OR PAY” EMPLOYER MANDATE — DETAILED ASSESSMENT

<b>Coverage</b>	
<b>People covered</b>	<p>This approach would achieve nearly universal coverage, although the coverage is a more fragmented than under some other approaches. Employer and dependents would be covered by either their employers or under the state pool. However, self-insured employers might choose to not contribute to coverage for dependents, and some of their employees might choose not to pay the premium for their dependents. The approach as described does not address how part-time and seasonal workers would be included. Non-employed people would be required to purchase coverage through the pool.</p> <p>Many employers that now offer coverage more comprehensive than the standard plan would likely choose the “play” option and offer the same coverage. Non-employed people are subject to an individual mandate to buy coverage through the pool. Access to care would obviously be improved for people who now lack coverage and for those who are “underinsured.” Financial barriers would be removed, but some people still might still face other barriers in getting access to care from high-quality providers. Problems related to portability and continuity of care caused by job changes or other changes in life circumstances would be greatly reduced for people covered through the pool but not for those in plans offered by employers.</p>
<b>Benefit package</b>	<p>The standard benefit package would be comprehensive but not as comprehensive as some now in force. However, people and employers could purchase more comprehensive coverage at their own expense. People covered by self-insured employers might have different coverage, but larger employers generally offer comprehensive benefits.</p>
<b>Quality/effect on delivery system</b>	<p>Nothing in the approach, by itself, is likely to affect quality of care or the delivery system. If a large proportion of employers choose the “pay” option, the state would have a large market share and perhaps leverage to negotiate changes to improve quality and efficiency.</p>
<b>Cost and Efficiency</b>	
<b>Cost</b>	<p><b>Resource cost</b> refers to the value of the new additional labor and medical technology resources that are consumed as a result of the coverage expansion. Uninsured people now consume some care, but they would consume substantially more when insured and thus use more medical resources (but, of course, that is the intention). Because the health of the population would improve, some real savings would be realized in the form of greater worker productivity and lowered social service costs.</p> <p>If a large proportion of employers choose the “pay” option, so that much of the population was in the state pool, some administrative economies might be realized.</p> <p>The resource costs associated with administration are likely to be higher than for the single payer or even multiple plan because much of current administrative duplication and inefficiencies inherent in a system with many insurers would likely continue.</p> <p><b>Governmental budgetary cost</b></p> <p>Because the cost of coverage for many newly covered people would be paid by those employers that decide to “play” and provide coverage themselves, this aspect of coverage expansion of coverage is achieved without any additional budgetary cost to the state. The state would incur new costs to provide coverage for people whose employers decide to “pay” and for the temporary subsidies to low-profit, low-wage employers. But much, perhaps all, of the cost would be offset by the fee assessed on employers who choose the pay option. To fully fund the costs of the pay option, the fee would have to be set high enough to pay for the</p>

