

Closing The Gap

**A Guide to
Understanding and
Improving Health
Insurance Coverage**

*Ten Steps to
Reduce the Number
of Maine People
Without Health Insurance*



Prepared by the Maine Hospital Association

December 2001

Table
of
Contents

Executive Summary	i
Introduction	1
Statement of the Problem	2
Analysis of the Problem	9
Program and Proposals	13
Conclusion	25
Appendix A	29
Appendix B	30
Appendix C	39
Endnotes	44

I. Executive Summary

Nearly six out of every ten Americans believe that people without health insurance obtain all the medical care they need.¹

Hospitals know better. In fact, few organizations today have a greater understanding of the many problems that result from lack of health insurance. Each day, Maine's hospitals experience the reality of what researchers have clearly proven: uninsured people tend to have more health problems and die earlier than individuals with health coverage.² This is a tragic fact, given that 11.8% of Maine's population, or approximately 150,441 people, currently are uninsured.³

Maine is not unique. Over 38 million Americans, or 14% of the total U.S. population, do not have health insurance.⁴ Maine's hospitals believe that this national problem would best be resolved with a national solution: the United States should ensure that everyone has health insurance coverage as a right of citizenship. Recognizing that, for a variety of political and economic reasons, nationally guaranteed

insurance coverage is not likely to occur in the foreseeable future, hospitals believe that states should take deliberate incremental steps to move us toward the goal of universal coverage.

As we work to identify practical, achievable ways to expand coverage in the near term, one fact cannot be ignored: most of the uninsured are employed.⁵ A recent study found that enrolling all of the uninsured persons who currently have access to employer-based health insurance would reduce the number of uninsured more than any other incremental expansions that have been implemented or are now under consideration.⁶

There are also employed individuals without access to employer-based coverage. Nationally, and in Maine, seven out of ten uninsured adults are employed.⁷ A national study found that half of that group does not have access to employer-based coverage; the other half declines employer-sponsored coverage due to the cost.⁸

Therefore, a focused effort should be undertaken to assist both employers and employees to purchase health insurance.

In addition to supporting employers and their employees, Maine should expand access to health insurance by building on the existing public structures: Medicaid and the Children's Health Insurance Program. Our first priority should be to enroll all of those currently eligible for existing government-assisted coverage. This will require continually improving marketing and outreach efforts for government programs and targeting working families, because 75% of the parents of uninsured children eligible for Medicaid are employed.⁹

Collectively, we must help the working uninsured to participate in their employer's plan, help small businesses gain easier access to affordable insurance plans, and expand public programs to help those unable to help themselves. At the same time, we must ensure that the public programs cover the cost of providing health care services

Closing the Gap

to avoid further cost-shifting to the private sector. We believe meeting these priority objectives are achievable through the following ten steps:

1. Advocate for a new state-wide program to assist low-wage workers to pay their share of employer-based health insurance plans, and offer subsidies to small businesses to help pay for health insurance premiums of low-wage and self-employed workers (this approach, modeled after the successful MassHealth initiative in Massachusetts, would require a waiver from the federal government);
2. Encourage the creation of purchasing cooperatives for small businesses to obtain coverage plans for their employees;
3. Support individual refundable tax credits for monies spent on health insurance coverage;
4. Raise income eligibility levels in existing state insurance programs to expand coverage to more of the unemployed and uninsured population;
5. Continue to streamline the application process for

Medicaid and the Children's Health Insurance Program, including allowing families to self-declare eligibility information;

6. Encourage the state to track enrollees and monitor reasons for disenrollment, including administrative errors and address changes, then act to correct any systemic shortcomings;
7. Intensify efforts to reach and enroll children in families with limited English-proficiency in our state programs;
8. Recruit more participating providers in government insurance programs to improve access to health care services, especially in areas of limited resources, such as dental services;
9. Make provider government program payment rates to providers comparable to the commercial market to eliminate cost shifting; and
10. Educate the public and policy makers about the importance of health insurance and preventive care.

Taking any of one of these steps alone will not maximize access expansion, because different

groups of uninsured and under-insured have different needs. However, in the absence of a national solution, we believe that this multi-pronged approach will provide health insurance to the greatest number of people. This is critically important because while coverage alone does not ensure good health, the absence of coverage is a major contributor to poor health.

II. Introduction

A majority of the American public, 57%, believe that people without health insurance receive all the care they need.¹⁰ Hospitals know better. In fact, few organizations understand better than hospitals the multitude of problems that result from lacking health insurance. It has been clearly established by many reputable researchers that the uninsured have poorer medical outcomes and higher mortality rates than the insured.¹¹ For example, uninsured adults are four times more likely to require emergency hospital care.¹² Health conditions that might be diagnosed and treated easily outside of the hospital can quickly become major medical emergencies when patients skip recommended medical tests or treatments, as one-third of the uninsured population does.¹³ Therefore, it is not surprising that the uninsured are hospitalized at least 50% more often than the insured population for “avoidable conditions,” such as uncontrolled diabetes.¹⁴

Uninsured children fare no better, as they are up to six times

more likely to have gone without needed health care services, and up to 40% less likely to receive any medical attention for a serious injury.¹⁵ When uninsured children do receive health care services, they are five times more likely to use the emergency room when seeking routine health care.¹⁶ The very least we can do is to ensure that children receive necessary and preventive health care services at the right time and in the most appropriate setting.

The fact that American adults are uninsured affects more than their own well being; it affects everyone who relies on them, including their spouses, children, co-workers and employers. Caring for the uninsured and underinsured also raises the overall costs of our health care system. Hospitals, which provide emergency care regardless of the patient’s ability to pay for services, serve as society’s “safety net.” Hospital emergency rooms, however, are simply not able to provide the ongoing coordinated oversight and preventive care that is necessary to maintain optimal

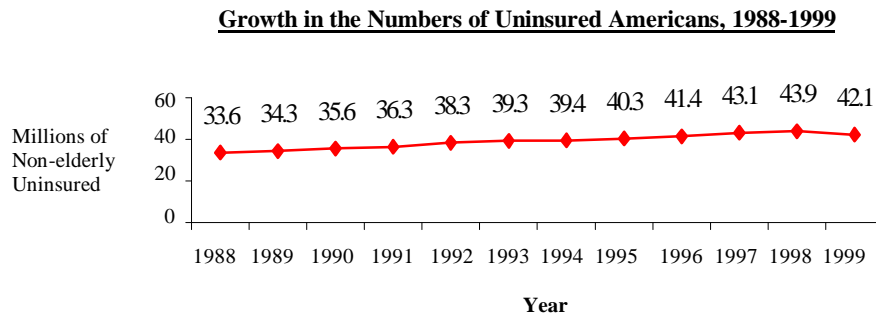
health status.

Moreover, some of the hospitals’ cost of caring for the uninsured and underinsured must be shifted to others in the form of higher charges. For example, in Maine, the health care providers’ charity care and bad-debt write-offs amounted to approximately \$163 million in 1999.¹⁷

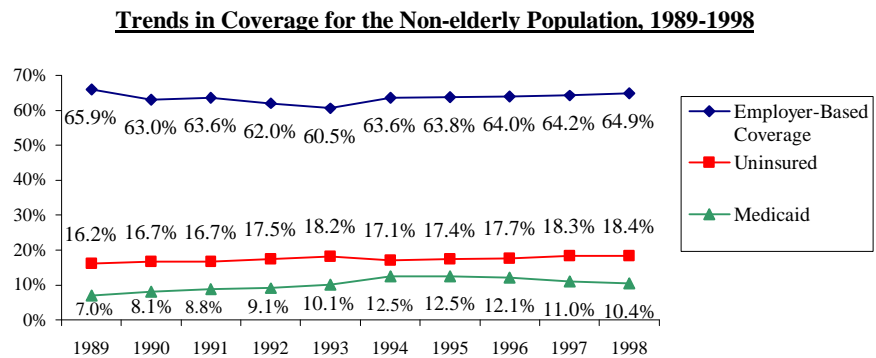
For all of these reasons, Maine’s hospitals support a national solution whereby this country ensures that every citizen has health insurance coverage as a right of citizenship. Unless or until our country is ready to accept this responsibility, however, we believe that the current system that combines public and private financing must be expanded to provide coverage to more of Maine’s uninsured population. The purpose of this paper is to review current programs and proposals at the state and federal levels to learn what incremental changes would assist us in reaching our goals.

III. Statement of the Problem

Currently, 38.7 million Americans, or 14% of the U.S. population, are without health insurance, including approximately 8.5 million children under the age of 18.¹⁸ Although these numbers are unacceptably high, they represent a continuing decline that began in 1999, which was the first year showing a decline in the uninsured rate since comparable statistics became available in 1987.¹⁹ The graph below shows the growth trend of uninsured Americans from 1988 through 1999.²⁰



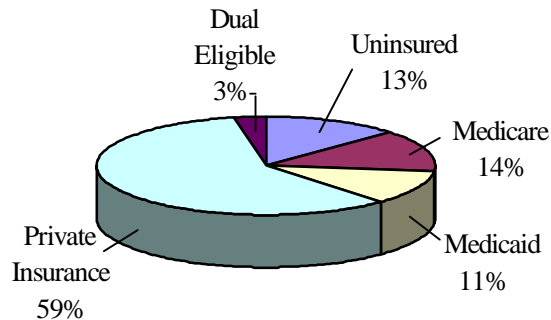
One reason for the recent decline in the uninsured rate is illustrated in the next two charts showing the source of health insurance coverage, first nation-wide and then for Maine.²¹



*Note that the data represented here is for the non-elderly population, a distinction often given that 99.3% of persons age 65 and older are insured, most likely reflecting widespread Medicare coverage.²² In 2000, although the overall rate of uninsured decreased, the employer-based coverage was relatively constant at 64.1% and the Medicaid coverage rate was unchanged.²³

Closing the Gap

Coverage Sources in Maine, as Percentage of Population



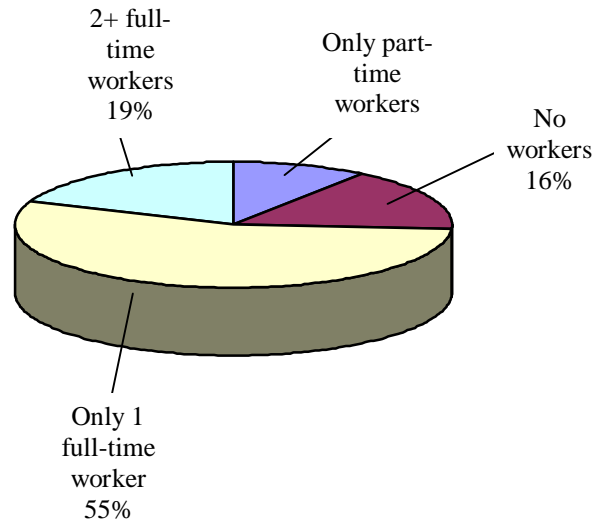
Note: These percentages are based on 1998 data, hence the state's 13% uninsured rate, rather than Maine's current uninsured rate of 11.8%.

These charts illustrate that the primary source of health insurance, at both the state and national levels, is employer-based coverage. Our nation's dependency on an employer-based health insurance system is not without risk, however. Regaining and maintaining a strong economy is critical to further decreasing the uninsured rate, or even holding the current level. The fragility of coverage in an employer-based system is particularly evident when the economy is weak because many workers are just one lay-off away from becoming uninsured.

It has been estimated that if everyone who currently has access to employer-based coverage actually took full advantage of their employer's plan, the total uninsured population would drop by 20%.²⁴ Given that employer-based insurance is the most prevalent source of coverage, and that many eligible employees do not enroll in their employer's plan, it is helpful to consider more detail regarding the employed uninsured. The national data shown in the graphics below provides more detail on uninsured workers and their families.²⁵

Closing the Gap

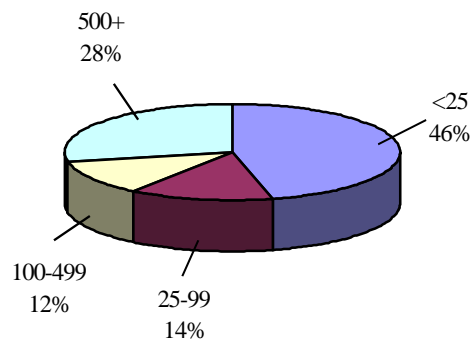
The Non-elderly Uninsured, by Family Work Status, 1998



This chart shows that almost 20% of our nation's uninsured population are in families where there are two full-time workers, and nearly 75% are in families where at least one person is working full-time. Families with only part-time workers are as likely to be uninsured as those with no workers because part-time jobs seldom offer

health benefits.²⁶ In Maine, 71% of uninsured adults are employed on a full or part-time basis, including at least 26,000 working parents.²⁷ Given the high number of full-time employees without health insurance, it is instructive to consider the size of businesses as it relates to the working uninsured.²⁸

Uninsured Workers, by Business Size, 1998



Closing the Gap

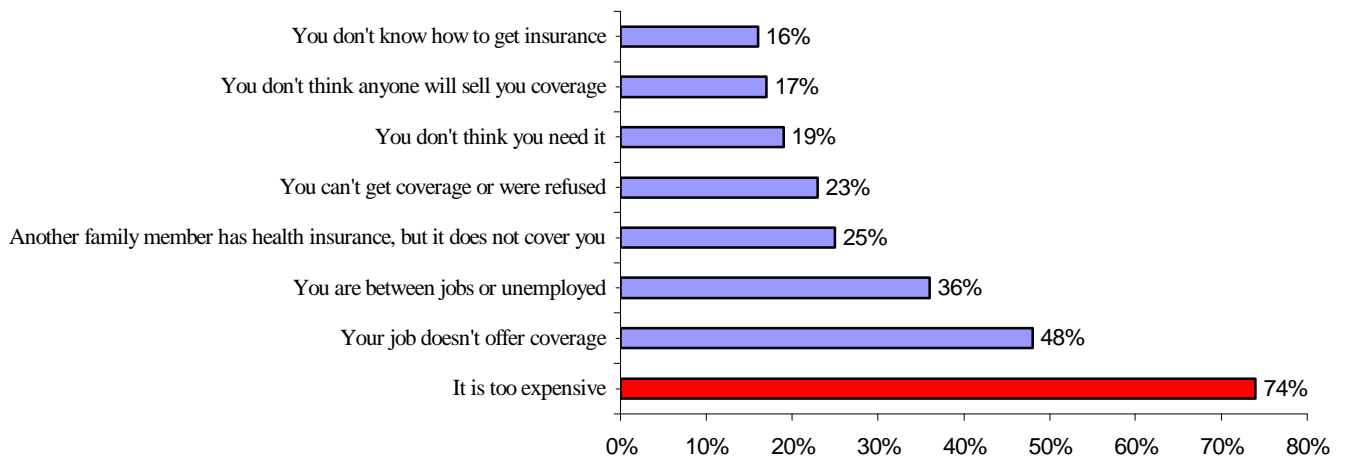
This chart shows that 60% of uninsured workers nation-wide are employed at businesses with fewer than 100 employees. In Maine, there are 43,666 businesses with fewer than 100 employees,²⁹ and businesses with fewer than 50 employees employ

half of all Maine workers.³⁰

Even if a Maine employer offers coverage, 66% of uninsured workers eligible for their employer's plan said they declined the benefit because it is too expensive.³¹ This finding is con-

sistent with national data on why uninsured adults lack coverage, as shown below.³²

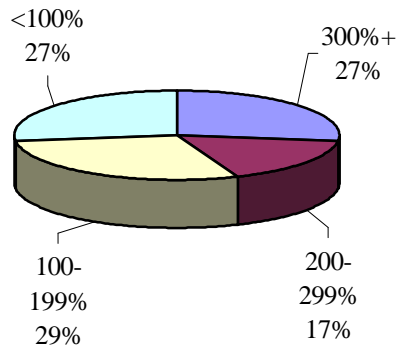
Major Reasons Reported By Uninsured Adults For Not Having Health Insurance, 2000



