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HEALTH INSURANCE SUBSIDY CONCEPT PAPER

PREPARED FOR ROSE COMMUNITY FOUNDATION

ARPEGIOHEALTH

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EXECUTIVE SUMMARY

Rose Community Foundation engaged ArpegioHealth, LLC to study the concept of providing financial assistance (i.e. subsidies) to lower-income individuals to help them obtain health care coverage. Several states, including Colorado, are considering implementing large-scale health insurance premium subsidy programs as a way to increase health care coverage for their residents. In Colorado, targeted subsidy programs already exist and may provide policymakers and others with valuable insight into how these programs benefit certain populations and could be a model for similar efforts in other communities or more expansive programs.

This study was intended to be broad and open ended, investigating known options and newly identified programs. ArpegioHealth evaluated options as they were identified using a variety of criteria. Prominent issues included administrative costs, development time, replicability and sustainability. ArpegioHealth identified several programs that represent a variety of models of subsidy programs. The list is not exhaustive; however, these are all established programs with some level of existing infrastructure. The programs include:

- Child Health Plan Plus (CHP+) at Work;
- Ryan White Insurance;
- CoverColorado;
- Three-Share; and
- The Micro Business Development Corporation, Mi Casa and the Kaiser Connections program.

The main finding of this report is that while there are significant issues to address in implementing a premium subsidy program, there are effective programs already established in Colorado that can be models for similar or more expansive programs that help make health insurance more affordable for participants. The approach of assessing the use of established programs with existing infrastructures as one step in developing and evaluating health care reform efforts also has potential for other states and nationally in implementing model programs.

STATEMENT OF THE PROBLEM

BACKGROUND

Health insurance plays a significant role in our society. Of the nearly 293 million Americans, 85% have health insurance coverage and of those individuals, nearly 64% have employer-sponsored insurance. However, nearly 45 million Americans (15%) are uninsured.[1] Of the 4.5 million people living in Colorado, almost 780,000 (17%) are uninsured.[2] Since 2000, the percentage of insured Coloradans has significantly declined[3] and nationally, all growth in the number of uninsured between 2000 and 2004 was related to adults:[4]

- 50% - adults under 100% FPL
- 20% - adults 100-199% FPL
- 24% - adults over 200% FPL

Contributing to uninsurance rates, both nationally and locally, is the increasing cost of health insurance - the main reason people give for being uninsured. Between 1996 and 2003, Colorado's family premiums increased 102% compared to 87% nationally.[5] In 2006, health insurance premiums grew twice as fast as wages and inflation.[6] Rather than paying for the increased cost of health insurance:

- more small businesses are choosing not to offer coverage; and
- more Americans are choosing to be uninsured.

On average, Coloradans who work for small employers pay 32.7% toward the cost of family coverage versus those who work for large employers who pay 26.1%.[7] In 2003-2004, employees in small- and mid-sized companies were nearly twice as likely to be uninsured as those who worked for large employers.[8] Employer-based coverage is increasingly threatened. Between 2001 and 2005, coverage for the middle class dropped from 82.4% to 78.5% nationally.[9] Since 2000, Colorado has been witnessing a significant decline in the number of small group carriers available (34%).[10]

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1 Kaiser Family Foundation. (2005) *Health Insurance Coverage of the Total Population, states (2004-2005), U.S. (2005).* Accessed June 13, 2007 at: http://www.statehealthfacts.org.

2 Colorado Health Institute. (November, 2006) *Profile of the Uninsured in Colorado, An Update for 2005.*

3 Colorado Health Institute. (November, 2006) *Profile of the Uninsured in Colorado, An Update for 2005.*

4 Kaiser Commission on Medicaid and the Uninsured. (January, 2007) *Health Care: Squeezing the Middle Class with More Costs and Less Coverage.*

5 Colorado Health Institute. (February, 2007) *Health Care Vision 2007 and Beyond: Colorado's Health Care Marketplace.*

6 Kaiser Commission on Medicaid and the Uninsured. (January, 2007) *Health Care: Squeezing the Middle Class with More Costs and Less Coverage.*

7 US Department of Health and Human Services, Agency for Healthcare Research and Quality. *Table II.D.3.(2004) Percent of total premiums contributed by employees enrolled in family coverage at private-sector establishments that offer health insurance by firm size and State: United States, 2004.*

8 Colorado Health Institute. (February, 2007) *Health Care Vision 2007 and Beyond: Colorado's Health Care Marketplace.*

9 Kaiser Commission on Medicaid and the Uninsured. (January, 2007) *Health Care: Squeezing the Middle Class with More Costs and Less Coverage.*

10 Colorado Health Institute. (November, 2006) *Profile of the Uninsured in Colorado, An Update for 2005.*

Families of workers who choose not to enroll in employer-sponsored insurance:[11]

- represent a substantial share of the uninsured and publicly-insured population;
- are more likely to report poor health;
- are more likely to face high expenditure burdens as a percentage of income; and
- are more likely to have financial barriers to care.

Absent employer-based coverage, the options for the uninsured are to remain uninsured, attempt to obtain coverage through a limited set of publicly financed programs or to purchase health insurance in the individual market, where they often find:

- higher deductibles;
- pre-existing condition limitations; and
- general coverage limitations for maternity or mental health.

