

NC IOM TASK FORCE ON COVERING THE UNINSURED
April 22, 2005
Raleigh, NC

Meeting Summary

Members: Carmen Hooker Odom, Tom Lambeth, Millie Brown, David Bruton, Pearl Burris-Floyd, Victor Dzau, Charles Frock, Ann Holton, Rep. Verla Insko, Connie Majure-Rhett, John Mills, David Moore, Graham Moore, Barbara Morales Burke, Aaron Nelson, Peg O'Connell, Barbara Pullen Smith, William Pully, Sen. William Purcell, Jack Rodman, Randy Rust, Adam Searing, Stephen Smith, Judith Tintinalli, Torlen Wade, Charles Willson

Steering Committee: Anne Braswell, Sandra Greene, Mark Holmes, Stephanie Poley, Dennis Williams

Staff: Pam Silberman, Matt Canedy, Kristen Dubay, Thalia Fuller, Jaime Jenkins, Adrienne Parker

Guests: Walker Armfield, N.G. Collins, Della Cross, Tim Doyle, Ches Gwinn, Alan Hirsch, Stacey Lampkin, Ben Money, Rick Mumford, Mark Payne, Andrea Radford, Jeff Spade, Michael Sparer, Roland Stephen, Pam Sutton Wallace, Phil Telfer, Cathy Wright

WELCOME

Tom Lambeth
Co-Chair

Tom Lambeth welcomed the group. He also mentioned that Pam Silberman was recently chosen as president-elect of the North Carolina Institute of Medicine, to fill the position July 1st after Gordon DeFriese retires.

RECOMMENDATIONS FROM THE INSTITUTE FOR EMERGING ISSUES

MAKING HEALTH CARE WORK IN NORTH CAROLINA: THE IEI REFORM AGENDA

Michael Sparer, Ph.D.

Dr. Sparer gave an overview of the Institute for Emerging Issues' Health Care Forum held on February 7-8, 2005. Several hundred people attended the Forum. Guest speakers spanned the ideological spectrum, ranging from Newt Gingrich to Bill Clinton. Overall, the event was a success, generating good discussion of important issues and garnering quite a bit of media attention.

The Forum represented just one piece of the Institute's engagement in healthcare reform, which continues today. Dr. Sparer provided an overview of what the Institute is currently doing to build upon the Forum's experiences, highlighting ways the work of the Task Force and Institute could beneficially overlap.

Governor Hunt indicated that he wanted the Forum to build upon work that started before it. Accordingly, the Emerging Issues Forum staff created several issue workgroups, composed of providers, payers, government officials, advocates, and representatives of the business community. Many of the Task Force members were involved in those discussions. The workgroups identified four broad issue areas: expanding public insurance, encouraging more affordable and accessible private insurance, improving the quality of care available to all (with a particular emphasis on the quality of care received by low income and certain populations and disparities), and making the healthcare system more efficient by utilizing technology and other medical advancements in ways that could save money and improve quality of care.

The workgroups met several times and reviewed over 40 proposals. Ultimately, they developed a handful of priority issues of that were presented at the forum. Those include:

Quality & Efficiency:

- *North Carolina “Best Care” – reducing practice pattern variation to reduce healthcare disparities.* The workgroups noted that there are significant disparities in obtaining quality care exist across various demographic groups. The goal of the “Best Care” approach is to identify best practices to improve quality and reduce healthcare disparities, and help disseminate these practices across the state.

The Institute is hoping to get a significant grant to build upon existing efforts aimed at reducing practice pattern variation and improve quality of care. Allen Feezor from the University Health Systems of Eastern North Carolina is working closely on this initiative, as are Bill Pully from the NC Hospital Association and Chuck Willson from the NC Medical Society. The Institute for Emerging Issues expects to move ahead and do something very interesting.

- *“Hill-Burton 2” – accelerating adoption of appropriate health information technology among healthcare providers in exchange for a service obligation* Many healthcare facilities do not have up-to-date information technology. The workgroup tried to determine how information technology advancements can be more broadly incorporated into healthcare practices. Under the original Hill-Burton program, the federal government gave money to communities to build hospitals, and in exchange, they agreed to provide care to the uninsured. “Hill-Burton II” is based upon the same premise: the state could assist facilities and providers in securing needed technology while imposing a similar obligation to provide health services to the uninsured.

Workgroups are continuing to think through how to implement a strategy to expand access to information technology around the state. There is a possibility to draw down federal funds to expand facility access to technology. The Institute believes that improving quality and increasing access to technology will improve healthcare provided to all North Carolinians.

Access:

The Forum discussed different public and private options to expand health insurance coverage to the uninsured:

- *Shifting S-CHIP Children to Medicaid.* Currently, there are two federally subsidized programs that provide health insurance coverage to low-income children: Medicaid and NC Health Choice (North Carolina's State Children's Health Insurance Program program for low-income uninsured children with incomes that are too high to qualify for Medicaid). Medicaid is an entitlement program, which means that any eligible child can qualify. However, NC Health Choice is a federal-block grant program, with a limited amount of federal funds. In 2001, the state froze new enrollment into the program for eight months. To increase coverage for uninsured children, the state could expand outreach to cover more eligible children. There is a concern that this approach will end up exhausting federal SCHIP block grant funds. One way to address this is to shift the younger children, birth through five, into Medicaid. Medicaid costs are generally lower than those of NC Health Choice (as provider reimbursement is lower). This would help reduce NC Health Choice program costs, freeing up funds to enroll more children.
- *Expanding Medicaid Coverage to Adults.* This is an option that the Task Force may consider. The feedback at the Emerging Issues Forum was that expanding Medicaid to cover certain segments of the adult population, if it were politically and financially feasible, made a lot of sense.
- *Exploring Medicaid Buy-In Options.* This approach would allow the low-income uninsured to purchase coverage through the Medicaid program. Questions still remain over whether they would be able to purchase a full or limited benefit package or whether they would even want to purchase coverage through the state. However, in NC, there is a better chance to make this work than almost any state in the country because the state's physician community actively participates in the Medicaid program in North Carolina.
- *Re-considering Purchasing Pools with Reinsurance.* Under this option, the uninsured would be offered a limited benefit package through an insurance purchasing pool, with some form of reinsurance guaranteed by the state to cap liability. This model has been implemented in other places around the country, such as New York. The Institute is continuing to explore their effectiveness in reducing uninsurance rates.

The Institute had intended to develop a special workgroup to focus explicitly upon access issues. However, given input provide by Pam Silberman, the Institute decided not to create another body that would duplicate the work of this Task Force. Instead, there was an attempt to identify ways the Institute and the Task Force could work together to

explore this issue further. The Forum is interested in any suggestions about ways that they could be helpful to the Task Force's work.

Where Do We Go From Here?

Regional Forums. The Institute believes that these ideas are reasonable and that they make sense for North Carolina. Many questions still remain regarding how these proposals will fare politically and financially. What is the Institute currently doing to advance these ideas further? Prior to this year, the Forum was a 2-day event, held once a year. Governor Hunt has now given the Institute's staff the task of making the Forum's work ongoing. The Institute is planning to create a series of regional forums to bring together ideas from across the state and solicit feedback from a variety of communities, to increase the likelihood of obtaining "buy-in" from a variety of interest groups. Four regional forums have already been scheduled for the fall in Boone, Charlotte, Greenville, and Fayetteville/Lumberton.

There may be additional forums added to the list. The Institute hopes the venues will provide the opportunity to present additional ideas and collaborate with additional groups, including the Task Force.

CEO Roundtables. Governor Hunt and the Institute would like to take better advantage the contacts and relationships they have with the North Carolina business community. Employers are an essential component of improving healthcare quality in the state. The Institute has begun holding CEO "roundtable" discussions to solicit ideas and feedback from key leaders in the private sector.

"Model County" Project: promoting excellence in county healthcare delivery and social assistance systems. The Institute is in the process of developing a concept of a "model county" in regards to social service delivery. This will involve selecting a county to conduct in-depth analysis of its existing service delivery mechanisms and to encourage methods to better integrate both health and social services functions.

Dr. Sparer then asked for feedback, advice, suggestions, comments, or questions from the Task Force.

