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PRESIDENT'S "AFFORDABLE CHOICES" INITIATIVE PROVIDES LITTLE SUPPORT FOR STATE EFFORTS TO EXPAND HEALTH COVERAGE

By Judith Solomon

The large and growing number of Americans without health care coverage is increasingly a focus of attention, especially at the state level.¹ A number of states are now considering proposals to expand coverage, and several states have already adopted such plans. The federal government has an important role to play in these efforts. Comprehensive plans to cover the uninsured adopted in Maine, Massachusetts, and Vermont — as well as plans being considered in states like California and Pennsylvania — all rely on federal funds to help finance subsidies for low-income, uninsured residents who cannot afford health care coverage on their own.²

In January 2007, the Bush Administration announced a two-part health initiative. The first part would alter the tax treatment of employer-sponsored health insurance and also create a standard deduction for health insurance costs. The second part of the initiative, named "Affordable Choices," attempts to respond

KEY FINDINGS

- The Administration's Affordable Choices initiative provides states with no new funds to help cover the uninsured; it simply redirects existing federal funds that now go to safety-net health-care providers who care for the uninsured.
- Many states currently receive only small amounts of federal funds for safety-net providers and thus would have few funds to redirect.
- Even states that do have significant funds that could be redirected still would not be able to cover all of their uninsured residents; the funds won't stretch that far. The result would be that many people remain uninsured, even as safety-net providers (such as public hospitals) were deprived of support they need to care for these patients.
- By allowing states to use redirected funds only to provide "basic" private coverage — and barring the use of these funds to expand coverage through public health insurance programs — the Affordable Choices proposal would deny states the flexibility to design their coverage initiatives to best meet their residents' needs.

¹ See, for example, Julie Appleby, "Who's uninsured in 2007? It's more than just the poor," *USA Today*, March 15, 2007; Robert Pear, "Without Health Benefits, a Good Life Turns Fragile," *The New York Times*, March 5, 2007.

² Alice Burton, Isabel Friedenzohn, and Enrique Martinez-Vidal, "State Strategies to Expand Health Insurance Coverage: Trends and Lessons for Policymakers," The Commonwealth Fund, January 2007; Marilyn W. Serafini, "The States Step Up," *National Journal*, March 17, 2007.

to the states' call for federal support to help them expand coverage to low-income uninsured individuals.³

Affordable Choices, however, falls well short in responding to states' need for federal assistance. Under the Administration's proposed initiative, states would receive *no new federal funds*. The Administration's plan simply offers states the option of diverting federal funds currently being used to help support hospitals providing care to the uninsured. States would be allowed to convert these funds to subsidies that uninsured people could use to help pay for "basic private coverage."

States would have limited flexibility in deciding *how* to expand insurance coverage. These funds could be used only for coverage in the private insurance market, primarily the individual health insurance market that is unfriendly territory for people not in good health. States would not be permitted to use the funds in whole or in part to expand coverage through public health insurance programs, or even to allow uninsured individuals to "buy into" those programs.

The Affordable Choices initiative has serious shortcomings. These shortcomings are illustrated by an examination of how the Administration has responded to efforts by the state of Louisiana to expand health care coverage and reform that state's system of delivering health care to low-income people.

The Administration's Proposal

Affordable Choices would allow states to fund private coverage for uninsured residents by redirecting federal Medicaid "disproportionate share hospital" (DSH) payments.⁴ DSH payments,

Affordable Choices Would Provide Little Help to States with Low DSH Allotments

Although DSH payments help support hospitals that care for the uninsured and for Medicaid beneficiaries, the amount of a state's DSH allotments does *not* depend on the extent to which a state's population is uninsured or enrolled in Medicaid. DSH allotments are based instead primarily on the amount of a state's DSH payment in 1997, when Congress placed a ceiling on DSH allocations. As a result, DSH allotments vary sharply — and irrationally — across states.