Lower-income families have little leeway in their budget for health expenditures. Demos, a Network for Ideas and Action, a non-partisan public policy research and advocacy organization, commissioned a national household survey to better understand medical expenses as a component of credit card debt. The survey consisted of 1,150 phone interviews with low and middle income families whose income fell between 50 percent and 120 percent of local median income. The study found that low- and middle-income families are turning to credit cards to pay medical bills. Twenty percent of the individuals surveyed reported having a major medical expense in the past 3 years that contributed to credit card debt.[12] And, when medical bills go unpaid, many health care providers shift the cost onto those who can pay – those individuals with health insurance.

Cost shifting is a hidden tax that Coloradans already pay. The hidden tax on families with health insurance today for covering the uninsured is $355 per year for each covered individual and $934 per year for each covered family.[13] On average, 10-11% of our health care premiums are to cover the uninsured. These dollars are currently used inefficiently – to pay for treatment of preventable disease for emergency room visits when a visit to a doctor would suffice.[14]

Since low-income people are at a higher risk of being uninsured, financial assistance is often necessary for them to obtain health insurance coverage.[15]

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[11] Bernard DM, Selden TM. Division of Modeling and Simulation, Center for Financing, Access and Cost Trends, Agency for Healthcare Research and Quality. (2006) *Workers who decline employment-related health insurance.* Med Care. 2006 May; 44(5 Suppl):I12-8.

[12] Demos – A Network for Ideas and Action. (January, 2007) *Borrowing to Stay Healthy: How Credit Card Debt is Related to Medical Expenses.*

[13] Families USA. (June, 2005) *Paying a Premium: The Added Cost of Care for the Uninsured.*

[14] Families USA. (June, 2005) *Paying a Premium: The Added Cost of Care for the Uninsured.*

[15] Institute of Medicine. (January, 2004) *Insuring America's Health: Principles and Recommendations.*

Health Care Reform

As states are attempting a new round of health care reforms in 2007, insuring all citizens has become a more cogent issue. While Massachusetts, California and Vermont are leading the way at implementing comprehensive health care reform proposals, Colorado has convened a Blue Ribbon Commission on Health Care Reform to study and recommend health care reform models for expanding coverage. One avenue that states have looked to in health care reform is premium assistance programs. These programs typically coordinate public and private health insurance to maximize the use of both employer and public funds to insure as many workers as possible. It has the further advantage of insuring whole families, as opposed to children in the public programs. There is a substantial body of research that shows that more people access both health insurance and health care when families (especially mothers and children) can receive care consistently through a coordinated system and medical home.

However, there are a number of barriers that have impeded the growth of these programs, including:

- regulatory requirements;
- lack of information about employer-sponsored plans/eligible employees to predict enrollment; and
- perceived large amount of money necessary to make coverage available.

In Colorado, several targeted subsidy models exist and provide policymakers and others with lessons for how a similar or more expansive premium subsidy program might operate and some of the potential benefits and challenges of different approaches. The approach of assessing the use of established programs with existing infrastructures as one step in developing and evaluating health care reform efforts also has potential for other states and nationally in implementing model programs.

POSSIBLE GOALS OF A HEALTH INSURANCE SUBSIDY PROGRAM

In order to evaluate whether an existing subsidy program can be a model for a similar or more expansive premium subsidy program, it is important to review the programs using certain criteria. For example, the following should be considered:

- *ease of implementation*: This includes such factors as development time, whether existing administrative infrastructure already exists, the need for legislative and/or regulatory changes, etc.
- *sustainability*: This refers to whether the program has a predictable and sustainable source of funding, and has the potential to leverage additional funding streams.
- *applicability*: Is the model able to provide coverage to the population that is being targeted, and how many people could be assisted?
- *affordability*: Is the program designed in a way—through subsidy levels, benefit coverage and leveraging of various funding streams—to make coverage affordable?

EXAMPLES OF SUBSIDY PROGRAMS IN COLORADO

There are several existing models either operating in Colorado or in development that use premium subsidies as a means to increase health care coverage. These include:

- Child Health Plan Plus (CHP+) at Work;
- Ryan White Insurance Program;
- CoverColorado;
- Three-Share; and
- Micro Business Development Corporation.

While these programs share common goals and employ premium subsidies to help achieve those goals, they are organized differently, target different populations and use different approaches to achieve their objectives.

All, however, provide policymakers and the public who are interested in replicating a premium subsidy model in their respective community or expanding the model to affect more people, with important lessons and information.

The following sections describe different premium subsidy models and discuss notable strengths and challenges of each approach.

CHILD HEALTH PLAN PLUS (CHP+) AT WORK

Background

The Colorado Child Health Plan Plus (CHP+) program is a statewide health insurance program for uninsured Colorado children ages 18 and under whose families earn too much to qualify for Medicaid, but cannot afford private insurance. Through a waiver from the federal government, the CHP+ program also provides coverage to pregnant women through their pregnancy and 60 days post-partum. The program is financed with state (35%) and federal funds (65%). Also through a federal waiver, CHP+ has started a "CHP+ at Work" program in which families can leverage the employer contribution toward health insurance with the federal subsidy toward CHP+ to lower their monthly premium. It is predicted, however, that the remaining monthly premium may still be too high for some low-income families to afford. Colorado's CHP+ at Work program currently covers families whose incomes are less than 205% of poverty. That translates to less than $27,384 per year for a family of two and $41,304 for a family of four. Families often report a "cliff-effect" as they move off of public programs - losing eligibility for all programs including child care, food stamps and health insurance. Families with incomes below 205% of the federal poverty level may also not be able to afford their share of their premium if the employer contributes a lower amount toward coverage.