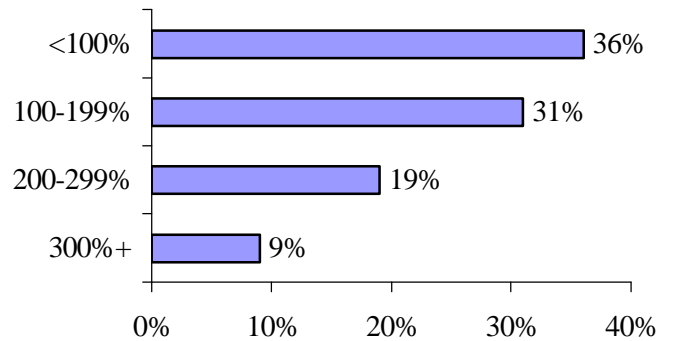
Given that so many uninsured are working people who say that health insurance is too expensive, it is useful to consider the income, relative to the federal poverty level, of the non-elderly uninsured, as shown on the next page.³³

Closing the Gap

The Non-elderly Uninsured, by Poverty Level, 1998



Risk of Being Uninsured



These charts illustrate the following facts of particular importance:

- Over half of America's uninsured have family incomes less than 200% of the federal poverty level;
- The poor have up to a four times greater chance of being uninsured as compared to higher income families; and
- Families with incomes between 100% and 200% of the federal poverty level run nearly the same risk of being uninsured as those with lower incomes, and may be ineligible for Medicaid.³⁴

The relationship between income and insurance coverage is alarming, because Maine's aver-

age per capita income is only about \$24,600.³⁵ It is therefore not surprising that 78% of Maine's uninsured earn less than \$35,000.³⁶ For reference, the year 2001 federal poverty guideline for a family of four is \$17,650, with 200% of that being \$35,300.³⁷ To put those figures in perspective for a single adult, a full-time single worker paid the federal minimum wage earns 133% of the federal poverty level.³⁸

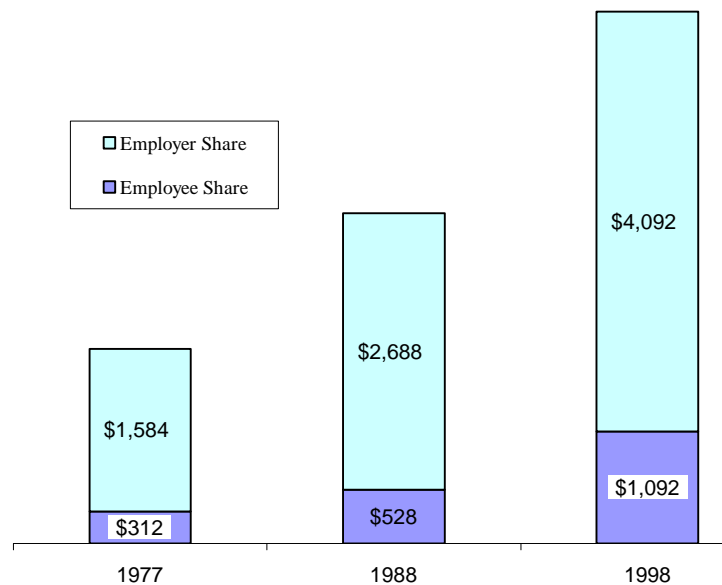
Maine residents are not alone; despite our nation's robust economy in 1999, a national survey showed that nearly one-third of working adults lived "from paycheck to paycheck" with insufficient financial re-

serves to cope with a major illness or injury.³⁹ Given the present state of the national economy, it is reasonable to expect the number of people with inadequate financial reserves will increase in the coming year.

Finally, when considering the working uninsured and their share of the health insurance premium, it is helpful to understand the trend in the average annual premium per worker, and the worker's share of that premium, as shown on the following chart.⁴⁰

Closing the Gap

**Average Annual Premium Cost
Per Worker, 1977, 1988 and 1998**
(in 1998 Dollars)



Although employer-based group insurance policies are certainly more economical than individually purchased policies, this bar graph illustrates both that the costs of health insurance has increased substantially over the last 20 years, and that employers are passing a greater share of that cost to their employees. Consequently, workers paid more than three times as much for health benefits in 1998 as in 1977 during a period when many workers' wages, relative to inflation, were actually declining.⁴¹ In addition, from 1999 to 2000, the cost of health insurance premiums nationwide jumped 8.3%, more than

double the inflation rate.⁴² In 2001, the premiums for employer-sponsored health insurance increased again, by 11%.⁴³ While the amount workers paid for their share of the premium remained statistically unchanged from 2000 to 2001, a recent study showed that 44% of employers indicated that they may shift a substantial share of the increasing premium costs to their employees in the upcoming year.⁴⁴ The total premium cost and its distribution are critical pieces of the puzzle, because cost is the primary factor affecting both the employer's decision to offer coverage and the employee's decision to accept it.⁴⁵

The rising costs of health insurance are especially difficult for small businesses. Between 1996 and 2001, the average costs of health insurance for Maine small businesses increased by 78% for fee-for-service coverage, and by 58% for health maintenance organization coverage.⁴⁶ It is no surprise that, of the small businesses in Maine that are not currently sponsoring coverage, 63% cite high costs as the reason they cannot offer a health insurance benefit to their employees.⁴⁷

Whatever the reason for being without health insurance coverage, there are substantial

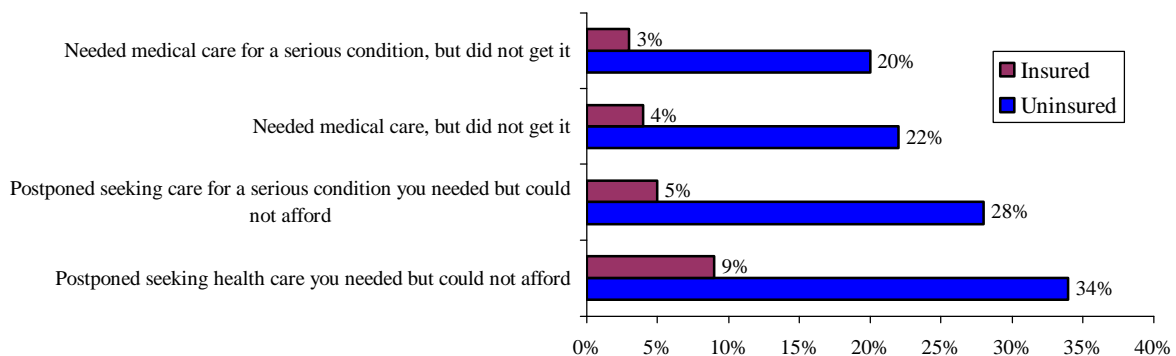
Closing the Gap

negative health consequences of being uninsured. It is well established that lack of health insurance leads to decreased access to

health care services and poorer medical outcomes. For example, people without health insurance may postpone or forgo necessary

health care services, as shown in the chart below.⁴⁸

Postponing or Foregoing Needed Care in the Past Year Among Non-elderly Adults, by Health Insurance Status, 2000



Deferring medically necessary health care services is the most disturbing fact associated with being uninsured. After evaluating ten years of published literature linking health insurance to health status, a report from the American College of Physicians-American Society of Internal Medicine researchers provides evidence that the:

- Uninsured are less likely to have a regular source of health care services;
- Uninsured are less likely to have had a recent physician visit;
- Uninsured are more likely to

delay seeking care;

- Uninsured are less likely to use preventive services;
- Uninsured experience a generally higher mortality rate, and a specifically higher rate of in-hospital mortality;
- Uninsured may be up to three times more likely than privately insured individuals to experience adverse health outcomes in general; and
- Uninsured have been found to be up to four times as likely as the insured to require both avoidable hospitalizations and emergency hospital care.⁴⁹

The consequences of lacking health insurance are clearly adverse to the individual and society. For the uninsured individual, postponing or forgoing medically necessary care may result in serious illness or even life-threatening emergencies that could have been prevented. From a societal perspective, individuals in poor health reduce overall productivity, add costs to the health care system, and negatively affect all who rely on those individuals, including their families, co-workers and employers.⁵⁰

IV. Analysis of the Problem

Based on the available data and experience, we believe policy makers face the following issues when developing mechanisms to expand health insurance coverage to all Americans:

- Most of the uninsured are employed.⁵¹ Approximately 25 million American workers had no health insurance in 1998.⁵² One study found that over 70% of the nation's uninsured live in households where at least one person is employed, but for half of that group, the employer does not offer coverage and in the other half, the employee declines the employer-sponsored coverage.⁵³ There are three possible explanations. Either the employer is unwilling or unable to sponsor a health insurance benefit, or the employee cannot afford to share the premium cost. Possible solutions include providing financial incentives to businesses to sponsor health insurance benefits, or subsidizing, in some form, the employer's costs and/or the employee's costs.

Supporting employer-based health insurance is important because, despite the rising costs, a recent study showed that most Americans prefer to continue having the employer-sponsored system as the primary source of coverage, rather than government or individually purchased coverage, even if they were currently uninsured.⁵⁴ The survey showed that just 18% of adults believed that the government should become the primary source of health insurance coverage, while 23% would prefer individually purchased coverage.⁵⁵ The authors suggested that the survey results reflect a preference for group insurance and confidence in the employer to select quality health plans.⁵⁶

Given that two-thirds of the respondents believed that funding for expanding employer-based coverage should come from the employers or insurance companies, the preference for employer-

based coverage may also reflect the common misperception that such coverage does not significantly affect wages. Support for employer-based coverage may also stem from the fact that enrollment at the workplace is generally easy, fast and convenient, unlike enrolling in an expanded Medicaid program.

Public policy initiatives to strengthen the employer-based system enjoy widespread public support. The survey showed that 85% of adults support governmental assistance to help low-income workers pay their share of the employer-sponsored health insurance premium.⁵⁷

- Most of the employed uninsured work in businesses with fewer than 100 persons.⁵⁸ From a purely economic viewpoint, small businesses lack the capital resources generally available to larger companies, and thus are more sensitive to fluctuations in annual costs. This

Closing the Gap

will tend to directly influence the decision that a company makes concerning insurance coverage benefits and premium sharing.

- Price is the primary reason why the working uninsured lack coverage.⁵⁹ Because of the rapidly rising cost of insurance premiums, both small businesses and individuals perceive that providing or acquiring coverage is prohibitively expensive. Individuals unable to afford comprehensive plans may opt for catastrophic coverage alone, and forgo preventive and semi-elective health care services until an emergency medical condition requires treatment. Larger companies may find that insurance coverage is too expensive, and decide to self-fund coverage, which may create a greater problem for small firms if insurance carriers raise rates to compensate for the loss of volume.
- Many of the uninsured are insurable through current public programs.⁶⁰ In addition to the access to employer-based coverage previously discussed, over one quarter of all uninsured

adults, and nearly two-thirds of all uninsured children, appear to be eligible for coverage in government health insurance programs.⁶¹ This important fact suggests inadequate marketing and/or outreach for government programs. It must be acknowledged, however, that there are significant barriers to outreach because of the process necessary to participate in the expanded Medicaid and Children's Health Insurance Programs (CHIP). Enrollment in Medicare and employer-sponsored plans is nearly automatic and potentially long-lasting. In contrast, state program enrollees must first hear about the program, understand that they may be eligible, take affirmative action to find an application form, complete it, enclose additional required information and return it to the state. Once enrolled, the burden is on the enrollee to become recertified as an eligible participant every twelve months.

Nonetheless, if all of the eligible people were enrolled in the appropriate federal and state sponsored programs,

the numbers of uninsured would markedly decrease, and such efforts may be more beneficial, at least in the short term, than establishing entirely new programs.

- Ignorance. In this arena, knowledge means coverage and coverage means better health. Constant outreach and public education is necessary to maximize enrollment of eligible populations in state health insurance programs. If former government program enrollees had known that they still qualified for coverage, or if the administrative system had been able to better track and reach the eligible population, there would be substantially lower numbers of uninsured. We must also educate the policymakers and general population regarding the importance of health insurance coverage, preventive care and options for obtaining coverage.
- Individual sensitivity to cost. If people do not have to bear the cost of the services that they utilize, then they are more likely to use services than if they paid for the

Closing the Gap

services directly. This inverse relationship is the hallmark of the insurance paradigm, and explains why health plans require co-pays and deductibles. However, for the uninsured population, there is also a clear and dramatic relationship between the amount uninsured people are required to contribute for health insurance and their acceptance of the coverage.⁶²

The low-income uninsured are much more likely to participate in a no-cost coverage program, than one that requires even modest premium sharing; in fact, participation markedly declines when the premium costs reach five percent of personal income.⁶³

- Social stigma associated with public programs. One of the fundamental problems with any type of social welfare program is the stigma associated with a program intended for the “poor and unemployed.” In many cases this stigma can result in people foregoing social support services or accepting “charity” care. For example, 37% of low-income parents do not want their children to be regarded as “Medicaid recipi-

ents.”⁶⁴ The language and terms used to describe government programs may influence enrollment. For example, when Congress created the Children’s Health Insurance Program, they did not call it Children’s Health Insurance for the Needy. In Maine, CHIP is called Cub Care, which sounds friendly and non-socioeconomic in nature. In addition, the Maine legislature recently acted to change the name of the state’s Medicaid and Cub Care programs to MaineCare.

- Expectations affect behavior.⁶⁵ As a group, U.S. citizens do not want to pay any more than is absolutely necessary to subsidize another’s health care services. In contrast, on an individual basis, we want the best and most technologically advanced services available for ourselves and our families, regardless of the cost. This dichotomy suggests that we will not spend more money than we have to until we are personally affected by the system, then we will do whatever is necessary, regardless of the cost.

In contrast to other types of insurance, health insurance has become nearly synonymous with access to services. While Americans do not expect their automobile insurance to finance the fuel or other routine maintenance expenses, they expect their health insurance to largely cover all of their health care expenses, including preventive care. As the scope of health care interventions has expanded, so have our expectations for insurance coverage.

Two other firmly entrenched attitudes also need to be considered. First, Americans want their own health care services promptly and locally available, and tend to be unwilling to wait or travel very far. Second, most Americans have a firmly held belief that employers have an obligation to provide health insurance coverage, again with minimal regard for the cost. Many employees erroneously perceive their employer-sponsored health insurance as “free” or nearly so, if there is premium-sharing.

Closing the Gap

- Administrative burdens and governmental control. On one hand, Americans are reluctant to accept undue governmental control over any aspect of their lives. In fact, only 30% of the general public believed that the “government can be trusted to do the right thing” in the year 2000 as compared with 76% in 1964.⁶⁶ On the other hand, people who receive benefits such as Medicare and Medicaid want them segregated and protected. Until this debate is satisfactorily resolved, it will continue to block development of a national health insurance program.

Regarding administrative inefficiencies, generally, the simpler a system is, the easier it is to administer efficiently. Unfortunately, Maine’s health care providers face heavy burdens of expensive, duplicative administrative requirements.⁶⁷ A recent study showed that for every hour hospital emergency room staff spends caring for a typical Medicare patient, they spend an additional hour on paperwork, much of it neces-

sary to comply with the vast number of complex, uncoordinated and sometimes duplicative state and federal regulatory requirements.⁶⁸ Government regulators must improve communication and coordinate regulatory actions to avoid unnecessarily adding to health care system costs.

- Prevention has not been adequately addressed. As a nation, we have taken steps to facilitate preventive care. For example, it is a national mandate that school aged children receive major vaccinations before attending school, and most public water supplies are treated with fluoride to help prevent dental problems. In many cases, states have legislatively mandated that insurance policies cover certain preventive screenings and services, such as mammography. Even without legislative mandates, insurance companies now cover more preventive care than in the past, recognizing that it is more cost effective to pay for preventive care than to pay for an extended hospitalization for a major illness that was not promptly diagnosed and treated.

