

HEALTH ACCESS STUDY GROUP

November 12, 2008

9:00-1:00

NC IOM

Meeting Summary

ATTENDEES:

Task Force/Steering Committee: Allen Dobson, Hugh Holliman, Tony Rand, Graham Barden III, Bonnie Cramer, Beverly Earle, Abby Carter Emanuelson, Kimberly Endicott, Allen Feezor, Tony Foriest, John Frank, Verla Insko, Eric Ireland, Sharon Jones, Eleanor Kinnaird, Ken Lewis, Carolyn McClanahan, David Moore, Barbara Morales Burke, Maureen O'Connor, John Perry, Mary Piepenbring, William Pully, Robert Seligson, Richard Stevens, A.B. Swindell, Brian Toomey, Tom Vitaglione, Steve Wegner, Gregory Wood

Interested Persons: Samantha Artiga, David Bruton, Jennie Dorsett, Andrew Dugan, Maeve Goff, Joshua Goldberg, Jean Holliday, Robert Jackson, Meredith Ledford, Kathryn Millican, Shannon Smith

Staff: Mark Holmes, Julia Lerche, Jesse Lichstein, Thalia Shirley-Fuller, Pam Silberman

WELCOME AND INTRODUCTIONS

Senator Rand welcomed attendees.

EXPANDING HEALTH INSURANCE TO LOW-INCOME ADULTS

Samantha Artiga, Senior Policy Analyst

Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation

In the United States, over half the nonelderly uninsured are low-income adults, 35% of whom are childless adults and 17% whom are low-income parents. Uninsured rates for low-income adults vary across the country, with North Carolina having the same rate as the nationwide average of 41%. The majority of uninsured, low-income, nonelderly adults work full-time, have no dependent children, and are between the ages of 19-29. Minimum Medicaid eligibility levels for adults are 63% of the federal poverty guideline for working parents and 0% for childless adults, compared to 133% of the federal poverty guideline for children. Uninsured adults have few insurance options other than public coverage. More than 90% have no access to employer-sponsored insurance or affordable non-group coverage. Health coverage has a significant impact on access to care for adults. The uninsured are more likely to report having no usual source of care, postponing seeking care due to cost, foregoing care even when needed, and not being able to afford prescription drugs. Insurance coverage for adults helps provide financial protections from medical bills, and coverage for parents helps support and increase coverage of children.

Medicaid can be used as a building block for expanding coverage to uninsured, low-income, nonelderly adults. It has readily available mechanisms for expanding coverage and a delivery system to build on, and provides federal assistance through matching funds. However, states

must still raise matching funds and federal rules limit coverage options and financing for adults. One option for leveraging Medicaid to expand coverage is through an optional parent expansion to increase parent eligibility. A second option for expanding coverage is to obtain a Section 1115 Medicaid waiver. This waiver allows states to expand coverage to both parents and other adults with the restriction that the expansion is budget neutral for federal costs (i.e. federal costs under a waiver cannot be more than expected federal costs without a waiver). A third option for states is to leverage Medicaid to expand coverage through private market approaches such as subsidizing premiums for private coverage or creating new subsidized coverage options for individuals and small employers. Additionally, a combination of methods can be used to expand coverage, as with the Massachusetts plan.

In expanding coverage to uninsured, low-income adults, three questions should be considered: 1) Which low-income adults are you trying to reach? 2) How can the state best leverage federal funds to expand coverage? and 3) What type of coverage will best match the health care needs and financial resources of the covered adults?

Discussion:

Discussion focused on inability to afford prescription drugs, the financial situation of Massachusetts' program, and the need for federal support with expansion efforts.

EXPANDING COVERAGE TO SMALL EMPLOYERS

Josh Goldberg

Health Policy and Legislative Analyst, National Association of Insurance Commissioners

Small employers face several problems when offering insurance, including higher costs due to higher administration costs, more volatile risk due to a small and unrepresentative risk pool, and higher risk of adverse selection. In addition, small employers are more acutely affected by the rapid growth in health care spending, which affects premiums. There is large variation in premiums across small businesses and across states. In an effort to reduce premium variation and make them more affordable to small-group employers, states enacted legislation restricting variation of premiums due to health status, age, industry, gender, and geography. Success of these rating reforms depends largely on the tolerance of healthier groups for higher premiums, which result from tighter regulations, and significant variation between states remains.

