

COVERAGE EXPANSION REFORM OPTIONS FOR OHIO



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INTRODUCTION

This paper begins the process of developing policies to cover the uninsured in Ohio. First, we synthesize and summarize the highlights of a series of interviews conducted by Health Management Associates (HMA), relate the key findings from our interviews to lessons learned from reviewing other states' experiences, and blend this information with our sense of the climate for reform in Ohio. We then draw on both the findings from our research and our own experience with policy analysis to develop a continuum of options, ranging from the more incremental to the more comprehensive, that would reduce the number of the uninsured in Ohio.

We develop this continuum of policy options against the backdrop of the current situation in the state – with 1.3 million people without health insurance, a series of jolts to the state's economy, pressure on employers from rising health outlays, and a number of gaps in the eligibility for government health insurance programs among poor and near-poor residents of the state. Ohio also has a new Governor who has demonstrated a commitment to reforming health care. Thus, our policy development takes into consideration the views of major stakeholders, as expressed in our interviews, and the political and economic environment within which any new policy proposals would be debated.

RESULTS OF STAKEHOLDER INTERVIEWS

Our interviews with key stakeholders in the state gave us valuable insights about the ways people are thinking about the problem of the uninsured and possible solutions. The interviews helped delineate the universe of viable options, distinguishing between the near-term (for example, the next year or two) and longer-term period. However, few of the people we interviewed expressed clear support for a particular approach to expanding coverage. While there was no clear consensus about specific strategies, our discussions with hospital officials, leaders in the physician community, insurers, business, labor, community leaders, and public officials helped identify various options that might have some traction. Our policy analysis is also informed by our research on the experiences of other states. The lessons learned from this research are summarized in a separate paper that was prepared for this project. Following are key findings from our interviews with stakeholders.

The process of developing options for covering the uninsured should take account of the clear need to improve quality of care, patient safety, and efficiency. Many people stress the need to address the flaws in our health care delivery system as a corollary of the effort to bring more people into the financing system. Observers highlighted the need to find a medical home for everyone, address the drivers underlying chronic illness (for example, obesity exacerbating the problem of diabetes), improve coordination of care, and reduce medical errors. We were advised to address the problem of barriers to effective treatment of mental illness as well as the potential of bottlenecks in the supply of care (particularly primary care) that potentially can thwart the effectiveness of policies aimed at covering the

uninsured. These issues are addressed in a separate report, “Mapping Health Spending and Insurance Coverage in Ohio,” that we prepared for this project.

A full treatment of all the quality, safety, and efficiency issues is beyond the scope of this project, which concentrates on developing viable policy options to cover the uninsured. But we will address these problems to the extent possible and be mindful of the need to work on them even as we find ways to extend coverage to the uninsured. In this paper we include a few such “non-coverage” initiatives as examples that could be built into virtually any of the policy reform options that we develop and show how coverage expansion initiatives can be used to leverage other important reforms.

There is little support for a single-payer system. Our interviews found that many of Ohio’s key players in the health care field have largely abandoned strong advocacy for a single-payer system. This is not to say that some of the stakeholders do not believe deep down that a single payer system, or some version of it, is the ultimate answer – some do. It is more a matter of realism and pragmatism. Most respondents believe it is better to invest in proposals that do not automatically trigger ideological or strong interest-group reactions and to focus on vehicles that have consensus-based elements.

Medicaid expansion is viewed skeptically for different reasons. The balance of opinion seems to be that if we are going to approach universal coverage in a series of steps, we should not rely primarily on major expansions of the Medicaid program as the first step. Because of Medicaid’s low provider compensation rates, the welfare image, and budgetary and political constraints, heavy reliance on expanded coverage under Medicaid was not viewed as a realistic approach to achieving major reductions in the number of uninsured. However, very modest Medicaid expansion to include more people living in poverty could greatly assist populations who as a result of structural and affordability barriers are unlikely to be reached by private insurance expansion. For example, reinstating the eligibility level for parents up to the poverty level or increasing eligibility for the disabled to a proportion of the federal poverty line (FPL) that is in line with the Supplemental Security Income (SSI) thresholds might gain some support since such an expansion still only covers the poorest people. Enabling poor adults who are ineligible because they have no dependent children is a bigger step but not out of the picture. Modest Medicaid expansions have the advantage of triggering access to federal matching funds to help fund the additional coverage.

We must bring the healthier and younger populations into the job-based system. Unless we retain and expand the “good risks” in employer-sponsored insurance, there will be a continuation of the erosion of this system. Unlike the late 1990s and first half of this decade, we cannot count on Medicaid expansion to pick up a good portion of the slack as employers drop coverage. Simply put, many believe that the textbook version of the insurance “death spiral” could become a reality. This involves the cycle of good risks leaving group insurance pools and either buying coverage on their own or opting to be uninsured. This drives up premiums inside the pools, leading more to jump ship. Challenges are how to keep the younger and healthier people from abandoning the job-based system, and similarly, how to lure those who have always been on the sidelines over their “tipping point” to get insured – either through the workplace or in the non-group market.

A public/private solution to the problem of the uninsured is favored. In addition to targeting workers, a key challenge in Ohio is to find effective ways to first, retain those employers who have been offering health coverage in the system, and second, to attract other firms who have opted out into the system. Meeting these challenges will require some government interaction with the private insurance system. Our discussions highlighted a growing feeling in Ohio that those who advocate market solutions to the problem must get together to devise a private-sector solution. These stakeholders generally agreed that a private-sector solution still will require government incentives, rules, regulations, and infrastructure. A “pure free market” approach with no role for government is not seen as a realistic strategy for significantly reducing the number of uninsured.