	<p>benefits available under the state plan for enrollees of average risk and, second, to cover any adverse selection the state pool might experience. It is probable that a disproportionate number of employers who choose to pay rather than play will be employers whose employees are older or of above-average risk, since it will often be cheaper for them to pay the fee than to buy coverage in the regular insurance market. If the state-provided pool experiences some adverse selection, the state will have to subsidize the cost of the adverse selection with new dollars, and then it will have to decide whether to collect those dollars through the fee or fund them from general revenues. (The higher the fee, the fewer the number of employers who will choose the pay option; but a higher proportion of those choosing that option will be higher-risk employers.)</p> <p>The state would pay 50% of the costs for the substantial number of people newly covered under Medicaid.</p> <p><i>Labor force effects.</i> Employers not now providing coverage will experience an initial labor cost increase under either the “play” or “pay” options. However, economists generally believe that in the longer run these costs will be passed back to employees in the form of reduced wages or cuts in other benefits. Total compensation costs for most employers would, thus, be little affected in the long run. Most employers, even in the short run, would not be likely to lay off significant numbers of workers as a result of the change in labor costs. This might not be true, however, for employers paying at or near the minimum wage. By law, they cannot pass back the costs to employees in the form of reduced money wages, so the increased labor costs might force some to hire fewer workers, laying off some of the employees that produce the least revenue for the firm per hour of work, that is, low-wage workers, such as teenagers. If over time the costs of coverage increase more rapidly than worker productivity, as has typically happened, this effect could persist over a number of years. To put this in perspective, the effect should be similar to an increase in the minimum wage (phased in over several years for small employers). Past experience suggests that no major labor disruptions are likely.</p> <p><i>Sustainability.</i> The revenue source for coverage provided through the state pool would not grow automatically (as a payroll tax-based funding source would). Assuming that medical costs continue to rise, the Commission would have to decide whether to increase the fee, cut benefits, or initiate cost-containment strategies. All of these might provoke unfavorable reaction.</p>
<p><b>Cost containment</b></p>	<p>This approach does not inherently introduce any new cost containment tools. Competition among insurers might be strengthened if a high proportion of the state’s population were to be covered in the state purchasing pool, since each year every covered individual could choose to switch to another health plan. In addition, the state would have considerable leverage in bargaining with health plans as it establishes contract provisions each year.</p>
<p><b>Implementation and administration</b></p>	<p><i>For the state,</i> initial implementation will require making a series of relatively complex administrative decisions and taking on new functions, especially around setting up and administering the state pool. A separate system will have to be established for non-employed people, who are covered under a separate arrangement, and that will involve some complexities (although that function could be outsourced to an insurer). The state will also have to negotiate contracts with insurers each year and initiate and administer a risk-adjustment mechanism.</p> <p><i>Employers</i> not now providing coverage who choose the pay option should experience minor administrative costs: they will simply pay the fee to the state. Employers choosing to newly cover their employees will experience the administrative costs of arranging for coverage, determining eligibility, paying premiums, etc.—all of the administration associated with offering health coverage. However, any employers who find this too burdensome can opt instead just to pay the fee.</p> <p>Negotiating with CMS AND OMB to get approval for the expansion and alteration of Medicaid coverage could be difficult.</p>

	<p>Overall, implementing this approach would not cause major disruption of the status quo.</p> <p><b>Locus of control/accountability for ensuring efficiency and quality.</b> For the most part, this approach leaves accountability for efficiency and quality essentially as it is with the status quo. Employers could still seek to promote efficiency and quality by working with health plans to promote these ends, as many do now. The state pool could use its leverage with participating health plans to achieve these ends as well. But no great changes from the status quo would be expected.</p>
<b>Equity</b>	
<b>Access to coverage/subsidies</b>	Under this approach nearly all legal residents would be covered and would have essentially the same financial access to (covered) services.
<b>Financing of costs</b>	Most economists agree that employer payments for health coverage, whether paid for through employer contributions or fees collected by the state, are ultimately paid for by employees in the form of reduced money wages. If employers think of the amount they pay for coverage (whether through the pay or the play option) as a more-or-less fixed amount per employee (as seems likely), then this is a regressive form of financing: people at low wage levels bear the same absolute burden as people at higher wage levels. But, of course, this is the situation currently with employer-based coverage.
<b>Sharing of risks</b>	This employment-based approach promotes broad sharing of risk, so that lower-risk people subsidize higher-risk people. Large employers who provide coverage spread risk automatically, since higher-risk employees pay no more than lower-risk employees for coverage. People covered through the pool would be community rated, since the amount paid for their coverage (from the employer and employee fee) would not in any way be related to their health status or other risk characteristics. Small employers choosing the play could pay premiums that vary by $\pm 20\%$ , a substantially smaller variation than now permitted. Non-employed people buying coverage in the pool could also face rates that vary by the same percentage, very substantially less than is now the case; currently individuals with poor health status can even be denied coverage altogether.
<b>Choice/Autonomy</b>	
<b>Choice of providers and health plans</b>	For people in the state pool, choice of health plans would likely be greater than now, since everyone could each year choose any plan participating in the pool. For people employed by employers that choose the play option, choice is similar to the status quo: employers could choose any health plan, just as they do now, which would allow workers to choose providers to the same extent they do now.
<b>Provider autonomy</b>	No change from the status quo would be expected.
<b>Government compulsion/regulation</b>	This approach involves substantial compulsion for employers that do not now offer coverage, since they would be required to pay a fee or to buy coverage for their employees and for non-employed people who do not now have coverage. Many employers who already offer good health coverage would be little affected, since their present coverage would meet the requirement. A significant exception could be the requirement that employer pay 80% of the premium for <i>dependents</i> ; substantial numbers of employers do not pay as much of the premium for dependent coverage as for employees.