Comment: The Community Care of North Carolina (CCNC) model needs to be looked at to determine if it is a valuable proposition for other regions/communities. It should be noted that CCNC has worked well for a specific population. In terms of covering children, they do not cost as much as adults, and pediatricians have generally agreed to accept lower reimbursement rates to provide them care. North Carolina pays providers 95% of Medicare, generally pediatricians are willing to accept this payment rate, but specialists are not always as willing. Therefore it might be difficult to expand Medicaid coverage to an adult population. Physicians may perceive any sort of Medicaid expansion is an assault on their current private pay reimbursement rates.

Response: That is very important point to consider in terms of “best care” and a possible Medicaid expansion. The idea of best care is to expand a similar model to other populations and other payers.

Q: Has there been any discussion of organizing workgroups of uninsured individuals?

A: The Institute is currently seeking grant funding to establish, in part, a steering committee and a series of workgroups, of which many would be community-based. It is hoped that the workgroup process will be both “top-down” and “bottom-up,” meaning that ideas originate from people at all different levels, from practicing physicians to the state medical director. This would enable solicitation of feedback about how various proposals would impact local communities.

Comment: As you deal with the issues of quality, there is a lot of expertise we can provide because there is a lot of science around healthcare quality improvement. There is a new charge to expand information technology into primary care situations.

Q: Is there an opportunity for the Task Force to contribute to the work of the regional forums?

A: Yes. The content of the regional forums is still evolving, but it is likely that the different regional forums will have agendas similar to some of the issues discussed within the Task Force. For instance, each regional forum could focus upon a different issue, such as access, quality, or technology. A third of the regional forum’s agenda is to involve feedback from local communities while another third is to facilitate a general conversation about the ranges of ideas that might address the identified issues. There are certainly opportunities for the Institute and the Task Force to work together.

Q: With regards to a Medicaid expansion, what role would the counties play? The counties are currently required to fund 15% of the non-federal share of Medicaid, which is significantly straining local budgets. In many counties, the Medicaid share requirement is siphoning funding away from low-wealth public schools. Any consideration of a Medicaid expansion should provide a new funding stream so that no further burden is placed on the counties.

A: The original proposal that came out of the North Carolina Institute of Medicine and the Emerging Issue Forum recommended that any expansion of Medicaid would not involve any county-related funding. This is an important issue, and it was brought up on several occasions at the Forum. Cost is certainly a key issue to the success of any proposal, and the Institute hopes to have an extensive dialogue about funding options as the process moves forward.

Comment: The Institute should keep in mind the sensitivity of the language used to describe its proposals. In terms of Medicaid, it is a program with quite a bit of “baggage” that cannot be easily overlooked by many stakeholders, including the

counties.

Response: There are many issues that must be considered as the process advances. Ultimately, there may only be a few options to achieve goals in the three identified issue areas and a strategy must be developed to generate the consensus and political will needed to enact relevant proposals. The only way to foster the right environment for change is to frame the uninsurance issue as one that affects all social and economic sectors.

The Institute for Emerging Issues believes that the best way to proceed with generating support for its proposals is to include important stakeholders, such as the public and the medical and business communities in the development of policy solutions. There are clearly positive features of the existing Medicaid and SCHIP programs. For instance, both have low overhead which means that more healthcare dollars actually go to delivery of services. In terms of physicians specifically, they may be currently treating uninsured patients for free, but with expansion of Medicaid, they would at least get some level of reimbursement.

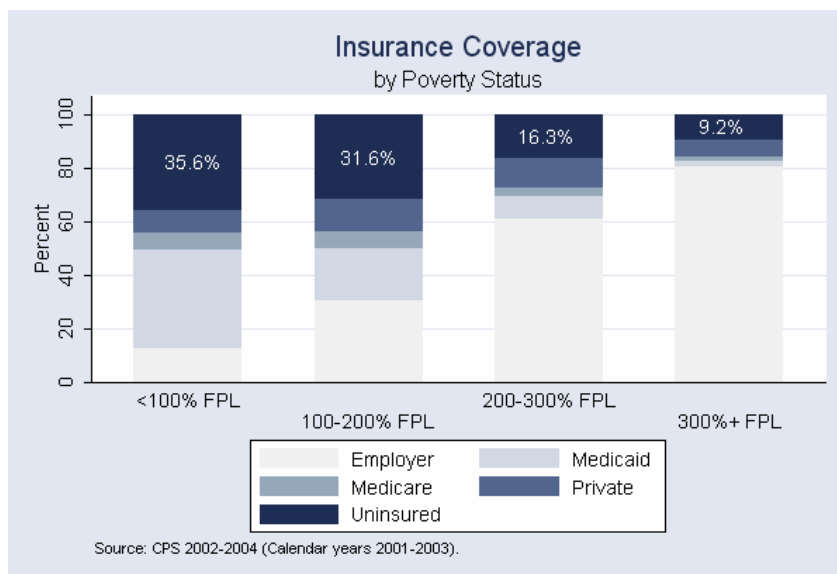
THE LOW INCOME UNINSURED IN NORTH CAROLINA AND THE ECONOMICS OF HEALTH INSURANCE

Mark Holmes, Ph.D.

Cecil G. Sheps Center for Health Services Research
University of North Carolina

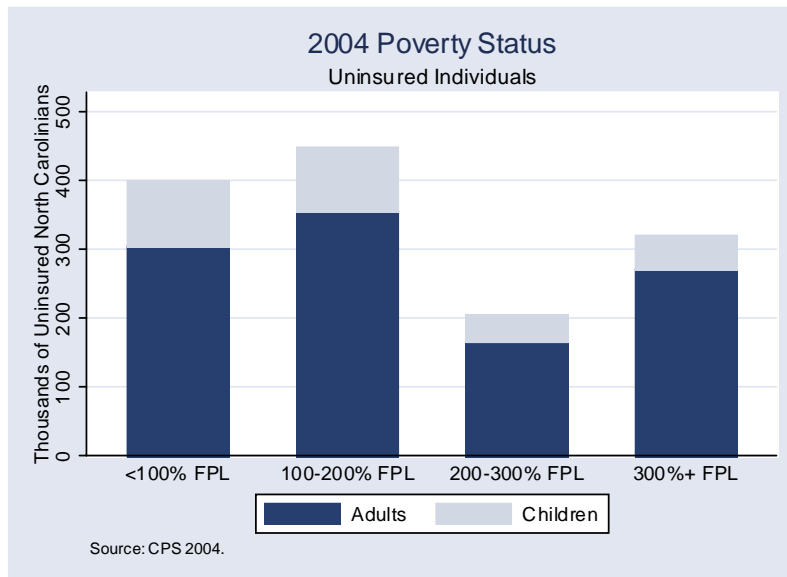
Mark Holmes began by providing an overview of his presentation, which began with a brief discussion of key concepts, then an exploration of the characteristics of the uninsured, and finally, discussion of how many uninsured individuals might be covered if the state expanded coverage. The estimates developed for the presentation are going to be very different than what the Mercer Consulting will provide at a later meeting because their estimates will include participation rates, whereas those developed for this presentation target only program eligibility.

Table 1.



Dr. Holmes first reminded the Task Force that most of the uninsured are low-income, as seen in Table 1. Uninsured children, specifically, have incomes generally below 200% of the federal poverty guidelines (FPG). Theoretically, because children under 200% FPG are eligible for Health Choice, there should be no uninsured in this sub-population, but many factors affect decisions to participate in insurance programs. Additionally, we know that these data from the Current Population Survey (CPS) seem to undercount enrollment in NC Health Choice. A similar pattern of uninsurance is found in the adult population, although adults are slightly more likely to have higher incomes. (See Table 2)

Table 2.



Why are low-income people considered separately? First, they have less ability to pay for health services and they are more likely to rely upon the safety net for accessing care. Since the low-income are more like to be uninsured, policymakers can increase the effectiveness of insurance initiatives by policy options to lower income populations (e.g., a policy initiative targeted at covering people with incomes below 100% FPG is more likely to enroll uninsured than one targeted to individuals with incomes above 400% FPG).