For example, New Hampshire, where 6.5 percent of 1.3 million state residents lack health insurance, has a fiscal year 2007 DSH allotment of roughly *\$151 million*. But New Mexico, where 19 percent of 1.9 million residents are uninsured, has an allotment of only *\$16.5 million*, or about one-ninth the size of New Hampshire's. Seven states account for more than half of federal DSH payments.

Affordable Choices will be of little or no help to many states that have low DSH allotments.

³ See White House fact sheet, "Affordable, Accessible, and Flexible Health Coverage," at <http://www.whitehouse.gov/stateoftheunion/2007/initiatives/healthcare.html>

⁴ Hospitals also receive DSH payments from Medicare. The Administration has described Affordable Choices as redirecting "institutional subsidies" and has not clearly stated whether *Medicare* DSH payments or any other federal funds would be available to states, in addition to Medicaid DSH payments.

which support hospitals that care for large numbers of uninsured patients and Medicaid beneficiaries,⁵ are the largest source of federal support for uncompensated care for uninsured patients.⁶

According to the Administration, diverting DSH funds would allow individuals to “own their own health plan.” States would be permitted to use the funds to:

- help low-income or “hard-to-insure” populations purchase private health insurance;
- establish high-risk pools or use existing high-risk pools⁷ “for very sick individuals who are deemed uninsurable in the non-group market”; or
- help pool individuals and small businesses and “organize their access to private health plans.”⁸

The Administration projects that its health care proposal as a whole — both the tax proposal and Affordable Choices — would provide health coverage to about 4 to 5 million of the estimated 45 million who are uninsured. Administration officials have said that 3 million people would become insured through the tax proposal, with the remainder gaining coverage through Affordable Choices.⁹

Louisiana May Provide a Guide to How Affordable Choices Would Work

Affordable Choices poses some risks for states. That this is the case can be seen by looking at the Administration’s approach to health care reform in Louisiana.

Since July 2006, the U.S. Department of Health and Human Services (HHS) has been working with Louisiana to develop a plan to expand coverage for children and adults, as well as to redesign the health care delivery system in New Orleans and surrounding areas affected by Hurricane Katrina. A 40-member collaborative initially recommended that the state expand Medicaid and SCHIP coverage to provide beneficiaries with coordinated and comprehensive care. HHS, however, refused to accept that approach. In the final plan it submitted to HHS, the collaborative bowed to pressure from HHS and agreed to provide individuals with vouchers or other types of subsidies to purchase private health insurance.¹⁰

After receiving Louisiana’s concept paper, HHS provided the state with a financial model for the state’s review. Consistent with Affordable Choices, the HHS model would provide an estimated 319,000 uninsured individuals with private insurance and pay for it by redirecting the DSH funds

⁵ Andy Schneider, *The Medicaid Resource Book*, Kaiser Commission on Medicaid and the Uninsured, July 2002.

⁶ Jack Hadley and John Holahan, “How Much Medical Care Do the Uninsured Use, and Who Pays for It?” *Health Affairs*, web exclusive, February 2003.

⁷ High risk pools are generally non-profit associations created by states to provide coverage to people who cannot get coverage in the private market because they have a health problem. They are often funded by assessments on insurers.

⁸ White House fact sheet.

⁹ Transcript, White House News Briefing on President Bush’s State of the Union Health Care Initiative, January 22, 2007.

¹⁰ Jan Moller, “Deal to revamp health care in N.O. stalls,” *The Times Picayune*, October 3, 2006.

currently used to support safety net hospitals and health clinics, as well as by using some savings derived from better management of Louisiana's Medicaid program.¹¹

The HHS proposal for the plan's financing is quite problematic, and the state has not agreed to it. The HHS proposal would provide only enough funding to cover *half* of the state's uninsured, while eliminating *all* of the federal funding for the health-care safety net that provides care for the uninsured.¹² Some 300,000-400,000 Louisiana residents would remain without health care coverage under the HHS proposal. Yet the state would be left without federal funds to help support the health-care providers that still would have to care for these people.