As individuals, however, we have much to learn about preventive care and personal responsibility. At the national level, Secretary Tommy Thompson of the Department of Health and Human Services stated that the incidence of diabetes, a disease linked to 22% of the entire Medicare budget, could be reduced by up to 80% with appropriate diet and exercise.⁶⁹ Locally, Maine residents are arguably less healthy than other Americans because of higher smoking rates, lack of regular exercise and poor diet.⁷⁰ These three major risk factors alone have made Maine the state with the fourth highest death rate due to four largely preventable diseases: cardiovascular disease, cancer, chronic lung disease and diabetes.⁷¹ These four chronic diseases are responsible for 70% of the health care problems in Maine and primarily result from our own lifestyle choices.⁷²

V. Programs and Proposals

1. Expanded Medicaid and the State Children's Health Insurance Program (CHIP)

In 1997, Congress enacted the Children's Health Insurance Program as Title XXI of the Social Security Act, and the Children's Defense Fund began tracking the effectiveness of program implementation in all fifty states. In July, 2000 the Children's Defense Fund published its initial findings in the report *All Over the Map: A Progress Report on the State Children's Health Insurance Program (CHIP)*. According to the report, almost two-thirds of the uninsured children in this country are eligible for either Medicaid or CHIP coverage.⁷³ The report goes on to say that of the 12 million currently uninsured children, 2 million are eligible for CHIP, and 4 to 5 million more are eligible for Medicaid.⁷⁴ This situation was discovered when state outreach workers found that for every child enrolled in CHIP, there was an additional child that could be enrolled in Medicaid, including many children who lost their Medicaid coverage through administrative error or over-

sight.⁷⁵ Research has shown that not only has children's Medicaid coverage been erroneously discontinued, but that 60% of parents with Medicaid-eligible children have tried to enroll in the program but did not succeed, usually because they found the process too difficult and complicated.⁷⁶ A New York study found that the majority of people disenrolled each year were eligible to continue enrollment, but simply failed to find their way through the mandatory recertification process.⁷⁷ Regrettably, many parents do not even try to enroll their families— about three out of five parents whose children qualify for CHIP or Medicaid do not believe that they are eligible, with the unfortunate consequence that seven million children unnecessarily lack coverage.⁷⁸

There are at least three implications that can be drawn from these facts. First, when assessing the number of uninsured children in any given state, the number reported might not reflect the true number of children ineli-

gible for, or unwilling to accept, state insurance. Second, when reassessing or redesigning Medicaid programs, states should first determine if persons recently dropped from the program are still eligible to receive benefits. Finally, these observations may indicate that one factor influencing the number of uninsured children is lack of information on which programs are available and/or the details of the eligibility requirements.

On a more positive note, by September 2000, the CHIP program had provided health insurance for 3.3 million children.⁷⁹ If every child eligible for a state's Medicaid or CHIP program enrolled, the number of uninsured children would decrease by five million.⁸⁰ The most recent Maine data shows that nearly 10,000 children have been added to the expanded Medicaid and CHIP programs in the last two years, leaving just six percent of Maine's children uninsured.⁸¹ Maine's rate of coverage for children is the fourth highest in the nation, but that still leaves

Closing the Gap

approximately 18,000 uninsured children in our state.⁸² Notably, about 25% of children in working low-income families that are eligible for Maine’s CHIP program, remain uninsured.⁸³

According to the U.S. Census Bureau, the foreign-born population is less likely than the native population to be insured, so we should consider increasing our outreach and educational efforts to the foreign-born population eligible for state programs.⁸⁴

From a state policy perspective, the usage of federal CHIP money to help relieve state level funding problems is a simple and desirable method to provide health care coverage to children and their families. (Please see Appendix A for a table summarizing the states’ coverage programs, including CHIP and Medicaid expansions.) Although Maine’s outreach and enrollment efforts have been particularly successful, among the top ten states according to this report, the report nonetheless offered several valuable recommendations that could be applied in our state:⁸⁵

- Expand financial eligibility for the CHIP and Medicaid programs— Connecticut,

Missouri and Vermont have raised eligibility standards to 300% of the federal poverty level, and raising the financial eligibility threshold from 200% to 250% of the federal poverty level in Maine would provide coverage to approximately 2,000 more Maine children.⁸⁷ Raising the eligibility thresholds should be done slowly and carefully, however, with close analysis of the new participants because of the danger that raising eligibility thresholds too high could cause “crowd-out,” whereby the program erodes the existing employer-based system by encouraging substitution of private insurance coverage with publicly subsidized coverage;

- Further streamline the application process, through such means as allowing families to self-declare eligibility information because requiring proof of income through a state-administered process is assumed to pose a significant obstacle to participation;⁸⁸
- Track enrollees and monitor reasons for disenrollment, including administrative errors and change of address, then act to correct any sys-

temic shortcomings;

- Intensify efforts to reach and enroll children in families with limited English proficiency;
- Increase provider payment rates to cover the cost of health care services; and
- Recruit more participating providers to improve access to health care services.

Medicaid under-reimbursement is a problem in Maine, and a recent analysis recommended a review of the rates.⁸⁹ Also, Medicare pays Maine’s hospitals less than the cost of services provided, 88 cents on the dollar. Together, Medicare and Medicaid provide coverage to nearly one third of Maine’s population.⁹⁰ Government programs that do not cover the cost of services provided encourage cost-shifting to the private sector.

2. Tax Incentives

Tax incentives are often suggested as an approach to increase the number of Americans with health insurance, particularly in light of the fact that 74% of our nation’s uninsured adults stated that they did not have health insurance because it was, “too expensive.”⁹¹ Tax incentives

Closing the Gap

at the state and/or federal level, could help uninsured workers afford their share of an employer-based health insurance benefit or purchase coverage on their own. In Maine, a 1998 legislatively created Commission to study the effects of government regulation on health insurance costs for small Maine businesses recommended consideration of tax incentive legislation that would lower employee health insurance costs, encourage small businesses to provide health insurance plans, and encourage employees to participate in their workplace coverage.⁹² Although the state has not yet acted on that recommendation, tax reforms are politically appealing, because it is easier to effect changes on a (tax) system that is already in place, rather than to budget for development and implementation of an entirely new program.

Careful structuring of tax-based subsidies would be critical to ensure participation by the low-income uninsured without unduly assisting the higher income population that could have access to coverage without the tax subsidy. With this in mind, a search of federal health care related tax proposals revealed at

least 23 different bills introduced during the last Congressional session. Each had advantages and disadvantages, as well as different target groups. For a summary of six major federal bills, please see Appendix B. Sixteen states also have some type of tax incentive program in place to increase access as shown in Appendix A.

Currently, there are four major tax based programs in effect. Each program targets a slightly different aspect of insurance coverage and beneficiaries, as described below.⁹³

- Tax Exclusion Of the four current programs, tax exclusion is by far the largest of the tax related subsidy programs. This benefit allows employers to deduct the amount of health insurance contributions they make from their gross income calculation when determining their annual tax liability.
- Individual Health Expense Deductions This program focuses on individuals and/or families who incur extensive medical expenses that are not covered by other medical insurance plans. It allows a tax deduction for individuals or families for the

non-reimbursed medical expenses. This program, however, requires the taxpayer to itemize all of the expenses incurred, and only covers expenses that exceed 7.5% of the household's adjusted gross income.

- Self-Employed Deduction People who are self-employed may deduct 60% of their health insurance costs from their taxable income, with the restriction that the deduction cannot exceed what was made in profit. Recently enacted federal legislation gradually increases this rate to 100% by 2003.
- Health Reimbursement Accounts These programs allow for benefits that come from flexible spending accounts and various "cafeteria plans" to be excluded from both income and employment taxation.

An analysis of any tax proposal must consider how a particular tax benefit generally affects individuals and businesses. Three key concepts are important for this purpose.

- Tax Deductions Under a tax deduction paradigm, people

Closing the Gap

deduct an amount equal to the amount spent on a deductible expense from their gross income. Tax deductions influence which tax bracket an individual falls into, and how much tax is paid out at the end of the year. Tax deductions, however, are regressive in nature. The more money that is earned, the greater the benefit becomes. Conversely, such benefits have no effect on people who do not itemize or have no tax burden, and most uninsured fall into this category. It has been estimated that a tax deduction for non-group health insurance premiums would reduce the number of America's uninsured by only about 250,000.⁹⁴

- Tax Credits In a tax credit system, a person applies a portion of incurred expenses towards the reduction of taxes owed. This affects the amount of taxes paid, but not the gross income calculations. Tax credits are simpler in design and easier to understand, but are also ineffective for people who have little or no tax burden.

Targeting businesses, rather than individuals, might be more effective tax credit for the purpose of expanding coverage. A consensus proposal set forth by Families USA and the Health Insurance Association of America advocates non-refundable tax credits for businesses to encourage them to make coverage affordable for their low income workers. This may be a new approach for expanding coverage, but the business community will recognize its structure from the Work Opportunity Tax Credit (WOTC). The WOTC provides a federal tax incentive for employers to hire individuals from eight target groups of individuals considered to be disadvantaged for employment purposes.

- Refundable Tax Credits Refundable tax credits effectively reduce insurance premium costs, because the credits are used to reduce the person's tax burden or are paid directly to the household if there is no tax liability. A similar approach, the Earned Income Tax Credit,

has successfully increased income for many low-income workers.⁹⁵ Of the three types of tax options currently available, this holds the most promise for reducing the number of uninsured people because approximately one-third of the uninsured have no tax liability.⁹⁶ It is also an appealing approach for people who have an aversion to public assistance programs, because a refundable tax credit would assist them to obtain coverage by privately filing a tax return, rather than enrolling in any specific public programs. It has been estimated that a federal refundable tax credit that could be used for individual or employer-sponsored health insurance would decrease the uninsured population by 12.4 million.⁹⁷

The individual market, however, presents special problems. The credit is unlikely to be large enough to make individual coverage affordable, given the rapidly rising rates in the market. In Maine, the Commissioner of Professional and Financial Regulation noted that about

Closing the Gap

32,000 people now have individual policies, but predicted that, under the current system, Maine's individual insurance market will collapse by the year 2010.⁹⁸ Commissioner Longley explained that Maine law limits the types of policies insurers can write in Maine and the discounts they may offer.⁹⁹ As a result, some carriers left the market, while the remaining ones increased rates so high that some young healthy individuals choose to be uninsured, causing the individual insurance market population to be dominated by older sicker people.¹⁰⁰ In addition, with fewer insurers to choose from, consumers may have much less bargaining power.¹⁰¹ One proposal to address this is to require that tax credits for use in the individual market be linked with a limited number of purchasing pools to keep all those subsidized in a single risk pool with community rating, achieve some administrative efficiencies and create bargaining power.¹⁰² If the tax credits were available *only* through these pools, it would also help assure that the

pools would be large enough to realize their potential.¹⁰³ President Bush, and many legislators, have expressed support for refundable tax credits for the purchase of health insurance.¹⁰⁴ In Maine, the Governor's Blue Ribbon Commission on Health Care recommended "favorable state tax treatment of health care premiums paid by individuals."¹⁰⁵ A refundable tax credit would do just that.

3. A Selection of National Organizations' Proposals

Many national organizations and health care provider associations have joined in the effort to expand coverage, and summaries of eight major proposals are set forth in Appendix C.

The American Hospital Association's (AHA) plan, Incremental Solutions for Improving and Increasing Health Coverage for the Uninsured, is a comprehensive private sector proposal. The AHA's plan targets all of the population groups that are in need of health care coverage: low-income children and their families, high risk individuals, self employed individuals, and employees in small firms that are

unable to sponsor health benefits. Highlights of the AHA proposal include the following incremental expansions.

AHA proposes that state governments expand their Medicaid and CHIP eligibility requirements to cover people now categorically ineligible, single and childless adults. In Maine, there are an estimated 20,871 such people with income below 125% of the federal poverty level.¹⁰⁷ The Maine legislature recently acted to provide coverage to about 16,000 of those adults, those whose incomes are at or below 100% of the federal poverty level.¹⁰⁸ To further assist the working non-categorically eligible population, AHA proposes a refundable tax credit to all low income individuals and families who have incomes up to 300% of poverty level as well as tax credits to small businesses as an incentive to providing insurance coverage plans.

To increase affordability for small employers, AHA suggests developing small employer purchasing cooperatives, seeded by federally provided start-up funding, and giving small employers the opportunity to purchase the

Closing the Gap

same policies that are available to federal workers. At least ten states have already developed reasonably successful group purchasing pools that allow small businesses to jointly purchase health insurance.¹⁰⁹ Insurance pools have several advantages. First, increased numbers of participants helps lower the premium costs to all (group versus individual rates). Second, it decreases the risk of adverse selection. Third, it allows groups that otherwise could not either afford coverage or provide coverage for employees to gain health insurance. Finally, it allows for the cost of health care to be shared by all parties involved.

The AHA proposal also protects high risk individuals with greater health care needs by calling for federal grants to states to create high-risk pools that would provide those individuals with access to affordable insurance. To protect the near-elderly, AHA suggests extending the applicable provisions of the federal Consolidated Omnibus Budget Reconciliation Act to uninsured individuals between the ages of 55 and 65 years old, which would allow them to purchase health coverage at group rates.

The AHA program is designed to be funded from three different sources: the current federal budget surplus, the establishment of a cap on employer health insurance tax exclusion and redirecting those funds into the program, and the investment of state tobacco settlement proceeds into the states health coverage access programs.

AHA's proposal balances social needs and economic constraints. By providing tax benefits to both employers and employees, more uninsured people would have access to health coverage, while requiring little in the way of administrative restructuring. One of the AHA proposal's strengths is the incremental manner in which they propose to enact their plan, because experience has shown that in health care, incremental changes tend to be more politically viable than dramatic comprehensive changes. Also, while taking small steps, there is time for adjusting to the new aspects of a program while at the same time providing an opportunity to ascertain the relative effectiveness of each step.

4. Select State Initiatives

Most states have begun enacting various programs or legislative policies aimed at helping their uninsured access health insurance. While CHIP and Medicaid expansion programs are the most pervasive and successful coverage solutions being utilized by the states, there are still a significant number of uninsured people in this country. This segment examines several state programs to help their uninsured, each offering a slightly different approach to creating new incentives and modes of access for their citizens.

Washington Basic Health Plan¹¹⁰

The Washington Basic Health Plan is a state health insurance program that began in 1987 as part of a health care reform initiative. At the end of 1999, the state programs had an enrollment level of 214,493 residents. This program is available to all Washington residents who meet income guidelines, who are not eligible for Medicaid and who are not institutionalized at the time of enrollment. Funding for this program is provided in part by state premium subsidies, and in

Closing the Gap

part by member premiums.

Members pay sliding scale premiums based on income, age, family size and the choice of health care plans as well as nominal co-payments. Currently, members pay as little as \$10.00 per month.

Benefits are provided through nine private health plans that have contracted with the state program. There are three main categories of benefits available to qualified members as described below.

- **Basic Health.** This is the basic plan for qualified adults. Benefits include hospitalizations, provider visits, emergency services, prescriptions, and other services. Basic Health members have to pay premiums and co-pays, so they will tend to be more cost sensitive. The programs are jointly administered with Medicaid, reducing the potential administration costs of setting up entirely separate programs.
- **Basic Health Plus.** This plan is a coordinated effort between Basic Health and Medicaid to sponsor health care coverage to children 18

years of age or younger.

Families with children who qualify for Basic Health automatically qualify for this program, with no premiums or co-payments. This comprehensive coverage for children adds dental care, vision services, physical therapy and more to the Basic Health benefits.

- **Maternity Benefits.** Basic Health enrollees who have met qualification criteria as set forth by the Department of Social and Health Services receive free maternity care. This program is also a joint effort between Basic Health and Medicaid.

Washington's program benefits both individuals and employers. State-based employers may use this program for their employees who meet the eligibility requirements. If employers choose to participate, they must pay a minimum monthly rate of \$45.00 per full-time employee and \$25.00 per part-time employee.

The Health Care Authority specifically states that this program is not welfare, but an alternative health care program for low-income working families, people

who are unable to receive coverage through their employers, or for people/families who may not be able to pay the cost of purchasing insurance on their own. This element helps to eliminate the stigma of receiving "welfare." In fact, Washington permits families to choose between Medicaid and the Basic Health Plan and has found that many choose the Basic Health Plan, despite the mandatory financial contribution and less comprehensive benefits.¹¹¹

Oregon Family Health Insurance Assistance Program¹¹²

The Family Health Insurance Assistance Program (FHIAP) is part of the Oregon Health Plan, and currently provides health insurance premium subsidies to 4,648 low-income working Oregon residents. Enrollment is capped according to available funding. As of September 24, 2001, 608 additional individuals had been approved to be enrolled in the program, 61 applications were under review and over 18,000 people on the waiting list for an application.

Established in 1997, FHIAP is a state paid subsidy program that is

Closing the Gap

designed to offset the cost of private insurance premiums. This program is administratively simple because the enrollee obtains the insurance coverage, with the state only then providing a subsidy to offset part of the cost. It also has the advantage of utilizing the existing private insurance industry, resulting in potential cost savings over setting up a separate system.