How does the direct subsidy plan work?

In September 2006, the federal government authorized the CHP+ program to provide premium assistance to families with CHP+ eligible children who enroll in their employer-sponsored plan. The CHP+ at Work program pays a direct subsidy to families who enroll in a guardians' employer-sponsored health insurance plan on a per eligible CHP+ child per month basis. The current program design allows for a CHP+ subsidy not to exceed $100 per eligible child per month. Generally, eligibility for the program is limited to individuals who are:[16]

- age 18 and under;
- not eligible for Medicaid;
- living in a family with incomes at or under 205% of the federal poverty level;
- Colorado residents;
- US citizens, refugees or asylees or permanent US residents who have had an Alien Registration number for at least 5 years;
- not covered under any other insurance; and
- eligible for employer-sponsored insurance.

This program does not require any change to the employer's insurance enrollment process – it is a direct subsidy to the family. Through the program, the family sends in a complete application to the CHP+ at Work program, including the employer-sponsored health plan the family is choosing. The

[16] State of Colorado. (2006) *Applicants – Children.* Accessed at http://www.cchp.org/chpweb/mainpage.cfm?pageToLoad=applicants.cfm#q4 on June 8, 2007.

CHP+ at Work program processes the application and determines eligibility for CHP+. Once determined eligible, the family completes the health plan enrollment process through their employer in the usual manner. The CHP+ at Work program verifies employment and employer-sponsored insurance enrollment with the employer.

Once the employer-sponsored insurance is effective, the CHP+ at Work program pays a direct subsidy of up to $100 per eligible child per month to the family depending on the total cost of the family contribution. While CHP+ provides a subsidy for each child, the family may (and usually does) use the subsidy to leverage the employer contribution toward family coverage. For example, if the average family premium is $951.50[17] per month for family coverage and the employer contributes 73%[18] of the family premium, the total cost to the family is $257 per month. If the family has two CHP+ eligible children, then the premium subsidy of $200 ($100 per child) would cover most of the employee contribution and the parents of the eligible children would be insured with minimal additional costs for the family ($57 per month). Obviously, these examples vary widely based on the employer contribution and the number of CHP+ eligible children.

While the CHP+ at Work program is designed to target medium- to large-employers, the CHP+ program piloted the CHP+ at Work program with one employer – Denver Health and Hospital Authority. The pilot began in October, 2006 with an employer-sponsored enrollment effective date of January 1, 2007 that covers more than 60 families. Due to the success of the pilot, the CHP+ at Work program is planning on making the program available statewide on July 1, 2008. This change would expand the program to include all employers of families with eligible children, not just the pilot employer.

What are notable strengths of this approach?

- *Leverages funds resulting in affordable family-based coverage*: The direct subsidy program leverages the employer contribution, employee contribution and public funds to make insurance more affordable for entire families.

- *Model already exists and has plans to expand*: The model is currently being piloted with one employer in the Denver metropolitan area and will be expanded to include all employers of families with eligible children statewide in July 2008.

- *Manageable administrative structure:* As indicated, the model is currently in operation and has eligibility criteria, application and enrollment processes that are not burdensome for participating employers and employees.

- *Standardized Benefits:* The benefits provided to enrollees are consistent across all enrollees within the employer-sponsored product and requires that the employer-sponsored plan provide at least: physician visits; hospital and inpatient services; and age appropriate immunizations.

[17] Families USA. (2005) *Paying a Premium: The Added Cost of Care for the Uninsured.*

[18] US Department of Health and Human Services, Agency for Healthcare Research and Quality. *Table II.D.3(2004) Percent of total premiums contributed by employees enrolled in family coverage at private-sector establishments that offer health insurance by firm size and State: United States, 2004.*

- *Consistent Provider Networks:* Since families are purchasing an insurance policy through an employer, individuals enrolled in the program are offered the same provider networks as other employees who are enrolled in the employer-sponsored product. Additionally, access is not limited to the geographic area that the individual lives in.

What are notable challenges of this approach?

- *Targets Narrow Population*: Only Coloradans who meet specific criteria (e.g., lower-income parents who have access to employer-provided insurance), can qualify for the subsidy program, meaning other populations that have difficulty affording insurance (e.g., lower-income childless adults who do not have access to employer-sponsored health insurance) do not receive assistance.

- *Administrative Barriers:* The CHP+ at Work program is state and federally supported. Any significant changes to the program could require time-consuming legislative and/or regulatory changes at the state and federal levels.