Before moving to a discussion of some of the estimates developed based on eligibility, a brief overview of some key insurance terms was provided:

- **Crowd-Out:** The degree to which individuals other than those targeted respond to a policy. This is a consequence of not restricting eligibility to only those in the target group. In terms of public insurance options, crowd-out refers to the unintentional migration of privately insured individuals to publicly funded insurance.

- **Take-Up:** The rate at which those who are targeted for the program enroll in the program. For instance, many individuals are eligible for the Earned Income Tax Credit and for Medicaid, but do not take advantage of either program.
- **Program Efficiency:** Efficient programs have high take-up and low crowd-out. Programs that aim to decrease the uninsured may suffer from a lack of exclusivity in targeting—ideally, the state would want to cover only those individuals that would otherwise be uninsured, but often these individuals are not easily identifiable.

From the standpoint of low-income individuals, crowd-out is expected to be low, while take-up is expected to be high. In general, the efficiency of public health insurance expansions should be high.

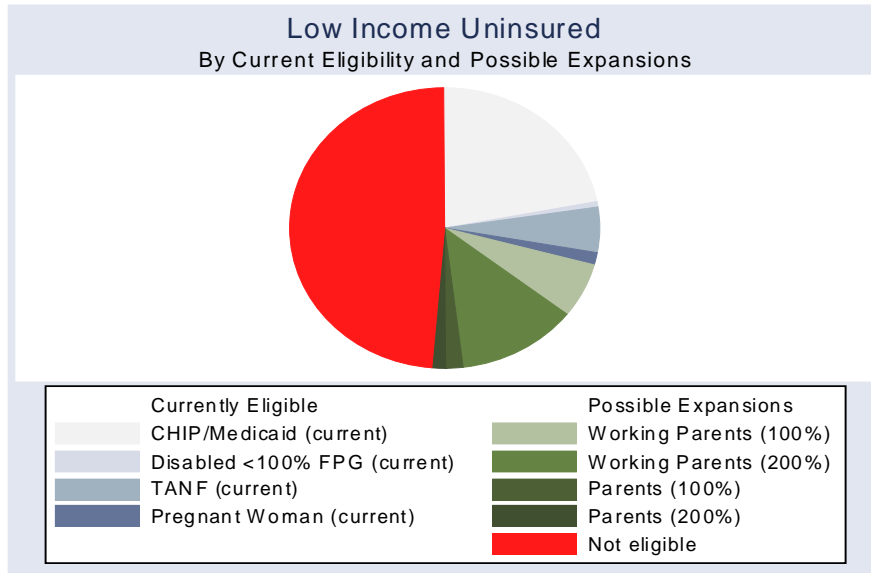
The low-income are referred to using a variety of points on the federal poverty guidelines index. Most often, proposals targeting the low-income use the following definitions of poverty:

- Less than 100% Federal Poverty Guidelines
 - Individual: \$9,570 / year in 2005
 - Family of four: \$19,350 / year in 2005
- Less than 200% Federal Poverty Guidelines
 - Individual: \$19,140 / year in 2005
 - Family of four: \$38,700 / year in 2005

What are the labor-related characteristics of the low-income? About one-third of those living in poverty (incomes equal to or less than 100% FPG) are working full-time, compared to more than half of those with incomes between 100% and 200% FPG. Most are working in the construction, manufacturing, and hospitality industries. The low-income uninsured typically work in small firms, with just over half working in firms with 24 or fewer employees.

Who is currently eligible for publicly sponsored programs among the uninsured? Looking at those with incomes below 200% FPG, just less than one-third are already eligible for the State Children's Health Insurance Plan (SCHIP) or Medicaid, because of income or disability status. (See Table 3)

Table 3.



Expanding Medicaid coverage to working parents of already eligible Medicaid or NC Health Choice children would cover about one-fourth of the uninsured. Removal of the work requirement only expands eligibility a very small amount. About half would not be eligible under the parent expansion because they are childless individuals.

The low-income uninsured are more likely to be in poorer health than the high-income uninsured. According to the 2003 Behavioral Risk Factor Surveillance System, uninsured individuals with less than \$20,000 in annual income are 4.5 times more likely to have diabetes; 30% more likely to have high blood pressure; 50% more likely to have high cholesterol; and almost twice as likely to report fair or poor health than the insured.

Q: Are individuals sicker because they do not have health insurance or do they not have health insurance because they are sicker?

A: That is a good question, but unfortunately, it cannot be answered.

A good estimation of the healthcare expenses of the low-income uninsured in North Carolina can be obtained from examining the southeast data in the Medical Expenditure Panel Survey. Overall, uninsured individuals spend more out-of-pocket than those with insurance coverage. However, the uninsured spend roughly the same amount out-of-pocket regardless of their income level (less than 100%FLP, 100-200%FLP, more than 200%FLP). While the amount spent may be similar across income levels, these out-of-pocket expenses represent a larger percentage of the lower income individuals' incomes.

Q: Are these charges?

A: No, these are not charges. These are expenses incurred.

In terms of use, the low-income uninsured, relative to higher income uninsured, use the emergency room about three times more, have twice the number of hospitalizations, are slightly less likely to have a usual source of care, are more likely to report being in poor health, and have fewer office visits (holding health status constant), even though they have about the same number of office visits overall. In general, the low-income uninsured see office-based providers less, but hospital providers more. It is unclear whether higher rates of emergency care use and hospitalization among the uninsured is a directed result of having less access to outpatient healthcare.

On a point of diversion, some Task Force members have indicated that the uninsured should be required to have health insurance, with enforcement occurring through state income tax filings. The Department of Revenue knows very little about the characteristics of individuals not filing a North Carolina income tax return. However, data in Table 4 estimates the number of non-filers for federal income taxes.

Table 4.

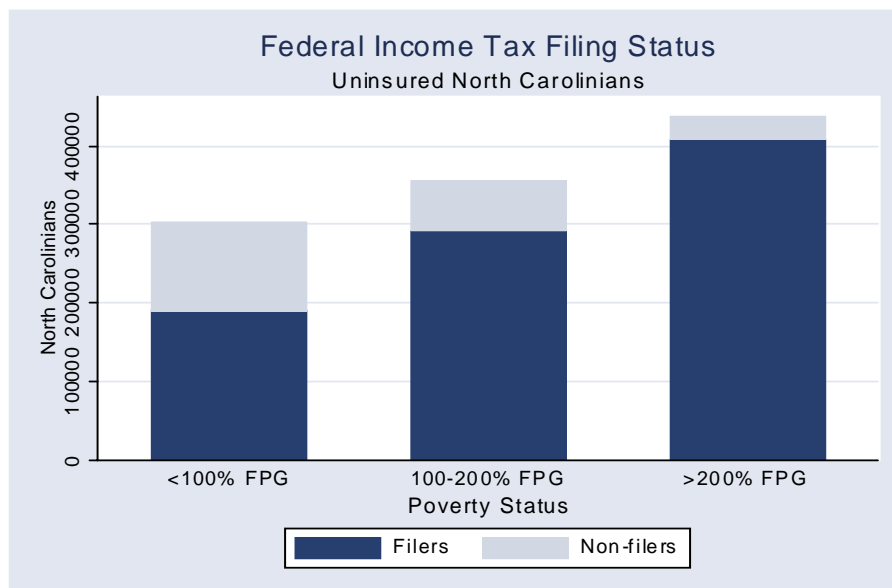


Table 4 indicates that most uninsured over 200% FPG file federal income tax returns, whereas only two-thirds file a return under 100% FPG. This would suggest that enforcement through the income tax system could theoretically be possible for higher income groups, but more difficult for lower-income individuals.

Q: How many of the currently uninsured might accept coverage if they had access to it?

A recent pilot study at UNC noted that of the adult patients in the emergency room claiming to be uninsured, 60% had insurance of which they were not aware or were eligible for some type of insurance (i.e., Medicaid or Worker’s Compensation). Another study at a hospital in Michigan found 40% of children treated said they were uninsured, but of that amount, 84% were eligible for

coverage though an existing program once they applied. This is an important issue for emergency room use, as it is a very common source of healthcare services for the uninsured.

Comment: My colleagues from Cleveland Metro health tracked people who lost insurance and they found the ED utilization was far less for that population than it was for the insured.