In other words, a private sector solution really means a mixed, public/private policy strategy. The public-sector role is neither to essentially run the system nor to fund it all via public insurance (single payer). Instead, an important public-sector role might be to use sliding scale subsidies, in one form or another, for people with limited means who do not qualify for public programs to purchase private coverage. Another important government responsibility involves regulatory reform in insurance markets. Complementing subsidies and insurance reform, public-sector sponsorship of pools of private plans that function as “insurance exchanges” may be another way to assure an affordable source of insurance for small businesses and individuals without access to employer plans. The insurance exchange could provide the vehicle to make the subsidies and market reform operative. Further along the continuum is for government to *require participation* in the health insurance system. What is important in pursuing policy options is to be sure that initial reforms lay the groundwork for building additional reforms in successive layers on top of the foundation. Coverage expansion should be structured as a continuum to avoid the need to reinvent the wheel with each new expansion. The initial question is: what are the elements of the strong foundation?

Generally speaking, there is a feeling that it is very important to keep employer dollars in the health care system. We have to retain these dollars and the people to which they are attached. Then we need to build out the job-based health care system. A related step is to strengthen the non-group market for those who cannot participate in the employer-based system. Once we start to solidify and strengthen this private-sector system, we can then fill in the gaps through limited expansion, where appropriate, of public programs.

People are willing to have the conversation about employer and individual responsibility. Many people favor using incentives rather than requirements to shore up the private insurance system. But there is also a new awareness in Ohio, and around the nation, that carrots may go only so far in covering the uninsured. Some sticks may be needed.

IMPROVING QUALITY AND EFFICIENCY

As noted earlier, the focus of this project is on coverage expansion. But virtually everyone agrees that coverage expansion will not ultimately be effective and sustainable unless it is accompanied by improvements in the quality and efficiency of health care delivery. The people we interviewed for this project consistently underscored the need to integrate and coordinate coverage expansion with controlling cost growth and improving quality. Below are a few options aimed at cost containment, better health outcomes, greater transparency, and other improvements in the performance of the health care system. We make no claim that this is an exhaustive list of the steps that Ohio might take to improve the quality and efficiency of the delivery system. To identify and assess all the options is well beyond the scope of this project. The options outlined here are based on elements of comprehensive reforms implemented or proposed in other states (for example, Vermont, Massachusetts, California).

Although initiatives like this are often considered in combination with coverage expansion reforms, they are, in fact, separable. They are worth pursuing on their own, even apart from any efforts to expand coverage. And they *could be combined with any of the three phases of coverage expansion reform described later in this paper.*

We must caution that, ultimately, meaningful cost containment will require a serious *national* effort to control spending. This would involve, among other measures, careful assessments of the application of expensive advanced medical technology, targeting the use of such technology to clinically appropriate situations. It is also important to have realistic expectations about how much savings all of these efforts will produce. Some of the quality improvement changes may, in fact, add to costs in the short run. The following state-level reforms, however, would improve public health and could, in combination, help moderate cost growth in the long run.

- *A chronic care initiative:* Under this proposal, the state would support an effort to target for special help the individuals and conditions that account for the greatest costs in the health care system. This could include an extensive care coordination system, including early and coordinated screening for conditions such as diabetes and asthma; patient self-management educational tools; education of providers and other stakeholders in promoting self-management for consumers; and reimbursement incentives such as pay-for-performance to encourage excellence in chronic disease management. The state could either directly fund some of these initiatives, or build them into its contracts with managed health care plans as it expands coverage to the uninsured.
- *A consumer health information website:* The state would coordinate and help fund an effort to collect health data and establish a user-friendly website comparing the cost and quality of health care services by facility and physician practice. Consumers, employers, and other purchasers could use this information in their care decisions, and providers could better gauge and focus efforts to improve

their performance. The state may also use this information to link reimbursement increases in the Medicaid and state employee benefit programs to performance.

- *A commission to set quality and HIT goals:* The state would establish a commission to set goals and timetables, and monitor progress for conversion to electronic health records, electronic prescribing, new safety measures and error reporting requirements, and implementation of evidence-based practices. This effort would need to be coordinated with the federal HIT initiative to assure uniformity and interoperability in the adoption of clinical data standards.
- *Fostering patient responsibility:* The state may also wish to consider promoting the more widespread use of Health Savings Accounts (HSAs) in order to encourage people to manage their routine medical expenses carefully. The cash accounts in HSAs are highly tax favored, with no tax liability at the time of contribution or withdrawal or on interest earned. It is worth noting that the health management/prevention attributes of HSAs are controversial because there is some indication that the substantial initial out-of-pocket costs for care actually discourage prevention, early intervention, and chronic illness management. By contrast, some private initiatives by Pitney Bowes and others offer reduced co-payments for medication compliance by those with chronic illnesses such as asthma and diabetes. Therefore, the state may want to consider promoting benefit structures that assure coverage or reduced co-payments for services such as influenza immunizations, chronic disease medications, and certain screenings that can help avoid the major expenditures that come with complications and advanced disease.

COVERAGE EXPANSION REFORM OPTIONS

The variety of ways to expand coverage to the uninsured is virtually unlimited. But the general approaches can be logically grouped into a limited number of categories. Based on the stakeholder interviews and the guidance we received regarding what is worth serious consideration in the present Ohio environment, we have chosen three categories.

- The first group is a set of policies that are modestly incremental in nature and are focused on setting up incentives to increase the purchase of private coverage. This is primarily a private-sector oriented approach that, while requiring some new public monies, does not involve any expansion of public coverage programs. This policy set does not mandate participation by households or employers.
- The second group of policies requires more government funding and a focus on modest expansion of public programs. This group still depends upon a voluntary system, with no mandates.
- The third group of policies represents comprehensive reform that involves greater public involvement, requirements for participation by individuals and employers, increased public funding, and more extensive insurance market reforms.

Although these approaches are grouped separately, it will be evident that, in some sense, they represent a continuum of options for moving toward coverage for everyone. They are constructed to form a set of “building blocks” toward universal coverage. The path toward this goal would likely not always follow a straight line, and some reforms put in place at one stage might need to be significantly modified or replaced by other reforms in a subsequent phase. In some cases, the addition of a particular new feature may render a policy step taken earlier to be unnecessary. But, generally speaking, each set of options would be carried forward to the next with new features added. Each successive step would move the state closer to universal coverage, but only the last step (or something similar to it) could actually achieve that goal.