RYAN WHITE INSURANCE PROGRAM

Background

The Colorado Department of Public Health and Environment (CDPHE) operates the Ryan White Insurance Program statewide to provide health insurance subsidies for individuals and families below 400% of the federal poverty level (about $82,000 of annual income for a family of four) who are living with HIV/AIDS. In 2007, there are 150 enrollees receiving health insurance through this program. CDPHE also operates an AIDS Drug Assistance Program that provides AIDS-specific medications to individuals with HIV/AIDS. All Ryan White Programs are designed to be the payer of last resort – meaning that all other sources of payment for services must be exhausted prior to being paid for through Ryan White. The Colorado Ryan White program is funded directly with State General Funds and Tobacco Settlement Funds and through a grant from the US Department of Health and Human Services.

How does the subsidy program work?

There are two levels of premium assistance under the Ryan White Insurance Program:[19]

- level I – Individuals under 185% of the federal poverty level may receive up to $9,000 per year toward the costs of health insurance premiums, co-pays and deductibles; and
- level II – Individuals under 400% of the federal poverty level may receive up to $400 per month toward the costs of health insurance premiums, co-pays and deductibles.

Ryan White Insurance Program subsidies are not paid directly to individuals and health insurance premiums, co-pays or deductibles are not reimbursable to the individual. Health insurance subsidies must be paid directly to employers or insurers and co-pays and deductibles must be paid to the pharmacy on behalf of the eligible individual. To receive a premium subsidy, the pharmaceutical coverage must be creditable and the total cost of the premium must be cost-neutral to the Ryan White AIDS Drug Assistance Program. This means that health insurance subsidies are provided **only if** the cost of the health insurance premium is less than the total cost of the medications that would be paid for the individual under the AIDS Drug Assistance Program.

Generally, eligibility is limited to individuals who:

- live in Colorado;
- have proof of an HIV diagnosis from a doctor or testing facility;
- have incomes less than 400% of the federal poverty level (including asset screening);
- are eligible for health insurance or a COBRA policy that provides affordable prescription coverage; and
- are not enrolled in Medicaid.

[19] Colorado Department of Public Health and Environment. *Ryan White Part B Continuation Program*. Retrieved June 15, 2008 at http://www.cdphe.state.co.us/dc/HIVandSTD/RyanWhite/insurance.html.

Eligibility for the program is determined regionally by different agencies throughout Colorado, including the:

- Boulder County AIDS Project – covers Boulder, Broomfield, Clear Creek and Gilpin counties;
- Colorado AIDS Project – covers Adams, Arapahoe, Denver, Douglas, and Jefferson counties;
- Northern Colorado AIDS Project – covers Larimer, Logan, Morgan, Philips, Sedgwick, Washington, Weld and Yuma counties;
- Southern Colorado AIDS Project – covers Alamosa, Baca, Bent, Chafee, Cheyenne, Conejos, Costilla, Crowley, Custer, El Paso, Elbert, Fremont, Huerfano, Kiowa, Kit Carson, Las Animas, Mineral, Otero, Park, Prowers, Pueblo, Rio Grande, Saguache, and Teller counties; and
- Western Colorado AIDS Project – covers Archuletta, Delta, Eagle, Delores, Garfield, Grand, Gunnison, Hinsdale, Jackson, Lake, La Plata, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel and Summit counties.

Once enrolled, one of the contracted service providers directly pays insurers or employers for the health insurance premium on behalf of the individual and the Colorado Department of Public Health and Environment reimburses the service provider for all premiums paid. Since health insurance benefits are provided through an insurer or an employer-sponsored plan, benefits and benefit design can be differential across those plans. The only benefit requirement is that the pharmaceutical benefit must be creditable and affordable (defined as annual cost of prescriptions less than $9,000 per year[20]).

What are notable strengths to this approach?

- *Provides broad assistance*: Individuals and families up to 400% of the federal poverty level (i.e., about $82,000 in annual income) are eligible for assistance.

What are notable challenges to this approach?

- *Federal funds are not leveraged:* This is a private only option and federal matching funds would not be available for any expansion.

- *Disease Specific:* The eligibility for the Ryan White Insurance Program is limited to those with HIV/AIDS. While this program provides a valuable service in making health insurance coverage more affordable to individuals with HIV/AIDS, it does not have the capability of serving the broader uninsured population.

[20] Todd Grove. Colorado Department of Public Health and Environment. Phone Conversation June 18, 2007.

COVERCOLORADO

Background

CoverColorado is a nonprofit entity created by the State of Colorado in 1990 to provide comprehensive medical insurance for eligible Colorado residents who, because of pre-existing medical conditions, are unable to get full or partial coverage from private insurers. CoverColorado only insures individuals – there is no family coverage option available.

CoverColorado's rate structure is set by a Board of Directors twice a year (a recent legislative change). Currently, the premium is set at 140% of the standard market rate in the individual market based on a survey of the 5 largest insurers in the individual market. Given that the individual market may already be too expensive for many low-income families, a product set at 140% of the individual market rate is priced beyond the resources of low-income individuals.

CoverColorado currently operates a small, privately funded health insurance subsidy program as well as a premium subsidy for low-income applicants. The premium subsidy program is available for individuals earning less than $50,000 as described below.

How does the direct premium subsidy plan work?

CoverColorado offers one official subsidy program. A reduced premium is available to applicants with incomes below $50,000 (and an asset test). There are two income categories for the subsidy, individuals up to $40,000 annual household income or less, adjusted by the reported amount of liquid assets, will receive an equivalent amount of up to 34% discount from the premium rates and individuals with $40,000 to $50,000 annual income as defined above will receive an equivalent amount of up to 20% discount from the premium rates. [21] We project that low-income individuals who purchase CoverColorado at the premium subsidy level have a disease that is severe enough to create a reason to purchase expensive coverage.