Qualified individuals and families purchase insurance either on their own or through their employer. The design of this program allows individuals and families to choose the program that best suits their needs, although employed persons must use their employer-sponsored coverage when available. To qualify, the prospective member must not have had insurance coverage for at least six months, meet specified income criteria, be ineligible for Medicaid and own no more than \$10,000 in investments, including cash, checking and savings accounts, but excluding Individual Retirement Accounts, cars and a home.

The state pays for a portion of the monthly insurance premium, while the enrollee finances the

remaining portion. Individuals and families must be enrolled in a group plan or have individual insurance coverage to receive the subsidy. In addition, this program applies to all insurance carrier plans, whether individually purchased or employer-sponsored.

This subsidy program does not compensate for the premium difference between the cost of group plans and the cost of individual plans. Under this plan the person who is able to take advantage of employer sponsored group coverage will, dollar for dollar, receive more benefit than the individual insurance purchaser.

FHIAP is available to both individuals and employers. This has the advantage of providing small firms with the ability to sponsor health insurance where they may not have otherwise been able to offer that benefit to their employees.

Wisconsin BadgerCare¹³

BadgerCare extends a Medicaid managed care plan to uninsured families with incomes at 185% of federal poverty level or less, with

families at or below 150% paying no premiums for access to insurance. Individuals without children are ineligible. BadgerCare became operational in July 1999 and is funded through a combination of state funds and federal CHIP money. State residents are not eligible for BadgerCare if they have had insurance coverage during the previous three months unless the coverage was lost for “good cause,” if they are eligible for Medicaid, or if any other type of health insurance currently covers the family, including employer sponsored plans as long as the employer pays at least 80% of the premium. Once enrolled, beneficiaries remain covered if they earn up to 200% of poverty level, and children remain covered up to age 19.

BadgerCare covers all of the same services offered by Medicaid. Members may have to pay a nominal co-pay on some services (such as prescriptions, dental, physician office visits, etc.), but this amount is never more than \$3.00 and as little as \$0.50. In order to have benefits covered by BadgerCare, a Medicaid certified provider must render services. The program began in 1999, and as of August 2001,

Closing the Gap

BadgerCare had enrolled a total of 87,372 people (24,792 children, 2,731 low-income teenagers and 59,849 adults). BadgerCare may also provide health care coverage to families through their employer's health insurance plan under the Health Insurance Premium Payment program. This option, however, requires that the state costs for paying the employee share of the premium plus the coinsurance and deductibles, must be less than the cost of Medicaid health maintenance organization coverage for the family.

MinnesotaCare¹¹⁴

Minnesota has the second lowest rate of uninsured residents in the country.¹¹⁵ One reason for that is MinnesotaCare, a state subsidized managed care program that has been in operation since 1992. This program is available to families with children who are at or below 275% of the federal poverty level; single adults and couples up to 175%; and to pregnant women and children up to 275% of the federal poverty level. In addition to meeting income guidelines, prospective recipients cannot receive benefits if they are covered by Medicaid, have had

health insurance coverage during the previous four months, or have current access to employer-sponsored health insurance where the employer pays at least 50% of the cost.

Funding for MinnesotaCare comes from a variety of sources, including a 2% tax on health care providers, enrollee monthly premiums (based on income and family size), state revenues and from matching federal funds and programs (such as CHIP). Also, all non-pregnant adults are required to pay a 10% co-pay (up to \$1,000 per health plan per adult or \$3,000 per plan per family) for services.

Benefits include many health services such as physician and hospital services, chiropractic services, mental health services, chemical dependency services, transportation to medical appointments, vision care, dental care for people up to age 21, including orthodontia, pregnancy and neonatal care, hospice care, most prescription drugs, and medical supplies.

As of June 2001, MinnesotaCare had enrolled 136,532 persons (45,028 adults with children,

25,137 adults without children and 66,367 children). One reason for such profound success has been the extensive community-based outreach program. Every county has some form of community program that is designed to provide information about various options and eligibility requirements to the general public. Every community program has mechanisms in place to identify people who may qualify for MinnesotaCare. Finally, all of the public, most of the private schools, and all hospitals provide informational services to all new students or patients.

One concern with this program is that it may give businesses currently covering more than 50% of the premium cost incentive to fund less, and pass on more of the cost to the employees through the state program. This does not appear to be the case in Minnesota, however, possibly because of the heightened level of community involvement.

New York's Health Care Reform Act 2000 (HCRA)¹¹⁶

New York's Health Care Reform Act 2000 is an extension of their 1996 Health Care Reform

Closing the Gap

Program. This plan targets two groups: those individuals and families who cannot afford health insurance on their own, and small businesses that are unable to sponsor health benefits. The HCRA is a subsidy-based program combined with several legislative enactments regulating health care services and insurance benefits packages.

Under this program, the state will reimburse associated health maintenance organizations (HMOs) for individual claims between \$30,000 and \$100,000, while requiring the HMO to cover the costs above and below these figures. Notably, these health plans are exempt from certain state-mandated benefits. HCRA will also provide state subsidies to qualified businesses of 50 employees or fewer to help defray the cost of insurance premiums. Through the New York State Small Business Health Insurance Partnership Program, the state assists eligible employers purchase small group health insurance policies for their full-time employees and dependents. Benefits in both of these programs include inpatient and outpatient physician and hospital services, maternity and family

care and a prescription drug plan.

In addition to providing financial assistance to individuals and businesses HCRA, through the Family Health Plus Program, expands a previous child-based initiative to the parents of children who are eligible for this subsidized health care, so that the parents can receive the same benefits. This effectively expands Medicaid benefits for families below 150% of the federal poverty level, and for individuals up to 100% of the poverty level. The Children's Health Plan, since 1996, has grown from an enrollment of 125,000 to more than 415,000 children. With the changes to the HCRA and the various other new implementations to the Medicaid and state sponsored initiatives, New York's plan has provided health care coverage to nearly one million residents. Also, in an attempt to support access to uninsured people who may not qualify for any of these new programs, New York has allocated \$765 million annually to be provided directly to various state hospitals to support indigent care.

One unique aspect of the HCRA

is its funding structure. In addition to the usual combination of federal and state funds that help support this program, New York receives additional funds from other sources. First, there is a high tax on tobacco products (currently \$1.11 per pack of cigarettes) that, combined with the Tobacco Settlement monies, supports the state's Tobacco Prevention Program and the HCRA. Additional funding comes from the county governments that must pay for a part of the Medicaid costs connected with providing coverage to Medicaid eligible people in their particular county.

Maryland Health Improvement Plan 2000-2010 (Draft)¹¹⁷

Similar to Maine, Maryland has an uninsured rate of 11.8%, and two-thirds of their uninsured are employed.¹¹⁸ Recognizing that those without coverage are more likely to be unable to obtain needed health care and/or forgo necessary care or prescriptions, the state of Maryland has formally set the goal of providing access to health care for all state residents by the year 2010. According to the draft plan, the state will legislatively create a

Closing the Gap

Task Group to develop a method to accurately assess and monitor the health coverage needs of Maryland residents by 2002. By 2006, Maryland will design a model plan to improve access and utilization of health care services based on the findings of the Task Group. By 2010, the state will implement the model plan to provide affordable access to health care for all Maryland residents.

Massachusetts: MassHealth Programs¹¹⁹

The Massachusetts state government designed the MassHealth Family Assistance Program (MFAP) to reduce barriers to health insurance coverage for both employers and employees. The program is financed with state and federal funds, and has two components. The first is the Premium Assistance Program that offers subsidies to help low-wage workers (up to 200% of the federal poverty level) pay their share of the employer-based health insurance plans. The employees' share of the premium is capped at up to \$25 per month per childless adult, or \$10 per child up to \$30 per month, and the state pays the rest.¹²⁰ There

is an additional benefit for participating employees in that the state provides them with the same level of benefits as the Medicaid program, which covers far more services than private insurance products.

The second component is the Insurance Partnership that offers subsidies to small businesses, including the self-employed, that sponsor health plans that meet minimum benefits standards.¹²¹ Businesses are eligible for the subsidy if they employ 50 or fewer full-time workers, offer comprehensive health insurance, and contribute at least 50% of the premium. The state reimburses qualified companies \$33 per month per individual plan, and up to \$83 per month per family plan.¹²² The state pays the total amount of the Insurance Partnership payment to the health insurance intermediary or directly to the employer.

The program's success can be shown in the dramatic decline in the state's uninsured rate. Before MFAP's implementation, the overall rate of the uninsured in Massachusetts was 11.4%. In the spring of 2000, it was just 8.1%.¹²³ Specifically, as of Sep-

tember 2000, the Premium Assistance Program subsidized approximately 12,000 employees and the Insurance Partnership subsidized approximately 1,620 employers.¹²⁴ The state attributes the program's success to outreach and marketing efforts, simplifying and automating its eligibility and enrollment systems, and comprehensive training of staff.¹²⁵ Generally, the simplified eligibility determination process allows applications to be processed within 3-5 days. Their successful outreach efforts have the additional benefit of making Massachusetts the second best among all states in its average monthly progress in enrolling eligible children for health insurance coverage under the CHIP and Medicaid programs.

Prior to implementing the demonstration project, the state began referring to its seven health insurance programs as sub-types of MassHealth coverage, rather than expanded Medicaid or CHIP programs.¹²⁶ This relatively small administrative step works to minimize the stigma associated with state assistance programs. The MassHealth member card looks very much

Closing the Gap

like a commercial carrier's card, which further blurs the distinction between public and private sector health coverage programs. In addition, the MFAP materials clearly state that the program is not a health insurance plan, but a program that helps pay for employer-based coverage.

There is no requirement that MFAP's enrollees be uninsured or that employers be offering health insurance benefits for the first time. Although most programs have such requirements to avoid crowd-out, approximately 60% of the participating employers in Massachusetts did not previously offer health insurance coverage.¹²⁷ It appears that the MFAP subsidy may provide sufficient assistance for employers to begin offering health coverage, and assist employers, who might otherwise stop offering the benefit due to increasing premium rates, to continue sponsoring health insurance for their employees.¹²⁸

Eligibility for MassHealth Family Assistance is income-based, rather than being tied to parental status. Although such a program requires a Medicaid Section 1115 waiver, it allows the program to

reach single adults and childless couples. The state recently announced its plans to request federal approval for a three year extension of its original 1115 Demonstration Project that allows for the successful operation of MassHealth Program.

VI. Conclusion

Approximately 150,441 Maine citizens have higher rates of morbidity and mortality than their neighbors just because they do not have health insurance coverage.¹²⁹ This is tragic and absolutely unacceptable. We can, and we must, do better. Maine's hospitals believe that this national problem would best be resolved with a national solution whereby this country ensures that every citizen has health insurance coverage as a right of citizenship. Unless or until our country is ready to accept this responsibility, however, we believe the most politically viable solution lies in taking carefully calculated incremental steps toward our goal of universal coverage.

We would begin by building on existing structures in the public and private sectors: Medicaid, CHIP, and the employer-based health insurance system. Our first priority would be to enroll all of those currently eligible for government assistance or employer-sponsored health insurance. We would continually work to improve the outreach

efforts for government programs, remembering that 75% of the parents of uninsured children eligible for Medicaid are employed.¹³⁰

Our second priority would be to provide coverage for the unemployed uninsured who are least able to afford it, and the most effective way to do that is to expand publicly provided insurance.¹³¹ We believe that a major factor contributing to the recent decreased number of uninsured are some states' successful efforts to cover families in expanded Medicaid programs as well as the federally sponsored Children's Health Insurance Program. Maine, in particular, has been a leader in such expansion of access through the Medicaid and CHIP programs. However, further expansions, or even sustaining these programs at their current levels, requires significant state and federal funding that may be harder to find as the surpluses of recent years are turning into deficits. This is especially true in Maine, where the \$6,888 per enrollee annual costs in the

Medicaid program is so much higher than the rest of the nation, making Medicaid the second largest component of the state budget.¹³²

If the funding is available, however, maintaining and expanding the public programs is a reasonably efficient method of increasing coverage. The Medicaid and CHIP programs already serve nearly 40 million people, and consequently already have the necessary provider contracts, the administrative infrastructure to determine eligibility and provider enrollment, as well as an established method for obtaining federal matching funds.¹³³ In addition, the Maine Medicaid program has low administrative costs of approximately 5%, contrasted with private insurers average administrative costs of about 15%.¹³⁴ Still, funding expansion will always be difficult. It is critically important to maximize use of federal funds to ease the burden on our state's budget, because expansion of coverage is an expensive undertaking. We should also keep in mind that the

Closing the Gap

federal match for our CHIP program is 1:3, but it is 1:2 for our Medicaid program.¹³⁵ Investment of public money, both state and federal, is absolutely necessary. The Secretary of the Department of Health and Human Services, Tommy Thompson, has often emphasized the need to invest in services for low-income people, as he stated at his confirmation hearing, “For welfare reform to be successful, you have to make an investment up front; it cannot be done on the cheap.”¹³⁶ Fortunately, Congress recently passed a budget resolution that would earmark funds for the uninsured. The resolution is for fiscal year 2002, and provides a \$28 billion reserve fund over ten years to cover costs of legislation that would provide coverage to the uninsured. Unfortunately, the resolution states the money will be available only so long as a surplus continues to exist, so the future availability of that funding is not assured.¹³⁷

Next, remembering that 71% of Maine’s uninsured are employed, we must assist both employers and employees to purchase health insurance. The low income workers face a triple threat:

they are less likely to be offered employer-based coverage; they have to pay considerably for coverage when their employers do offer it; and they have the least amount of discretionary income available to pay for coverage.¹³⁸ However, enrolling all of the uninsured persons with access to employer-based health insurance would shrink the ranks of our nation’s uninsured more than any other incremental expansions that have been tried or are being considered.¹³⁹

In summary, we should begin by facilitating enrollment of the uninsured in any access option currently available to them. We also need to expand public programs to help those unable to help themselves, assist those working uninsured who need assistance to participate in their employer’s plan, and help small businesses gain easier access to affordable insurance plans. We believe those objectives are achievable through the following actions:

- Advocate that the state apply for the necessary federal waivers to set up a program modeled after MassHealth that would subsidize certain low-wage workers’ share of eligible employer-based

health insurance plans, and offer subsidies to small businesses to help pay for health insurance premiums of low-wage workers;

- Encourage the creation of purchasing cooperatives for small businesses to obtain coverage plans for their employees;
- Support refundable tax credits for monies spent on health insurance coverage;
- Expand coverage for the unemployed uninsured by raising eligibility income levels of state programs;
- Further streamline the application process for Medicaid and the Children’s Health Insurance Program, including allowing families to self-declare eligibility information;
- Encourage the state to track enrollees and monitor reasons for disenrollment, including administrative errors and change of address, then act to correct any systemic shortcomings;
- Intensify efforts to reach and enroll children in families with limited English proficiency in our state programs;
- Recruit more participating providers to improve access

Closing the Gap

to health care services, especially in areas of limited resources such as dental services;

- Make government program payment rates to providers comparable to the commercial market to eliminate cost shifting; and
- Educate policy-makers and the general public about the importance of health insurance and preventive care.

Taking any of one of these steps alone will not maximize access expansion, because different groups of uninsured and underinsured have different needs.

However, in the absence of a national solution, we believe that this multi-pronged approach will provide coverage to the maximum number of people, thereby improving the health of Maine's people because while coverage alone does not ensure good health, the absence of coverage is a major contributor to poor health.

APPENDICES

Appendix A State Coverage Matrix¹⁴⁰

Fifty state table indicating type of Medicaid and CHIP expansions, and whether there are other coverage programs, high-risk pools and/or tax incentives.