Ohio may want to move down this path one step at a time or instead jump more directly into more comprehensive reform. Clearly, there is more than one path to universal coverage. And the policy elements outlined below can be mixed and matched. This paper provides a sketch of one way to progress toward covering the uninsured.

GETTING STARTED: SHORING UP THE PRIVATE INSURANCE SYSTEM

The first group of options is based on setting up incentives to make existing private insurance more affordable and accessible. These options represent relatively modest incremental changes that aim at improving the private insurance system and avoiding changes that could cause disruptions of the status

quo. But as a consequence, these policies are likely to produce only an incremental reduction in the number of uninsured people. This is far from an exhaustive list of incremental options, but they are chosen because they appear to be feasible and offer a reasonable prospect of success.

Extend private family coverage to adult children

A very high proportion of young adults are uninsured. They are often not fully employed, in transition to employment, or employed by a firm that does not offer coverage. First, we need to persuade young adults that they need to find coverage. Second, finding coverage that seems worth the money is not always easily accomplished, especially if the young adult has a prior medical condition. A simple solution to this problem would be to modify the present provision in most health policies that cover adult children up to some age as long as they are students. The revision would be to require all family policies issued by insurers to cover young adult children on their family health insurance policies, regardless of student status, up to a more advanced age such as 30, assuming that the young adult does not have access to employer-based coverage or some similar group arrangement. (The state cannot require self-insured employers to conform to such a requirement because of ERISA prohibitions on the state regulation of employer benefits.) This coverage would be an automatic part of all family health insurance policies, and the cost of providing this coverage would be reflected in premiums for all family health plans.

Another alternative, though less likely to ensure significant coverage expansion, would be to allow families to buy such coverage as a rider. In other words, coverage would not be automatic; families would have to take the explicit step of adding such coverage once their children reached adult status and pay an extra premium amount to cover the child. This approach has two disadvantages relative to the other: some families will forget or choose not to buy the coverage. In addition, the families most likely to take the rider are those with higher-risk adult children, which would create significant adverse selection and cause premiums to be higher and perhaps unaffordable for some families that would otherwise choose this coverage.

High-risk pool for “uninsurable” individuals

A high-risk pool is designed to provide subsidized coverage to people in the individual market whom insurers deem to be “uninsurable.” In reality, this means that the insurers believe that they are very likely to incur high medical claims. Very often these are people with serious pre-existing medical conditions. The insurers know that if they charged such people a premium that reflected their risk, it would be so high that no one could afford it. So they simply deny them coverage. The high-risk pool serves such people by offering a rate that is higher than a person of their age and general characteristics other than health status would pay in the normal market (typically 125% to 150% of that rate) but not as high as would be needed to fully cover their risk. The difference is made up by a subsidy, often with funds collected through some kind of levy on insurers. The subsidy goes to pay the difference between the amount collected in premiums from those who are insured and the amount of medical claims they generate. This represents another way of spreading the insurance risk more broadly to make coverage more affordable for higher-risk people.

To implement this policy, the state would establish a high-risk pool that would offer subsidized coverage to individuals seeking coverage in the non-group/individual market who have been turned down for coverage or whose only option is coverage that excludes some medical condition. The premium would be limited to perhaps no more than 125 percent of what a person of similar characteristics but without the person's medical problems would pay for the same coverage. To make the coverage even more affordable for lower-income people, larger subsidies could be offered to them – that is, the subsidies could be graduated by income. A challenge would be to ensure that the pool is adequately funded so that insurance companies will participate on an ongoing basis and individuals can afford the coverage. The experience in many states has been that funding has been insufficient, with the result that there is a waiting list, coverage is insufficiently comprehensive, or the subsidies are not large enough to make coverage affordable.

In concept at least, a high-risk pool could be made more inclusive, providing relief to more higher-risk people, if the standards for eligibility were relaxed. It could, for example, be opened up to anyone whose rate exceeded some multiple of the average premium rate – perhaps to anyone whose rates was 200% above the average rate for people buying a particular benefit package. The problem with this approach, or any other that compresses rates in the individual market (including a prototypical high-risk pool), is that it creates an incentive for people to wait to buy insurance until they know they are likely to incur high medical expenses. If people know that there is no severe penalty for waiting to buy coverage, they will often postpone doing so until they conclude that they are likely to need services. Thus they are not paying premiums when they are healthy. As a result premiums for the people in the market will be higher, which will discourage younger, healthier people from buying coverage, which would further cause premiums to rise.

The state would need to decide how to fund the subsidies that make it possible for high-risk people to afford the coverage. As noted, states have often required insurers in the individual market to contribute to the pool's costs. The problem with this approach is that it spreads the risk just across those people who buy individual coverage, when such coverage is already more expensive and/or less comprehensive than what is available to people who are covered through their employers. Requiring contributions from all insurers, not just those serving the individual market, still exempts self-insured employers from contributing. A more equitable approach would be to fund the program from more broadly based revenue sources, such as general fund revenues, which “spreads the risk” across the whole tax-paying population.

Insurance rating reforms

Small groups that have a disproportionate number of higher-risk members frequently find that coverage is too high-priced to be affordable. One way to address the problem is through changing the premium rating rules that insurers who sell small-group coverage are permitted to use. Insurance rating rules in the small-group market could be changed so that the gap between what high-risk and low-risk groups pay would be narrowed, with the expectation that more small employers with higher-risk groups would offer coverage as a result. The obvious limitation of this approach is that if the insured population stays the same, when rates are lowered for higher-risk groups they have to be increased for lower-risk groups. If the increase is too great, some lower-risk groups could drop coverage, which would cause premiums to rise for all small

groups. However, the evidence regarding small employers' sensitivity to premium changes suggests small increases in premiums are not likely to cause many employers to drop coverage.

