

## NC IOM Task Force on Covering the Uninsured

August 11, 2005

Cary, NC

### MEETING SUMMARY

***Members:** Carmen Hooker Odom, Tom Lambeth, Millie Brown, David Bruton, Allen Feezor, Ches Gwinn, Bill Ray Hall, Ann Holton, Robert Jackson, Connie Majure-Rhett, John Mills, David Moore, Barbara Morales Burke, Peg O'Connell, Barbara Pullen Smith, William Pully, Randy Rust, Stephen Smith, Judith Tintinalli, Torlen Wade, Charles Willson*

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

***Staff:** Pam Silberman, Kristen Dubay, Thalia Fuller, Adrienne Parker, Kristie Weisner Thompson*

***Guests:** Tim Carey, Chris Fitzsimmons, William Lawrence, Kathryn Millican, Jeremy Moseley, Connie Mullinix, Rick Mumford, Gail Pruett, Andrea Radford, Phil Telfer, Walker Wilson, Cathy Wright*

#### WELCOME

##### **Carmen Hooker Odom**

Co-Chair

Secretary

NC Department of health and Human Services

##### **Tom Lambeth**

Co-Chair

#### ENCOURAGING PERSONAL RESPONSIBILITY FOR HEALTH

##### **Barbara Morales Burke, MHA**

Assistant Commissioner

NC Department of Insurance

Barbara Morales Burke, from the NC Department of Insurance, provided some initial thoughts regarding regulatory considerations for health insurance plans that would encourage health and wellness responsibility among their clientele. First, she noted the need to look at the federal Health Insurance Portability and Availability Act (HIPAA), which addresses discrimination against individuals based on health status, and North Carolina laws, such as the North Carolina codification of HIPAA.

#### **Health Status**

The first issue that arises is whether or not a health plan is allowed to treat insured members differently based on their health status. This is being considered as a process for encouraging people to take responsibility for their own status. However, based on HIPAA

regulations and North Carolina's version of HIPAA, insurers cannot treat an individual in a group plan differently based on their health status or health status-related factor. NCGS 58-68-35 and HIPAA read:

*A group health insurance plan shall not require any individual to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of individual.*

According to the legislation, a health status-related factor is defined as: health status, medical condition (physical and mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.

Therefore, in a group health plan, large or small, an insurer would not be permitted to charge a different premium based on a health insurance factor. However, for large groups, the insurer can consider the health status (other than genetic factors) of the employees that make up a group in determining whether or not to offer coverage to the group. And for all groups, the insurer can consider health status of group members when determining the premium that will be charged to the group as a whole. Although North Carolina's small-group rating laws limit how much group-level premiums can be impacted by the health status of the group members. On the other hand, in the individual market, HIPAA does not apply. With an individual policy, the insurer can collect health status and then determine if it will issue a policy to an individual. The insurer can also determine the rate based on health status and/or even exclude coverage for a particular condition forever or for a certain period of time. Because of the significant limits on group carriers' ability to use the health status of an individual in determining premiums, health status is not promising as a means for insurers to encourage persons to be responsible for their health.

### **Wellness Programs/Health Promotion, Disease Prevention**

The second issue Ms. Morales Burke addressed was whether or not enrollment in wellness programs could be used by health insurance companies as a basis for treating individuals differently in an effort to encourage them to maintain or improve their health. According HIPAA and North Carolina state law, it appears the answer is yes, although there are limits that surround how it is done. HIPAA has explicit language that states this exception:

*Exception for bona fide wellness programs. Notwithstanding paragraphs (c)(1) and (2) of this section [which prohibits discrimination on the basis of health status], a plan may establish a premium or contribution differential based on whether an individual has complied with the requirements of a bona fide wellness program.<sup>1</sup>*

In addition, North Carolina law states:

*Nothing in subdivision (1) of this subsection shall be construed...to prevent a group health insurer from establishing premium discounts or modifying*

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<sup>1</sup> 45 CFR 146.121(c)(3)

*otherwise applicable co-payments or deductibles in return for adherence to programs of health promotion and disease prevention.<sup>2</sup>*

Both of these laws make it permissible to differentiate among members of a health plan based on health status as it relates to wellness programs or health promotion and disease prevention. North Carolina law also sites specific ways plans can offer such incentives.

Further, a couple of years ago, the Centers for Medicaid and Medicare Services (CMS) issued some temporary rules that explain what is entailed in a bona fide wellness program. The rules stated that, according to HIPAA rules, a bona fide wellness program, or health promotion and disease prevention program, has a reward limited to 10/15/20% of the cost of employee-only coverage (employee and employer share); is reasonably designed to promote good health, with opportunity to earn reward at least annually; and is available to all similarly situated individuals, unless the program offers a reasonable alternative standard to those for whom the “regular” standard is unreasonably difficult to satisfy due to a medical condition or is medically inadvisable. Also, alternatives must be disclosed in program materials.<sup>3</sup> For example, if a wellness program called for a person to visit a health club two times a week, but that is not medically possible or advisable for that person, the health plan would have to come up with some alternative standard that was medically appropriate for the individual.

North Carolina law does not have any specific guidance on wellness programs and when they can be used in conjunction with incentives. The federal rules provide some guidance. As a state agency, the NC Department of Insurance (DOI) would not have the authority to require compliance with the federal regulatory rules; therefore, it may be useful for North Carolina to adopt the same or similar guidelines in law or regulation. It is also important that DOI evaluate other laws in the state, such as small-group rating laws, unfair trade practicing, nondiscrimination laws, and others.