Response: Yes, but the population losing insurance may have very different characteristics than the population that does not have health insurance. The issue of individuals being unaware of their eligibility status for an existing program is well known. Additionally, it is difficult to use these data to talk about how insurance status affects the risk of hospitalization.

Turning to the economics of healthcare utilization, economists believe that individuals are always motivated by the cost of goods and services, so that as cost increases, consumption decreases. Because individuals pay only part of the cost of healthcare services when insured, the insurer has an interest in keeping total expenditures “low.” However, insured individuals do not have the same incentive to keep expenditures low if they are only required to pay a small part of the total healthcare costs.

Individuals help pay for healthcare costs through a variety of mechanisms, including premiums, enrollment fees, and out-of-pocket cost-sharing. Cost-sharing includes deductibles (the amount an individual must pay out-of-pocket before the insurer pays for any services/procedures), co-payments (the amount an individual must pay for healthcare at the point-of-service, independent of the cost of treatment) and coinsurance (the percentage of approved charges that the individual must bear).

Insurance plan design is generally quite complicated, using different combinations of enrollee cost-sharing. Cost-sharing may be capped annually, and benefits may be subject to annual or lifetime maximum amounts. For instance, an insurer may have \$1 million lifetime maximum for all services and/or a cap on the number of specific procedures an individual may have within a given year. What is most important to note is that plan design has a direct effect upon employer decisions to offer health insurance, employee decisions to take-up insurance, and individual decisions to substitute other forms of coverage or purchase healthcare services.

Essentially, increases in cost-sharing amounts decrease the total cost of insurance coverage. Economists believe that increasing required cost-sharing will increase the consumers’ cost-consciousness, thus leading to lower utilization and/or more appropriate use of health services. This idea is counterbalanced by the possibility that cost-sharing may deter individuals from purchasing less expensive, yet beneficial, services such as preventive care, which may lead to poorer health and more expensive treatment in the long-run.

Cost-sharing is anticipated to address the problem of moral hazard, a concept that holds that fully insured individuals (i.e. those with little to no cost burden in purchasing

healthcare services) have little incentive to responsibly use care, as they bear no financial risk. In terms of healthcare, individuals with required cost-sharing have lower medical expenditures since they bear some of the cost of treatment.

How does the amount of cost-sharing affect individuals' "take-up" rates? Research evidence varies, but overall, research suggests that higher enrollee cost-sharing results in lower take-up of insurance coverage.

A study by the Kaiser Family Foundation shows that even small premiums significantly decrease take-up among the low-income population. The study suggests that all eligible people do not enroll, even if they have no premium. Insurance take-up rates are only expected to be 74% for individuals and 82% for families at or below 150% FPG with no premium. Imposing a premium cost of as little as 2% of annual income for the same population reduces participation to 36% for individuals and 60% for families.

Table 5.

Premium As a Percent Of Income	Cash Income		
	<150% of Poverty	150-250% of Poverty	250+% of Poverty
Free	74%	79%	86%
\$1	49	56	63
<2%	36	43	52
2-6%	25	33	39
6-10%	20	28	31
10-14%	16	19	24
14-20%	11	16	20
20+	8	11	14

Moving vertically across Table 5, it is evident that as premiums increase, take-up rates decrease for all categories of poverty status. For a given premium, individuals with higher income are more likely to pay the costs, even when it is a percent of income, because higher income individuals have more disposable income to invest into health insurance.

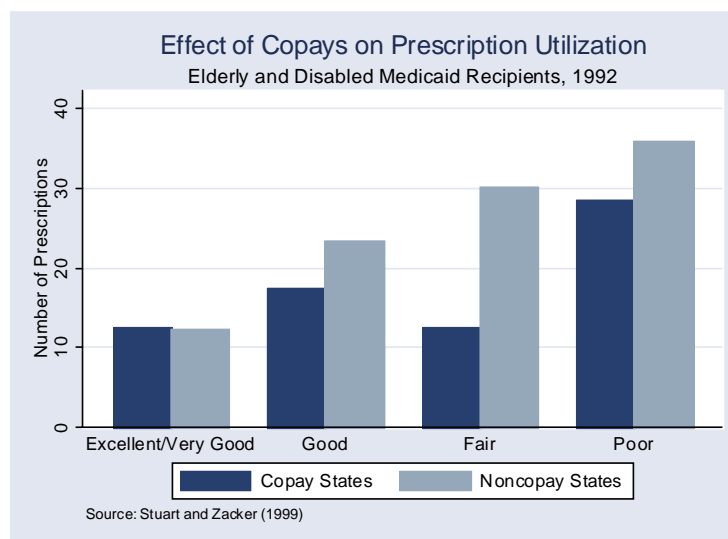
A similar pattern can be seen for family coverage in Table 6:

Table 6.

Premium As a Percent Of Income	Cash Income		
	<150% of Poverty	150-250% of Poverty	250+% of Poverty
Free	82%	88%	95%
\$1	70	80	90
<2%	60	72	86
2-6%	50	65	78
6-10%	40	55	62
10-14%	32	38	47
14-20%	22	31	39
20+	15	22	28

As for co-payments, even small amounts have significant and real consequences in terms of utilization. Studies have shown that a co-payment for physical examinations resulted in a 14% decline in use (larger effect for children, smallest for males). The use of screenings for prostate cancer was 62% lower in high cost-sharing plans and emergency room use fell 15% after a \$25-\$35 co-payment was imposed. Among the elderly and disabled Medicaid population, individuals in states that imposed copayments on prescription drugs resulted in less utilization, an effect that varied across health status. (See Table 7)

Table 7.



Comments and Questions

Q: There has been some discussion of different people using different amounts of healthcare, but clearly some individuals use less than others. Five percent of the population uses 50% of all healthcare services. How does cost-sharing affect people that use different amounts of healthcare services?

A: The numbers presented in these studies are typically averages. The moderating effect of health status between cost-sharing and utilization should also be noted. While an increase in the deductible probably does not affect the take-up or utilization patterns for an individual with cancer, it may affect what an individual does with a minor ailment. Clearly, the effects of cost-sharing on utilization will vary depending upon person-specific characteristics.

Q: If you have a small number of people who need a lot of healthcare and they are not going to be affected by the cost-sharing imposed, then the cost-sharing method may not reduce the overall amount they are spending on healthcare. Would we expect a larger cost-sharing/utilization effect for those with lower utilization, but larger financial effect on those who are higher utilization?

A: Economists typically have a problem with the concept of fairness. If the goal is to reduce total costs, cost-sharing could be imposed upon just the high utilizers, even though that solution is not at all equitable.

Comment: Cost-sharing may inadvertently prevent those who use non-essential services, such as preventive care, from using it, and would not impact individuals with a chronic illness, e.g., those who will use health services regardless of how much it costs. It is much more complicated than the “economic” standpoint would suggest.

Response: It is important to note that it is not always necessarily good idea to attempt to decrease healthcare expenditures. If cost-sharing decreases primarily preventive care use, it would increase costs in the long run.

Comment: Cost-sharing does make people think more about the care they use, and it may prevent the use of more discretionary services. Although, once someone has a legitimate healthcare need, it is difficult to manage overall expenditures effectively with the use of cost-sharing requirements.

Comment: You mentioned that increasing the co-payment for emergency room visits reduced utilization by 10%, but you also indicated that all individuals use the emergency room, so does requiring a co-payment reduce utilization among the low-income simply because they are unable to pay?

A: To clarify, one reference specifically referred to utilization by the low-income uninsured. The other involved the imposition of a co-payment for all individuals using the emergency room, which showed that visits declined. The general finding is that co-payments will reduce utilization more among the low-income uninsured.

Q: Will decreasing utilization affect health status? There may be something to learn from other countries in terms of how the cost-sharing affects both expenditure growth and health status. Singapore may be a good case to explore. It is clear that cost-sharing decreases utilization, but what happens ten years down the road? How does it affect health status?

A: Currently there is not a great deal of evidence on the relationship between cost-sharing and health status simply because it would require long-term data and tracking of individuals’ health status over time. While not a focus of this presentation, the experiences of other countries might be interesting to explore.