Aggravating the problem, HHS's assumptions on the costs of providing coverage to the uninsured are significantly below Louisiana's estimates. The difference is attributable in part to the fact that HHS failed to factor in the state's estimate that 17 percent of the childless adults who would be covered under the expansion have a chronic illness or disability.¹³ (Since more than half of uninsured Americans are childless adults, reaching this group is especially important for states seeking to shrink the ranks of the uninsured.¹⁴)

This difference in cost estimates is particularly important, because Louisiana would bear *all* of the risk if health care costs under the plan prove higher than HHS has estimated. HHS is requiring that the final plan be budget neutral to the federal government. If the costs of providing coverage to childless adults turn out to be greater than HHS estimated or if health care costs for Medicaid beneficiaries rise more quickly than anticipated, the state will have to fill the gap entirely with state funds (or cut eligibility, benefits, or provider payments to lower costs).¹⁵

Diverting Payments from Safety Net Providers Would Likely Leave Them With Insufficient Support to Care for the Uninsured

The example of Louisiana shows that even in a state with a DSH allotment large enough to provide coverage to a sizeable number of uninsured individuals, Affordable Choices would not eliminate the need for payments to safety-net health care providers. *Louisiana has the fourth-largest allotment of DSH funds in the country, yet those funds would be sufficient to cover only half of the state's uninsured.*

¹¹ Testimony of Frederick P. Cerise, M.D., M.P.H., Secretary, Louisiana Department of Health and Hospitals, House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, March 13, 2007.

¹² Letter from Secretary Cerise to Louisiana Health Care Collaborative, March 2007. Secretary Cerise called the HHS model a "trade" that would redirect "the funds that support access points of care across the state for the uninsured population for an insurance product for less than 50 percent of those uninsured."

¹³ *Ibid.*

¹⁴ John Holahan, Allison Cook, and Lisa Dubay, "Characteristics of the Uninsured: Who Is Eligible for Public Coverage and Who Needs Help Affording Coverage?" Kaiser Commission on Medicaid and the Uninsured, February 2007. States cannot provide Medicaid coverage to childless adults, including the poorest of such adults, unless they secure a federal waiver.

¹⁵ In a Section 1115 waiver, a state agrees to a cap on the federal funds it will receive during the five-year waiver period. The cap is an estimate of the amount the state would have received from the federal government in the absence of the waiver. In Louisiana, the cap proposed by HHS was based on its estimate of the amount that the state would spend on beneficiaries eligible for Medicaid under regular rules, plus most of the state's DSH allotment. The state would have to cover childless adults within this overall budget cap.

Administration Also Proposing to Reduce Federal Funding For Public Hospitals, Which Would Worsen Their Funding Squeeze

In January 2007, the Centers for Medicare and Medicaid Services (CMS) published proposed regulations that would change the way states pay public providers in the Medicaid program. The rules would reduce federal Medicaid funding provided to the states by \$3.8 billion over five years.

The most significant change that the regulations would make is to limit payments to public hospitals to the hospitals' actual cost in providing Medicaid services. Under the current rule, states can make payments to public hospitals that are larger than the hospitals' costs in treating Medicaid patients, as long as the total Medicaid payments that a state makes to all public hospitals do not result in payments greater than what Medicare would have paid for the same services. This enables states to help defray costs that public hospitals incur in serving the uninsured, as well as to support needed investments in health technology. Because public hospitals serve a lower percentage of private-pay and Medicare patients than *private* hospitals do, they are less able to cover the costs of serving the uninsured through reimbursements from private insurers and Medicare.

The proposed regulations would adversely affect public hospitals that serve the uninsured in two ways. First, the amount of Medicaid funding that states could provide to such hospitals would be reduced. Second, federal funding would be cut off altogether for certain useful arrangements that states employ to help cover the costs of uncompensated care. Some states such as California, Florida, and Massachusetts have Medicaid waivers that allow them to use the additional Medicaid payments they are allowed to make to fund pools that help pay the cost of uncompensated care for the uninsured. Under the proposed regulations, these types of arrangements would no longer be allowed, even though the use of these funds to subsidize coverage for the uninsured would appear to be consistent with the Administration's Affordable Choices proposal.