# **BUILDING BLOCKS APPROACH**

## **Summary of Plan Elements**

- Make Medicaid and SCHIP a single program, covering everyone up to 200% of the poverty level, and wherever possible, making enrollment automatic.
- Establish a state purchasing pool for small employers and individuals that offers multiple insurers.
- Put greater restrictions on insurers' ability to set premiums based on risk in both small-group and individual markets.
- Allow young adults to continue coverage under their parents' health plan.
- Offer tax credits, graduated by income, to subsidize cost of coverage for high-risk individuals and for people with incomes between 200% and 300% of the poverty level.
- Finance state subsidies from general revenues.

## **Summary of Assessment**

- Substantially more people would be covered, but coverage sources would remain fragmented, though somewhat less than now.
- Portability would be somewhat better than currently for those now covered by Medicaid and SCHIP, which becomes one program with one set of eligibility requirements, and for those continuously covered through the state pool.
- Real resource costs would be significantly higher because many people now uninsured would be covered and would use more health care. There would be little reduction in system-wide administrative costs, and some new administrative functions for the state.
- Substantial new state government funding would be required to cover those newly eligible for the Medicaid replacement program and those receiving tax credits.
- Equity would be improved because there would be more nearly equal treatment of people in equal circumstances. New financing comes from general revenues and is thus modestly progressive.
- No new cost containment tools would be introduced, although if the state purchasing pool were to enroll large numbers of people, it would have some bargaining power with health plans.
- Risk sharing would be somewhat broadened because of more limitations on insurers' ability to use risk rating in the small-group and individual markets.
- People in the state pool would have expanded choice of health plans.
- The approach involves very little government compulsion or new regulation.