A: There was an experiment conducted in the 1970s in the United States that addressed this very issue. The RAND Health Insurance Experiment randomly assigned people to different health plans, each one having different cost-sharing requirements. It was noted that co-payments were associated with use of fewer healthcare services, and people were not very effective in choosing between essential and non-essential services. Overall, most individuals used services appropriately and were not adversely affected by the imposition of cost-sharing. However, the health status of low-income participants generally got worse over the course of the experiment. Even though the RAND experiment is dated, is still

provides some interesting insights into the relationship between cost-sharing and health status.

Q: Do we know how the creation of insurance has affected the long-term cost of healthcare in the U.S.? Would healthcare be less expensive if we never had developed the insurance system?

A: It is fair to say that healthcare would not be as expensive as it is currently. The introduction of health insurance has certainly increased overall costs, but it has also enabled individuals to be able to afford healthcare.

OVERVIEW OF PUBLIC INSURANCE OPTIONS TO EXPAND HEALTH INSURANCE COVERAGE

Pam Silberman, JD, DrPH

Vice President, NC Institute of Medicine

There are several ways in which government-sponsored health insurance could be expanded to cover more uninsured in North Carolina. Those include: simplification of the enrollment process and greater promotion of program availability to those currently eligible; Medicaid expansions that do not require a program waiver; Medicaid and/or SCHIP waiver options; and other creative approaches. The steering committee has been exploring approaches to expanding Medicaid because the federal government would finance part of the coverage extended to new populations (currently at a rate of 63%), which may make the a public expansion more fiscally feasible than a private expansion.

There have been several studies conducted that have shown that many eligible individuals do not enroll in Medicaid. There are a number of reasons that eligible individuals do not enroll, including lack of knowledge of eligibility requirements, perceived complication of the enrollment process, and concern over the social stigma of being enrolled in a “welfare” program.

Other states have simplified the enrollment process to make it easier for people to apply. For example, some states have adopted mail-in applications or streamlined the application form. North Carolina could rely more upon mail-in applications for adults so that they do not have to go to a local Department of Social Services (DSS) to apply. The state allows families to mail-in applications for their children (in both Medicaid and NC Health Choice), but not for adult coverage. Currently, four or five counties have implemented a pilot program testing the effectiveness of the mail-in eligibility process for adults. Some individuals might be deterred from filing an application at a local DSS (because of the stigma), others may simply not be able to take time off of work. Thirty-three states have eliminated the face-to-face interview requirement altogether. The North Carolina Medicaid application used to be a 40-page form, but has since been pared down to ten pages for adults, and four pages for children. The Department of Health and Human Services is also testing a simplified application form in several counties across the state.

Eligibility could also be facilitated if the state chose to eliminate the assets test for family

coverage. North Carolina currently examines an individual's countable resources to determine eligibility, including bank accounts, stocks and bonds, real estate (primary residence excluded), and cars (one care excluded). There is no resources eligibility test for children or pregnant women, but for all others, there is a maximum of \$3,000 in countable assets per family, \$2,000 for individuals, or \$4,000 for a couple or for the elderly and disabled. Twenty-two states have eliminated assets test for parents/family coverage. Some of these states have noted overall cost savings because many of the states no longer have to go through the intensive process of exploring an individual's assets. In other words, the administrative savings outweigh any increased costs associated with enrolling individuals that may have excess assets above the previous limitations.

North Carolina also has continuous eligibility for children (one year) and for pregnant women (through pregnancy and 2-months post partum). Families and the elderly and disabled have six-month eligibility. Thirty-seven states have implemented 12-month eligibility for families as well as children, which helps maintain eligibility for longer periods of time. Additionally, county administrative costs may decrease because DSS employees determine eligibility less frequently. It should also be noted that this is not a new entitlement group; it is simply an effort to enroll more individuals who are already eligible. One possible disadvantage is that the increased enrollment associated with continuous eligibility will increase state and local expenditures.

Medicaid Expansion without a waiver. States can increase the income and/or resource eligibility limits under their state plans to cover more children, families, pregnant women and working disabled. Also, the state has the authority to expand the income eligibility rules for NC Health Choice (the State Children's Health Insurance Program or SCHIP). SCHIP provides a higher federal match (approximately 75%), but has finite federal funds (as it is a block grant). This means that the federal contribution could be exhausted if enrollment in the program becomes too high.

The following are North Carolina's current Medicaid/SCHIP eligibility guidelines:

Children

Medicaid entitlement:

Under age one: 185% FPG

Ages 1-5: 133% FPG

Ages 6-18: 100% FPG

NC Health Choice (SCHIP) block grant:

Ages 0-18: children with incomes too high for Medicaid but less than 200% FPG

Pregnant Women

Medicaid: 185% FPG

Parents

Medicaid: 37% FPG (family of four)

Older Adults (65+) or People with Disabilities

Medicaid: 100% FPG

One option for North Carolina is to expand Medicaid coverage to more children with higher income guidelines, as a number of states have done (California, Connecticut, Georgia, Maryland, New Hampshire, New Jersey, New York, Vermont, and Washington). For pregnant women, the state could also cover more uninsured by raising the income eligibility guidelines (Arkansas, California, Delaware, DC, Georgia, Illinois, Iowa, Louisiana, Maine, Maryland, Maine, Minnesota New Jersey, New York, Rhode Island, and Vermont). Currently, North Carolina is around the “middle of the pack” in terms of Medicaid eligibility for both children and pregnant women.

Q: Aren't only wealthy states expanding Medicaid? Those who have changed their eligibility guidelines may be fundamentally different from North Carolina.

Comment: Expanding eligibility implies that there are important choices that must be made, and often they are related to expected outcomes. There is clearly an outcome expected to be achieved by covering more pregnant women. Simply comparing North Carolina to other states in terms of eligibility does not indicate if those states are meeting intended outcomes through expansions.

A: That is a good point. North Carolina increased its income guidelines in the late 1980s/early 1990s to reduce the infant mortality rate and improve birth outcomes.

In regards to working parents, North Carolina does not fare as well as other states. Twenty-four states and the District of Columbia have higher income guidelines for parents than North Carolina: Alaska, Arizona, California, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Iowa, Maine, Massachusetts, Minnesota, Missouri, Nevada, New York, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Washington, and Wisconsin

Some states have increased coverage to this population in order to cover the working poor. Medicaid coverage could be expanded to working parents by amending the state plan, but coverage to working single adults would require a special 1115 Medicaid waiver.

The advantage of a no-waiver Medicaid expansion is that it would provide health insurance coverage to more low-income and moderate-income individuals who are working but may be unable to afford coverage on the private market. Additionally, the federal government pays most of the costs of coverage, although the state/counties would be required to contribute their portion of the match to draw down additional federal dollars. However, the expansion would create new entitlement groups.

Medicaid 1115 Waiver. North Carolina can waive many of the rules governing Medicaid coverage by developing a demonstration project under an 1115 Medicaid waiver, but the expansion must be budget neutral. Limiting coverage and benefits and/or imposing greater cost-sharing requirements can achieve this. Also, North Carolina could use any program savings within the existing Medicaid program to fund coverage to an expansion population, such as childless adults.

Health Insurance Flexibility and Accountability (HIFA) demonstrations are a special type of 1115 waiver targeted to expand coverage to populations under 200% FPG. The Center for Medicaid and Medicaid Services encourages states to explore using premium assistance programs in their HIFA demonstrations. Currently, nine states have expanded coverage using HIFA waivers.

An example of coverage expansions using 1115 waivers:

- Arizona covers adults under 100% FPG
- Alaska covers uninsured children below 200% FPG
- District of Columbia provides Medicaid coverage to childless adults 50-64 up to 50% FPG
- Hawaii covers adults below 100% FPG
- Massachusetts covers children, families, and disabled people below 150% FPG as well as long-term unemployed (greater than 12 months) childless adults below 133% FPG
- Maine provides coverage to parents and children below 275% FPG
- Missouri covers adults transitioning off welfare who are not otherwise eligible for Medicaid under 300% FPG, uninsured custodial parents under 100% FPG, and certain uninsured non-custodial parents under 125% FPG
- New Mexico provides Medicaid coverage to children with incomes between 186-235% FPG

It should be noted that many states extending coverage under 1115 waivers do so with a managed care plan.

