

Public Options to Expand Health Insurance Coverage

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Recommendations from July Meeting

- Further outreach and simplification, to encourage currently eligible to apply and maintain eligibility
- Recommend that the General Assembly expand Medicaid
 - Top priority is to cover all working parents with incomes up to 200% FPG under Medicaid benefits light package

Outreach and Simplification

- Thousands of North Carolinians who are eligible but not enrolled in Medicaid/NC Health Choice
- Potential recommendations:
 - Increase number of outstationed eligibility workers
 - Eliminate the requirement for face-to-face application interview for adult coverage (i.e. for people who are blind or have disabilities and elderly people)
 - Simplify the adult application form
 - Eliminate the asset (resource) test for low-income parents

Outreach and Simplification (cont'd)

- Potential recommendations (cont'd)
 - Expand the eligibility certification period from six months to 12 months
 - Streamline the recertification process. Either
 - Send out pre-printed renewal forms asking for updates or changes. Renewal forms must be returned, and changes reviewed, before being recertified
 - Assume that person continues to be eligible unless they notify the agency of change
 - Agency can check Social Security and/or ESC records to see if unreported or changes in income

Medicaid Expansion

- Recommend that the General Assembly expand Medicaid
 - First priority should be to cover working parents with incomes below 200% FPG with the limited benefits package
 - For approximately \$100 million (in state and county funds), North Carolina could expand Medicaid to cover 77,000 adults
 - Should seek 1115 or HIFA waiver to cover working parents in order to offer more limited benefit package
 - State should cover county share
 - Would combine expansion with voluntary premium assistance program

Medicaid Expansion Parents (37-200% FPG)

	Full Medicaid benefits	Limited Benefit (\$5,000 IP Deductible)	\$Limited Benefit (\$10,000 IP Limit)
Avg. Covered Lives	129,917	77,916	77,916
Total Cost	\$808,808,000	\$278,959,000	\$296,246,000
Federal (63%)	\$509,549,040	\$175,744,170	\$186,634,980
State (31.5%)	\$254,774,520	\$87,872,085	\$93,317,490
County (5.5%)	\$44,484,440	\$15,342,745	\$16,293,530

Medicaid Expansion: Limited Benefit Package

- Work group interested in further refining benefit package to reduce costs
 - Possible areas for further reduction
 - Hospital inpatient (deductible for \$10,000 IP package)
 - Hospital outpatient (total limits in addition to 20% coinsurance)
 - Physician (fewer visits/yr.)
 - Pharmacy (fewer scripts/mo.)
 - Lower annual limit in coverage (currently \$1.0 million)

<u>Services</u>	<u>Medicaid Light</u>	<u>Medicaid "Light"</u> <u>Possible modifications</u>
Inpatient hospital (Non-maternity, non-BH)	Covered: \$5,000 deductible or \$10,000 total; 20% coinsurance (only includes facility IP costs)	Add \$250-\$350 deductible to \$10,000 plan (to discourage inpatient use when outpatient available)
Outpatient hospital	Covered 20% coinsurance	Should there be an annual outpatient maximum? Outpatient hospital is a large cost driver. However, need to balance any maximums against potential to encourage inpatient use
Skilled nursing	Not covered	
Emergency room	Covered, \$100 copay (waived if admitted), 20% coinsurance	

<u>Services</u>	<u>Medicaid Light</u>	<u>Medicaid "Light"</u> <u>Possible modifications</u>
Primary care physician	Covered (sliding scale copay: \$10, \$20 for below/above 150% FPG)(5 visit limit)	5 visit applies to outpatient primary care and specialty (total). Individuals actively participating in disease management can have additional visits with prior approval by PCP.
Wellness visit	Well visits and immunizations only (not full EPSDT coverage)	Well visits not part of the 5 visit limit; subject to periodicity schedule for adults and children

<u>Services</u>	<u>Medicaid Light</u>	<u>Medicaid "Light"</u> <u>Possible modifications</u>
Specialty physician	<p>Covered (sliding scale copay: \$20, \$40 for below/above 150% FPG)(24 visit limit)</p> <p>Costs currently includes optometrist, chiropractic, podiatrists</p>	<p>5 visit applies to primary care and specialty (total).</p> <p>Individuals actively participating in disease management can have additional visits with prior approval by PCP.</p> <p><i>Should we exclude optometrist, chiropractic, podiatrist (or put separate limit)?</i></p>
Outpatient therapy	Covered, 20% coinsurance, 25 visit limit for PT, OT, Speech therapy	Note: not much savings can be gained from reducing number of therapy visits further.