The proposed regulations would thereby exacerbate the funding problems that safety-net providers could experience under the Affordable Choices initiative and leave them even less able to provide care for people who remain uninsured.

Source: National Association of Public Hospitals and Health Systems, Final Comments on CMS-2258-P, Medicaid Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership.

While increasing health coverage for the uninsured should reduce the need for uncompensated care payments over time, the need for these payments will not be entirely eliminated as long as some people remain uninsured or underinsured.

The health reform plan adopted by Massachusetts, in contrast to the HHS plan for Louisiana, strikes a careful balance between providing ongoing support to safety-net health care providers and providing subsidies to cover the uninsured. Under a Section 1115 waiver agreement with the federal government, Massachusetts has established a Safety Net Care Pool that makes \$1.34 billion in state and federal funds available each year for a combination of subsidies for insurance coverage, provider-rate increases, and payments to safety-net health care providers. The plan takes into account the need for a transition period in which payments for uncompensated care are gradually reduced as the number of people with health coverage increases. Between fiscal years 2007 and 2009, the amount budgeted for payments to providers for uncompensated care declines from \$610

million to \$320 million to reflect the expected decline in number of uninsured; during this same period, subsidies for coverage are slated to increase from \$160 million to \$725 million.¹⁶

Even with near-universal coverage, however, the Massachusetts plan recognizes that safety-net health care providers will still need support to care for individuals who either are uninsured or whose insurance does not cover all of the care they need.

Coverage Provided Through Affordable Choices Is Likely to Be Inadequate or Inaccessible For Many

Under the Affordable Choices initiative, states would provide uninsured individuals with funds to purchase what the Administration terms “basic private coverage.” States could also establish high-risk pools for “hard-to-insure” individuals.¹⁷ Like other parts of the Administration’s strategy for increasing access to health insurance, Affordable Choices favors the unregulated health insurance market, with a preference for individual rather than group coverage.¹⁸

In all but three states, some Medicaid beneficiaries are already enrolled in private managed care organizations that contract with the state.¹⁹ Moreover, research has found that Medicaid coverage is substantially less expensive than private health insurance.²⁰ Yet under Affordable Choices the Administration would not approve a state plan to cover more of the uninsured by expanding Medicaid, including Medicaid managed care. Instead, states would have to provide vouchers or other payments that individuals would use to purchase private health insurance coverage (or to help pay for employer-sponsored coverage, where it is available.²¹)

¹⁶ “The MassHealth Waiver: An Update,” Massachusetts Medicaid Policy Institute, September 2006. Funds from the Safety Net Care Pool are also designated for rate increases for providers and supplemental payments to Medicaid managed care organizations.

¹⁷ Katherine Baicker, a member of President Bush’s Council of Economic Advisers, has said that as an alternative to high-risk pools, states could provide “health status adjusted payments” to individuals with chronic health conditions to allow them to pay higher prices for insurance.
http://www.allhealth.org/briefingmaterials/031907_expansion_transcript-630.pdf

¹⁸ Besides Affordable Choices and the tax proposal, the Administration’s strategy includes expanded use of Health Savings Accounts (HSAs) and high-deductible health plans, as well as of Association Health Plans (AHPs), which would roll back state regulation of insurance. For a discussion of the problems with HSAs and AHPs, see Edwin Park, “Informing the Debate About Health Savings Accounts: An Examination of Some Misunderstood Issues,” Center on Budget and Policy Priorities, June 13, 2006; Mila Kofman and Karen Pollitz, “Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change,” Georgetown University Health Policy Institute, April 2006.

¹⁹ In 2004, 60 percent of Medicaid beneficiaries were enrolled in managed care organizations. Centers for Medicare and Medicaid Services, Medicaid Managed Care Overview at <http://www.cms.hhs.gov/MedicaidManagCare/>.