Cost neutrality required for 1115 waivers can be determined by two methods: a projected per person cost basis, which holds that per person costs may not exceed the amount a state would have spent for groups covered by Medicaid prior to the waiver; or a global cap basis, in which the federal government determines how much Medicaid would have spent in total costs over a five year period in covering the Medicaid population. HIFA waivers rely upon a per capita basis of determining cost neutrality.

It is important to negotiate an accurate allowable growth rate with the federal government because states can be severely fiscally hurt by unfavorable rates. This is the amount of cost growth that is allowed each year in the expansion. A state is entirely responsible for all costs that exceed the negotiated growth rate.

There are clearly many advantages to implementing an expansion through a Medicaid waiver, including greater cost-sharing flexibility, more latitude to reduce benefit packages, and wider discretion over the types of populations covered, including those not considered historically Medicaid eligible. Disadvantages including meeting cost-neutrality requirements and the risk of exceeding the program cost growth rate.

Another option is a premium assistance program, currently employed by 16 states. This

involves the state using Medicaid and/or SCHIP funds to pay Medicaid/SCHIP eligible employees' premium costs of employer sponsored insurance. It is generally believed that paying for private coverage with public funds is less expensive than providing full coverage through Medicaid or SCHIP because the employer may contribute to the premium cost as well. Generally, states must provide wrap-around coverage (e.g., cover those Medicaid or SCHIP services that are not covered through employer-sponsored insurance), unless they seek a waiver exemption. However, premium assistance programs have not been as successful as some had hoped. There may be more potential for more success under the HIFA waiver initiative, because it gives states more flexibility in designing the program and in ensuring cost neutrality.

Q: Do you know whether or not those states are only offering mandatory services?

A: It really varies by state. More recent waivers have focused upon pared-down benefit packages. States may save money under premium assistance programs, but states have had limited success to date. Eligible individuals must have access to employer sponsored insurance (or to a policy in the non-group market, if cost-effective), and this presents a challenge given that the target population may not work for employers that offer insurance coverage. This option would be particularly difficult in North Carolina, given that the current income eligibility index of 37% FPG. The threshold for covering adults in Medicaid is so low that most of those people would not have access to employer-sponsored health insurance. Some states have considered developing their own insurance product that low-income individuals could buy into.

Medicaid Buy-in. Under this option, states create a Medicaid look-alike program that allows individuals and/or employers to purchase coverage for both Medicaid eligibles and non-eligibles. The program could rely upon existing Medicaid provider networks and provider payment levels and use the existing administrative structures to determine eligibility. In North Carolina, a “buy-in” program could enroll individuals in Community Care NC for disease and case management services, accompanied with a pared down benefit package, and higher levels of cost-sharing.

A Medicaid “buy-in” option could take advantage of existing health plan efficiencies, lower administrative overhead within Medicaid, and deeply discounted provider reimbursement. Additionally, it could assist individuals with chronic illness better manage their care, as there is the potential to build upon Community Care of NC. And most importantly, a “buy-in” option could take advantage of Medicaid premium assistance dollars for certain individuals. However, no federal funding would be available for people who are not otherwise eligible for Medicaid, which means that state funds may be needed to subsidize premiums for lower-income individuals. Crowd-out may also be an issue, but requiring minimum lengths of uninsurance could ameliorate this problem. It would require the state to collect premiums from enrolled individuals.

Mercer Analysis of Public Options. Mercer is broadly looking at two things: the cost of offering a full Medicaid benefit package and a pared down package to a variety of populations. The targeted groups are:

Adults: 37% - 100% FPG
 Adults: 100% - 200% FPG
 Adults: 200% - 300% FPG
 Children: 200% - 300% FPG

Table 8 is a comparison of the full Medicaid and pared-down benefit packages:

Table 8

Services	Full Medicaid	Medicaid “Light”
Inpatient hospital (Non-maternity, non-BH)	Covered (no copay)	Covered: \$5,000 deductible or \$10,000 total; 20% coinsurance
Skilled nursing	Covered (no copay)	Not covered
Outpatient physical health	Covered (no copay)	Covered, 20% coinsurance, 25 visit limit for PT, OT, Speech therapy
Emergency room	Covered (no copay)	Covered, \$100 copay (waived if admitted), 20% coinsurance
Primary care physician	Covered (\$3 copay) (24 visit limit/yr)*	Covered (sliding scale copay: \$10, \$20 for below/above 150% FPG)(24 visit limit/yr)
Specialty physician	Covered (\$3 copay) (24 visit limit/yr)*	Covered (sliding scale copay: \$20, \$40 for below/above 150% FPG)(24 visit/limit/yr)

The pared-down benefit package includes primary care, but hospitalization is covered only after \$5,000 or up to \$10,000 (two alternative packages). The alternative packages do not include nursing home care, home health services, labor and delivery, or therapy services. Costs are actually being developed for four different alternatives: hospitalization (\$5,000 deductible or \$10,000 limited benefit) and whether behavioral health services are covered. It was the intent of the steering committee to develop a product that is more primary care rich, with some coverage of hospitalization, but less than what would be covered by Medicaid or a similar commercial policy. The developed premium structure, based upon federal poverty guidelines and cost-sharing components, were designed to result in a 50% take-up rate.

Q: What about preventive services and wellness care?

A: Those services would be covered under the primary care package. The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program would be included in the full benefit package for children, but the pared down benefit package would not include those services. It would still provide immunizations, health screenings, etc. Dental, vision, or hearing are also not included in the pared down benefit package. At this point, it does not look like excluding behavioral health will make a big difference on costs, so it may ultimately be

included. Adjustments to the benefits packages can still be made.

Q: Do the plans being developed include any incentive, such as cost reductions, for “good behavior” in terms of healthcare use, or will costs be the same amount regardless of the type and quantity of care used? Do the plans scale costs?

A: No, the plans do not scale costs primarily because of the concern that it would be difficult for people with chronic illnesses to properly manage their care. There is an exception in part of this for life threatening or certain other chronic conditions.

Comment: It would be nice to see prevention and wellness “carved out” from the developed plans, so that there would be no co-payments for those services. It is more likely that the services will be used if there are no co-payments.

Response: The case management component of the pared down benefit plan involves the enrollment of the covered individual in the CCNC network. There is no cost sharing for disease management or case management services.

Q: If a Medicaid “buy-in” were to be considered, what additional information would need to be provided?

A: Mercer will develop some actuarial data related to this, including costs, enrollment projections, and estimates of adverse selection. If financial barriers to enrolling are imposed, then it is the sickest who are going to be the most likely to enroll, which will increase the per person cost. Under the current scenario with modest cost sharing, take-up is expected to be 50% and we would assume that there would be some adverse selection.

Q: Are estimates being developed for premium assistance options?

A: That is certainly a possibility and those figures can be developed if the Task Force would like.

PRIVATE AND PUBLIC-PRIVATE OPTIONS TO EXPAND COVERAGE TO THE UNINSURED

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Many private sector based options to reduce the uninsured are actually public/private partnerships that involve some form of government subsidization of costs.

Many states are trying to expand health insurance coverage for small businesses. Many uninsured are working in small firms that don't offer healthcare coverage because it is too expensive. The following are strategies through which states are trying to expand coverage in the small group market:

Purchasing pool for small employers. The goal of this option is to create cost efficiencies by pooling together groups of small employers, which creates better purchasing leverage to reduce negotiated premium costs. Pools may be combined with

other strategies to lower premiums, such as tax credits or forms of government reinsurance. North Carolina had a purchasing pool (Carolinance) that failed in the 1990s. At its peak, Carolinance had 4,300 individuals enrolled, but it struggled to attract healthy groups who were able to purchase inexpensive policies outside of the pool in the private market. If the Task Force chooses to recommend developing a pool, what groups will be covered? How will healthy groups be encouraged to join so that risk might be equalized? Kansas is currently trying to combine a pool with reinsurance and tax credits to encourage low-risk small businesses to join the pool.