<u>Services</u>	<u>Medicaid Light</u>	<u>Medicaid "Light"</u> <u>Possible modifications</u>
Inpatient behavioral health hospital	\$5,000 deductible or \$10,000 total; 20% coinsurance	In \$5,000 deductible package, should limit inpatient behavioral health to 20 days, substitution allowed
Outpatient behavioral health	Covered. Sliding scale copay (\$20, \$40 for below/above 150% FPG) 20% coinsurance, 20 visit limit/yr., PA after 8 visits for adults	
Behavioral health other	Not covered	Intensive day treatment allowed as substitution for inpatient with prior approval

<u>Services</u>	<u>Medicaid Light</u>	<u>Medicaid "Light"</u> <u>Possible modifications</u>
Pharmacy	Covered: \$15 copay (generic), \$25 (brand), \$60 (brand, non-formulary) (6 script limit/mo.). Assumes a formulary.	2 script/mo. limit; waived for maintenance drugs for chronic illnesses when in CCNC disease management. Copay modified to: \$10 (generic), \$30 (brand), \$60 (brand, non-formulary) 2 script limit does not include contraceptives. Assumes a formulary.
Family planning	Contraceptives only	Contraceptives only, not included in 2 script limit/mo.

<u>Services</u>	<u>Medicaid Light</u>	<u>Medicaid "Light"</u> <u>Possible modifications</u>
Case management	CCNC only	Participation in CCNC required, must select medical home
Home health	Not covered	
Personal care	Not covered	
School based health services	Yes, to extent school is provider of covered services, same cost sharing as with primary care physician	

<u>Services</u>	<u>Medicaid Light</u>	<u>Medicaid "Light"</u> <u>Possible modifications</u>
Lab & radiology	Covered, 20% coinsurance; requires pre-authorization of MRI/PET scan	
Dental	Not covered	
DME/Supplies	Covered, 20% coinsurance. \$500 limit (includes glasses) (diabetic supplies unlimited)	
Ambulance	Covered, \$150 copay (waived if admitted), 20% coinsurance	

<u>Services</u>	<u>Medicaid Light</u>	<u>Medicaid "Light"</u> <u>Possible modifications</u>
Maternity	Covered <i>prenatal care only</i> for adult women with incomes > 185% FPG (<185% covered by Medicaid); not covered dependents.	
Annual benefit limit	\$1 million	
Out-of-pocket maximum	None	Suggest \$2,000-\$3,000/person out-of-pocket maximum on coinsurance (Note: will increase costs slightly)

Personal Responsibility

- CCNC provides care and disease management to individuals with chronic or high cost health problems
 - Disease management and care management services offered to target populations, but no penalty for failing to participate
- Currently, Medicaid does not cover:
 - Health risk assessment for every adult
 - Separate payment for counseling around smoking cessation and/or nutritional counseling (included as part of regular reimbursement to primary care provider)

Personal Responsibility: Design Issues

- Should newly eligible Medicaid enrollees be charged differential premiums or cost sharing depending on participation in CCNC or lifestyle behaviors? Examples:
 - Should copays be lower for maintenance drugs for people participating in CCNC
 - Should smokers be charged higher premiums
- Should service limits (physician visits/drugs) be waived for people actively participating in CCNC?

Personal Responsibility: Design Issues

- Should Medicaid implement a health risk assessment for all new eligibles?
 - If so, how would it be administered?
 - What is the incentive to fill out form?
 - What is the incentive to make lifestyle changes?
- Other ways to encourage personal responsibility for health?

High Risk Pool: Benefit Design

- What benefits should be offered in the high-risk pool?
 - Limited or comprehensive? HMO, PPO or HSA?
 - If limited, what would be covered?
 - One option or multiple policy options?
 - Maximum out-of-pocket expenses?
 - Should there be annual and lifetime limits? If so, what should they be?
 - Disease management and/or case management?

High Risk Pool: Eligibility Criteria

- What are the eligibility criteria that would qualify someone to enroll in the high-risk pool.

Examples:

- Turned down once/twice from insurance carrier
- Ineligibility for other coverage (Medicaid, Medicare, COBRA)
- Specific health condition (e.g., AIDs, Leukemia, Hodgkins' disease)
- Unable to purchase a policy except with a premium higher than that offered through the pool
- Waiting period?

High Risk Pool: Eligibility Criteria

- Should high-risk pool serve as the insurance product for:
 - HIPAA individual guaranteed product
 - Trade Adjustment Act

High Risk Pool: Premium Costs

- What are allowable factors to vary rates
 - age, sex, use of tobacco, geography
- What is the maximum that can be charged for the premium (e.g., X% of the standard risk)
 - 150%, 175%, 200%?
- Any subsidy for low income families

High Risk Pool: Financing

■ Financing

- Public subsidy? Assessment on insurers?
Assessment on reinsurers, MEWAs, TPAs?
Capped reimbursement to providers?
Provider tax? Some combination thereof?