Appendix B Side-By-Side Analysis of Congressional Proposals¹⁴¹

H.R. 2488- The Taxpayer Refund and Relief Act of 1999

H.R. 2020- Tax Relief for Working American Act of 1999

H.R. 2185- Health Insurance for Americans Act of 1999

H.R. 2362- Fair Care for the Uninsured Act of 1999

H.R. 1819- Working Uninsured Tax Equity Act of 1999

H.R. 1687- Patients' Health Care Choice Act of 1999

Appendix C Meeting the Challenges of the Uninsured: Comparison of Proposals¹⁴²

American Hospital Association: Incremental Solutions for Improving and Increasing Health Coverage for the Uninsured

American Medical Association: Rethinking Health Insurance to Expand Coverage to All Americans

American Nurses Association: Achieving Access for All Americans

The Catholic Health Association of the United States: Building an Infrastructure for Universal Coverage Expanding Coverage to America's Uninsured

Families USA: The Building Blocks of Universal Coverage

Health Insurance Association of America: InsureUSA

Service Employees International Union: The American Health Security Plan

United States Chamber of Commerce: Discussion Outline for Affordable Access to Health Care

APPENDIX A

State Coverage Matrix

State	Medicaid				State Children's Health Insurance Program				State-Only		
	Section 1115	Section 1931	HIPP	TMA	SCIP Program	Employer Buy-In	Section 1115	Full Cost Buy-In	Coverage Program	High-Risk Pool	Tax Incentives
Alabama					*					*	
Alaska		*			*					*	
Arizona	*	*		*	*						
Arkansas	*	*			*					*	
California		*		*	*					*	*
Colorado					*					*	*
Connecticut		*		*	*			*		*	
Delaware	*			*	*						*
District of Columbia		*			*						
Florida		*			*			*		*	
Georgia					*						*
Hawaii	*				*						
Idaho					*					*	*
Illinois					*				*	*	*
Indiana					*					*	
Iowa		*	*		*					*	*
Kansas		*			*					*	*
Kentucky					*					*	
Louisiana					*					*	
Maine		*			*						*
Maryland		*			*	*					
Massachusetts	*				*	*			*		
Michigan					*						
Minnesota	*	*			*		*		*	*	
Mississippi					*	*				*	
Missouri	*		*		*					*	*
Montana		*			*					*	
Nebraska		*		*	*					*	
Nevada		*			*						
New Hampshire		*			*						
New Jersey		*		*	*	*					*
New Mexico	*	*			*					*	*
New York	*	*			*			*			
North Carolina				*	*			*			*
North Dakota		*			*					*	
Ohio		*			*						
Oklahoma		*			*					*	
Oregon	*	*			*				*	*	
Pennsylvania		*	*		*						
Rhode Island	*	*		*	*		*		*		
South Carolina		*		*	*					*	
South Dakota					*						
Tennessee	*			*	*						
Texas			*	*	*					*	
Utah				*	*					*	*
Vermont	*	*		*	*						
Virginia			*		*	*					
Washington		*			*				*	*	
West Virginia					*						
Wisconsin	*	*	*		*	*	*			*	*
Wyoming		*			*					*	
All States	14	30	6	13	51	6	4	4	6	29	15

Appendix B

SIDE-BY-SIDE ANALYSIS OF CONGRESSIONAL PROPOSALS

	H.R. 2488	H.R. 2020 (Johnson)	H.R. 2185 (Stark)	H.R. 2362 (Arney)	H.R. 1819 (McDermott)	H.R. 1687 (Shadegg) ¹²
A. Tax Benefit						
Tax Deduction	Above-the-line deduction for percentage of the amount paid for health insurance. ¹³	Above-the-line deduction for percentage of the amount paid for health insurance (including the self-employed). ¹⁴	No provision	No provision	No provision	No provision
Tax Credit	No provision	Non-refundable tax credit for percentage of amount paid for health insurance.	Refundable tax credit for the amount paid for qualified health insurance.	Refundable tax credit for the amount paid for health insurance. ¹⁵	Refundable tax credit for percentage of amount paid for health insurance.	Refundable tax credit for purchase of qualified health insurance.
Self-Employed Deduction	Accelerates the self-employed health insurance deduction.	No provision	No provision	No provision	No provision	No provision
Exclusion of Employer Payments	No provision	No provision	No provision	No provision	No provision	Exclusion of employer's "compensating coverage payments" from employee's gross income. ¹⁶
Exclusion of Employee Payments	No provision	No provision	No provision	No provision	No provision	No provision
B. Value of Benefit						
Tax Deduction	Deductible percentages are 25% in 2002-2004; 35% in 2005; 65% in 2006; and 100% in 2007 and thereafter.	Deductible percentages are 60% in 2000; 70% in 2001; 80% in 2002; 90% in 2003 (100% for the self-employed); and 100% in 2004 and thereafter.	No provision	No provision	No provision	No provision

	H.R. 2488	H.R. 2020 (Johnson)	H.R. 2185 (Stark)	H.R. 2362 (Arney)	H.R. 1819 (McDermott)	H.R. 1687 (Shadegg)
B. Value of Benefit (cont.)						
Tax Credit	No provision	60% of the amount paid for health insurance, up to \$1,200 for individual coverage and \$2,400 for family coverage.	100% of the amount paid, up to \$1,200 each for the taxpayer and spouse and up to \$600 each for up to 2 dependent children. ⁷ The credit is advance-payable directly to insurers (administered through a new Office of Health Insurance (OHI)).	100% of the amount paid, up to \$1,000 each for the taxpayer and spouse and \$500 each for up to 2 dependent children. ¹⁸ The credit is advance-payable to the individual's health insurer.	30% of the amount paid (limited to amount of earned income); limited to sum of income and social security taxes.	100% of the amount paid, up to \$500 for individual coverage And \$1,000 for family coverage. ¹⁹
Self-Employed Deduction	Increases deductible portion to 100% in 2000 (currently scheduled for 2003).	No provision	No provision	No provision	No provision	No provision
Exclusion of Employer Payments	No provision	No provision	No provision	No provision	No provision	Excludes from the employee's income the amount of the employer payment to employees electing not to participate in employer health plan. Payment cannot be less than what the employer would have paid for the employee's health insurance if the employee had elected to be covered. ²⁰
Exclusion of Employee Payments	No provision	No provision	No provision	No provision	No provision	No provision

This information was reprinted with permission of the Henry J. Kaiser Foundation of Menlo Park, California. The Kaiser Family Foundation is an independent health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries. Weiss, Randall and Mark GaryRecent Tax Proposals to Increase Health Insurance Coverage, p. 7-15. January 2000, The Henry J. Kaiser Family Foundation. Available at: kff.org/content/2000/1563/sidebyside.pdf [April 1, 2001].

	H.R. 2488	H.R. 2020 (Johnson)	H.R. 2185 (Stark)	H.R. 2362 (Arney)	H.R. 1819 (McDermott)	H.R. 1687 (Shadegg)
C. Eligibility						
Tax Deduction	Taxpayer must not participate in an employer-sponsored plan where 50% or more of the cost is paid by the employer. ²¹ or not be enrolled in Medicare, Medicaid, FEHBP, CHAMPUS, VA, Indian Health Service, or a State Children's Health Insurance Program. ²²	Taxpayer must not participate in an employer-sponsored plan where at least 50% of the cost is paid by the employer.	No provision	No provision	No provision	No provision
Tax Credit	No provision	Available to taxpayers who for at least one year have not been eligible to participate in an employer plan or who have not participated in any group health plan of any other entity; with incomes below \$40,000 (\$70,000 for families); not enrolled in Medicare, Medicaid, FEI-IBP, CHAMPUS, VA, Indian Health Service, or a State Children's Health Insurance Program. ²³	Available to everyone not participating in an employer-subsidized health plan, Medicare, or Medicaid; not receiving VA or Indian health benefits; not in prison; and who is living in the U.S. at least half the year. ²⁴	Available to everyone not participating in an employer-subsidized health plan, Medicare, or Medicaid; not receiving VA or Indian health benefits; not in prison; and who is living in the U.S. at least half the year. ²⁵	Available to all persons not eligible to participate in an employer-subsidized health plan or Medicare. Full credit is available for those with AGI not exceeding \$30,000 for individuals/\$50,000 for joint returns; a reduced credit is available for those with AGI up to \$40,000/\$60,000. ²⁶	Available to everyone not participating in an employer-subsidized health plan, and not receiving a "compensating coverage payment" excluded from gross income.

This information was reprinted with permission of the Henry J. Kaiser Foundation of Menlo Park, California. The Kaiser Family Foundation is an independent health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries. Weiss, Randall and Mark Garay, Recent Tax Proposals to Increase Health Insurance Coverage, p. 715, January 2000, The Henry J. Kaiser Family Foundation. Available at: kff.org/content/2000/1563/sidebyside.pdf [April 1, 2001].

	H.R. 2488	H.R. 2020 (Johnson)	H.R. 2185 (Stark)	H.R. 2362 (Armey)	H.R. 1819 (McDermott)	H.R. 1687 (Shadegg)
C. Eligibility (cont.)						
Self-Employed Deduction	Available to self-employed taxpayers only in months when the taxpayer does not participate in a subsidized health plan maintained by any employer of the taxpayer or the taxpayer's spouse. No provision	No provision	No provision	No provision	No provision	No provision
Exclusion of Employer Payments	No provision	No provision	No provision	No provision	No provision	Not available to any employee: (1) covered under a subsidized health plan of another employer; ²⁷ (2) normally working fewer than 25 hours per week; (3) normally working not more than 6 months during any year; (4) under age 21; or (5) covered by a collective bargaining agreement.
Exclusion of Employee Payments	No provision	No provision	No provision	No provision	No provision	No provision

This information was reprinted with permission of the Henry J. Kaiser Foundation of Menlo Park, California. The Kaiser Family Foundation is an independent health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries. Weiss, Randall and Mark Garay, Recent Tax Proposals to Increase Health Insurance Coverage, p. 715, January 2000, The Henry J. Kaiser Family Foundation. Available at: kff.org/content/2000/1563/sidebyside.pdf [April 1, 2001].

	H.R. 2488	H.R. 2020 (Johnson)	H.R. 2185 (Stark)	H.R. 2362 (Arney)	H.R. 1819 (McDermott)	H.R. 1687 (Shadegg)
D. Other Significant Limitations						
Tax Deduction	Amounts taken into account for this deduction cannot also be used for the itemized medical deduction or the self-employed health insurance deduction. No provision	Amounts taken into account for this deduction cannot also be used for the itemized medical deduction. Limited to taxpayers who purchase individual or COBRA health insurance. Amounts taken into account for this credit cannot also be used for the above-the-line deduction described above.	No provision Available to buy only private insurance sold through new OHI. Amounts taken into account for this credit cannot also be used for the itemized medical deduction. The self-employed could elect either the credit or the deduction for self-employed health insurance expenses.	No provision Amounts taken into account for this credit cannot also be used for the itemized medical deduction. The self-employed elect either the credit or the deduction for self-employed health insurance expenses. ²⁸	No provision Amounts taken into account for this credit cannot also be used for the itemized medical deduction. The self-employed elect either the credit or the deduction for self-employed health insurance expenses. ²⁸	No provision Qualified insurance ²⁹ excludes: (1) policies with an annual deductible or out-of-pocket expenses which are more than allowed under high deductible health plans used in conjunction with MSAs; ³⁰ or (2) policies with certain exclusions from, or limitations on, coverage for pre-existing medical conditions of certain applicants; ³¹ (3) Medicare, Medicaid, FEHBP, CHAMPUS, VA, or Indian Health Service coverage.
Tax Credit						

This information was reprinted with permission of the Henry J. Kaiser Foundation of Menlo Park, California. The Kaiser Family Foundation is an independent health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries. Weiss, Randall and Mark Garay, Recent Tax Proposals to Increase Health Insurance Coverage, p. 715, January 2000, The Henry J. Kaiser Family Foundation. Available at: kff.org/content/2000/1563/sidebyside.pdf [April 1, 2001].

	H.R. 2488	H.R. 2020 (Johnson)	H.R. 2185 (Stark)	H.R. 2362 (Armey)	H.R. 1819 (McDermott)	H.R. 1687 (Shadegg)
D. Other Significant Limitations (cont.)						
Self-Employed Deduction	None	No provision	No provision	No provision	No provision	No provision
Exclusion of Employer Payments	No provision	No provision	No provision	No provision	No provision	The employer is required to agree to make such payments to all its eligible employees and to permit employees to make this election when first hired and during open enrollment periods held at least annually.
Exclusion of Employee Payments		No provision	No provision	No provision	No provision	No provision
E. Effective Date						
Tax Deduction	Taxable years beginning after December 31, 2001.	Taxable years beginning after December 31, 1999.	No provision	No provision	No provision	No provision
Tax Credit	No provision	Taxable years beginning after December 31, 1999.	Taxable years beginning after December 31, 2000.	Taxable years beginning after December 31, 1999.	Taxable years beginning after the date of enactment.	Applies to taxable years beginning after December 31, 1999, and terminates for taxable years beginning after December 31, 2002. ³²
Self-Employed Deduction	Taxable years beginning after December 31, 1999.	No provision	No provision	No provision	No provision	No provision
Exclusion of Employer Payments	No provision	No provision	No provision	No provision	No provision	Taxable years beginning after December 31, 1999.
Exclusion of Employee Payments	No provision	No provision	No provision	No provision	No provision	No provision

This information was reprinted with permission of the Henry J. Kaiser Foundation of Menlo Park, California. The Kaiser Family Foundation is an independent health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries. Weiss, Randall and Mark GarayRecent Tax Proposals to Increase Health Insurance Coverage, p. 7-15, January 2000, The Henry J. Kaiser Family Foundation. Available at: kff.org/content/2000/1563/sidebyside.pdf [April 1, 2001].

	H.R. 2488	H.R. 2020 (Johnson)	H.R. 2185 (Stark)	H.R. 2362 (Arney)	H.R. 1819 (McDermott)	H.R. 1687 (Shadegg)
F. Non-Tax Subsidies and Related Reforms	None	None	Any insurer covering federal workers through FEHBP is required to sell one or more policies through OHI. These policies will provide benefits equivalent to those available through FEHBP. ³³	Directs the HHS Secretary to study and recommend by October 1, 2000, ways to encourage states to help individuals who are too sick to insure at rates that reflect their true risk, but are willing to pay more than what healthy people pay through high-risk pools.	None	Establishes HealthMarts, Association Health Plans, and individual Membership Associations. ³⁴ Provides that each state receive from HHS an amount equal to 50% of the funds expended by the state for a health benefits high risk pool, reinsurance pool, or other risk adjustment mechanism to subsidize the purchase of private health insurance. ³⁵
G. Status	These provisions, which were part of a larger tax cut bill, were approved by Congress in August 1999, but vetoed by the President on September 23, 1999. The tax provisions to increase health insurance coverage in H.R. 2498 were subsequently included in H.R. 2990, the Quality Care for the Uninsured Act of 1999, which passed the House on October 6, 1999.	Referred to the House Ways and Means Committee on June 7, 1999.	Referred to the House Ways and Means Committee on June 14, 1999.	Referred to the House Committees on Ways and Means, and Government Reform on June 14, 1999.	Referred to the House Ways and Means Committee on May 14, 1999.	Referred to the House Committees on Commerce, Ways and Means, and Education and the Workforce on May 5, 1999.

This information was reprinted with permission of the Henry J. Kaiser Foundation of Menlo Park, California. The Kaiser Family Foundation is an independent health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries. Weiss, Randall and Mark Garay, Recent Tax Proposals to Increase Health Insurance Coverage, p. 715, January 2000, The Henry J. Kaiser Family Foundation. Available at: kff.org/content/2000/1563/sidebyside.pdf [April 1, 2001].

IV. ENDNOTES FOR APPENDIX B

¹See Section III of this analysis for definitions of many of the terms used in the Overview and in the Side-by-Side table.

²Internal Revenue Code section 213.

³Internal Revenue Code section 106.

⁴Internal Revenue Code section 105.

⁵The self-employed health deduction also applies to qualified long-term care insurance premiums treated as medical care for purposes of the itemized deduction for medical expenses.

⁶For tax years beginning on or before December 31, 1998, the applicable percentage for calendar year 1999 is 45 percent. For tax years beginning after December 31, 1998, the applicable percentages are as indicated. Internal Revenue Code section 162(l)(1).

⁷Internal Revenue Code section 162(l)(3).

⁸Internal Revenue Code section 162(a); Treasury Regulation section 1.162-10.

⁹The Johnson bill is second because it shares an almost identical above-the-line deduction with H.R. 2488, and because it serves as a bridge to the other plans that have tax credit provisions like it does. The Stark and Armev proposals are next because they both have refundable tax credits that are advance payable. The McDermott and Shadegg plans follow because they each propose refundable tax credits that are not advance-payable.

¹⁰In the description of its plan, the ACP-ASIM materials indicate that Congress "should consider making coverage available to all Americans with income within 200 percent of poverty. This could be accomplished by enacting the proposals in this plan and expanding the refundable tax credits to all individuals within 200 percent of poverty."