²⁰ Jack Hadley and John Holahan, “Is Health Care Spending Higher under Medicaid or Private Insurance?” *Inquiry*, 40 (2003/2004): 323-42.

²¹ A number of states already have premium assistance programs, which provide individuals and families eligible for Medicaid with subsidies to purchase employer-sponsored insurance. To date, these programs have had limited enrollment. Brendan Krause, “Helping the Working Poor Buy Insurance: Addressing Barriers to Premium Assistance,” NGA Center for Best Practices, September 28, 2006; Joan Alker, “Premium Assistance Programs: How Are They Financed and Do States Save Money?” Kaiser Commission on Medicaid and the Uninsured, October 2005.

What Kind of Coverage Would Affordable Choices Provide?

The model that HHS provided to Louisiana suggests that coverage under Affordable Choices could be both inadequate and unaffordable for many low-income people.

Under the HHS plan for Louisiana, individuals aged 19 to 64 who have income below 200 percent of the poverty line could choose from four plans, with varying premiums and cost-sharing. The premiums are not specified, but each plan has high cost-sharing, a \$500,000 cap on lifetime benefits, and a \$100,000 cap on annual benefits. Before receiving any coverage, participants would have to satisfy annual deductibles ranging from \$1,000 to \$5,000. After satisfying the deductible, participants would still have significant costs, as all of the plans would pay *only 75 percent* of the cost for most health care services. Moreover, some services would not be covered at all, such as treatment of mental health problems or substance abuse, dental care, or eye exams.

The combination of premiums, a high deductible, steep cost-sharing on the services that are covered, and the exclusion of important services means many low-income people would likely continue to go without a number of necessary health care services if offered this type of plan. A large body of research shows that even relatively low premiums result in a sharp decrease in participation in health coverage by low-income individuals. In addition, cost-sharing has been shown to cause low-income people to delay or reduce their use of health care services and to result in poorer health outcomes among low-income individuals who are not in good health.

Source: "Health Coverage for Low-Income Americans: An Evidence-Based Approach to Public Policy," Kaiser Commission on Medicaid and the Uninsured, November 2006.

The Administration contends that its proposal to allow a standard deduction for health insurance, combined with Affordable Choices, would bring down the price of individual coverage, making it more affordable and available to those with health problems. The idea is that a larger market for individual coverage would spur competition among insurers and make it less likely that they would reject people for coverage based on their health conditions.

Many leading analysts, however, dispute this view. They believe that the Administration's tax proposal could encourage a substantial number of (primarily smaller) employers to drop health coverage or not to offer it in the first place, and thereby drive more people into the unregulated individual insurance market that would likely continue to exclude (or to charge exorbitant premiums to) individuals in poorer health. Those who could not obtain or afford coverage in the individual market would end up uninsured.²²

Regardless of the impact of the Administration's tax proposal on the individual market, the tax proposal has not been enacted and is unlikely to advance in the current Congress. Yet the

²² Karen Davis, "The 2007 State of the Union Address: The President's Health Insurance Proposal is Not a Solution," The Commonwealth Fund, February 2007; Len Burman, Jason Furman, and Roberton Williams, "The President's Health Insurance Proposal — A First Look," Tax Policy Center, January 23, 2007. The Congressional Budget Office (CBO) estimates that the Administration's standard deduction for health insurance would cause the number of Americans covered through employer-sponsored insurance to decline by 7.8 million, with 1.5 million of these individuals becoming uninsured. Overall, CBO estimates that the President's proposal would reduce the number of uninsured people by 6.8 million. Congressional Budget Office, "An Analysis of the President's Budgetary Proposals for Fiscal Year 2008," March 2007.

Administration is still proceeding with its Affordable Choices plan, under which individuals would use diverted DSH funds to purchase coverage in the individual market *as that market exists today*.