CoverColorado also allows objective, independent third parties who will not gain financially in any way from the individual's health insurance, such as parents, grandparents and truly independent foundations, without ties to the health industry, to pay for the health insurance for qualified individuals through electronic funds transfer from their own or a separate bank account. This is not an official subsidy program but has been allowed to accommodate families that want to assist family members with severe illnesses.

[21] CoverColorado letter to Participants, December 1, 2006. www.covercolorado.org

Eligibility for CoverColorado includes the following criteria:

- residency in Colorado for at least 6 months with a HIPAA exception;
- denied coverage for health insurance due to a presumptive medical condition;
- offered coverage for health insurance but has a pre-existing condition exclusion;
- diagnosed with a presumptive medical condition;
- offered health insurance with a premium higher than that in CoverColorado;
- health insurance has been involuntarily terminated;
- federally eligible through HIPAA;
- federally eligible through the Trade Adjustment Assistance Act; or
- transferred from another state's High Risk Pool.

There is a common misperception that to be eligible for CoverColorado, the individual has to have a major chronic or acute illness. These criteria demonstrate that there are a large number of Coloradans eligible for CoverColorado (but perhaps not insured through them) who merely have a pre-existing condition with a rider on their health insurance policy. This could be as benign as allergies or eczema.

There are currently 474 children enrolled in CoverColorado. Their presenting diagnoses are diverse representing everything from critical diseases such as premature infants, cancer, and heart disease to asthma, diabetes, skin conditions and allergies. Children are sometimes enrolled by families because the child's presenting disease is causing the whole family's health insurance premium to be inflated.

The CoverColorado web site allows an interested individual to obtain a rate quote prior to applying. The individual must provide demographic information such as age, sex and address prior to the rate calculation. Since September, 2006, 29,253 individuals have completed the process of obtaining a rate quote but have not applied for coverage. A former Executive Director of CoverColorado believes that a significant portion of these individuals would be eligible for CoverColorado and are not able to obtain adequate health insurance in the individual market. However, since the CoverColorado premium is set at 140% of the market rate, individuals are unable to afford the premiums.

The rates for health insurance for children within CoverColorado are significantly lower than adult rates reflecting the overall healthy status of children. For a $1,500 in-network, $3,000 out of network deductible plan, rates range from $135.32 per month for a non-smoking male aged 20-24 to $888.15 per month for a female smoker aged 60-64. The full rate table is available on the CoverColorado website.[22] Another issue for the premium subsidy program currently offered by CoverColorado is that the applicant is expected to submit the full monthly premium (not at the subsidized rate) at the time of application. The applicant then waits to hear if he/she is eligible for the subsidy. We know from previous research and the CHP+ experience that low-income applicants cannot afford the up-front cost of health insurance, especially without knowing if they will receive a subsidy.

[22] CoverColorado website: www.CoverColorado.org.

What are notable strengths of this approach?

- *Administrative Simplicity:* CoverColorado has an existing individual subsidy that is very simple. The member pays the premium through electronic funds transfer (EFT). The premium subsidy is linked through a computer system to the member and the funds are directly transferred to the health insurer.
- *Existing Structures:* The program's infrastructure exists and would not have to be modified to provide coverage to eligible subscribers if it were to be expanded. This would merely be a premium assistance program for individuals who already meet criteria and are willing to participate in an existing health insurance program including benefits, providers and other operational processes.
- *Leverages various funding sources*: CoverColorado receives public funds, premium contributions from individuals and funding from objective third parties to help make coverage more affordable.

What are notable challenges to this approach?

- *Individual Product:* CoverColorado is only an individual product. It does not offer family coverage and there is no way to combine the CoverColorado product with family coverage the rest of the family might have available through an employer or other public insurance.
- *Targets Narrow Population*: CoverColorado as currently structured does not generally assist healthy individuals who are eligible for private insurance coverage but cannot afford the premiums.

THREE-SHARE

How does the Three-Share plan work?

The Three-Share model is a community-based program designed to increase access to health care coverage. Three-Share is based on the idea that employers, employees and the community should share in the responsibility of purchasing health coverage. This concept places a strong emphasis on using a collaborative approach among community stakeholders to evaluate, plan, educate, implement and pay for a community-based health care plan.

The Three-Share model has its origins in Muskegon County, Michigan. Muskegon's project was initiated in 1994, through a grant from the W.K. Kellogg Foundation. At present, more than 400 small businesses and 1,500 individuals participate in the program, referred to as Access Health,[23] a 501(m) corporation governed by an eight-member community board.[24]

Several other communities around the country subsequently have adopted the Three-Share model, with plans to be implemented in additional areas including Pueblo, Colorado.[25]

Under the Three-Share model, employers, employees and the community share in the cost of obtaining health coverage. In Muskegon County, for example, employers and employees each pay for 30 percent of the cost of the program while the community pays the remaining 40 percent.[26] Pueblo is considering having each stakeholder contribute a third of the cost.[27] In 2003, employers and employees in Muskegon County each paid $46 per month for coverage, while the community share was $62 per month.[28] Members enroll through their employer.