States have employed several other reform strategies to make coverage more available and affordable to small employers. Self-employed "groups of one" allow self-employed individuals to purchase coverage in the small group market, but carry a high risk of adverse selection. Purchasing arrangements allow small business to combine to purchase coverage, but for most arrangements have not resulted in reduced premiums compared to the outside market. Purchasing arrangements include purchasing cooperatives, Association Health Plans, connectors and exchanges, and government employee plan buy-in. "Mandate-Lite" plans allow small businesses to purchase plans without mandated benefits, however take-up of these plans has been very low. Subsidies, provided directly through the tax code or through a subsidized health plan, lower premiums by contributing to the employee's share of the premium, the employer's share, or both. Public-private partnerships typically divide premiums between the employer, employee, and the state or other underwriter of the program. Reinsurance is an indirect subsidy that

transfers catastrophic risk to the state, where the state would pay a large portion of high costs. Purchasing across state lines allows small businesses to purchase less expensive coverage available in other states. Of these strategies, rating rule reforms, reinsurance, and subsidies have been successful in reducing premiums and variation in premiums. Purchasing pools and “mandate-lite” plans have shown only limited effectiveness, and federal association health plans and purchasing across states lines do not work.

Discussion:

Discussion focused on subsidy levels to induce buy-in from businesses, state regulatory approaches, rating reform, the use and effectiveness of 125 plans, high-risk pooling, and reimbursement standardization.

NORTH CAROLINA SMALL BUSINESS INNOVATIONS: FIRSTPLAN

Ken Lewis

CEO, FirstCarolinaCare

President of the Board, North Carolina Association of Health Plans

FirstPlan is a group of subsidy plans offered by the FirstCarolinaCare Insurance Company to provide small business employees with accessibility to coverage. Premiums are based on actuarial risk, and three premium assistance tools are available to make the premiums more affordable: CareCredits, Premium Assistance, and reduced provider reimbursement. CareCredits are based on four components that FirstCarolinaCare uses in determining the final premium rate: contribution level, contribution level on dependent coverage, prior coverage history, and participation levels. To be eligible for the Premium Assistance Program subsidy one must be an employee of a small business in the program area, earn \$10 an hour or less, and there must be 100% participation of all eligible employees in the small business.

Lessons learned from this community effort to increase accessibility to coverage for small businesses include: shared responsibility for the community can work; requiring 100% participation is the same as a universal coverage at the micro level; subsidies are not always needed to gain participation; not everyone will participate, regardless of subsidy or cost; there is not pent up demand for services from the uninsured; it is necessary to engage the community through businesses, leaders, and physicians. FirstPlan credits a large part of its success, a 10% reduction in the number of uninsured, to community engagement and participation from hospitals, insurers, participating physicians, and small businesses.

Discussion:

Discussion focused on eligibility requirements, grant funding, and costs of the program. In addition, questions regarding the feasibility of duplication across the state, capacity, and business community buy-in were discussed.

LARGE GROUP DISCUSSION AND IDEAS FOR POTENTIAL RECOMMENDATIONS

Discussion focused on ideas for potential recommendations, as well as the need to further investigate cost containment strategies and an individual mandate. Recommendations from past meetings were also discussed, including ways to increase provider supply, per member per month payments based on number Medicaid and uninsured patients, incentives for students to go

into underserved specialties, and the possibility of reducing the escalation of costs through better management of care.

Low-Income Adults

- Prioritization of parents with a Medicaid expansion, and phased enrollment of low-income adults.
- Sliding-scale buy-in for Medicaid.
- Premium assistance option for higher-income, low-income adults.
- Increase Medicaid coverage for children.
- Support changes at the federal level for increasing matching funds and reducing eligibility restrictions.

Small Business

- Requirement or incentive for all employers to offer 125 plans. Possible subsidy for employers, employees, or both.
- Need for increased coordination with Chambers of Commerce.
- Possible creation of a new delivery model based on FirstPlan and Community Care of North Carolina.
- Need to focus on business with less than ten employees.