If Ohio wishes to make coverage more affordable for higher-risk groups by narrowing the rate variation between high-risk and low-risk groups, it could take the route that states have typically followed: they decide on particular factors that insurers can use for risk rating, such as age and geography, and then set variation limits for each factor. However, a different approach is more straightforward and much simpler: the state could simply set a limit on the *total* maximum rate variation for all factors in combination. For example, total variation might be limited to plus or minus 50 percent (a 3:1 variation) for all rating factors in combination. Thus if a particular benefit plan cost the lowest-risk group \$100 per person per month, the highest-risk group would pay no more than \$300 per month per person for the same coverage. With such a total limit in place, it is less important what factors insurers are permitted to use in varying rates for each group.

When insurers' ability to vary rates based on risk is restricted, there is a possibility that some insurers could become victims of accidental adverse selection because of the population groups they naturally attract. An insurer that happens to enroll a disproportionate number of older and sicker people could be at a competitive disadvantage when they have little room to vary rates based on risk. If, for example, an insurer had a disproportionate number of 50 to 60 year olds, whose expenses were six times the average for people of all ages but they could charge them only three times what they charged the youngest people, the rates for young people would be quite high compared to an insurer that had a much higher proportion of young people and few older people. An appropriate way to address this problem is to establish a risk-adjustment mechanism for insurers participating in the individual and small-group markets, which would transfer funds from insurers with a disproportionate share of lower-risk enrollees to insurers with a disproportionate share of higher-risk enrollees. The objective is to treat insurers equitably and also eliminate any reasons for insurers to compete by trying to select "good" risks. If the risk adjustment mechanism could work perfectly, there would be no advantage or disadvantage to attracting and enrolling high-risk or low-risk groups. Insurers would have to compete by being efficient, providing good service, and improving quality.

It is important to recognize that, while rate compression does make coverage more affordable for higher-risk groups as well as improving year-to-year stability in rates, the evidence shows that it does not lead to an appreciable increase in the total number of people insured.

Employer auto-enrollment

One of the reasons that the employer-based system is covering fewer people than in the past is that more employees are failing to sign up for coverage when their employers offer it. Research related to the take-up rates for employer-sponsored retirement plans show that the sign-up rate is likely to be much higher if employers notify employees that unless they actively decline to sign up for the retirement plan, they will be enrolled. In other words, when the default option is enrollment, more people participate. There is reason to believe that the same kind of result would be realized if employers used the default enrollment approach when offering health insurance to their employees. Under this approach, all employees would be enrolled in one of the company's health plans unless they specifically opted out.

It seems sensible to encourage employers to adopt this auto enrollment approach for their employees. Employers offer coverage in part because they want to ensure that their employees have good access to medical services so that they are not absent from work because of untreated illness or failure to get preventive care. Given that motivation, it would seem that employers would support the process that encourages more employees to get coverage. On the other hand, when the employer contributes to coverage, as most do, if more people enroll, the employer's premium payment increases. So employers may have some ambivalence about the concept of auto-enrollment. This suggests that some kind of modest economic incentive, perhaps a small, temporary tax credit, could be offered by the state as a way to encourage more employers to adopt this auto enrollment approach.

Government-subsidized reinsurance for low-wage employers

Low-wage employers, many of whom are small, are least likely to offer health insurance for their workers for the obvious reason that the health insurance premium would represent a large proportion of a worker's total compensation. Affordability is a problem for both the employer and the firm's employees. Any step that could lower the net premium cost would make coverage more affordable and more attractive. One way to achieve that would be for the state to subsidize premiums for such employers and their employees.

One approach that New York has adopted is for the state to "reinsure" coverage available to small, low-wage employers. Under this approach, low-wage employers would be eligible to purchase private small-group insurance through a program that would have the state absorb the cost (without a federal match) of a significant portion (perhaps 80 percent) of the medical costs incurred by every individual whose annual medical expenses exceed some threshold, for example, \$50,000. Because insurers are relieved of having to pay much of the expense for high-cost cases, their liability is limited and they can thus lower their premiums. It is important that the state-funded reinsurance not cover all of the costs once the reinsurance threshold is reached because then the insurer would have no reason to be concerned about controlling the cost of high-cost cases. Another slightly different approach is for the state as reinsurer to cover most of the costs over some corridor. For example, in Healthy New York, the reinsurance covers 90 percent of the costs between \$5,000 and \$75,000, which is said to have produced a 17 percent reduction in premiums. This program is available to small employers that meet certain criteria, including not having offered insurance in the previous year. It is also available to individuals and self-proprietors.

In effect, this reinsurance mechanism is a way of spreading the risk/costs of catastrophic cases to the population as a whole through the public revenue system.

One of the disadvantages of a reinsurance approach, depending on the way it is structured, is that a significant proportion of the subsidy may go to people who are already voluntarily buying the coverage without a subsidy. If the program is not restricted to employers who have not previously offered coverage, some of the money will go to reduce premiums for people who are already buying coverage and paying a premium that reflects the insurers' costs in paying for high-cost cases. Thus subsidies going to those people would not be spent to increase the number of people covered. If the same amount of money were used to directly subsidize low-wage employees and employers who do not now have coverage, it would likely have greater impact.

Premium assistance for employee coverage

Premium assistance allows the state to leverage employer funds. It helps avoid more working families being squeezed out of the job-based health care system.

Premium assistance allows Medicaid or SCHIP to pay a portion of a low-income workers' share of the employer-sponsored insurance (ESI) premiums for those who are currently eligible for these programs and have access to ESI. Programs are now operating in Rhode Island, Oklahoma, New Mexico, Illinois, and other states. Under New Mexico's program, employers pay \$75 per employee per month and the employee pays up to \$35 per month, depending on income. Health services require co-payments on a sliding scale related to income. Pennsylvania's premium assistance program, which pays the worker's share of the ESI premium, is one of the oldest and largest, with 21,000 members enrolled.