¹¹The analysis of the provisions of the HIAA InsureUSA Initiative is based on an outline of the plan presented in the testimony of HIAA President, Charles N. Kahn, 111, before the House Committee on Ways and Means, June 16, 1999, and on fact sheets obtained from the InsureUSA Initiative web site at www.insureusa.org.

¹²The bill also includes provisions to expand the availability and the value of current law MSAs.

¹³The deduction applies only to health insurance for medical care (i.e., it does not apply to non-insurance medical expenses themselves). Another provision of the bill provides a similar deduction for qualified long-term care insurance expenses. The bill also allows qualified long-term care insurance to be offered under a cafeteria plan or a flexible spending account.

¹⁴Rep. Johnson also proposes a similar deduction for long-term care insurance costs.

¹⁵The credit could be used with an MSA.

¹⁶Employer payments to a medical savings account of the employee or the employee's spouse also are excluded.

¹⁷These amounts are adjusted annually for inflation in health plan costs.

¹⁸These amounts are adjusted annually for changes in the Consumer Price Index.

¹⁹Adjusted annually for changes in the Consumer Price Index.

²⁰Employers may take into account (on an actuarial basis) the age, sex, and geography of the employee and similarly situated beneficiaries in determining such payments.

²¹In determining whether the 50-percent threshold is met, all health plans of the employer in which the employee participates are treated as a single plan. If the employer pays for less than 50 percent of the cost of all health plans in which the individual participates, the deduction is available only with respect to individual plans for which the employer subsidy is less than 50 percent.

Any amount excludable from the gross income of the employee under the exclusion for employer-provided health coverage is treated as paid or incurred by the employer. So, for example, health insurance purchased by an employee through a cafeteria plan with salary reduction amounts is considered to be paid for by the employer. Excludable employer contributions to a health flexible spending arrangement or medical savings account (including salary reduction contributions) are also considered amounts paid by the employer for health insurance that constitutes medical care. Salary reduction contributions are not considered to be amounts paid by the employee.

²²So, for example, the deduction is not available with respect to Medigap coverage (private insurance for medical expenses not covered by Medicare) because such coverage is provided to individuals enrolled in Medicare.

²³So, for example, the credit is not available with respect to Medigap coverage (private insurance for medical expenses not covered by Medicare) because such coverage is provided to individuals enrolled in Medicare.

²⁴See Endnote 24.

²⁵See Endnote 24.

²⁶See Endnote 24.

²⁷Or covered under a health plan of an employer of the employee's spouse.

²⁸The credit is not available for amounts paid for Medicare Part B or Medicare supplemental insurance.

This information was reprinted with permission of the Henry J. Kaiser Foundation of Menlo Park, California. The Kaiser Family Foundation is an independent health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries. Weiss, Randall and Mark Garay, *Recent Tax Proposals to Increase Health Insurance Coverage*, p. 7-15, January 2000, The Henry J. Kaiser Family Foundation. Available at: kff.org/content/2000/1563/sidebyside.pdf [April 1, 2001].

Endnotes for Appendix B continued

²⁸The credit is not available for amounts paid for Medicare Part B or Medicare supplemental insurance.

²⁹Insurance purchases taken into account for the credit could not also be used for purposes of the itemized medical deduction or for the self-employed health insurance deduction.

³⁰The highest deductible limit allowable for such plans is \$2,250 (\$4,500 for family coverage) and the highest out-of-pocket expense allowable is \$3,000 (\$4,500 for family coverage). Internal Revenue Code section 220(c)(2)(A).

³¹This applies to individuals who have been continuously insured for one year under otherwise qualified health insurance, Medicare, Medicaid, FEHBP, CHAMPUS, VA, or Indian Health Service programs.

³²According to the statutory language, "Although Congress intends that the credit be permanent, providing that the credit be extended in 2-year intervals insures proper oversight. During the oversight and extension process, the credit should be adjusted to maintain tax equity with the average tax subsidy received by those in an employer-provided group health plan and ensure the ability to purchase at least catastrophic health coverage." Section 502(b) of H.R. 1687.

³³OHI would hold an annual open enrollment period (similar to FEHBP's fall open enrollment) at which insurers would be required to sell a policy similar to that which they offer to Federal workers. Such policies could not have pre-existing condition exclusions or waiting periods, their premiums and benefits would be negotiated between the carrier and OHI, and they would be community-rated (i.e., the premium would not rise in price as individuals age).

³⁴These entities would be intended to create new pooling mechanisms for companies and various associations to lower the cost of providing health insurance.

³⁵The bill also would require health insurance issuers offering coverage in connection with a group plan to provide enrollees with specific information concerning the plan description, and prior notice of exclusion from any drug formulary of a specific drug or biological that is used in the treatment of a chronic illness or disease.

³⁶The proposal also includes provisions to expand the availability and the value of current law MSAs.

³⁷This description is based on the following language included in the June 16, 1999 testimony of HIAA President, Charles N. Kahn, 111, before the House Committee on Ways and Means: "HIAA's proposal would extend full tax deductibility of premiums to everyone purchasing individual health insurance policies and would take effect upon the date of enactment rather than 2003."

³⁸Under present law, as previously noted, the self-employed health insurance deduction is scheduled to phase up from the current law 60 percent deduction in 1999 to 100 percent in 2003.

³⁹The Ways and Means Committee testimony and the available web site documents are unclear as to how this credit operates. It is assumed to be a nonrefundable business tax credit available to those firms that purchase or contribute toward the purchase of employer-sponsored health insurance for employees.

⁴⁰Cafeteria plans allow employees to make premium payments to their employer-sponsored health insurance plans with pre-tax dollars. Internal Revenue Code section 125.

⁴¹Under the advanced payment option, enrollees would receive a monthly voucher to purchase insurance, or the enrollee could direct the voucher amount to the health plan. The actual magnitude of the tax credit would be reconciled each year when enrollees file their federal income tax returns.

This information was reprinted with permission of the Henry J. Kaiser Foundation of Menlo Park, California. The Kaiser Family Foundation is an independent health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries. Weiss, Randall and Mark Garay, *Recent Tax Proposals to Increase Health Insurance Coverage*, p. 7-15, January 2000, The Henry J. Kaiser Family Foundation. Available at: kff.org/content/2000/1563/sidebyside.pdf [April 1, 2001].

Health Coverage 2000: Meeting the Challenges of the Uninsured

	American Hospital Association	American Medical Association	American Nurses Association	Catholic Health Association	Families USA	Health Insurance Association of America	Service Employees International Union	US Chamber of Commerce
Target populations	*Low-income children. *Low-and moderate-income individuals and families. *High-risk individuals. *Self-employed individuals. *Employees of small firms.	*Individuals without access to employer-sponsored insurance. *Self-employed individuals. *High-risk individuals. *Low-income children, individuals and families.	*Universal coverage, with children phased in first.	*Low and moderate income individuals and families. *Some provisions for individuals without access to employer-sponsored insurance.	*Low-income individuals and families.	*Low-income individuals and families. *High-risk individuals. *Employees of small firms. *Self-employed individuals. *Taxpayers without access to employer-sponsored insurance.	*Universal coverage by 2005, beginning with low-and moderate-income individuals. *High-risk individuals. *Self-employed individuals. *Taxpayers without access to employer-sponsored insurance.	*Low-and moderate-income individuals And families. *High-risk individuals. *Self-employed individuals. *Taxpayers without access to employer-sponsored insurance.
Approaches								
i) Expansion of or creation of government programs	*State mandate to provide 12 months of continuous eligibility for children on Medicaid/CHIP. *State option to expand Medicaid to cover families for 2 years after they leave welfare. *State option to expand CHIP to parents of CHIP children. *State option to expand Medicaid/CHIP to more low-income pregnant women (including legal immigrants). *State option to expand Medicaid to childless	*State option to expand CHIP to children in families at higher percentages of FPL. *State option to subsidize low-income individuals to buy in to Medicaid.	*Expansion of Medicare to cover all Americans (phased in over a 3-year period).	*State mandate to expand Medicaid/CHIP or create a new state program to cover non-elderly people up to 150% FPL. (Workers <150% FPL may use subsidy to buy employer-sponsored coverage.) *State option to expand Medicaid/CHIP to more low-income pregnant women (including legal immigrants). *State option to expand Medicaid/CHIP to legal Immigrant children.	*State mandate to expand Medicaid for all persons <133% FPL (with a higher matching rate for states than usual Medicaid). *State option to expand CHIP to cover all persons between 133% and 200% FPL. (States may require families Above 150% FPL to make limited contributions to premiums and pay some cost-sharing.)	*Creation of a new state/federal program (modeled on CHIP) for all persons up to 100% FPL who are not otherwise eligible for public programs.	*State option to expand CHIP for all persons up to 300% FPL. (Mandatory after 2005 if state has not already achieved universal coverage through other programs.) *After 2005, mandate for all employers to pay 10% of wages up to 80% of premium (unless state has already achieved universal coverage). *Maintenance of effort through 2005 for state Medicaid programs and employers offering insurance. *After 2005, requirement for all	*None

This information was reprinted with permission of the Robert Wood Johnson Foundation. Robert Wood Johnson Foundation Health Coverage 2000: Meeting the Challenges of the Uninsured: Comparison of Proposals." Robert Wood Johnson Foundation. Available at: rwjf.org/app/rw_news_and_events/events/shc2000/sideby-side.htm [October 8, 2001].

Health Coverage 2000: Meeting the Challenges of the Uninsured Comparison of Proposals

	American Hospital Association	American Medical Association	American Nurses Association	Catholic Health Association	Families USA	Health Insurance Association of America	Service Employees International Union	US Chamber of Commerce
	adults up to 150% FPL. *State option to expand Medicaid/CHIP for legal immigrant children. *State option to grant automatic Medicaid eligibility to TANF families.						workers in firms <500 and individuals/families <300% FPL, to be in state pool (unless state has already achieved universal coverage).	
ii) Reforms of government programs	*Provide enhanced federal match for some optional state Medicaid expansions to working families. *Provide enhanced federal match for automatic eligibility for TANF families.	*Give individuals the option to receive a voucher or tax credit to buy private insurance in lieu of Medicaid coverage.	*Use competitive bidding for Medicare services. *Restructure Medicare cost sharing. *Combine Parts A and B of Medicare. *Convert Medicaid into a program providing coverage for long-term care and wrap-around benefits.	*Remove barriers to enrollment and expand outreach for Medicaid/CHIP.	*Provide incentive payments for states meeting enrollment targets for low-income children. *Allow states to set adult eligibility levels lower than those for children (but parents and their children must be in same program). *Abolish asset test for determining Medicaid eligibility for all persons <133% FPL.	*Encourage states to use new, low-income program funds to buy employer-sponsored coverage.	*Create state-operated community-rated pool that buys insurance for Medicaid, CHIP, self-employed workers, and workers in firms <500. (Optional for firms >500). *Provide federal incentive payments for states meeting enrollment targets for enrolling persons <300% FPL. *Add prescription drug benefit to Medicare by 2002.	*Make it easier for states to use CHIP funds to pay for coverage of dependents of eligible workers under their employer sponsored plan.

Health Coverage 2000: Meeting the Challenges of the Uninsured Comparison of Proposals

	American Hospital Association	American Medical Association	American Nurses Association	Catholic Health Association	Families USA	Health Insurance Association of America	Service Employees International Union	US Chamber of Commerce
<p>iii) Changes in tax policy or vouchers to expand private coverage</p> <p>*Refundable tax credit for individuals and families up to 300% FPL who are ineligible for employer-sponsored insurance public or programs. (Credits are \$1000 per adult, \$500 per child, \$3000 per family.)</p> <p>*Tax credit of 25% of total premium costs for small business.</p> <p>*Full tax deduction for health insurance for self-employed.</p>	<p>*Refundable tax credit for individuals and families. (Size of credit is inversely related to income.)</p>	<p>*None</p>	<p>*Premium subsidies (potentially administered as refundable tax credits) for up to 2/3rds of premiums for non-elderly people to buy employer-sponsored coverage, if available, or coverage through FEHBP. (Subsidies are for single individuals <\$35,000 and families <\$50,000.)</p>	<p>*None</p>	<p>*Federal vouchers to subsidize insurance for persons between 100% and 200% FPL. (Vouchers are worth 75% of the national average FEHBP premium, and must be used for employer-sponsored coverage, if available.)</p> <p>*Tax credit for small business to offer insurance (larger for smaller businesses), phased in first for smallest businesses.</p> <p>*Tax exclusion for employee share of employer-sponsored insurance premiums.</p> <p>* Tax deduction for health insurance premiums for individual insurance.</p> <p>* Full tax deduction for health insurance for self employed.</p>	<p>*None</p>	<p>*Tax deduction for individuals without access to employer-sponsored coverage.</p> <p>*Full tax deduction for health insurance for self-employed.</p> <p>*Tax exclusion for employer contributions to individual policies.</p> <p>*Refundable tax credits for persons up to 300% FPL who are ineligible for public programs and either buy individual coverage or pay at least 50% of premium for employer-sponsored insurance. (Credits are \$600 for individuals and \$1200 for families, up to 200% FPL; gradual phase-out to 300% FPL.)</p>	

This information was reprinted with permission of the Robert Wood Johnson Foundation. Robert Wood Johnson Foundation Health Coverage 2000: Meeting the Challenges of the Uninsured: Comparison of Proposals," Robert Wood Johnson Foundation. Available at: rwj.org/app/rw_news_and_events/events/c:2000/sideby-side.htm [October 8, 2001].

Health Coverage 2000: Meeting the Challenges of the Uninsured

	American Hospital Association	American Medical Association	American Nurses Association	Catholic Health Association	Families USA	Health Insurance Association of America	Service Employees International Union	US Chamber of Commerce
Sources of funding for increased government expenditures	*Cap on tax exclusion for employer-sponsored insurance. *Tobacco settlement funds. *Federal budget surplus.	*Elimination of tax exclusion for employer-sponsored insurance. *Tobacco tax. *Capture of benefits from for-profit conversions of health plans or hospitals. *DSH savings.	*5% Medicare payroll tax. *Federal general revenues. *During phase-in, shift of current employment-based insurance premiums to a public trust fund. *Administrative savings. *Continued expansion of prospective payment.	*Federal budget surplus. *Tobacco and alcohol taxes. *State general funds. *Tobacco settlement funds.	*None	*No specific recommendations. (Funding sources should be broad: e.g. federal and state budget surpluses and tobacco settlement funds.)	*Federal budget surplus. *State general funds (could include tobacco settlement funds.) *Employer contributions. *3% surcharge on health insurance premiums.	*None
Other key elements	*None	*Encourage employers to switch to declined contributions.	*Expand GME for graduate nursing education. *Expand use of advanced practice nursing services.	*Provide \$500 million per year in grants for safety-net hospitals and clinics.	*None	*Reform laws to promote individual responsibility for cost of care (to encourage people to buy insurance and reduce uncompensated care). *Streamline funding streams for safety net providers. *Emphasize prevention/wellness.	*Establish national commission on restructuring financing and delivery systems for long-term care, with funding for state demonstrations. *Establish federal standards for patient and worker protections.	*Establish external review of health coverage decisions involving medical judgment. *Increase the availability of information about plan benefits, access to providers, and provider quality and price.

This information was reprinted with permission of the Robert Wood Johnson Foundation. Robert Wood Johnson Foundation Health Coverage 2000: Meeting the Challenges of the Uninsured: Comparison of Proposals." Robert Wood Johnson Foundation. Available at: rwj.org/app/rw_news_and_events/events/c2000/sideby-side.htm [October 8, 2001].