The "community" share can come from multiple entities such as local hospitals, local government and foundations. Conceivably, all of these entities could combine their funding to constitute the community share. Officials in Muskegon County originally considered seeking a coverage subsidy from the Kellogg Foundation, but there were concerns over the uncertainty of grant funding.[29] At present, the community share in Muskegon County comes primarily from Medicaid Disproportionate

[23] Muskegon Community Health Project. *Models that Work: Sharing Our Success With Other Communities*. Retrieved May 15, 2007 from http://www.mchp.org/models.html.
[24] Health Management Associates (2004, September 28), *Community Health Initiative*, 5.
[25] Wood, M. (2007, May 1). Health care crisis target of program. *The Pueblo Chieftain*.
[26] Fronstin, P. and Lee, J. (2005). The Muskegon Access Health "Three-Share" Plan: A Case History. *EBRI Issue Brief, No. 282*, 1.
[27] Adams, C. (2007, May 9). Interview with Dan Meyers. *Pueblo Program Targets Working Uninsure*d. Colorado Matters.
[28] Fronstin, P. and Lee, J. (2005). The Muskegon Access Health "Three-Share" Plan: A Case History. *EBRI Issue Brief, No. 282*, 1.
[29] Ibid., 12.

Share Funds (DSH) that are passed from local hospitals to Access Health,[30] which, incidentally also raises long-term funding concerns.

Under the Three-Share model, the plan can either be designed as health coverage or health insurance. The difference between coverage and insurance can be substantial. Under a traditional insurance model, risk lies with the insurance company (i.e., the insurer assumes the risk for the costs of health care services that are provided under the plan). Under a coverage model, risk for costs of the program can fall on the plan, and/or its members and providers. The coverage model provides more flexibility in designing benefits because it is not subject to state laws that stipulate what type of benefits must be covered under insurance products. The coverage model also avoids state requirements for ensuring financial solvency. Muskegon and Pueblo have both chosen a "coverage" model so they have more flexibility in designing benefits and avoid state-funding requirements for the program.

How Three-Share works for either an individual or an employer:

- eligible **employers** enroll in the program. It is a voluntary program; employers do not need to participate.
- eligible **employees** are enrolled through their employer- although it is still not coverage in a credible insurance plan.
- once enrolled, individuals have access to local physician services, in-patient hospitalization, outpatient services, emergency services, behavioral health, prescription drugs (formulary), diagnostic lab and x-rays, home health and hospice care. This is an important distinction: they have access to care, not to benefits.
- all members need to choose a primary care physician who coordinates all of the individual's health care needs, including providing referrals to specialists and community-based services.

The emphasis of Three-Share programs is on wellness and prevention through personal responsibility. Enrollees are required to select a primary care physician and have an office visit within a set time period. Moreover, the plan can deny certain services if the member has not followed recommended treatments or made required lifestyle changes to improve their health (additional program flexibility that might not be possible under a traditional insurance plan).

As previously mentioned, the benefits members receive in Muskegon County include primary care and preventive services, specialty services, inpatient and outpatient hospital services, emergency and ambulance services, behavioral health, diagnostic lab and x-rays, home health, hospice care and prescription drugs (formulary). However, it also has important exclusions such as dental and vision coverage. The benefit packages are also designed to complement, not duplicate, those services already provided by existing programs (e.g., Breast & Cervical Cancer Screening Program). Health care services are provided only within the county in which the plan was formed. Services rendered outside of the county, including emergency services, are not covered.[31] Case management services are also provided.

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[30] Ibid., 13.

[31] Health Management Associates (2004, September 28), *Community Health Initiative*, 5

Three-Share programs are typically targeted toward low-income workers in small businesses that do not currently offer health insurance. For example, Pueblo's program targets workers earning about $12 an hour, at an employer with no more than 25 people that currently does not offer health insurance to its employees.[32] There are also criteria (e.g., hours worked, uninsured and not eligible for other public programs) that employees and dependents must meet in order to be eligible for the program.

What are notable strengths of this approach?

- *Provides affordable coverage*: Employees have access to affordable health coverage. In Muskegon County, for example, the employee share is about $50 per month. Moreover, the program has experienced a slow rate of cost growth that is significantly less than the increase for health insurance.
- *Leverages funds from various sources*: Employer, employees, and the community (comprised of several sources) all contribute to Three-Share programs.
- *The Three-Share Model Already Exists*: Although there would be implementation issues as described below, replicating or initiating an expanded Three-Share program would benefit from having the experience of existing models and Colorado-specific expertise of those involved in efforts to help develop a new program in Pueblo.
- *Significant Participation from the Physician Community*: Ninety-seven percent of physicians in Muskegon County participate in Access Health so participants could expect to have sufficient access to physicians within the defined geographic area of the program.
- *Flexibility*: If defined as 'coverage' and not 'insurance', the program is not subject to state mandates and solvency requirements. As it relates to the former, you can design benefit packages with more flexibility.
- *Community-based*: The local community is involved and has a stake in the success of the program.
- *Emphasis on Prevention, Wellness and Medical Home*: Programs typically focus on health, not just health care.

What are notable challenges to this approach?