With the limited funds that Affordable Choices would make available for redirection in most states, states generally would not be able to provide low-income uninsured individuals with sufficient assistance to buy affordable, comprehensive coverage in the individual market. This would especially be true for individuals who have health conditions. It thus is likely that individuals would generally secure coverage that provides limited and inadequate benefits and carries high cost-sharing requirements. Moreover, the Administration has said that funding for Affordable Choices would depend on a state's willingness to relax provisions in the state's insurance laws that require insurers to provide coverage for certain health benefits and treatments.²³

For example, Louisiana sought to expand coverage to childless adults with incomes below 200 percent of the poverty line (\$20,420 per year for one person). In its proposal back to the state, HHS allotted a monthly payment of just \$157 (or \$1,884 on an annualized basis) for private coverage for each of these adults, an amount far below what would be needed to purchase comprehensive coverage.

A recent analysis examined the affordability of private coverage for individuals at different income levels. Because estimates of the cost of coverage in the individual market are difficult to obtain, the analysis used 2004 national data on the cost of insurance in the small group market for employers with less than ten workers. For an individual policy, the cost of coverage averaged \$3,998 per year in 2004. That is more than double the \$1,884 per year allocated by HHS for coverage in Louisiana in 2007.²⁴

The problem with the HHS approach is even more evident when the health status of the low-income population is considered. Roughly 12 percent of uninsured childless adults with income below 300 percent of the poverty line report that their health is fair or poor.²⁵ These individuals would have significant difficulty obtaining affordable coverage in the individual market. Most states allow insurers to turn down people with health problems.²⁶ Often people with even minor health conditions are only able to obtain coverage that excludes treatment of their existing health conditions, which are usually the conditions for which they sought coverage in the first place.²⁷

Affordable Choices assumes that states would cover individuals with health problems through high-risk pools or special "health status adjusted payments." That is not likely to be an adequate solution. A 2002 study of 30 states operating high-risk pools found that the pools mirrored the problems of the individual market:

²³ White House fact sheet.

²⁴ Lisa Dubay, John Holahan, and Allison Cook, "The Uninsured and the Affordability of Health Insurance Coverage," *Health Affairs*, web exclusive, November 30, 2006.

²⁵ Holahan, Cook and Dubay.

²⁶ Kofman and Pollitz.

²⁷ Karen Pollitz and Richard Sorian, "Ensuring Health Security: Is the Individual Market Ready for Prime Time?" *Health Affairs*, web exclusive, October 2002.

- All of the high-risk pools had waiting periods for coverage of preexisting conditions.
- All charged a higher premium than the standard market rate for comparable coverage and varied the premium for age and other factors.
- Nearly all required substantial cost-sharing, including deductibles, coinsurance, or co-payments.
- Most imposed separate limits or additional cost-sharing for mental health care, and in ten of the 30 states, the pools also significantly limited coverage for maternity care.²⁸

Similarly, providing “health status adjusted payments” to people with health problems is not likely to work. Given the limited funds that would be available to states, it is highly unlikely that states could provide individuals in poor health with payments sufficient to enable them to purchase insurance in the individual market that provides the benefits they need.

Conclusion

The Administration’s Affordable Choices initiative would provide no new federal resources to expand coverage among the uninsured; it would merely divert federal funds that currently go to safety-net health care providers. The initiative would provide little help to states that currently receive limited federal funds for this purpose.

In addition, the experience of Louisiana shows that even in states with higher DSH allocations, the Administration’s approach would leave many state residents uninsured, would provide inadequate coverage to many who do obtain insurance, and would leave safety-net health care providers without the necessary support to provide care to people who remain uninsured or are underinsured. Furthermore, by requiring states that participate in the initiative to expand coverage primarily through the highly problematic individual market, the Administration’s proposal would deny states the flexibility to design coverage initiatives that best meet their needs.

²⁸ Deborah Chollet, “Expanding Individual Health Insurance Coverage: Are High-Risk Pools the Answer?” *Health Affairs*, Web Exclusive, October 2002.