### **Premium Discounts**

Premium discounts for individuals participating in or adhering to wellness programs could be accomplished through initial underwriting and product pricing. Insurers can re-rate individuals to decrease premiums for improved health or participation in wellness programs, but cannot increase rates for worse health or non-participation.

For the small-group market, NC small-group rating laws restrict insurers from varying premiums for individuals based on individual participation or adherence to wellness programs. However, premiums at the overall group level can reflect participation by members of the group. The discounted rates would need to fall within the rating bands prescribed in the small-group rating laws. (Presumably, employers can decide whether/how to pass “rewards” back to individual employees.) Small-group discounts would need to comply with HIPAA rules on bona fide wellness plans.

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<sup>2</sup> NCGS 58-68-35

<sup>3</sup> 26 CFR 54.9802-1T

In the large-group market, plan documents must explicitly explain when a premium discount applies, and it must be available to all covered members under the policy. It would also need to comply with HIPAA rules on bona fide wellness plans.

### **Premium Rebates**

Insurers could offer premium rebates to insured individuals for participation in a wellness program. For example, insurers could offer premium rebates if the individuals could certify that they didn't smoke at all that year. In individual market, insurer would have to disclose the availability of rebates, and the rebates must be made available to all qualifying plan individuals in order to satisfy North Carolina laws related to rebates and unfair discrimination. In small-group market, premium rebates are not permitted at the individual employee level, but may be permissible at the group level. This will require further study by the NC Department of Insurance. If rebates can go to the employer, presumably, employers could decide whether/how to pass the rebates back to individual employees, but the process would have to comply with HIPAA rules on bona fide wellness plans. In the large group market, plan documents must describe when a rebate applies and must be available to all persons covered under the policy. It would also need to comply with HIPAA rules on bona fide wellness plans.

### **Benefit Cost-Sharing**

Benefit cost-sharing examples include reducing or waiving deductibles, copays, and coinsurance. These could be combined with participation in or adherence to wellness programs in a manner similar to premium rebates. In the individual market, plan documents must describe when reduced cost-sharing applies and must be available to all persons covered under the policy. In the small- and large-group markets, plan documents must describe when reduced cost-sharing applies and must be available to all persons covered under the policy. Both also must comply with HIPAA rules on bona fide wellness plans.

Thus, under federal and state law, it is possible for insurers to offer incentives, but it is easiest for them to encourage policy-holders to participate in wellness programs.

### **Caveats**

Ms. Morales Burke noted that the analyses presented were the NC Department of Insurance's first look at these issues and things could change upon further analysis. There have not been many requests of DOI related to these issues, so it would need to be reevaluated if a company filed with the Department a new plan offering a wellness program. Furthermore, each and every product filing must be evaluated on its own, considering the exact details proposed.

*Q: This discussion is focused on what an insurance company can do to sell a product. There have been numerous articles about employers adjusting their contributions to the insurance plan based on their employees' participation in wellness programs. How does the employer's role factor into this?*

*A: In general, the NC laws apply to the insurer, not the employer. I am not sure if HIPPA is not a consideration though. However, based on examples that I have read, I believe*

*there is latitude for employers to modify their contributions based on that type of employee activity.*

*Comment: There has been discussion about incentives both on the public and private sides. Under large-group policies there are more opportunities to target individuals. In our own state laws, it is not possible to provide premium-based incentives in the small-group market. If the people in the private group discussions think this is an important issue, we should think about whether or not we need to build more flexibility into small-group reform to allow more of those differences for individuals in the small-group market.*

*Comment: Health savings accounts and health risk assessments can both be employer-based, rather than insurance based. Employers could choose to put a set contribution in the employee's health savings account and could increase that contribution if the employee participates in a wellness program.*

*A: It is important to note that the same limits on insurers are not necessarily put on the employers.*

*Comment: Regulations on the bona fide wellness plan that were implemented by the federal government were temporary. They asked the public to comment on the 10/15/20% of cost options to help determine how much variance could be allowed for the bona fide wellness plan. So, anything under 20% of cost would be allowable.*

*Q: You mentioned that the Department of Insurance doesn't have much experience in this area because there haven't been many requests regarding these types of plans. Are you aware of activity in health insurance markets outside of NC that are dealing with this?*

*A: Not specifically. I have read some articles, but often they are on the employer side.*

*Q: Life insurance has had smoker and non-smoker rates for years. What about those rates for health insurance?*

*A: In the individual market, carriers have a lot of latitude through the underwriting process. In the large-group and even (within limits) the small-group markets, smoker-status can be factored into the premium charged. Under the federal regulations defining a bona fide wellness plan, there are specific examples given where a person who is a smoker may be addicted to nicotine, and, thus, treating them differently would be based on health status, which is not allowed.*

*Comment: On the individual market, most companies have a 30% load factor on smokers. When you apply and get approved for coverage, you may not be a smoker, but you may start smoking the day after approval. Underwriters see smoking as a negative factor, so if no one smokes, it is just a no-factor in increases, it is not a discount.*

*Comment: There are many preventive benefits offered for the small- and large-group markets that employers can take advantage of for their employees. Smoking cessation*

*is one example. The benefits are available, but how the rewards are structured should be considered more closely.*