## DETAILS OF THE BUILDING BLOCK APPROACH ELEMENTS

<p>Under this approach the state would combine a build-out and consolidation of Medicaid and S-CHIP with the establishment of a statewide health insurance pool for small employers. Subsidies (via tax credits or vouchers) would be provided for people with incomes too high for Medicaid and S-CHIP but too low to afford coverage. This strategy is modeled along the lines of initiatives undertaken in states such as Minnesota, Washington, Maine, and Rhode Island, with elements from other states and proposals.</p>	
<p><b>Public program expansion and simplification</b></p>	<p>Delaware would consolidate Medicaid for low-income families and S-CHIP into a single program called FirstCare. Whenever possible, state officials would maximize receipt of federal funding at enhanced S-CHIP levels (for example, by increasing S-CHIP coverage to higher age levels), but all distinctions between Medicaid and S-CHIP would be invisible to beneficiaries. FirstCare would cover all state residents up to 200 percent of the FPL.</p>
<p><b>Automatic enrollment</b></p>	<p>The state would work toward universal coverage for children by automatically enrolling uninsured children, when they start school, in either FirstCare or the purchasing pool, described below. The state would also use presumptive eligibility,<sup>2</sup> continuous eligibility, and increased out-stationing of enrollment workers. To the extent possible, applications for FirstCare would be incorporated into applications for other assistance, including unemployment insurance, fuel assistance, subsidized child care, Section 8, WIC, etc.</p>
<p><b>Insurance Reforms and Purchasing Pool</b></p>	<p>The state rating rules would be changed to stipulate that rate variation in the small-group market could not vary by more than <math>\pm 40\%</math> for all factors combined; rating based on health risk or prior medical condition would be prohibited. Insurers could offer lower rates through the state purchasing pool, but rates outside the pool could not be lower than inside the pool.</p> <p>Insurers doing business in Delaware would be required to continue to include young adults up to age 25 in their families' health plan (regardless of whether they have completed their education).</p> <p>The state would establish a purchasing pool to serve small employers and individuals without another source of coverage. The purchasing pool would negotiate with health plans to get the best price possible for several standard benefit packages.</p> <p>Small employers (under 50 employees) could offer coverage through the pool. Individual employees, not their employer, would determine which plan they wished to enroll in, choosing from those offered through the pool.</p> <p>Individuals not covered through an employer could choose to buy coverage through the pool, but they would be medically underwritten. The maximum premium would be 250% of the average premium in the pool, but the premium would vary based on income. The premium could not exceed 7.5% of income, with the state subsidizing the difference. Tax credits would cover any excess of the 7.5% of income.</p>
<p><b>Tax Credits</b></p>	<p>Delaware would establish a fully refundable, advanceable health insurance tax credit (or a voucher) to pay a percentage of premiums for individuals with incomes between 200 percent and 300 percent of FPL. Individuals would establish eligibility for subsidies by applying to the same agencies that determine eligibility for FirstCare. The subsidy would be greatest for the lowest-income recipients. If possible, the state would maximize receipt of federal matching funds for such credits, through Medicaid and S-CHIP waivers. FirstCredits could be used either to help pay the worker's share of employer-based coverage or for insurance available through the Purchasing</p>

<sup>2</sup> This allows the state to enroll a lower-income person presumed to be eligible for a public program right away, and then verify eligibility later.

	Pool.
<b>Financing</b>	Delaware would use general revenues to cover operating costs of the HealthCoverage Pool and the state's share of expanded coverage through FirstCare and FirstCredits.
<b>Variations</b>	<p>If they work as intended, the above mechanisms would give every state resident access to comprehensive, affordable health coverage. These policies could be coupled with a substantial state income tax penalty that would apply to any state resident who could not show on their tax return that they had health insurance during the tax year in question. That would accomplish three goals: moving closer to universal coverage; providing new revenue to help fund program costs; and increasing enrollment of low-risk individuals into the HealthCoverage Pool.</p> <p>Risk-rating could be reduced by state-purchased reinsurance for the highest-cost Pool enrollees.</p> <p>Rather than establish two subsidy systems – FirstCare and FirstCredits – and a Purchasing Pool, FirstCare could cover state residents with incomes up to 300 percent FPL, with sliding scale premiums charged for households with incomes between 200 and 300 percent FPL. Under that configuration, FirstCare would contract with a number of health plans, furnishing supplemental benefits for the lowest-income enrollees, consistent with current Medicaid and S-CHIP rules. Small employers could buy into FirstCare, giving their workers access to the plans contracting with the state. Individuals with access to employer-based coverage could use their FirstCare subsidy to pay the worker share of premiums for employer coverage; above 200 percent FPL, such individuals would have to enroll in employer-based coverage, rather than a FirstCare plan.</p>