IV. ENDNOTES

- ¹October 2000 survey cited in: Schroeder, Steven A., *Prospects for Expanding Health Insurance Coverage*, March 15, 2001, *New England Journal of Medicine* 344, no. 11. Available at: www.nejm.org/content/2001/0344/0011/0847.asp [March 15, 2001].
- ²American College of Physicians-American Society of Internal Medicine, *No Health Insurance? It's Enough to Make You Sick-Scientific Research Linking the Lack of Health Coverage to Poor Health*, ACAP-ASIM Online. Available at: www.acponline.org/uninsured/index.html [January 6, 2000].
- ³Author's calculation based on 2000 Census data found in: Mills, Robert J., *Health Insurance Coverage 2000, Issued September 2001*, p. 11, U.S. Census Bureau. Available at: www.census.gov/prod/2001pubs/p60-215.pdf [October 1, 2001]; U.S. Census Bureau, *State and County QuickFacts*, U.S. Census Bureau. Available at: quickfacts.census.gov/qfd/states/23000.html [October 1, 2001].
- ⁴Mills, Robert J., *Health Insurance Coverage 2000, Issued September 2001*, p. 1, U.S. Census Bureau. Available at: www.census.gov/prod/2001pubs/p60-215.pdf [October 1, 2001].
- ⁵Center for Studying Health System Change, *Press Release: Study Shows 20% of Uninsured Have Access to Employer-Sponsored Coverage*, October 12, 1999, Center for Studying Health System Change. Available at: www.hschange.com/CONTENT/183/?words=tax [October 4, 2000].
- ⁶*Ibid.*
- ⁷Healthcare Leadership Council, *Press Release: Over 70 Percent of Uninsured Can be Reached Through Current Employer-Based Insurance System, HLC Head Tells Senate Panel*, October 4, 2000, Healthcare Leadership Council. Available at: www.hlc.org/Making_News/Press_Releases/2000_Press_Releases/October_4__2000PRM/october_4__2000prm.html [November 16, 2000]; Year 2000 Blue Ribbon Commission on Health Care, *The Cost of Health Care in Maine*, p. 8, November 2000, Maine Development Foundation. Available at: www.mdf.org/chc/ [November 2000].
- ⁸Healthcare Leadership Council, *Press Release: Over 70 Percent of Uninsured Can Be Reached Through Current Employer-Based Insurance System, HLC Head Tells Senate Panel*, October 4, 2000, Healthcare Leadership Council. Available at: www.hlc.org/Making_News/Press_Releases/2000_Press_Releases/October_4__2000PRM/october_4__2000prm.html [November 16, 2000].
- ⁹Perry, Michael and Susan Kannel, *Medicaid and Children: Overcoming Barriers to Enrollment, Findings from a National Survey*, p. v, January 2000, The Henry J. Kaiser Family Foundation: The Kaiser Commission on Medicaid and the Uninsured. Available at: www.kff.org/content/2000/2174/MedicaidandChildren.pdf [April 17, 2001].
- ¹⁰October 2000 survey cited in: Schroeder, Steven A., *Prospects for Expanding Health Insurance Coverage*, March 15, 2001, *New England Journal of Medicine* 344, no. 11. Available at: www.nejm.org/content/2001/0344/0011/0847.asp [March 15, 2001].
- ¹¹American College of Physicians-American Society of Internal Medicine, *No Health Insurance? It's Enough to Make You Sick-Scientific Research Linking the Lack of Health Coverage to Poor Health*, ACAP-ASIM Online. Available at: www.acponline.org/uninsured/index.html [January 6, 2000].
- ¹²*Ibid.*
- ¹³Hoffman, Catherine and Alan Schlobohm, *Uninsured in America, a Chart Book, Second Edition*, p.56, May 2000, The Henry J. Kaiser Family Foundation: The Kaiser Commission on Medicaid and the Uninsured. Available at: www.kff.org/content/archive/1407/Uninsured%20in%20America.pdf [September 2000].
- ¹⁴*Ibid.*
- ¹⁵American College of Physicians-American Society of Internal Medicine, *No Health Insurance? It's Enough to Make You Sick-Scientific Research Linking the Lack of Health Coverage to Poor Health*, ACAP-ASIM Online. Available

Endnotes (continued)

www.acponline.org/uninsured/index.html [January 6, 2000].

¹⁶Ibid.

¹⁷Year 2000 Blue Ribbon Commission on Health Care, *The Cost of Health Care in Maine*, p. 2, November 2000, Maine Development Foundation. Available at: www.mdf.org/chc/ [November 2000].

¹⁸Mills, Robert J., *Health Insurance Coverage 2000, Issued September 2001*, p. 1, U.S. Census Bureau. Available at: www.census.gov/prod/2001pubs/p60-215.pdf [October 1, 2001].

¹⁹Mills, Robert J., *Health Insurance Coverage 1999, Issued September 2000*, p. 1, U.S. Census Bureau. Available at: www.census.gov/prod/2000pubs/p60-211.pdf [December 1, 2000].

²⁰This information was reprinted with permission of the Henry J. Kaiser Foundation of Menlo Park, California. The Kaiser Family Foundation is an independent health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries. Hoffman, Catherine and Alan Schlobohm, *Uninsured in America, a Chart Book, Second Edition*, p. 3, citing Employee Benefits Research Institute, 2000 and Current Population Surveys (March) 1989-1999, May 2000; *Health Insurance Coverage in America, 1999 Data Update*, p. 5, December 2000, The Henry J. Kaiser Family Foundation: The Kaiser Commission on Medicaid and the Uninsured. Available at: www.kff.org/content/archive/1407/Uninsured%20in%20America.pdf [September 2000].

²¹The national information was reprinted with permission of the Henry J. Kaiser Foundation of Menlo Park, California. The Kaiser Family Foundation is an independent health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries. Hoffman, Catherine and Alan Schlobohm, *Uninsured in America, a Chart Book, Second Edition*, p.4, citing Urban Institute, 1999 and Current Population Survey, (March) 1990-1994, May 2000, The Henry J. Kaiser Family Foundation: The Kaiser Commission on Medicaid and the Uninsured. Available at: www.kff.org/content/archive/1407/Uninsured%20in%20America.pdf [September 2000]; State chart reprinted with permission from the Maine Development Foundation. Year 2000 Blue Ribbon Commission on Health Care, *The Cost of Health Care in Maine*, p. 12, November 2000, Maine Development Foundation. Available at: www.mdf.org/chc/ [November 2000].

²²Mills, Robert J., *Health Insurance Coverage 2000, Issued September 2001*, p. 3, U.S. Census Bureau. Available at: www.census.gov/prod/2001pubs/p60-215.pdf [October 1, 2001].

²³Ibid., 2.

²⁴Center for Studying Health System Change, *Press Release: Study Shows 20% of Uninsured Have Access to Employer-Sponsored Coverage*, October 12, 1999, Center for Studying Health System Change. Available at: www.hschange.com/CONTENT/183/?words_tax [October 4, 2000].

²⁵Hoffman, Catherine and Alan Schlobohm, *Uninsured in America, a Chart Book, Second Edition*, p. 12, May 2000, The Henry J. Kaiser Family Foundation: The Kaiser Commission on Medicaid and the Uninsured. Available at: www.kff.org/content/archive/1407/Uninsured%20in%20America.pdf [September 2000].

²⁶Ibid.

²⁷Year 2000 Blue Ribbon Commission on Health Care, *The Cost of Health Care in Maine*, p. 8, November 2000, Maine Development Foundation. Available at: www.mdf.org/chc/ [November 2000]; Guyer, Jocelyn and Cindy Mann, *Employed But Not Insured: A State-by-State Analysis of the Number of Low-Income Working Parents Who Lack Health Insurance*, February 9, 1999, Center on Budget and Policy Priorities. Available at: www.cbpp.org/2-9-99mcaid.htm [April 16, 2001].

²⁸This information was reprinted with permission of the Henry J. Kaiser Foundation of Menlo Park, California. The Kaiser Family Foundation is an independent health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries. Hoffman, Catherine and Alan Schlobohm, *Uninsured in America, a Chart Book, Second Edition*, p.25, May 2000, The Henry J. Kaiser Family Foundation: The Kaiser Commission on Medicaid and the Uninsured. Available at: www.kff.org/content/archive/1407/Uninsured%20in%20America.pdf [September 2000].

Endnotes (continued)

- ²⁹Statistic obtained by phone on 3-16-01 from Tower Publishing, 588 Saco Road, Standish, Maine 04084; 1-800-969-8693.
- ³⁰U.S. House of Representatives, *Health Insurance Costs are Rising for Maine Small Businesses*, Prepared for Representative Tom Allen by Minority Staff, Special Investigations Division, Committee on Government Reform, U.S. House of Representatives, May 21, 2001, p. 1.
- ³¹Pohlmann, Lisa and Christopher St. John, *Within Reach, Health Coverage for Working Families* (Augusta: Maine Center for Economic Policy, December 1999), 4.
- ³²This information was reprinted with permission of the Henry J. Kaiser Foundation of Menlo Park, California. The Kaiser Family Foundation is an independent health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries. Hoffman, Catherine and Alan Schlobohm, *Uninsured in America, a Chart Book, Second Edition*, p. 35, citing The NewsHour with Jim Lehrer/Kaiser Family Foundation National Survey on the Uninsured 2000, May 2000, The Henry J. Kaiser Family Foundation: The Kaiser Commission on Medicaid and the Uninsured. Available at: www.kff.org/content/archive/1407/Uninsured%20in%20America.pdf [September 2000].
- ³³This information was reprinted with permission of the Henry J. Kaiser Foundation of Menlo Park, California. The Kaiser Family Foundation is an independent health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries. Note: The 1998 federal poverty level for a family of three was \$13,650. Hoffman, Catherine and Alan Schlobohm, *Uninsured in America, a Chart Book, Second Edition*, p. 13, citing the Urban Institute 1999 and the Current Population Survey, March 1999, May 2000, The Henry J. Kaiser Family Foundation: The Kaiser Commission on Medicaid and the Uninsured. Available at: www.kff.org/content/archive/1407/Uninsured%20in%20America.pdf [September 2000].
- ³⁴Hoffman, Catherine and Alan Schlobohm, *Uninsured in America, a Chart Book, Second Edition*, p. 13, May 2000, The Henry J. Kaiser Family Foundation: The Kaiser Commission on Medicaid and the Uninsured. Available at: www.kff.org/content/archive/1407/Uninsured%20in%20America.pdf [September 2000].
- ³⁵Editorial, "King's Pruned Budget Fits a Slowing Economy," *Maine Sunday Telegram*, January 7, 2001.
- ³⁶Year 2000 Blue Ribbon Commission on Health Care, *The Cost of Health Care in Maine*, p.12, November 2000, Maine Development Foundation. Available at: www.mdf.org/chc/ [November 2000].
- ³⁷U.S. Department of Health and Human Services, *Annual Update of HHS Poverty Guidelines, 10695-10697*, Federal Register, February 16, 2001. Available at: aspe.hhs.gov/poverty/01fedreg.htm.
- ³⁸Inquiry, *Press Release: Expanding Health Insurance for Working Americans*, August 27, 2001, The Commonwealth Fund. Available at: www.cmwf.org/media/releases/inquiry_release08272001.html [September 5, 2001].
- ³⁹Budetti, John et al., *Can't Afford to Get Sick: A Reality for Millions of Working Americans*, p. 9, September 1999, The Commonwealth Fund. Available at: www.cmwf.org/programs/insurance/budetti_sick_347.asp [September 8, 1999].
- ⁴⁰This information was reprinted with permission of the Henry J. Kaiser Foundation of Menlo Park, California. The Kaiser Family Foundation is an independent health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries. Hoffman, Catherine and Alan Schlobohm, *Uninsured in America, a Chart Book, Second Edition*, p. 37, citing Gabel, J. 1999, May 2000, The Henry J. Kaiser Family Foundation: The Kaiser Commission on Medicaid and the Uninsured. Available at: www.kff.org/content/archive/1407/Uninsured%20in%20America.pdf [September 2000].
- ⁴¹Hoffman, Catherine and Alan Schlobohm, *Uninsured in America, a Chart Book, Second Edition*, p. 37, May 2000, The Henry J. Kaiser Family Foundation: The Kaiser Commission on Medicaid and the Uninsured. Available at: www.kff.org/content/archive/1407/Uninsured%20in%20America.pdf [September 2000].

Endnotes (continued)

- ⁴²U.S. House of Representatives, *Health Insurance Costs are Rising for Maine Small Businesses*, Prepared for Representative Tom Allen by Minority Staff, Special Investigations Division, Committee on Government Reform, U.S. House of Representatives, May 21, 2001, p. 2.
- ⁴³Agovina, Theresa, "Workers Face Rise in Insurance Costs," *Bangor Daily News*, September 7, 2001.
- ⁴⁴The Henry J. Kaiser Family Foundation, *2001 Employer Health Benefits Survey: Report, Section 7, p. 85*, The Henry J. Kaiser Family Foundation. Available at: www.kff.org/content/2001/3138 [September 11, 2001].
- ⁴⁵Bilheimer, Linda T. and David C. Colby, "Expanding Coverage: Reflections on Recent Efforts," *Health Affairs* 20, no. 1 (January-February 2001): 94.
- ⁴⁶U.S. House of Representatives, *Health Insurance Costs are Rising for Maine Small Businesses*, Prepared for Representative Tom Allen by Minority Staff, Special Investigations Division, Committee on Government Reform, U.S. House of Representatives, May 21, 2001, p. 8.
- ⁴⁷*Ibid.*, 1.
- ⁴⁸This information was reprinted with permission of the Henry J. Kaiser Foundation of Menlo Park, California. The Kaiser Family Foundation is an independent health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries. Hoffman, Catherine and Alan Schlobohm, *Uninsured in America, a Chart Book, Second Edition, p. 58*, citing The NewsHour with Jim Lehrer/Kaiser Family Foundation National Survey on the Uninsured 2000, May 2000, The Henry J. Kaiser Family Foundation: The Kaiser Commission on Medicaid and the Uninsured. Available at: www.kff.org/content/archive/1407/Uninsured%20in%20America.pdf [September 2000].
- ⁴⁹American College of Physicians-American Society of Internal Medicine, *No Health Insurance? It's Enough to Make You Sick-Scientific Research Linking the Lack of Health Coverage to Poor Health*, ACAP-ASIM Online. Available at: www.acponline.org/uninsured/index.html [January 6, 2000].
- ⁵⁰*Ibid.*
- ⁵¹Year 2000 Blue Ribbon Commission on Health Care, *The Cost of Health Care in Maine, p. 8*, November 2000, Maine Development Foundation. Available at: www.mdf.org/chc/ [November 2000].
- ⁵²Hoffman, Catherine and Alan Schlobohm, *Uninsured in America, a Chart Book, Second Edition, p. 24*, May 2000, The Henry J. Kaiser Family Foundation: The Kaiser Commission on Medicaid and the Uninsured. Available at: www.kff.org/content/archive/1407/Uninsured%20in%20America.pdf [September 2000].
- ⁵³Healthcare Leadership Council, *Press Release: Over 70 Percent of Uninsured Can Be Reached Through Current Employer-Based Insurance System, HLC Head Tells Senate Panel*, October 4, 2000, Healthcare Leadership Council. Available at: www.hlc.org/Making_News/Press_Releases/2000_Press_Releases/October_4__2000PRM/october_4__2000prm.html [November 16, 2000].
- ⁵⁴Duchon, Lisa et al, *Listening to Workers: Findings from the Commonwealth Fund 1999 National Survey of Workers' Health Insurance, p. 5*, January 2000, The Commonwealth Fund. Available at: www.cmwf.org/programs/insurance/duchon_workerssurvey_362.pdf [September 28, 2001].
- ⁵⁵*Ibid.*, 6.
- ⁵⁶*Ibid.*
- ⁵⁷*Ibid.*, 33.
- ⁵⁸Hoffman, Catherine and Alan Schlobohm, *Uninsured in America, a Chart Book, Second Edition, p. 25*, May 2000, The Henry J. Kaiser Family Foundation: The Kaiser Commission on Medicaid and the Uninsured. Available at: www.kff.org/content/archive/1407/Uninsured%20in%20America.pdf [September 2000].
- ⁵⁹*Ibid.*, 35.
- ⁶⁰Edmunds, Margo, Martha Teitelbaum, and Cassy Gleason, *All Over the Map: A Progress Report on the State Children's Health Insurance Program (CHIP)* (Washington, D.C.: Children's Defense Fund, July 2000), 1; Year 2000 Blue Ribbon Commission on Health Care, *The Cost of Health Care in Maine, p. 8*, November 2000, Maine Devel-

Endnotes (continued)

opment Foundation. Available at: www.mdf.org/chc/ [November 2000].

⁶¹Glied, Sherry A., "Challenges and Options for Increasing the Number of Americans with Health Insurance," *Inquiry* 38, no. 2 (Summer 2001):93.

⁶²Feder, Judith, Cori Uccello and Ellen O'Brien, *The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance* (Washington, D.C.: The Henry J. Kaiser Family Foundation, October 1999), 8.