## **SMALL GROUP BREAKOUTS**

### **PRIVATE INSURANCE OPTIONS**

**Sandra Greene, DrPH**

Facilitator

Senior Research Fellow, Cecil G. Sheps Center for Health Services Research  
University of North Carolina at Chapel Hill

### **Reinsurance: Healthy NC and Healthy NY**

Healthy NY is a program designed to encourage small employers to offer health insurance to their employees, dependents, and other qualified individuals. It is available to three categories of people: uninsured individuals, small employers, and sole proprietors. Individuals must have some employment experience within the past 12 months with an employer that does not offer health insurance and must be uninsured for a minimum of 12 months. Individuals must also be ineligible for public insurance and meet income guidelines. Small business with fewer than 50 employees, 30% of whom earn wages \$33,000 or less, can also qualify. The employer must not have offered group health insurance coverage to employees within the previous 12 months, and they must assure that 50% of their employees will participate. The employer must contribute at least 50% of the premium. Sole proprietors of a business who have not had health insurance for a preceding 12-month period are also eligible, but they must meet the same income criteria as the uninsured individuals.

New York acts as the reinsurer of the Healthy NY program in an effort to keep premiums low. The state pays 90% of all Healthy NY members' claims between \$5,000 and \$75,000. This reinsurance was initially between \$30,000 and \$100,000, but the enrollment was lower than hoped for, so the corridor was lowered to decrease the costs of coverage and increase enrollment. Lowering the corridor succeeded in increasing enrollment and reducing premiums. The premium costs dropped by approximately 15%. Most of the initial enrollees had annual claims of less than \$5,000, so the reinsurance costs will change in more recent years since the corridor has changed. The program offers lower premiums than those offered in the small-group market, and it provides a good set of services. It does not, however, include mental health coverage. Every HMO in the state is required to offer a standard Healthy NY plan. This year, 92,000 people enrolled, which was the target for the first year.

*Q: Do they have to keep their coverage for 12 months?*

*A: No, it can be dropped.*

*Comment: An individual with COBRA would not have to be uninsured for 12 months before they could qualify, but others would. And the only time a person is not eligible for COBRA is if employment was terminated in the case of fraud.*

*Comment: In NC, COBRA goes below 20, so we have state COBRA. You have to be employed a minimum of three months to apply for COBRA, but once a person reaches that minimum, he/she will qualify for COBRA. The North Carolina proposal has no mention of COBRA, but the Healthy NY reason for the 12-month waiting period is to encourage employers to continue coverage, rather than incentivizing them to drop coverage for employees.*

*Q: What is the price difference between how much a New York HMO would charge and how much healthy NY would charge?*

*A: The plans' premiums aren't regulated in Healthy NY (though benefit packages are standardized), so cost varies across the state. There is a 40% difference, but it varies, and it varies by carrier because the insurers are not required to offer the same benefits at the same prices.*

*Q: When was the first year that the state started picking up claims above the threshold?*

*A: From inception in 2001. However, the corridor changed in 2004. Claims paid for the corridor in 2003 were \$13 million.*

*Q: Is there any indication what happens to case management in the HMOs? A one-day stay in a hospital costs \$5,000, so in-patient case management is a very valuable part of this plan, and I would be curious what happens to that now that the threshold is so low.*

*A: We don't know yet. The literature is very broad, and it is still very early. The New York health department did an assessment of the program, but it was a couple years ago. There could be something in that report.*

*A: The Commonwealth report discussed reinsurance and how states can make insurance more affordable for states and workers. However, from a review of the report, there doesn't seem to offer an answer to that question.*

*Comment: The richness of the base program in Healthy NC is surprising. Most groups don't have benefits this rich.*

*Q: The best number for what this cost New York was \$13 million in 2003?*

*A: Yes*

*Comment: Compare the North Carolina proposal and the New York program. Some of the differences you would expect and want to see aren't there, and some that you didn't want to see are there. The benefit package is equally rich in the North Carolina proposal. One big difference is that the North Carolina proposal doesn't have any type of wage criteria. So, it would effectively open this up to a much larger number of people.*

*Comment: The Healthy NY requirement that eligible individuals work a minimum of 20 hours per week opens it up to a lot of people.*

*Comment: According to the North Carolina proposal, it seems that a person doesn't need to be employed when he/she applies, but must have been employed sometime in the last year. So, a person could work one day in the year and then they qualify as an employed, but uninsured individual.*

*Q: Who would monitor eligibility once individuals qualify and enroll in the program?*

*A: Healthy NY may have a provision for that, but we are not aware of it. Guidelines could be written into the North Carolina program to monitor eligibility.*

### **Healthy NC Estimates**

Dr. Mark Holmes evaluated some different reinsurance corridors to investigate how varying plan design changes affect claims cost estimates per enrollee. He used data on 2002 healthcare expenditures for 18-64-year-olds employed in small businesses and covered by employer sponsored insurance. The state range of coverage was fixed at 90%, but the minimum and maximum for the claims corridor were varied. The minimum of the corridor varied from \$10,000 to \$50,000 by \$5,000 increments, and the maximum varied from \$50,000 to \$100,000 by \$10,000 increments, with the addition of a \$75,000 cap to match the circulated proposal.