Buy-in to state employees' plan

As a purchaser of health coverage, state employees' health plans have several advantages: they nearly always command a large enough market share to make insurers/plan intermediaries compete for their business on price and the administrative costs are usually relatively low because of economies of scale. A number of states have considered allowing uninsured groups or individuals to buy into the state employees' plan to take advantage of its cost savings. The idea is that premiums would be lower, so some uninsured firms or individuals could newly afford coverage.

Perhaps the most difficult challenge to taking this course is the problem of adverse selection. Opening up the state plan to all small firms and making coverage available at the average cost for state employees could cause the state to attract a disproportionate number of high-risk firms. If that happened, the state would find that its average claims cost rise more rapidly than they otherwise would. And the likelihood is that the plan *would* disproportionately attract firms of higher-than-average risk. Even though the state plan may have some cost advantages because of economies of scale and bargaining power, the lowest-risk firms can probably already buy insurance at rates that are as low as or lower than those offered through the state plan because the state plan reflects the risk of a more or less "average-risk" population. So the low-risk small employers may not find the new option particularly attractive. But the state's rates will be a good deal for higher-risk firms, so they will likely join. (This illustrates the general proposition that any insurer that applies more lenient rating rules in accepting higher-risk firms than the rest of the market—for example, uses community rating—is in danger of becoming a victim of adverse selection.) A similar, perhaps worse, problem could arise if individuals were allowed to buy in.

There are a number of ways to address the adverse selection problem. One is to put the newly insured firms in a risk pool separate from state employees, so that their rate reflects the risk of the people in the separate pool. If they turn out to be higher-risk, the cost would not be passed on to state employees. Of course, the result would be that the premium would be less attractive. Another possibility is for the state to restrict participation to just certain firms, perhaps just low-wage firms without previous coverage. This would limit the state's exposure even if the firms proved to be of above-average risk. Yet another alternative would be for the state to subsidize some or all of the cost of adverse selection. This approach has the advantage of keeping premiums more affordable and at the same time making the coverage more

likely to attract average-risk and lower-risk firms. Of course, such an approach would be most defensible if the subsidized coverage was available only to “needy” firms.

Any of these approaches is compatible with having the state plan offer participating firms a different benefit package than that provided to state employees.

BUILDING ON THE CURRENT SYSTEM WITH EXPANSION OF EXISTING SUBSIDY PROGRAMS

The next set of options along the continuum would build on the incentives to make existing coverage more affordable by adding new purchasing arrangements, an all-out push to enroll people already eligible for but not participating in public programs, and modest expansion of public programs. This group of options, however, would still not include mandates on either employers or individuals. It would use the S-CHIP program and the state employee benefit program as the centerpieces of a buy-in strategy for people in the moderate-income range who do not have an affordable private-sector option.

Auto-enrollment for Medicaid/S-CHIP

The state would make an all-out push to enroll children and adults who are already eligible for Medicaid and S-CHIP but not enrolled. For children, another form of “auto-enrollment” would be used, under which children participating in federal nutrition programs (for example, Food Stamps, WIC, or National School Lunch Program) would be presumed eligible for Medicaid/S-CHIP and automatically enrolled in S-CHIP unless their parents opted out.

Most uninsured, low-income children live in families who receive means-tested nutrition assistance. A study by Stan Dorn and Genevieve Kenney of the Urban Institute analyzed data from the 2002 National Survey of America’s Families (NSAF) concerning the relationship between income, health coverage, and participation in three means-tested nutrition programs: namely, the National School Lunch Program (NSLP), the Special Supplemental Program for Women, Infants, and Children (WIC), and Food Stamps. The study found that, in 2002, more than two-thirds (71 percent)¹ of low-income, uninsured children lived in families who received one or more of these nutrition benefits.

This suggests that most low-income, uninsured children who qualify for Medicaid or SCHIP could be enrolled if children received health coverage based on their families’ receipt of means-tested nutrition assistance. The maximum income eligibility for NSLP and WIC is 185 percent of FPL. For Food Stamps, gross income levels may not exceed 130 percent of FPL, and the maximum net income level is 100 percent of FPL. Accordingly, children whose families receive these nutrition benefits almost always are income-eligible for SCHIP, which extends to 200 percent of FPL or higher in most of the country.

¹ Stan Dorn and Genevieve Kenney. Automatically Enrolling Eligible Children and Families into Medicaid and S-CHIP: Opportunities, Obstacles, and Options for Federal Policymakers. Urban Institute. 2006. Tabulations based on 2002 NSAF. Low-income children have family incomes at or below 200% of the FPL.

To make auto-enrollment work best, the state's computers used to administer health and non-health programs have to communicate more effectively. Ohio could try to use Medicaid Information Technology Architecture (MITA) funds to develop the IT system needed to use digital exchange and analysis of eligibility information instead of trying to convey information by hand.²

Ohio could also seek a waiver from federal law to permit the state to disregard minor technical differences in various means-tested programs' income determination methodologies. This approach has been used in the low-income subsidies (LIS) program under MMA for Medicare Part D prescription drug benefits. When lower-income seniors qualify for the Medicare Savings Program (MSP), which covers cost-sharing under Medicare, they are automatically eligible for LIS under Part D.³

Expand Medicaid eligibility

Medicaid eligibility would be increased somewhat to include more of the population living in poverty. For example, the threshold for eligibility for parents would be reinstated to the prior level of 100 percent of the FPL, up from 90 percent. The expansion of Medicaid to cover all poor adults without dependent children is discussed in the next section as it is a bolder step. But under current law, one group of childless adults – those with qualifying disabilities – are eligible for Medicaid. In Ohio, however, such adults must have incomes below 64 percent of the federal poverty line to qualify. This threshold could be raised closer to the federal poverty line to help more people in this very needy group. In this phase Ohio might also consider a pilot project under a waiver from the federal government to cover one small segment of this group, such as older adults (e.g. 50-64) with incomes below 50 percent of the FPL. This is a very needy group, some of whom are homeless and lacking any access to affordable private insurance.