Reinsurance for small group market. Reinsurance is a strategy to spread risk and improve the predictability of claims so that insurers reduce the mark-up they impose to protect against unanticipated costs. Connecticut, Indiana, New Mexico, Massachusetts, Arizona, and New York have reinsurance systems to support small-group coverage and/or improve individual access to coverage. Prices charged to small employers tend to be higher than prices charged to larger employers because of increased risk. One option to address this problem is to have all insurers in a reinsurance pool. For instance a large insurer, such as Blue Cross Blue Shield would be placed in a pool with smaller insurers so that risk is distributed more evenly across covered individuals. Another option is to promote predictability of claims by having the government subsidize a portion of costs above a certain threshold amount. (See discussion of Healthy New York, below).

Small group reform. This approach would involve altering rating mechanisms in the small group market. Another option would be to exclude the self-employed from the definition of a small group. North Carolina presently includes them in the definition of small group (1-50 employees) but federal law excludes them (2-50). In the 1990s, the state changed the rating rules used to calculate small group health insurance premiums. They imposed an adjusted community rating system. First, insurers calculate a pure community rated premium (for all the small groups they cover). The insurance company then varies this community-rated premium based on the demographics and location of a particular small group (e.g., the age and sex of the covered employees, and geographic location—as certain communities have higher health care costs than others). The insurer is then able to increase or decrease this premium by 20% (either up or down), based on expected utilization. North Carolina instituted this “adjusted community-rating” system in the early 1990s in order to reduce the variation on premium costs in the small group market.¹ While this system may help some employers with higher than average costs, it may have made the premiums cost prohibitive for small employers who might have otherwise had low-cost policies.

State tax credits/tax deductions for targeted employers/employees. Fifteen states offer tax credits or deductions targeted to individuals. If designing a tax incentive approach,

¹ Adjusted community rating was particularly intended to help small employers with higher health care costs or health risks, as the healthcare costs of a high-risk group cannot be more than 50% higher than the premium costs of a lower-risk group with similar demographics and geographic location. (For example, assume that the community rated premium, after demographic and geographic adjustments is \$100/month, then with the 20% variation the maximum premium charged could be no more than \$120, and the lowest premium charged could be no more than \$80—a difference of 50% between high and low premium).

the Task Force would need to determine who would be targeted.

Elimination of state coverage mandates. To date, at least 12 states have provided insurers the option of providing insurance products that does not provide coverage for statutorily mandated services. Generally, the “mandate light” policies have been unpopular and many groups have chosen not to purchase these products. In most cases, eliminating mandated benefits has not significantly reduced premium costs. If the Task Force was interested in pursuing this option, however, it would be necessary to recommend which benefits should be excluded in the pared-down benefit policies.

Trade Adjustment Assistance Reform Act. Congress passed this legislation in 2002 to assist states in coping with the economic impacts of the Trade Adjustment Act. Under the Trade Adjustment Assistance Program, the federal government provides tax credits equal to 65% of eligible individual’s premiums for qualified health insurance coverage. Eligible individuals are those who have been displaced by layoffs certified as trade-related; adults 55—64 who receive pensions through Pension Benefit Guarantee Corp; adults 50-64 who receive Alternative Trade Adjustment Assistance; and, their dependents. The tax credits are refundable and advanceable, however, there has been a very low take-up rate for this program. Even with the subsidy, 35% of premium costs is still unaffordable to many who are unemployed. Additionally, the delay in the start of advance payment presents a barrier to some eligibles, and the program itself is somewhat complex and confusing. In North Carolina’s case, medical underwriting contributed to higher costs (and lower take-up rates). Is it possible for the state to subsidize the 35% of premiums not covered by federal funds?

High-risk pool for individuals. Blue Cross Blue Shield of North Carolina currently offers Blue Advantage, a non-group policy that is available to anyone, regardless of health status. However, premiums can be up to 7 times the standard risk rate for a person who is in poor health, which makes the product unaffordable to many people. Thirty-two states have created subsidized risk pools that are funded largely in part by enrollee premiums and assessments on insurance companies. The Trade Adjustment Assistance Reform Act did include some federal funding to help states create risk pools, but it expired in 2004. Currently, the U.S. Senate is considering a proposal to extend the availability of that funding.

Unemployment tax. States collect unemployment taxes from employers to help pay for unemployment benefits for workers when they lose their jobs. In times of strong economic growth, states have had surpluses in their unemployment pools. Massachusetts used some of the unemployment funds to help subsidize health insurance coverage (through COBRA) for unemployed workers. However, there is little discretionary funding in the North Carolina unemployment pool, because most of it has been spent assisting unemployed workers during the most recent downturn in the economy.

Private Options Implemented in Other States.

Healthy New York: The Healthy New York Program is a government financed

reinsurance initiative that seeks to provide insurers a certain degree of financial assurance in covering groups that have historically had problems obtaining affordable insurance policies. These include small businesses, sole proprietor groups, and working individuals not covered under a small business plan. All licensed HMOs are required to offer a “pared-down” benefit package to enrollees in the Healthy New York program. To be eligible for coverage, sole proprietors and individuals must be uninsured for at least 12 months, and must have incomes of less than 250% FPG. Small group coverage is further limited to those businesses with fewer than 50 employees, 30% of whom must have an income of less than \$33,000 annually, adjusted for inflation. Additionally, 50% of employees must participate in the policy and the employer must pay at least 50% of the employee premium. Employers do not have to offer dependent coverage, but if they choose to do so, they are not required to subsidize it.

The Healthy New York policy offers the following benefit package:

- Inpatient and outpatient hospital (\$500 deductible/member/year; \$50 copay for ER)
- Physician services
- Lab/x-ray; pre-admission and diagnostic services
- Preventive health services
- Maternity care
- Therapeutic services
- Pharmacy optional (\$3,000 annual drug limit with \$100 deductible), but only 12% of enrollees declined prescription drug coverage; lowered premiums by ~12%

Dental, mental/behavioral health, home health, and chiropractic services are explicitly excluded.

As part of the reinsurance, New York initially paid HMOs to cover 90% of any costs of services for any particular enrollee between \$30,000-\$100,000 in a year. This threshold was lowered in July 2003 so that the state now pays 90% of costs between \$5,000 and \$75,000 in a calendar year. The HMOs are responsible for all individual member costs up to \$5,000, or those that exceed \$75,000.

In terms of the cost of reinsurance, the state allocated \$89.4 million in CY 2003, \$49.2 million in CY 2004, and \$22 million for the first half of CY 2005. The program allows for carryover of unexpended funds to future years. EP&P Consulting estimated that the state spent \$13 million in 2003 and \$25 million in 2004 on paying claims in excess of the established threshold.

Health New York has been modestly successful, with approximately 80,000 enrollees as of February 1, 2005. Small businesses account for 23% of that total, and they represent the fastest growing group purchasing coverage through the program. Sole proprietors represent 19% of total enrollees and working individuals not enrolled in a small business plan account for 58%. When the state changed the reinsurance formula to cover expenses between \$5000-\$75,000, the HMOs lowered their premiums by 17%. Very few of the enrollees in CY 2003 exceeded the \$5,000 threshold, with only 21 total members having

claims in excess of \$40,000. A full report of the Healthy New York program is available as www.healthyny.com.

Maine: Maine's Dirigo Health Reform Act established a comprehensive insurance program that focuses upon quality, costs, and access. A variety of policy options were employed to contain overall program costs, including: hospital planning (2003 moratorium on new CONs), price disclosure, paperwork reduction efforts, enhanced public purchasing, increased oversight of premium rates in the small group market, reductions in cost-shifting, and voluntary limits on growth of insurance premiums and healthcare costs.

As for quality improvements, Dirigo provides for educating providers and consumers about best medical practices and other quality of care indicators. Access is promoted through a voluntary market-based program to help small businesses, the self-employed, and individuals afford coverage.

The initiative's health insurance product is known as DirigoChoice.TM It is a PPO plan offered through a public/private partnership with Anthem BCBS. It is available to small employers (less than 50 employees), the self-employed, and individuals and it covers a variety of services, including hospital stays, physician and specialist visits, prescription drugs, and mental health parity. The plan also covers 100% of all costs of wellness and prevention care. Additionally, a financial discount on premiums, deductibles, and cost-sharing is provided, based upon individual/family income.