Results indicated that most enrollees would not have claims amounts in the reinsurance corridor because 90% of individuals had claims below \$5,000. Therefore, coverage in a \$15,000-\$75,000 corridor is estimated to cost about \$400 per enrollee, which is about one sixth of the individual's premium. A Healthy NY-style corridor (\$5,000 - \$75,000) reduced premiums by roughly 32%, and this analysis found a similar level of reduction, at 29%. Based on this information, the group could discuss what type of risk it thinks is appropriate for the state to cover. NC Senate Bill 255, recommending Healthy NC proposes \$1 million in funding for the reinsurance program. Based on a \$400 per enrollee cost, that level of funding would only cover a demonstration project because it could not cover more than 2,500 individuals.

Insurance companies must have confidence that reinsurance funds are available to honor the agreement before they are going to reduce premiums and offer this type of coverage. In New York, the initial funding was approximately \$30 million, which came from the tobacco settlement. Since that time, New York has continued to appropriate funds for the program each year. Clearly, the funds available in New York are very significant. Whatever North Carolina puts into the program needs to be more than what it believes claims against reinsurance would be.

*Q: Is everyone that meets the eligibility criteria for Healthy NY accepted, regardless of health status?*

*A: Yes, but they do not cover substance abuse and mental illness.*

*Q: Why don't they get more people in it? New York has a lot of people in the state that would be eligible for the coverage.*

*A: It seems that until they changed the corridor, the premiums were still fairly high for individuals.*

*Comment: They have some responsibility for getting the word out about the product. I think it is about working with the carriers to administer the reinsurance aspect and not touching the enrollee at all.*

*A: To a certain extent, you would never expect 100% of eligible individuals to enroll in a product. Mercer said that you would only expect about 10% of eligible individuals to enroll in a benefit package. If you've lost your job, you may not have the money to buy the insurance anyway.*

*Q: Do we know the type of enrollment the Healthy NY program has?*

*A: It is mostly individuals and sole proprietors. Between 20-30% are employers.*

New York's efforts to publicize Healthy NY were hampered by the terrorist attacks of 2001. The number of enrollees almost doubled in 2004, and there was a decline in the number of people who left the program. Premiums initially offered were about half of the premiums for the individuals in the direct pay. Healthy NY premiums declined by six percent in the second year and then 176% after the change in the band. They were two-thirds lower than the self-pay premium.

*Comment: Considering the cost disparity versus market price and the fact that the program has been in existence for three years, there should be some real acceleration. How interested are insurance agents in promoting this program? Has anyone looked into the idea of giving them a tax break on commission for selling this product?*

*Comment: When you talk to some of the uninsured, many of them are still not going to be interested in a policy like this.*

*Comment: It is not a surprise that there aren't a million people insured in the Healthy NY program because this type of program will only be attractive to a certain portion of the population.*

This Healthy NY product is an in-network only product, which is a little unusual in North Carolina. In addition, it is not the normal small-employer benefit structure. In North Carolina, we don't have a lot of HMOs like they do in New York. The North Carolina proposal compels all insurers to sell the product, not just HMOs. In NY, the HMOs are required to offer the product. Other insurers are not excluded, but do not seem to be participating.

NC Senate Bill 255 was on the Senate commerce calendar, but they didn't get to it. It is still possible that it could still pass in its current form; however the discussion is that a study bill will be made out of it. This seems particularly likely because there were probably no funds appropriated for it in the budget.

*Q: What is the effect of New York's high-risk pool on this program?*

*A: That is a misnomer. New York doesn't have a high-risk pool.*

*Q: Are there any questions about how Healthy NY determines eligibility? Do you think there should be some eligibility criteria built into the North Carolina proposal and, if so, what are the highest priorities?*

*A: There should be income eligibility requirements so that the program is focused on the low-income, uninsured population.*

*Comment: It would be a nightmare to keep up with the eligibility for part-time workers because part-time workers typically change jobs frequently.*

*Comment: The eligibility criteria should include a minimum 30-hour work week rather than a 20-hour work week. Thirty hours is more consistent with other insurance plans. Also, the 30-hour standard should be based on the individual's total employment, so that if a person works two 15-hour jobs, he/she would be eligible.*

*Comment: The rate won't change by the area of the state, so if only high-cost areas participate in the program, there will be no lowered premiums.*

*Comment: In NY, the plans vary by region. The North Carolina proposal talked about geographic variation, and that could be included in the proposal. There are also requirements that the employer contribute at a certain level for each individual. It may be possible to do a subsidy based on the number of hours worked? Or you could require 30 hours for the small group.*

*Comment: If there is a Healthy NC package like the one outlined here, and it costs only 25% more than an average plan in the state, then a small employer with an inexpensive plan might find this plan to be very rich in comparison. However, it is possible that the difference in rates could be substantial. We may want to recommend that this include some options in a tiered benefit format.*

*Q: Does this plan really only call for a \$75 fee for an outpatient surgical facility? That would cost a ton of money to fund.*

*A: The reinsurance will be pretty fixed, but the underlying benefit plan will be very high because of that point you are making.*

*Q: Why wouldn't the outpatient fee be the same as the surgical fee? The surgical fee is too low anyway.*

*Q: Has the mental health authority protested against this yet? They always want full coverage, and this excludes mental health coverage totally.*

*A: We may need to include a standard mental health benefit because if people don't have a basic one, their costs may be higher. The richness of the plan should be something on the lower end, but each mandated benefit needs to be examined to determine if it is a cost saver in the long run.*

*Comment: But if we don't go with a basic requirement, we could be debating each of the mandates forever. To get started, if we go with some thing like that, I would cover more people in the pilot, and then you could discuss changes in the plan as you gain experience.*

The reinsurance cost by itself will vary based on the underlying design, but in general it will be about the same amount of money. Once an individual meets his/her co-insurance, most companies start paying anyway. Depending on what the low end of the corridor is, \$5,000 would have some impact.