Expand S-CHIP

The S-CHIP program could be opened to parents of participating children (who therefore have family incomes up to 200 percent of poverty). These families would pay sliding scale premiums varying with their incomes. This would require new federal funds (not just moving money out of the existing S-CHIP budget). There were 10.9 million uninsured parents in the US in 2005, about a quarter of all the uninsured. Some 82 percent of this group has at least one full-time worker in the family, and 68 percent have incomes below 200 percent of the FPL. As of January 2007, 11 states had implemented S-CHIP waivers from the federal government permitting them to use S-CHIP funds to cover parents. In 2005, S-CHIP covered about 600,000 adults in addition to about 6.1 million children.⁴ A proposal by President Bush would disallow parental coverage under S-CHIP.

Universal coverage for preventive/primary care

The state could offer universal coverage for preventive and/or primary care. Any *uninsured* resident of the state, regardless of income, could apply for a card that would allow the person to seek preventive and/or primary care services from any participating physician or clinic. The coverage would not be insurance in

² Stan Dorn and Genevieve Kenney. Op. cit.

³ Ibid.

⁴ Kaiser Commission on Medicaid and the Uninsured. "Health Coverage for Low-Income Parents." February 2007.

the sense that there would be no premium. The services would be reimbursed at a standard insurance rate (for example, rates could be based on the fee schedule of the largest insurer in the state). The person seeking services would meet a co-pay for each service received that would vary with the person's income (determined at the time of the application for the card) to ensure that services are affordable. The state would pay the remainder of the fee. A somewhat more comprehensive, but still affordable option is to develop an insurance-like program that covers primary and preventive care, but also specialty care and diagnostics. This model excludes inpatient care, seeking other funding for the indigent for this type of care. A third approach involves "three-share" or "multi-share" models under which small employers and their employees each pay a portion of the premium while the state and local government, providers and other non-profit organizations pay the rest. Michigan has operated successful programs in each of these last two areas.

APPROACHING UNIVERSAL COVERAGE

The third group of options adds elements needed to achieve the goal of near-universal coverage. Almost all analysts agree that that goal is not achievable in a system that depends entirely on incentives and voluntary actions. Regrettably, some element of compulsion is necessary. Moreover, substantial new state funding will be essential to make the program viable. But, as the state of Massachusetts has shown, a single payer system is not the only option.

In 2006, the Massachusetts legislature passed a major coverage expansion reform that, for good reason, has received much attention. While it builds on the present system, it is much more than incremental reform, and in some ways it departs from what any other state has done. But Massachusetts launched their reform plan from a platform that already reflected higher Medicaid eligibility levels than in Ohio, and Massachusetts had an 1115 waiver that had helped create a federally supported indigent care program. Thus, Massachusetts was in a stronger financial position with a smaller coverage gap to close. The elements we bring together below recognize this difference and, as a consequence, in some ways go beyond what Massachusetts adopted. An approach based on these elements goes very far toward achieving universal coverage. This approach also bears some resemblance to the new initiative just proposed by California Governor Arnold Schwarzenegger. As with Massachusetts, however, we have not just taken the California approach as a model for Ohio, but rather used that type of framework as a starting point and then built in variations.

The basic challenges in achieving universal coverage are finding a way to ensure that everyone acquires coverage and finding a way to pay for the subsidies that are necessary to make coverage affordable for people whose resources are limited. The approach below addresses these two challenges through a system of shared responsibility. As with all approaches to reform, there are always alternatives to the particular elements we outline here. While it is almost certainly necessary to move away from an entirely voluntary system to achieve universal coverage, some of the elements below may be desirable but not essential to achieving that objective and could be replaced with others. For example, the funding sources that are described need not all be included or could be combined with other forms of revenue generation.

Individual Responsibility

All residents would be required to have coverage that meets a minimum benefit standard or to pay a substantial penalty if they failed to meet the requirement. To make this requirement effective, the incentive to comply must be strong.

One approach might be start with a penalty equal to one-half of the cost of the least expensive plan available through a new purchasing pool (see below). The penalty would rise over perhaps three years to 100 percent of the cost of such coverage. For persons not acquiring the coverage, the penalty would become a liability on their state income tax. The penalty would be prorated for every month the person was without coverage. Everyone would be required to file a simple form to demonstrate coverage status; in addition, this tax form would be the basis for establishing eligibility for subsidies. At the end of each year, insurers would be required to supply evidence of coverage to each person covered for any part of the year. This form would be submitted with the person's state income tax filing. (It would be possible to administer this system through an agency other than the income tax system.)

This type of incentive directly relates the penalty to the cost of acquiring coverage. Since the intent is to ensure that everyone acquires coverage, an approach that ultimately makes the penalty equal to the cost of complying with the requirement seems appropriate.

Making Coverage Affordable

A mandate cannot be effective or fair unless coverage is affordable for everyone subject to the requirement.

Expansion of Medicaid and S-CHIP. A sensible approach to making coverage affordable for low-income people is to expand eligibility under Medicaid and S-CHIP higher up the income scale, beyond the limited steps outlined in the previous set of options. For example, Medicaid coverage might be extended to both parents and adults without dependent children up to 100 percent of the federal poverty level. S-CHIP eligibility for children could be increased to 300 percent of the poverty level, with sliding scale premium contributions related to income. The clear advantage of expanding coverage through these programs is that the federal government pays a major portion of the cost, with an enhanced match for S-CHIP expansion. Some elements of the expansion would require a federal waiver. Current efforts by the Administration, if successful, to restrict S-CHIP to only children living under 201 percent of the federal poverty level obviously would preclude this option.