Under the DirigoChoiceTM PPO plan, two options are available. The first includes higher monthly premiums, but lower out-of-pocket costs. The deductible is \$1,250 for an individual and \$2,500 for a family. Maximum annual out-of-pocket costs are \$4,000 for individuals and \$8,000 for families. The premium for this option is \$310 per month for an individual; \$558 for an employee and a child; \$650 for an employee and spouse; and, \$930 for a family. The second option provides lower premiums, but higher out-of-pocket costs. The deductible is \$1,750 for an individual and \$3,500 for a family. Maximum out-of-pocket costs are \$5,600 for an individual and \$11,200 for a family. This option's premium is only \$287 per month for an individual; \$516 for an employee and a child; \$602 for an employee and a spouse; and \$860 for a family. Individuals and the self-employed must enroll in the second option.

As noted, DirigoChoiceTM offers discounted cost-sharing based upon family income; however, they only apply to an employee or enrollee's share (employers are required to pay 60% of employees' share of premium to participate). The discount schedule is as follows:

- Below 150% FPG: 80% subsidy for those not currently eligible for Medicaid
- 150% - 200% FPG: 60% subsidy
- 200-250% FPG: 40% subsidy
- 250% - 300% FPG: 20% subsidy
- 300% +: no subsidy

Enrollment in the program was budgeted for 31,000 enrollees in the first year and between October 2004 and February 2005, 2,700 had purchased coverage. Policies are sold to individuals and self-employed at a capped rate of \$4,500 to ensure employer contributions and limit adverse selection. Coverage is financed through a variety of mechanisms. Employers are required to pay 60% of employee costs and enrollees pay the remaining 40%, unless their share is subsidized by program discounts. For the first year, the state allocated funds for administrative costs and enrollee discounts but ultimately, it is assumed that the program will be self-financed through employer and enrollee payments, the Medicaid dollars (for eligibles) and assessments on insurer's gross premium revenues and on third-party administrators (if the state can demonstrate cost savings through reduced cost-shifting).

West Virginia: West Virginia created a special small business initiative that permits private carriers in the small group market to use the state's Public Employees Insurance Agency (PEIA) negotiated reimbursement rates, which are lower than those typically offered in commercial policies. This allows for less expensive premiums to be provided to small businesses. Coverage under the initiative is estimated to be between 20-25% below usual market rates. The special policies are available to employers with 2-50 employees who have had no coverage for 12 consecutive months. Employers must pay 50% of premium costs for employee-only coverage and 75% of eligible employees must be covered under the policy. As of December 2004, only one carrier filed to offer the new product, which became available in January of 2005. This option is similar to the Medicaid "buy-in" approach, relying instead upon the state employees' health plan.

Massachusetts: Massachusetts recently enacted a medical security plan for the unemployed that helps pay the costs of health insurance. Eligibility is limited to families without income for six months prior to the date applying for Medical Security Plan, plus projected unemployment and other family income to be less than 400% FPG. The state pays for 75% of premiums up to \$580 per month for family coverage or \$245 for individual coverage.

The state is also providing a tax credit directly to businesses and employees to encourage them to offer health insurance coverage and increase enrollment. It is tied to employee's wages, so that it does not apply to higher-income small businesses. Under the Insurance Partnership for Businesses initiative, subsidies are available for businesses that have 50 or fewer employees, but the employer must agree to pay at least 50% of the cost of coverage. The state will pay up to \$1,000 per year for each eligible employee, who must have an annual gross family income below 200% FPG. As of June 2004, this initiative had provided subsidies to 5,000 employers. The state also created an Insurance Partnership for Employees, which provides subsidies to cover the premium costs of employees of small firms with incomes below 200% FPG. Premium costs to the employee are limited to \$27 for an adult with children or \$12 per child, up to a maximum of \$36 per family. The state had provided subsidies to 9,390 people by June 2004.

Q: Are Chambers of Commerce allowed to negotiate group insurance policies on behalf of members? Experience would suggest that they can, but they are rated individually, not

as a collective group. In Pennsylvania, small businesses are allowed to obtain group-rated policies through professional associations, such as Chambers of Commerce with rates based upon the collective association, not the individual business.

A: In North Carolina, a professional association may purchase insurance as a group, however if the members of the association are small group employers, they are rated individually, not as a group. Because of existing small group rating laws, the starting point for a small group rate is the community rate. The benefit of the community rate is that its base starts with the big benefit of looking at the entire pool of small employers. An adjusted community rate is then calculated, which accounts for the age and gender mix of the employee population, a geographic factor adjustment, and the number of family members. When it is a newly issued policy, the carrier can take the adjusted community rate and charge up to 20% more or 20% less based on the expectations of that employer. Once the renewal rates apply, carriers have to apply the same increase to all their similar groups, except they can vary by 15%. The starting point is better than an average of just the groups. With association plans, there is the concern that “cherry picking” may occur. If you are an association that is geared to a certain profession, you may have people that are comparably more healthy or unhealthy, so then it would be beneficial if you can be associated with non-small group rating laws because that leaves the less healthy groups out.

The problem with association groups is that as soon as a person can get cheaper insurance on their own, they will leave the association plan, thus leaving the pool with only higher risk employers in the pool. It would be interesting to learn more about what Pennsylvania has done to make their association purchasing pools effective.

Q: In one of the focus groups for small-group employers, someone mentioned the role of professional employer organizations (PEOs) in assisting small businesses with human resources and other administrative functions. How is the health insurance priced that a PEO offers? PEOs services are costly, but there are clear benefits. In some cases, small employers are turning to PEOs because they cannot afford to offer health insurance on their own.

A: A PEO is a company that leases employees to small employers, but the employees remain technically employed by the larger PEO and have their benefits provided by the PEO. The size of the PEOs enables them to obtain health insurance rates that are comparable to those in the group market. Their services may be expensive; sometimes 2% of the payroll costs are associated with all leased employees. PEOs may allow small businesses to get around minimum participation requirements, a policy that insurers use to avoid adverse selection.

A: It is also possible that the PEO operates out-of-state and they may be subject other laws.

Q: What if North Carolina law was changed to allow small employers to have their policies rated based upon the total membership of a professional association?

A: Professional associations/small employers would be rated as they see fit, recognizing that at any time, a member employer could leave the association pool and rates could be affected.

Comment: Cleveland has had success with an association-rated health plan initiative. It is a sizable pool because so many businesses have been drawn into it.

Q: What about Pennsylvania?

A: We will look into association plans and purchasing pools that are attractive to those who are healthy.

C: It would be helpful if the Task Force could be provided with more information on Section 125 plans. They have been shown to save employees quite a bit of money and there might be more people that would buy in to such plans if they knew they had that option. People might be more likely to participate if they had more flexibility in choosing the type of plan they enroll in.

Q: Is it too early to find out how much savings have been generated under the Dirigo initiative?

A: Yes, the program only began last October. Savings are supposed to be captured by enrolling more people. Program administrators are arguing that if more people can be enrolled who were previously uninsured, there may be less cost shifting, and those savings can be captured and infused back into the premium assistance programs.

Comment: If the Task Force is unable to extend health insurance coverage to everyone, it should consider costing out a plan that would cover every child from 0-18 above 200% FPG. This is an important policy matter because success in school and later in life is improved if children have access to a medical home. Children could be identified leaving the hospital after birth, and at that time an assessment could be made to determine if they have a medical home. If not, the family would be given the option to enroll the child in Medicaid or HealthChoice or the new initiative that could then be administered through the existing community care program infrastructure. It is not a good idea to wait until a child reaches kindergarten to gather such information. It could be more effective if it was done as a discharge planning assessment. The cost estimation should be from 0-5 if you add above 200% and then up to 10 to 18 years. It should be clear that if the state invests money into a medical home for every child, negative health outcomes should decrease.

Q: To add to that comment, would the cost-estimates include any savings from cost-shifting?

A: The Steering Committee does not have the capability to do that yet, although staff is attempting to determine if there is a method to calculate the amount of money that is being cost-shifted in the existing system.

Comment: If you consider statistics showing an increasing number of children with chronic illness, evidence suggest that placing these children in a medical home will create cost- efficiencies for care provided by avoiding future hospitalizations and emergency room utilization. Physicians dealing with chronically ill children are getting overwhelmed with how to deal with present reimbursement levels. The medical home approach would address this problem by generating huge cost-savings and efficiencies.

Meeting Adjourned