*Q: In the North Carolina proposal, is there no mention of prescription drugs?*

*A: In the initial piece it mentions something about a \$3,000 maximum on prescriptions, but it doesn't say what the benefit package is, and then it says there is supposed to be a co-pay benefit in January 2007. It is not clear.*

*Comment: It would be appropriate to have prescription drugs covered by the plan or to have a plan option that includes prescription drug coverage.*

*Q: You feel the benefits drafted by the steering committee for the Healthy NC plan are particularly rich. What benefits would you exclude to make it more in line with what small employers would offer in North Carolina?*

*A: The per admission deductible of \$500 is low. Most plans have a deductible with co-insurance and an out-of-pocket maximum. After the deductible, there likely would be a co-insurance maximum limit of \$2,000 to \$3,000. This benefit costs \$500 if you go to the hospital and is free after that. Other services outlined have a \$75 deductible and then are covered 100%. Most insurance plan emergency department co-pays are \$150, but this co-pay is only \$50. It is the cost-sharing structure that is more rich in this plan, rather than the services that are covered.*

There is some interest in the Healthy NC idea, but there are a number of areas around how the proposal was drafted that need more attention. Particular issues include eligibility, the benefit structure and coverage, and the reinsurance corridor.

*Comment: If we are looking to the state as a funding source for the reinsurance, I have concerns that this would be similar to the state children's health insurance plan (SCHIP) experience, in that funding for this program would be seen as interchangeable funding with the Medicaid program. It needs to be seen as a separate issue, so that it doesn't take funds away from Medicaid and SCHIP. Money coming from the state may create a more viable market if (1) the agent and producers community is engaged and believe in the product, thus promoting it, and (2) some of the lesser players in the marginal- and small-group markets show considerable interest in these plans. We have a slightly more viable marketplace in this particular corridor.*

### **Small-group rating bands**

Small-group rating bands define the range of premiums an insurer can charge to a small-group, based on their demographic factors. Once you first factor in differences for age and gender for the small employer, geographic location, medical inflation over time, and rate bands, there can be very big differences in health insurance costs from one small employer group to the next. Everyone covered in a small-group policy falls within a 40% rate band of premium costs.

Rating methodology is called adjusted community rating with rate bands. It is important to understand that the methodology uses a blend of the experience of the entire small-group market of the carrier and then some deviation against that cost. That was a policy decision made to say that rather than having each small-group employer on its own, there is some cross-subsidy between small groups to reduce the amount of cost variation for the employers. But, it doesn't go so far as charging everyone the same rate.

The community rate is the average cost for covering all small groups. For the ultimate in subsidy and risk spreading, there would be a community rating under which everyone covered in a small-group plan would pay the same premium. Rather than doing that, there is a variation from the community rate, called the adjusted community rate. The adjusted community rate takes into account the demographic mix and the geographic location of the small employer. Factoring age, gender, family size, and geographic location differentiates each group from the community rate, by varying premiums based on the small group's actual demographics. Then, there are rate bands, which limit variation based on the health of each employer group. Health status information is either gathered up front or through claims experience over time. The rate band at the initial policy decision is +/- 20% of the community rate and, from that point, the rate cannot change at renewal by more than +/- 15% per small-employer group and the rate can't be beyond the initial 20% range. So no group can ever be more than 20% above or below the average community rate. The rate bands represent a public policy decision to spread risk over the entire group, rather than allowing small-groups with greater health risks to bear so much of the financial risk that health insurance could become unaffordable. On the other hand, this policy tries to balance the increased costs for the healthy small groups, so that they do not choose to access healthcare on the individual market, which could leave an unhealthier overall group, thus raising the general community rate for those remaining in the small-group market. It is a balancing act.

The increases in costs each year are really due to the medical trend, or increasing costs of medical care. If there is a 30% rate increase for health insurance plans, then it is a result of a 16% medical trend increase. And that affects all the small groups because it affects the community rating. So, maybe we should be looking more into that issue. If you look at the prescription drugs that Blue Cross Blue Shield of NC pays for, the high-utilization items are mostly related to lifestyle, high cholesterol, high blood pressure, stress, and depression.

*Comment: The Department of Insurance will ask the General Assembly for a review of North Carolina's small-group rating laws to see if any changes are appropriate. However, it does not seem as though the Task Force should recommend any specific changes until further analysis has been completed. Instead, there should be a general recommendation to reevaluate the small-group rating laws. The Department of Insurance itself is considering reevaluating them.*

*Comment: One thing that could be evaluated is the experience of groups that are rated at 80% and 120% of the community rate. Are we finding that groups rated at 80% actually qualify for premium rates at 65% of the community rate and those at 120%*

*should pay substantially more? What affect is that having on their respective participation levels?*

*A: The problem is that the Department of Insurance does not have that data. DOI would have to request the data and work with the insurance carriers in North Carolina to provide the data.*

*Comment: We would like to have requirements for insurers to have data on individual employers in the group market.*

*Comment: Even if the rate bands in the small-group market are adjusted, North Carolina still has much fewer small employers covered in this state. We need to determine why that is the case. Is it that the population is less educated, and those people don't take care of themselves? Are they lower income? Do physicians in rural areas dominate the market such that they cannot be negotiated with? It may not have to do with the structure of the small-group market. Is anyone looking at those other things or are they too politically volatile?*

*A: Healthy NC would really address some of that. If you take low-wage employers and say you would reduce their costs by subsidizing them, more employers may be able to participate if the bill is 20-30% less than what it is in the open market.*

The discussion group determined that it would be helpful for the Task Force to make a recommendation that a study be done to look at how North Carolina has fared in the small-group market, including the issue of how it has impacted coverage. That analysis would be helpful if it included a correlation analysis of what other states with a higher percentage of small employers covered are doing, and evaluating income and claims experience costs by illness. Looking at the macroeconomic level would help provide a better sense of where the big problems are so that small-group policy can be directed at those areas.