## BUILDING BLOCKS DETAILED ASSESSMENT USING CRITERIA

Coverage	
<b>People covered</b>	This approach would expand coverage significantly by making it more affordable for people who now find it unaffordable. Low-income, childless adults would be newly eligible for the Medicaid replacement program, and modest-income people would receive subsidies to help make private coverage affordable. But the approach would not achieve universal coverage because there is no mandate that anyone purchase coverage. Some people eligible for subsidized programs would not enroll, despite increased efforts to facilitate enrollment, and some higher-income people would choose not to buy coverage. Because there would be multiple coverage sources, some people would fall through the cracks during life transitions. Portability would likely not be much different from the status quo except it would improve for people below 200% of the poverty level.
<b>Benefit package</b>	Coverage benefits would vary essentially as they do now, since the system is voluntary.
<b>Quality/effect on delivery system</b>	Nothing in the approach, by itself, is likely to have a major impact on quality of care or the delivery system.
Cost and Efficiency	
<b>Cost</b>	<p><b>Resource cost</b> refers to the value of the new additional labor and medical technology resources that are consumed as a result of the coverage expansion. Uninsured people now consume some care, but they would consume substantially more when insured and thus use more medical resources (but, of course, that is the intention). The real resource cost would be significant because many, but not all, people now uninsured would have coverage. Because the health of the population would improve, some real savings would be realized in the form of greater worker productivity and lowered social service costs.</p> <p>This approach would reduce administrative the complexity of the system that covers people with incomes below 200% of the poverty level—certainly a benefit for those eligible for the coverage. The administrative costs attributable to a multi-payer system would remain. The state would assume new administrative functions to operate the purchasing pool and to implement the voucher program, but the administrative burden should be quite modest.</p> <p><b>State budgetary costs</b> would increase appreciably because the Medicaid/SCHIP replacement program would cover substantially more people, and the state would have to pay its portion of the state-federal match, and because the state would have to fund the full costs of the credit/vouchers for people between 200% and 300% of the poverty level and subsidize premiums for individuals buying coverage through the pool for whom the cost would exceed 7.5% of income.</p> <p>The cost of these programs is likely to increase more rapidly than general revenue sources over time.</p>
<b>Cost containment</b>	This approach does not introduce any new cost containment tools, although if the state purchasing pool were to enroll large numbers of people, it would have some bargaining power with health plans, as if now true for large employers.

<b>Implementation and administration</b>	<p>Combining the Medicaid and SCHIP programs would require substantial effort, and the state would have to establish a purchasing pool and negotiate with insurers annually and set up a system for administering tax credits. Initiating these programs would involve substantial work, and many difficult issues would have to be addressed. Once the programs were underway, the administrative burdens should be modest.</p> <p>Negotiating with CMS AND OMB to get approval for the expansion and alteration of Medicaid coverage could be difficult.</p> <p>Overall, implementing this approach would cause little disruption of the status quo. Changes in insurance rating rules would affect insurers.</p> <p>For the most part, this approach leaves accountability for efficiency and quality essentially as it is with the status quo.</p>
<b>Equity</b>	
<b>Access to coverage/subsidies</b>	<p>The present system fares poorly when measured by the standard of equal treatment of equals, especially because low-income childless adults are not eligible for subsidized coverage. This approach would eliminate that inequity. Since access to other subsidies would vary by income, the burden of paying for coverage would be much more closely related to households' ability to pay for coverage.</p>
<b>Financing of costs</b>	<p>The subsidies included in the approach would be funded by general revenues, a somewhat progressive tax source, so that collection of revenue is consistent with the ability-to-pay principle.</p>
<b>Sharing of risks</b>	<p>This approach broadens risk compared to the status quo but incorporate less broad risk sharing than some other approaches. Insurers would be substantially more limited than now in their ability to charge premiums to small employers based on the risk profile of their employees, but the state would not move to full community rating. People buying individual coverage would still be risk rated, but the maximum premium would be limited to 250% of the average (which means the system functions as a high-risk pool), and the total premium cost to the household could not be more than 7.5% of income.</p>
<b>Choice/Autonomy</b>	
<b>Choice of providers and health plans</b>	<p>For people in the state pool, choice of health plans would likely be greater than now, since everyone could each year choose any plan participating in the pool. For others, the choice of plan and providers would remain essentially as now.</p>
<b>Provider autonomy</b>	<p>No change from the status quo would be expected.</p>
<b>Government compulsion/regulation</b>	<p>This approach involves little government compulsion or regulation, apart from greater restrictions on insurers' ability to rate based on risk and a requirement to allow people up to age 25 to be covered under their parents' health plan. There are no mandates for either employers or individuals to buy coverage.</p>