- *Sustainability*: The community share has typically relied on funding sources for long-term sustainability that could be precarious, such as Disproportionate Share Funding.
- *Coverage Has Geographic Limitations*: Coverage is typically limited to certain geographic areas and provider networks (i.e., an individual only has coverage for benefits in the geographic area that he or she resides in). This presents access issues for those who have medical issues that require attention outside of where they live if this program is limited to a specific community.

[32] Wood, M. (2007, May 1). Health care crisis target of program. *The Pueblo Chieftain*.

- *Fairness Issue*: Typically only employers that have not offered coverage are eligible. Employers that have been offering coverage might object to this policy.

- *Financial Solvency*: If defined as 'coverage' and not 'insurance', the plan is not subject to solvency requirements. Thus, plan members would be responsible for claims and providers could be on the hook for any unpaid claims if the plan were to go insolvent.

- *Complexity*: Typically there are complex criteria that employers need to meet to qualify for the program, which could limit the participation of businesses and their employees.

- *Time Before Implementation*: This is a community-based approach to health care that requires a significant process to survey the needs of a community, educate stakeholders, build consensus, plan for and implement. It took Muskegon County almost five years from the time it received a planning grant to the time it started to administer the program. Pueblo has moved at a much quicker pace, but nevertheless, expects their process from start time to implementation to be about 19 months.[33]

[33] Chris Adams, The Adams Group. Phone interview.

MICRO BUSINESS DEVELOPMENT CORPORATION

How does the direct subsidy plan work?

The Micro Business Development Corporation, Mi Casa and Kaiser Permanente's Connections program have partnered to target outreach and provide health insurance to entrepreneurs and their employees living in the Denver metropolitan area. This partnership is based on the concept that the economic independence of micro businesses is significantly improved if entrepreneurs are at decreased risk for unexpected financial hardship of medical expenses.

Through this partnership:

- outreach for the program is conducted by the Micro Business Development Corporation and Mi Casa, targeting Micro Business Development Corporation and Mi Casa clients;
- eligibility for the program is determined by Micro Business Development Corporation staff; and
- health insurance coverage is provided through Kaiser Permanente's dues subsidy program, Kaiser Connections.

Micro Business Development Corporation, a Colorado non-profit organization, was founded in 1993 to eliminate barriers to economic independence for community entrepreneurs, both youth and adult, through access to markets, resources, and business capital. The Micro Business Development Corporation targets underserved populations. In 2006, the Micro Business Development Corporation served 1,743 individuals of whom:[34]

- 76% were ethnic minorities;
- 72% were low-income;
- 70% were women; and
- 11% were youth.

Mi Casa Resource Center for Women, Inc., a 501(c)(3) Colorado non-profit corporation, was created to advance self-sufficiency among primarily low-income Latinas and youth. In 2005, 305 Mi Casa clients completed the entrepreneurial training course and 41 started their own businesses.[35] Mi Casa has a much larger overall client base and can easily reach low-income families through the multiplicity of programs that it offers. Their existing clients are low-income families and children. Many of the children are eligible for CHP+ and Medicaid.

[34] Micro Business Development Corporation. (2006) *Micro Business Development 2006 Annual Report.*
[35] Mi Casa Resource Center for Women. (2005) *Mi Casa Resource Center for Women 2005 Annual Report.*

Health insurance is provided through Kaiser Permanente's Connections program. Premiums are based on a sliding-fee scale depending on family size and income. One hundred thirty-five individuals are enrolled in Kaiser Connections through Micro Business Development and enrollment has been increasing steadily. In 2006, monthly premiums ranged from $24.01 - $72.02 for an individual and $69.37 – $208.12 for a family.[36] Enrollees may remain enrolled in the program for up to 24 months. Eligibility is limited to individuals who:

- live in the Kaiser Permanente Denver metropolitan service area;
- are ineligible for Medicare, Medicaid, CHP+ or an employer sponsored plan where the employer pays more than 50% of the cost of coverage;
- have incomes less than 250% of the federal poverty level; and
- have less than $10,000 in cash or other liquid assets.

Health insurance benefits are based on the Colorado Standard Plan, and include: primary and preventive health care; specialty care; diagnostic lab and x-ray; inpatient and outpatient hospital services; urgent and emergent care; durable medical equipment; behavioral health services; physical, occupational and speech therapy; home health care; hospice care; prescription drugs (formulary); and optical services.[37]

Kaiser Connections does not medically underwrite the program, meaning they do not deny individuals coverage based on their health status. Representatives of Micro Business Development and Kaiser Connections reported that a number of Micro Business Development and Mi Casa clients who were in need of health insurance were not currently enrolling in the program.

What are notable strengths to this approach?

- *Provides affordable coverage*: Entrepreneurs, their employees and families have access to insurance coverage- although there is some debate on its affordability for low-income workers. Through the Kaiser Connections, families pay $69.37 - $208.12 per month for a family policy (sliding scale up to 250 percent of poverty).

- *Targeted community-based outreach*: Outreach for the partnership is targeted toward new and existing clients of the Micro Business Development Corporation and Mi Casa. Since these individuals are already seeking financial and other support services to start and expand their businesses, they may be more likely to realize the importance of health coverage and protecting themselves from large medical expenses. Therefore, the targeted client base, which historically has high rates of uninsurance, may be more motivated to enroll in health insurance. The Micro Business Development Corporation also has strong relationships with other community agencies including the City and County of Denver through the employment and training services.