*Comment: If medical trend is going to be 15% per year, and small-group incomes are going to go up 5% per year, you're going to run into people not being able to afford a 15% increase each year. That has to do with the underlying costs of medical care. So, the employees are paying more and getting less coverage.*

*Comment: An article by the NC Health Access Coalition indicated that the Triad area average is 15% uninsured. Sixty-five percent of Hispanic adults had no health insurance, and 35% of English-speaking people had no coverage compared to 75% of those that do not speak English.*

*A: Actually, research indicates that some of the biggest factors of cost increases actually have to do with technology, especially the imaging technology. The rates of increase are very high in those areas. In addition, the prescription drug cost trends are also increasing rapidly.*

*Q: What can we do in collaboration around the broad definition of consumer-directed plans? Maybe we could be more proactive with the consumer.*

*Comment: But the physician community needs to be more focused on evidence-based medicine and determine when they need to provide each service.*

*Comment: As some insurance plans move to high deductibles with health savings accounts or health risk assessments, and the patient is paying out of his/her own wallet, maybe people will become better consumers. But most people won't question their doctor.*

*Comment: Consumer education is fine, but it is unrealistic to expect a patient to question a doctor about what they are doing.*

*Comment: CCNC has been able to change local practices by working with doctors to make sure that the standard of care is appropriate so that individuals don't end up in the hospital. Disclosure of information to consumers helps raise the level of care in the community. That is one way of effectively changing trends.*

*Comment: If the legislature approves associate health plans, the small-group market will be destroyed. There is a state bill in committee, but it did not make it to the floor. We need to be aware of that, and we should be against it.*

*Comment: There are some companies that are doing preventive care and encouraging employees to be healthier, and they actually see the cost of care stabilize much below the national average. How would those efforts be reflected in premiums?*

*A: Everyone in the small-group market gets the same medical trend in the base rates.*

*Where improved health of a group is factored in is in the health risk assessment. If a group was average one year, and they were healthier the prior year, that factor could be reduced by 10%, but not below the overall 20% below average.*

**Tiered benefit plans in the small-group and non-group market**

The details of the three-tier health insurance plan designed to guide Mercer's cost estimates are outlined in Table 1. The first tier of the plan is a very low level of coverage. However, there have been discussions with Mercer about including a benefit component in the first tier that would encourage people to participate in disease management. So, if a person is participating in a particular disease management program, he/she would be eligible to go beyond the maximum eight office visits. This would increase the premium costs, and Mercer is trying to determine how it would increase costs.

**Table 1: Three-tier health insurance guidelines for Mercer cost estimates**

	Tier 1 Plan	Tier 2 Plan	Tier 3 Plan
Physician Visits	4 Office visits/year with \$25/visit copay. Maximum of \$500 per year.	8 Office visits/year with \$25/visit copay. Maximum of \$1,000 per year.	Unlimited office visits with \$25/visit copay. Maximum of \$2,000 per year.
Inpatient Hospital Care	80% coverage, subject to \$500 deductible. \$10,000/year max.	80% coverage, subject to \$500 deductible. \$25,000/year max.	80% Coverage, subject to \$500 deductible, \$50,000/year max.
Diagnostic Testing	80% coverage; subject to \$250/year max.	80% coverage; subject to \$500/year max.	80% coverage; subject to \$1000/year max.

ER	\$150/year max, subject to \$75 copay. Waived if admitted.	\$150/year max, subject to \$75 copay. Waived if admitted.	\$150/year max, subject to \$75 copay. Waived if admitted.
Prescription Drug Benefit	3 Tier Copay: \$15 generic; \$30 brand name when generic not available; \$50 brand name when generic available. Annual max \$1,000/year.	3 Tier Copay: \$15 generic; \$30 brand name when generic not available; \$50 brand name when generic available. Annual max \$2,000/year.	3 Tier Copay: \$15 generic; \$30 brand name when generic not available; \$50 brand name when generic available. Annual max \$4,000/year.
Mental/Behavioral Health Services	N/A	12 office visits/year with \$35/visit copay. Maximum of \$1,000 per year.	24 office visits/year with \$35/visit copay. Maximum of \$2,000 per year.
Other	N/A	Disease management services for select conditions.	Same as Tier 2.

\*Not including disease management

The prices quoted by Mercer include the claims costs and, exclude administrative costs and disease management programs. This cost analysis was based on a commercial population, not a Medicaid population. The commercial population was used because this is meant to be a product for the private insurance marketplace. Therefore, it would be a very different product if it had Medicaid rates and was for Medicaid-based programs. The idea was to have a plan for the commercial population somewhere in the \$100 range so that if the worker paid \$50 and the employer paid \$50, it may be a realistic and attractive plan for some portion of the uninsured population.