⁶³Glied, Sherry A. and Joseph L. Mailman, *Challenges and Options for Increasing the Number of Americans with Health Insurance*, p. 9, December 2000, The Commonwealth Fund. Available at:www.cmf.org/publist/publist2.asp?CategoryID=4 [April 30, 2001].

⁶⁴Perry, Michael and Susan Kannel, *Medicaid and Children: Overcoming Barriers to Enrollment, Findings from a National Survey*, p.14, January 2000, The Henry J. Kaiser Family Foundation: The Kaiser Commission on Medicaid and the Uninsured. Available at: www.kff.org/content/2000/2174/MedicaidandChildren.pdf [April 17, 2001].

⁶⁵Year 2000 Blue Ribbon Commission on Health Care, *The Cost of Health Care in Maine*, p. 23, November 2000, Maine Development Foundation. Available at: www.mdf.org/chc/ [November 2000].

⁶⁶Schroeder, Steven A, *Prospects for Expanding Health Insurance Coverage*, *New England Journal of Medicine* 344, no. 11, March 15, 2001. Available at: www.nejm.org/content/2001/0344/0011/0847.asp [March 15, 2001].

⁶⁷Year 2000 Blue Ribbon Commission on Health Care, *The Cost of Health Care in Maine*, p. 25, November 2000, Maine Development Foundation. Available at: www.mdf.org/chc/ [November 2000].

⁶⁸PricewaterhouseCoopers, *Patients or Paperwork? The Regulatory Burden Facing America's Hospitals*, Prepared for the American Hospital Association, 2001, p. 3,4.

⁶⁹"HHS Will Simplify Medical Privacy Rule, Lessen Financial Burden, Thompson Says," *Bureau of National Affairs Health Care Policy Report* 9, no. 13 (April 2, 2001): 509.

⁷⁰Year 2000 Blue Ribbon Commission on Health Care, *The Cost of Health Care in Maine*, p. 8, November 2000, Maine Development Foundation. Available at: www.mdf.org/chc/ [November 2000].

⁷¹Campaign for a Healthy Maine: The Issue, Bureau of Health, Maine Department of Human Services, 2000.

⁷²Year 2000 Blue Ribbon Commission on Health Care, *The Cost of Health Care in Maine*, p. 5, November 2000, Maine Development Foundation. Available at: www.mdf.org/chc/ [November 2000].

⁷³Edmunds, Margo, Martha Teitelbaum, and Cassy Gleason, *All Over the Map: A Progress Report on the State Children's Health Insurance Program (CHIP)* (Washington, D.C.: Children's Defense Fund, July 2000), 1.

⁷⁴Ibid.

⁷⁵Ibid., 11.

⁷⁶Ibid., 65, citing the Kaiser Commission on Medicaid and the Uninsured 2000.

⁷⁷"State Medicaid, CHIP Programs Suffer Because of Enrollee Churning, Report Says," *Bureau of National Affairs Health Care Policy Report* 8, no. 31 (July, 31, 2000): 1314.

⁷⁸"Kids Missing Out on Insurance," *U.S.A. Today*, August 9, 2000. Available at: www.usatoday.com/life/health/hcare/lhhca119.htm [August 10, 2000].

⁷⁹Wheatley, Benjamin et al., *State of the States Report*, p. 5, January 2001, Academy for Health Services Research and Health Policy. Available at: www.statecoverage.net/State01.pdf [April 12, 2001].

⁸⁰Bilheimer, Linda T. and David C. Colby, "Expanding Coverage: Reflections on Recent Efforts," *Health Affairs* 20, no.1 (January-February 2001): 93.

⁸¹Moore, Michael, "Hospitals to Promote Availability of Insurance," *Bangor Daily News*, January 4, 2001.

⁸²Adams, Glenn, "More Children Insured," *Kennebec Journal*, November 1, 2000.

⁸³Weinstein, Joshua L, "Maine Among Top 10 States for Children," *Portland Press Herald*, May 22, 2001.

⁸⁴Mills, Robert J., *Health Insurance Coverage 1999, Issued September 2000*, p. 3, U.S. Census Bureau. Available at: www.census.gov/prod/2000pubs/p60-211.pdf [December 1, 2000].

⁸⁵Edmunds, Margo, Martha Teitelbaum, and Cassy Gleason, *All Over the Map: A Progress Report on the State*

Endnotes (continued)

- Children's Health Insurance Program (CHIP)* (Washington, D.C.: Children's Defense Fund, July 2000), 6,7.
- ⁸⁶*Ibid.*, 20.
- ⁸⁷Health Care Alert, Consumers for Affordable Health Care, (Augusta, Maine, May 25, 2001).
- ⁸⁸Feder, Judith, Cori Uccello and Ellen O'Brien, *The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance* (Washington, D.C.: The Henry J. Kaiser Family Foundation, October 1999), i.
- ⁸⁹Year 2000 Blue Ribbon Commission on Health Care, *The Cost of Health Care in Maine*, pp. 3, 44, November 2000, Maine Development Foundation. Available at: www.mdf.org/chc/ [November 2000].
- ⁹⁰*Ibid.*, 7.
- ⁹¹Hoffman, Catherine and Alan Schlobohm, *Uninsured in America, a Chart Book, Second Edition*, p. 35, May 2000, The Henry J. Kaiser Family Foundation: The Kaiser Commission on Medicaid and the Uninsured. Available at: www.kff.org/content/archive/1407/Uninsured%20in%20America.pdf [September 2000].
- ⁹²Final Report of the Blue Ribbon Commission to Study the Effects of Government Regulation and Health Insurance Costs on Small Businesses in Maine, p. 18, State of Maine 118th Legislature, January 1998. Available at: www.state.me.us/legis/opla/bluerpt.htm [April 2, 2001].
- ⁹³Meyer, Jack A., Sharon Silow-Carroll and Elliot K. Wicks, *Tax Reform to Expand Health Coverage: Administrative Issues and Challenges* (Washington, D.C.: The Henry J. Kaiser Family Foundation, January 2000), 7,8.
- ⁹⁴Kaiser Family Foundation, *Assessing Tax Subsidies to Cover the Uninsured*, January 2000, Kaiser Family Foundation. Available at: www.kff.org/content/2000/1567 [April 12, 2001].
- ⁹⁵Feder, Judith et al., "Covering the Low-Income Uninsured: The Case for Expanding Public Programs," *Health Affairs* 20, no.1 (January-February 2001): 36.
- ⁹⁶Butler, Stuart and David B. Kendall, "Expanding Access and Choice for Health Care Consumers through Tax Reform," *Health Affairs* 18, no. 6 (November-December 1999): 48.
- ⁹⁷Kaiser Family Foundation, *Assessing Tax Subsidies to Cover the Uninsured*, January 2000, Kaiser Family Foundation. Available at: www.kff.org/content/2000/1567 [April 12, 2001].
- ⁹⁸Rhoades, Rex, "Insurance Disaster Dead Ahead," *Lewiston Sun Journal*, April 22, 2001.
- ⁹⁹*Ibid.*
- ¹⁰⁰*Ibid.*
- ¹⁰¹Trude, Sally and Paul B. Ginsburg, *Issue Brief, Number 36: Tax Credits and Purchasing Pools: Will This Marriage Work?* April 2001, Center for Studying Health System Change. Available at: [www/hschange.org/CONTENT/306/](http://www.hschange.org/CONTENT/306/) [April 12, 2001].
- ¹⁰²*Ibid.*
- ¹⁰³Curtis, Richard E, Neuschler, Edward and Forland, Rafe, "Private Purchasing Pools to Harness Individual Tax Credits for Consumers," *Inquiry* 38, no. 2 (Summer 2001):161.
- ¹⁰⁴"Senators Unveil Revised Tax Credit to Aid in Purchase of Health Coverage," *Bureau of National Affairs Health Care Policy Report* 9, no. 11 (March 19, 2001): 434.
- ¹⁰⁵Year 2000 Blue Ribbon Commission on Health Care, *The Cost of Health Care in Maine*, p. 41, November 2000, Maine Development Foundation. Available at: www.mdf.org/chc/ [November 2000].
- ¹⁰⁶Information available at: www.aha.org/campaign/1299uninsuredsoln.asp [April 16, 2001].
- ¹⁰⁷Kessler, Warren, "Lives Can Be Saved," Letter to the Editor, *Kennebec Journal*, May 25, 2001.
- ¹⁰⁸Kesich, Gregory, "Health Insurance Bill Scaled Back," *Portland Press Herald*, June 22, 2001.
- ¹⁰⁹Wheatley, Benjamin et al., *State of the States Report*, p. 21, January 2001, Academy for Health Services Research and Health Policy. Available at: www.statecoverage.net/State01.pdf [April 12, 2001].
- ¹¹⁰Information, facts and statistics available at: www.wa.gov/hca/basichealth.htm [April 12, 2001].
- ¹¹¹Wheatley, Benjamin et al., *State of the States Report*, p. 5, January 2001, Academy for Health Services Research and Health Policy. Available at: www.statecoverage.net/State01.pdf [April 12, 2001].

Endnotes (continued)

- ¹¹²Information, facts and statistics available at: www.ipgb.state.or.us/Docs/fhiaphome.htm [April 12, 2001].
- ¹¹³Information, facts and statistics available at: www.dhfs.state.wi.us/badgercare [April 12, 2001].
- ¹¹⁴Information, facts and statistics available at: www.dhs.state.mn.us/HlthCare/AsstProg/mncare/default.htm [April 12, 2001].
- ¹¹⁵Wheatley, Benjamin et al., *State of the States Report*, p. 3, January 2001, Academy for Health Services Research and Health Policy. Available at: www.statecoverage.net/State01.pdf [April 12, 2001].
- ¹¹⁶Information, facts and statistics available at: www.hanys.org/newsview/issues/state/nychra.htm [April 12, 2001].
- ¹¹⁷Maryland Community and Public Health Administration, *Maryland Health Improvement Plan 2000-2010 Draft, Access to Health Care*, August 2000, Maryland Community and Public Health Administration. Available at: mdpublichealth.org/ohp/pdf/hip/access.pdf [March 4, 2001].
- ¹¹⁸Wheatley, Benjamin et al., *State of the States Report*, p. 3, January 2001, Academy for Health Services Research and Health Policy. Available at: www.statecoverage.net/State01.pdf [April 12, 2001].
- ¹¹⁹Information, facts and statistics available at: www.state.ma.us/dma/masshealthinfo/applmemb_IDX.htm [April 2, 2001].
- ¹²⁰Powell, Jennifer Heldt, "Plan Aids Health Costs: Businesses Can Get Assistance With Insurance," *Boston Herald*, April 24, 2000.
- ¹²¹Silow-Carroll, Sharon, Emily K. Waldman, and Jack A. Meyer, *Expanding Employment-Based Health Coverage: Lessons From Six State and Local Programs* (New York: The Commonwealth Fund, February 2001), 23.
- ¹²²Powell, Jennifer Heldt, "Plan Aids Health Costs: Businesses Can Get Assistance with Insurance," *Boston Herald*, April 24, 2000.
- ¹²³Commonwealth of Massachusetts Division of Medical Assistance, *MassHealth 1115 Demonstration Project Annual Report*, p. 1, May 26, 1999, Commonwealth of Massachusetts Division of Medical Assistance. Available at: www.state.ma.us/dma/researchers/res_IDX.htm [April 14, 2001].
- ¹²⁴Silow-Carroll, Sharon, Emily K. Waldman, and Jack A. Meyer, *Expanding Employment-Based Health Coverage: Lessons From Six State and Local Programs* (New York: The Commonwealth Fund, February 2001), ix.
- ¹²⁵Commonwealth of Massachusetts Division of Medical Assistance, *MassHealth 1115 Demonstration Project Annual Report*, p. 1, May 26, 1999, Commonwealth of Massachusetts Division of Medical Assistance. Available at: www.state.ma.us/dma/researchers/res_IDX.htm [April 14, 2001].
- ¹²⁶*Ibid.*, 5.
- ¹²⁷Silow-Carroll, Sharon, Emily K. Waldman, and Jack A. Meyer, *Expanding Employment-Based Health Coverage: Lessons From Six State and Local Programs* (New York: The Commonwealth Fund, February 2001), 6.
- ¹²⁸*Ibid.*
- ¹²⁹Author's calculation based on 2000 Census data found in: Mills, Robert J., *Health Insurance Coverage 2000, Issued September 2001*, p. 11, U.S. Census Bureau. Available at: www.census.gov/prod/2001pubs/p60-215.pdf [October 1, 2001]; U.S. Census Bureau, *State and County QuickFacts*, U.S. Census Bureau. Available at: quickfacts.census.gov/qfd/states/23000.html [October 1, 2001]; American College of Physicians-American Society of Internal Medicine, *No Health Insurance? It's Enough to Make You Sick-Scientific Research Linking the Lack of Health Coverage to Poor Health*, ACAP-ASIM Online. Available at: www.acponline.org/uninsured/index.html [January 6, 2000].
- ¹³⁰Perry, Michael and Susan Kannel, *Medicaid and Children: Overcoming Barriers to Enrollment, Findings from a National Survey*, p.v, January 2000, The Henry J. Kaiser Family Foundation: The Kaiser Commission on Medicaid and the Uninsured. Available at: www.kff.org/content/2000/2174/MedicaidandChildren.pdf [April 17, 2001].
- ¹³¹Feder, Judith et al., "Covering the Low-Income Uninsured: The Case for Expanding Public Programs," *Health Affairs* 20, no.1 (January-February 2001): 27.

Endnotes (continued)

- ¹³²Carrier, Paul, "Medicaid Expenses to Receive Close Look," *Maine Sunday Telegram*, January 14, 2001; Medicaid Spending per Recipient Statistic from Presentation by Commissioner Concannon in Portland, Maine, June 14, 2001.
- ¹³³Feder, Judith et al., "Covering the Low-Income Uninsured: The Case for Expanding Public Programs," *Health Affairs* 20, no.1 (January-February 2001): 29.
- ¹³⁴Kessler, Warren, "Lives Can Be Saved," Letter to the Editor, *Kennebec Journal*, May 25, 2001.
- ¹³⁵State of Maine, Office of Policy and Legal Analysis, 120th Legislative Session, Health and Human Services Committee, Health Coverage Bills Chart.
- ¹³⁶Pear, Robert, "Bush Budget Would Cut 3 Programs to Aid Children," *New York Times*, March 23, 2001.
- ¹³⁷Editorial, "As \$28 Billion Disappears," *The Washington Post Online*, July 27, 2001, p. A30. Available at: www.washingtonpost.com/wp-dyn/opinion/A58479-2001Jul26.html [July 30, 2001].
- ¹³⁸Kahn, Charles N. III and Ronald F. Pollack, "Building Consensus for Expanding Health Coverage," *Health Affairs* 20, no. 1 (January-February 2001): 44.
- ¹³⁹Center for Studying Health System Change, *Press Release: Study Shows 20% of Uninsured Have Access to Employer-Sponsored Coverage*, October 12, 1999, Center for Studying Health System Change. Available at: www.hschange.com/CONTENT/183/?words_tax. [October 4, 2000].
- ¹⁴⁰Reprinted with permission of the author. Molinari, Sarah, State Coverage Matrix, March 7, 2001, State Coverage Initiatives, Academy for Health Services Research and Health Policy. Matrix and more information available at: www.statecoverage.net/matrix.htm [April 1, 2001].
- ¹⁴¹This information was reprinted with permission of the Henry J. Kaiser Foundation of Menlo Park, California. The Kaiser Family Foundation is an independent health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries. Weiss, Randall and Mark Garay, *Recent Tax Proposals to Increase Health Insurance Coverage*, p. 7-15, January 2000, The Henry J. Kaiser Family Foundation. Available at: kff.org/content/2000/1563/sidebyside.pdf [April 1, 2001].
- ¹⁴²Reprinted with permission from the Robert Wood Johnson Foundation. Robert Wood Johnson Foundation, *Health Coverage 2000: Meeting the Challenges of the Uninsured: Comparison of Proposals*, Robert Wood Johnson Foundation. Available at: rwjf.org/app/rw_news_and_events/eventshc2000/side-by-side.htm [October 8, 2001].



Maine Hospital Association

150 Capitol Street
Augusta, Maine 04330
Tel. 207-622-4794
Fax 207-622-3073
Website: www.themha.org