Subsidies for lower-income adults not eligible for Medicaid. Many of the uninsured whose incomes are high enough to make them ineligible even for expanded public programs still cannot afford to pay the full price for private coverage. Without subsidies, complying with the mandate would impose a financial hardship on them. The state would need to subsidize the purchase of coverage for such people. Subsidies would probably be necessary for people with incomes as high as 250 percent to 300 percent of the poverty level to ensure that people are not asked to spend an unreasonable proportion of their income for coverage. The subsidies could take the form of a voucher to be used only for the purchase of health insurance. The amount of the voucher should be graduated by income. For example, the requirement could be that adults with incomes just above the poverty level pay up to 2 percent of income for

premiums, with the subsidy paying the remainder, whereas people at 300 percent of the poverty level might be expected to pay as much 8 percent of income, with gradations in between.

An important policy question is whether the subsidies would be available to people who meet the income eligibility standards but already have coverage. It is certainly more equitable to treat everyone at the same income level in the same way, but providing subsidies to those who already have coverage obviously adds significantly to the budget cost.

Minimum Benefit Package

If there is a mandate, the state must define what package of benefits qualifies as meeting the requirement. A benefit package includes two elements: the services covered, and the level of consumer cost sharing. Consistent with the notion of insurance as protection against large, unpredictable losses, it is sensible to have the minimum benefit be reasonably comprehensive in terms of services covered but with substantial cost sharing. There is a direct trade-off between the richness of the benefit package, on one hand, and the cost to consumers and to the state for subsidies, on the other. Significant levels of cost sharing also encourage people to use services economically (until the deductible is reached). In addition, there is no reason to require higher-income people to buy a low-cost sharing plan, when they can afford to pay the deductible. As an example of a possible cost-sharing amount, Governor Schwarzenegger of California has proposed a \$5,000 deductible plan with a maximum out-of-pocket limit of \$7,500.

One way to ensure that the paying the deductible does not cause hardship for modest-income families would be to include out-of-pocket cost sharing with the maximum proportion of income families must spend before they are eligible for subsidies. For example, if the subsidy is available once the person has spent 4% of income, the 4% would include the sum of premium payments and out-of-pocket cost sharing payments. This might also mitigate the danger of forgoing preventive services and care management.

Insurance Exchange and Insurance Reform

Analysts of insurance markets generally agree that the individual and small-group insurance markets do not perform as well as would be ideal. Partly because of diseconomies of scale, people buying in these markets generally pay more and have unaffordable choices. The individual market, in particular, does not perform well. These problems can be addressed through insurance reforms and the establishment of an insurance exchange, often referred to as a purchasing pool. This is an entity that contracts with a number of insurers to offer one or more standardized plans and then takes responsibility for enrolling consumers, billing them, etc.—much as the state employees' plan does for state workers in most states.

If the purchasing pool accounts for a large proportion of the small-group and individual markets, it can provide consumers with information to help them make well-informed choices among health plans, and it can use its market clout to get a “good deal” from insurers and ultimately providers. Ideally, even when employers choose the exchange as their source of coverage, individual enrollees (rather than employers) should be allowed to choose whichever plan they think best suits their needs. The advantage of this approach is that it places insurers in head-to-head competition every year for each person buying through the exchange. To retain enrollees at the time of open enrollment, each insurer has to demonstrate that it is

offering an attractive combination of price, quality, and service. Such competition should help improve performance and quality and keep prices from escalating as rapidly as they otherwise might.

Purchasing pools have often not done well in the past because they could not attract enough consumers or insurers to realize economies of scale and bargaining power. One way to make certain that the exchange avoids this problem is to require all small-group and individual coverage to be sold through the exchange. Consumers would still have the same wide choice of plans, since all plans would sell through the exchange. There seems to be no serious disadvantage to this approach, except from the standpoint of insurers, who would face a higher probability that people might switch health plans more frequently and that the increased bargaining power of the pools will hold down insurance premiums.

Even with an insurance exchange, if insurance market rules are not changed, coverage will still be unaffordable or unavailable for some high-risk people. The first change that is needed is to require all insurers in the individual market to accept all applicants. (This is already required by federal law in the small-group market.) No one could be denied coverage regardless of health status or past medical experience, nor could coverage for prior medical conditions be excluded for a time. These current practices are designed to protect insurers against people who wait to insure themselves until they have some medical condition, but they would no longer be necessary, since everyone would always have coverage. And there is also no justification for denying people coverage because of previous medical conditions. So both practices common today in the individual market should be prohibited once an individual mandate is in place along with other reforms ensuring that coverage is affordable for high-risk people.⁵

Other desirable insurance reforms include limiting insurers' ability to vary premiums based on risk. The types of changes needed to protect higher-risk people from having to pay very high premiums are outlined in the first set of reforms presented earlier in this paper.

Universal Section 125 plan

One way of making coverage more affordable is to take advantage of the federal tax provisions which have the effect of providing indirect subsidies for the purchase of insurance. Federal tax law excludes from employees' taxable income the portion of employer compensation that goes to pay for health insurance. In addition, when employers offer "cafeteria plans," often known as Section 125 plans, employees can also tax shelter *their* part of the insurance premium contribution. Money put into the Section 125 account is before-tax income and thus buys more when spent for medical services and

⁵ In a market where people can choose not to buy coverage, such an opening up of the individual market for high-risk people is not workable: if coverage is optional but always available with no penalty for waiting to buy it, many people will wait to buy coverage until they think they need expensive medical intervention. This kind of adverse selection is cause for market failure: when people are lower risk, they do not contribute to the insurance pool; then when they enter the pool at the time when they need care, their premium contribution does not nearly cover their cost. Insurance works only when most of the people paying premiums incur only small or no expenses. If the pool begins to enroll a disproportionate number of higher-risk people, the premium will have to rise, and the lower-risk people will drop out because the cost is too high. But this problem is eliminated entirely if everyone is required to have coverage all the time. The lower-risk people cannot postpone buying coverage; they contribute when they are lower risk, as well as when they need expensive services. And lower-risk people cannot drop out. So there is no potential for adverse selection against the market as a whole.

insurance. Of course, people who are not working for employers that sponsor coverage plans and have to buy coverage on their own do not enjoy the benefits of these tax subsidies.