- *Manageable administrative structure:* The model is currently in operation in the Denver metropolitan area. The Micro Business Development Corporation works with community agencies and acts as an interface with the insurer. Eligibility criteria, application and

[36] Kaiser Permanente. (2006) *Kaiser Permanente Connections Brochure.*
[37] Kaiser Permanente. (2006) *2006 Benefit Chart.*

enrollment processes are structured to be as simple as possible. As the Micro Business Development Corporation has expanded the program with Kaiser, the Micro Business Development Corporation has accepted the role of enrollment facilitator. The partner agency does an initial screen for eligibility as part of its existing service intake. The insurance application is processed through a very simple intake conversation with the Micro Business Development Corporation and the forms are submitted to Kaiser for all the participating organizations.

- *Standard Benefits:* The benefits provided to enrollees are consistent with the Colorado Small Group Standard Plan.

- *Consistent Provider Networks:* Since individuals are purchasing an insurance policy, individuals enrolled in the program are offered the same provider networks as those who are enrolled in an employer-sponsored product. Additionally, access would not be limited to the geographic area that the individual lives in, as is the case with the Three-Share Model.

What are notable challenges to this approach?

- *Federal funds are not leveraged:* Unlike the CHP+ at Work option, this is a private only option and federal Medicaid and S-CHIP matching funds are not leveraged.

- *Subsidy may not be sufficient to make health insurance affordable.* There seems to be widespread agreement that health insurance is not affordable below 200 percent of the federal poverty level. New entrepreneurs struggling to start a business have reported that premiums of $150- $200 per month, even for a family, were not affordable.

- *Asset test might be a barrier*: Limiting liquid assets to $10,000 for someone starting a new business may create a barrier to enrollment. Most of the businesses created through the Micro Business Development Corporation are sole proprietor businesses in which there is no practical distinction between the family's assets and the business assets.

- *Serves a narrow population*: This program is specifically targeted toward a narrow population (e.g., lower-income entrepreneurs and their employees).

SUMMARY OF KEY FINDINGS

As policymakers and the public consider ideas for increasing access to health insurance, some have looked to providing financial assistance (i.e. premium subsidies) directly to individuals to help them purchase health care coverage. This study provides the public with a broad overview of some existing premium subsidy programs that could serve as a model for similar or more expansive efforts.

In the course of our analysis, we have discovered that several different premium models exist in Colorado and vary significantly in how they are organized, who they provide assistance to and how they provide support. Each program has its own strengths and challenges that policymakers should consider before crafting their own program.

Policymakers also will want to consider criteria such as: ease of implementation, sustainability, applicability and affordability. The models evaluated as part of this study provide valuable information on how a similar program would measure up to these criteria.

Ease of Implementation

Those interested in implementing a program in a short time-frame will want to consider factors such as development time, whether existing administrative infrastructure already exists and the need for legislative and/or regulatory changes. For example, the Three-Share program can be a complex and time-consuming option to implement. According to those involved in establishing this plan elsewhere, a major component of a Three-Share Plan is community and business buy-in. Estimates of the community development time range from 20 months to several years. Another approach with a longer lead-time is a blended public-employer sponsored insurance product, such as the CHP+ at Work program. This is not necessarily due to the complexity of the program, but is due to the federal regulations and oversight that accompany the use of federal matching funds and any negotiations around program design with the appropriate state agency.

Sustainability

Successful premium subsidy programs leverage various predictable and sustainable sources of funding. For example, the CHP+ at Work program combines federal, state, employer and individual contributions. CoverColorado also combines multiple funding sources, and has a unique policy of allowing third parties (such as grandparents or foundations) to provide assistance to individuals. Another interesting model is the Three-Share program, which combines employer, employee, and community funds to help employees. In this model, the community share can include various entities including foundations, government and providers. These programs, however, are not immune from the risk that funding might be endangered at some point. For example, CHP+ at Work relies on federal funds that are part of a politicized appropriation process, while Three-Share models have relied on federal disproportionate share funds, which are considered somewhat precarious.

Applicability

Although programs that serve a targeted population may work well for that specific population, it limits how many people the programs can serve, and the types of populations that can be assisted. In some cases, this might occur because the program's statutory charge requires them to focus on a particular group. For example, the Ryan White Insurance Program is designed to assist persons living with HIV/AIDs, while CoverColorado is primarily focused on helping those who are denied health insurance coverage in the individual health insurance market. So although an exact replication of these programs might not be appropriate to serve a broader or different population, policymakers can still learn from other aspects of these models such as level of premium subsidy, benefit design, administrative structure, etc.

Affordability

Providing affordable coverage can be achieved through high premium subsidy levels, benefit design, and the leveraging of various funding streams. The models evaluated have taken different approaches to this issue. Three-Share has created a very affordable model by leveraging funding from the employer, employee and community, and through benefit design. The trade-off, though, is there are limits for employees. For example, the Three-Share model limits coverage to the program's geographic area. CHP+ at Work combines funding streams and uses a benefit package that is comparable to the average plan in the marketplace to address the affordability issue.