*Q: Is this a product that would be included in a network?*

*A: Yes.*

The idea is for this plan to be one that North Carolina would recommend or require carriers to sell on the market. Ideally, requiring carriers to offer the plan could remove any barriers of implementing a plan like this, such as eliminating any mandates that would prevent insurance companies from offering it. Therefore, what would it take to make this type of product attractive for a private insurer in the market to develop and offer it?

We considered limiting the population eligible to buy the product, and we may go back and do that, but these prices reflect data for everyone. And this gets to the point that we wouldn't necessarily eliminate this to a population without insurance because the population without health insurance has, on average, greater health risks than the general population. By offering it only to that population, it would have a crowd-out effect of driving up the costs and reducing participation of healthy individuals, who could find less expensive comprehensive care.

*Comment: Allen's idea to have a lowered tax on earnings for brokers who sell this type of plan is a good idea.*

*Comment: If you start to have incentives like that, you may want to think about some kind of eligibility criteria because otherwise you could push people from some more generous products to this one.*

### **Suggested changes**

*Comment: There should be no maximum applied to generic drugs. Blue Advantage has an annual maximum on drugs, but that does not apply to generics.*

*Q: Is 38% a reasonable estimate of administrative costs?*

*A: That may be a little high, but it would be at least 25%.*

*Q: What is the prior history of this type of plan in other states? What is the take-up rate?*

*A: It is too early to say, some insurers are looking at providing something like this now.*

*Comment: My business has been offering its minimum wage employers a similar tier 1 plan for years, and the take-up rate is almost non-existent. They are charged \$22/week. Of course, 85% of the employees are less than 25-years of age, and they may not be able to afford it.*

*Comment: Maybe the rates should be banded by age. You could do 10-year brackets.*

*Comment: In an employer group, could any employee in a group choose to buy this plan, or would it be outside of the employee-employer stream? Could these plans be targeted toward contract workers, seasonal workers, or part-time workers? The positioning of who this plan is targeted to may be important to its take-up rate. If the plan was dropped into a normal employer plan, would there be employer contributions or not? How would these products be offered?*

*A: The goal was to try to find something attractive for small employers who currently don't offer insurance. The plan is not meant to for a large employer who is offering comprehensive coverage, however, large employers may want to consider it for the part-time or contract workers.*

*Comment: This option would be more of interest for the dependents of employees.*

*Comment: Blue Cross Blue Shield of NC covers a lot of dependents individually because it is cheaper than buying coverage through the employer.*

*Comment: It would be good to have some restrictions so this plan wouldn't displace better coverage for workers. Crowd-out issues could arise. What about a 12-month uninsured waiting period provision?*

*Comment: Blue Cross Blue Shield of NC has priced many designs like this before, but we don't offer any right now. When we offered lower option plans, we saw an uptake in the small-group market, and a number of the people buying them were those that didn't have coverage before. The only place we have done something like this before was the Kids Care program.*

*Q: When folks buy Blue Advantage, are employers buying that with pre-tax dollars?*

*A: No, employers can't pay the premium and can't purchase it pre-tax. In many situations, the employer is paying nothing for the dependent coverage.*

*Comment: If the employer facilitates the purchase of this insurance through payroll deduction and the employees pay the premium, it qualifies as small-group. So, if this type of plan was to be offered for dependents, there would need to be a regulatory change so it would not inadvertently be considered the small-group market.*

*Comment: Some insurers left the North Carolina insurance market a couple of years ago because they couldn't do payroll deduction on individual products.*

*Comment: I would think the costs would be in the front end of these plans. To put in bigger maximums on the back end would cost pennies. Would it cost much more to put in hospital care?*

*Comment: United Healthcare has developed a continuum of products similar to this and they have determined that there is a market for these products.*

## **PUBLIC OPTIONS TO EXPAND HEALTH INSURANCE COVERAGE**

**Pam Silberman, JD, DrPH**

President & CEO

NC Institute of Medicine

Dr. Silberman began by reviewing the recommendations made in the July Task Force Meeting. The group had two overall recommendations: (1) DMA should increase outreach and further simplify the Medicaid application process to encourage those who are currently eligible to apply and maintain their eligibility and (2) the General Assembly should expand Medicaid, with the top priority to cover all working parents with incomes up to 200% FPG under a Medicaid benefits light package.

### **Outreach and Simplification**

There are thousands of North Carolinians who are eligible, but not enrolled in Medicaid and NC Health Choice. To address this, the group specifically recommended increasing outreach efforts and simplifying the eligibility and recertification processes to encourage more eligible people to apply. Some options the state could consider include increasing the number of out-stationed eligibility workers; eliminating the requirement for face-to-face application interview for adult coverage (i.e., for people who are blind or have disabilities and elderly people); simplifying the adult application form; eliminating the asset (resource) test for low-income parents; expanding the eligibility certification period from six months to 12 months; and streamlining the recertification process.