One way to address this inequity and increase the indirect federal subsidy would be to require all employers to establish a Section 125 plan, even if they do not offer coverage. Employees would be allowed to designate how much the employer should withhold against which they could withdraw for medical expenses, including premium contributions. Employees would benefit from being able to participate in such a plan even if the employer did not contribute to health premiums and employees had to pay the full premium, because they would be using the cafeteria plan to pay with before-tax dollars.

Financing

A reform that makes more people eligible for Medicaid and S-CHIP and that provides subsidies for modest-income people to buy private coverage will require significant new state budget dollars. Determining how this money will be raised is perhaps the most difficult political challenge in achieving universal coverage. As with all new government spending, there are a variety of ways to generate new revenue. Some of the obvious approaches include new state income taxes, so-called “sin” taxes on cigarettes, liquor, etc., and sales taxes. Ideally, in determining a revenue source, the state would apply the principle that the burden should be equitably and progressively distributed. But political realities require compromise, and an approach that might be ideal from the standpoint of equity may not be politically possible. One approach that does seem to have political viability is to view funding of coverage expansion as a shared responsibility and to support an approach that requires contributions from individuals, employers, providers, and the state and federal government.

Individuals. Individuals would contribute in the form of premiums and cost sharing. (Of course, ultimately, all costs are borne by households as they are passed through from those who pay the initial assessment.)

Employers. About six of ten of employers now offer coverage to their workforce, and many of the stakeholders we interviewed in Ohio agreed that it is desirable to preserve and expand employers’ role in funding coverage. One way to accomplish this is to require employers either to offer coverage or to pay a fee in lieu of doing so, with that revenue being used to help fund coverage for people who need subsidies. This is the so-called “play or pay” approach. Ideally, the amount of the fee would be large enough to encourage most employers to choose the “play” option, that is, to offer coverage themselves. A fee in the range of 7% to 8% of payroll might be appropriate, since that approaches the amount that many employers pay to offer coverage.

In addition to the political difficulty of imposing such a fee, a required contribution in this range could represent a real hardship for firms that are only marginally profitable and hire predominantly low-wage workers. The fee would represent a major increase in employee compensation, and if employees are being paid a wage near the legal minimum, employers could not pass back the cost by lowering employee wages. This suggests that some accommodation needs to be made for such employers – for example, the fee could begin at a low rate and gradually increase over several years until it reached the standard rate. Alternatively, the state could choose to impose a lower tax rate on all employers, perhaps something like

4%, as Governor Schwarzenegger has proposed in California. The Massachusetts law requires only a nominal contribution of \$295 per year per employee. While lower payroll contributions may be more politically palatable, the result is that more revenue has to be raised from other sources.

The way a required employer contribution is structured is very important if it is to avoid running afoul of the federal ERISA law. ERISA prohibits states from regulating employee benefits. Thus a play or pay approach that required employers to offer a particular benefit package as a condition for not paying the fee would almost certainly be overturned in the courts. But the legal experts generally conclude that if the state imposed a percentage payroll contribution on all employers and then allowed any amount the employer contributes to employee health premiums as a credit against the fee, the approach has a good chance to pass the ERISA test.

Providers. A strong case can be made for asking providers to share in the financing burden. Although controversial, a provider assessment has two important advantages. First, unlike revenue from most tax sources, revenues from a provider assessment are unlikely to fall during an economic downturn. People still use health services in hard economic times. Second, health expenditures, and thus the cost of a health coverage reform, are almost certain to rise more rapidly than the rate at which the state's economy grows. Most revenue sources increase in pace with the economy as a whole, which could leave the state with a shortfall to coverage a universal coverage program. But a provider assessment would grow at roughly the same pace as health costs grow because provider revenues *are* health costs.

Over time at least, the burden of such a provider tax is likely to be passed on to insurers and then to employers and consumers, as is appropriate. Such a tax would obviously add to the cost of doing business for providers and would thus represent a legitimate expense that should be compensated by those who consume medical services. Whether purchasers would make providers whole for such a cost increase remains to be seen. (Governor Schwarzenegger's proposal combines a new provider tax on hospitals and physicians with an increase in Medicaid reimbursement rates.) If the tax amounts in essence to a sales tax on the services of all medical providers, one would expect that cost to be passed on to consumers of medical services, just as retail sales taxes are normally passed on.

Nevertheless, depending on how it is structured, a uniform tax on all providers could have inequitable distribution effects, hitting some providers harder than others, and it would be important to try to anticipate such inequities and make corrections where possible. For example, a tax increase would not trigger an increase in Medicare payment rates, so providers with a disproportionate share of Medicare revenue would be disadvantaged. (A possible solution would be to exclude Medicare patient revenue from the tax base.)

Federal Government. It is to the state's benefit to take maximum advantage of available federal matching funds under Medicaid and S-CHIP. Some steps to expand coverage (e.g. raising the income eligibility thresholds for parents) can be done through state Medicaid plan amendments. Others such as bringing childless adults into coverage require a waiver to obtain federal matching contributions. Ohio should consider taking advantage of these provisions to draw in federal funds as it attempts to cover the uninsured.

SUMMARY AND CONCLUSION

This report began by summarizing the results of our stakeholder interviews and explaining the challenge of improving the quality and efficiency of the health care system. The bulk of the report was devoted to developing three categories of policy options to cover the uninsured in Ohio. The first group is a set of incremental reforms and focuses on developing incentives to increase private insurance. The second group requires more government funding and some modest expansions of public programs. The third group is a more comprehensive approach to covering the uninsured that involves greater public involvement, required participation in the health care system by individuals and employers, and more extensive insurance market reforms.

The purpose of this report is not to push for any particular set of reforms or to make the case that one approach is superior to others. Rather, the intent is to begin a dialogue by showing that a range of approaches are possible. These reforms can be taken in sequence, and various elements within each policy set could be substantially modified. The hope is that this menu of possible alternatives will stimulate discussion and debate about how to cover the uninsured in Ohio.

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