### **Medicaid Expansion**

The discussion group determined that one option for expanding health insurance to uninsured North Carolinians is through the expansion of Medicaid. The first priority for Medicaid expansion would be to cover working parents with incomes below 200% of

federal poverty guidelines (FPG) with a limited benefits package. For approximately \$100 million (in state and county funds), North Carolina could expand Medicaid to cover 77,000 adults. The state would need to seek an 1115 or HIFA waiver in order to offer a more limited Medicaid benefit package to cover working parents. In addition, the group felt that the state should cover the county share to avoid undue financial burden on county governments. The Medicaid expansion would also be combined with a voluntary premium assistance program

**Table 2. Cost of Medicaid Expansion for Working Parents at 37%-200% FPG**

	<b>Full Medicaid benefits</b>	<b>Limited Benefit (\$5,000 IP Deductible)</b>	<b>\$Limited Benefit (\$10,000 IP Limit)</b>
<b>Avg. Covered Lives</b>	129,917	77,916	77,916
<b>Total Cost*</b>	\$808,808,000*	\$278,959,000*	\$296,246,000*
<i>Federal (63%)</i>	<i>\$509,549,040</i>	<i>\$175,744,170</i>	<i>\$186,634,980</i>
<i>State (31.5%)</i>	<i>\$254,774,520</i>	<i>\$87,872,085</i>	<i>\$93,317,490</i>
<i>County (5.5%)</i>	<i>\$44,484,440</i>	<i>\$15,342,745</i>	<i>\$16,293,530</i>
*Costs do not include administrative costs of 3-4%.			

At the previous meeting, the work group had also expressed interest in further redefining the limited benefit package to reduce the costs of the Medicaid expansion to this population. Possible areas for further reduction included: hospital inpatient (deductible for \$10,000 IP package), hospital outpatient (total limits in addition to 20% coinsurance), physician visits (fewer visits/yr.), pharmacy (fewer scripts/mo.), and lower annual limits in coverage (currently \$1.0 million). Table 3 provides an outline of the benefits included in the limited benefit plan as it was priced out by Mercer (column titled Medicaid Light) and the possible modifications discussed to reduce the costs of the program (in italics).

The original Medicaid Light plan priced out by Mercer excluded skilled nursing, eye exams, home health personal care, dental, and podiatry. Case management services were only available through Community Care of North Carolina (CCNC) and family planning only included contraceptives. Services available through the Medicaid Light program included some services for inpatient hospital, outpatient hospital, emergency department, primary care physician, wellness, specialty physicians, outpatient therapy, inpatient behavioral health, outpatient behavioral health, pharmacy, lab and radiology, DME/supplies, ambulance, and maternity. The workgroup considered some modifications to further limit the Medicaid light package.

*Inpatient hospital services:* The group determined that if the decision was to recommend inpatient hospital services with a \$10,000 total, a deductible would need to be built into the plan to discourage people from choosing inpatient services over the outpatient services, which are less costly. A \$100, rather than a \$250-\$300 deductible was chosen because the group felt that a \$100 deductible, in addition to 20% co-insurance, would be enough to deter people who could otherwise choose outpatient hospital services.

The work group discussed the difference between choosing a \$5,000 deductible or \$10,000 maximum for inpatient hospital services. There was some support for the \$10,000 maximum because these people are already low income and many would only use inpatient services if they were admitted by their primary care provider. However, most private plans have inpatient deductibles, which may make that option easier to sell. Also, the \$5,000 deductible plan helps protect against catastrophic illnesses.

*Q: What has the Centers for Medicaid and Medicare Services (CMS) approved for Medicaid light plans? It would be helpful to see other states' plans.*

*A: CMS is giving states a lot of flexibility for Medicaid light and it is better to make this look as much like a commercial plan as possible given the current administrator.*

*Outpatient hospitalization:* Dr. Silberman noted that another way to further reduce the Medicaid light package is to further limit coverage of hospital outpatient services. Hospital outpatient care is one of the faster growing health services (both in commercial and in the Medicaid program). However, it was not easy to determine an appropriate outpatient limit. If the limit is too low, it might encourage people to use hospital inpatient services. Further, it may not cover certain life-saving treatment (such as radiation or chemotherapy). On the other hand, if the workgroup is developing a Medicaid "light" package, then there probably should be some limits.

Some of the ideas discussed include:

- Outpatient primary care or specialty visits: Some hospitals operate primary care or specialty outpatient clinics. If these are really ambulatory provider visits, they should be subject to the same visit limits as above (e.g., 5 visits/year unless waived as part of CCNC case management or disease management).
- Imaging services: A lot of the cost escalation for hospital outpatient services is due to the increase in diagnostic imaging (e.g., PET or CT scans). As part of the proposed Medicaid light package, these services will be subject to prior authorization by CCNC.

The workgroup suggested further analyses to determine what additional cost savings measures are appropriate.

*Emergency services:* To deter non-emergent use of the emergency department, the Medicaid light package includes a \$100 co-pay which is waived if the patient is admitted.

*Outpatient primary care and specialty visits:* One way to further limit the Medicaid light plan was to include a five-visit limit on outpatient primary care and specialty visits. Enrollees could also have one annual preventive check-up (not included in the five visit/year limit), and could get exceptions to the five visit limit for individuals who are actively participating in CCNC care management or disease management. Workgroup members expressed concern about the need for additional visits for patients with cancer who don't fit into existing CCNC case management programs. However, NC DHHS staff noted that CCNC is going to gear up a more sophisticated case management system that will eventually provide services for different patients with complex or high cost medical

conditions. The work group felt that a limit on outpatient ambulatory office visits would be good if it provided an incentive for individuals with chronic conditions to actively participate in CCNC's care management and disease management programs.

CCNC requires Medicaid recipients to select a medical home. CCNC offers both case management and disease management services. One workgroup member expressed concern that there may not be enough physicians to serve as the primary care provider (medical home) for the new population. However, DHHS staff and physician workgroup members did not think this would be a problem. They suggested that moving this population into medical homes may make it easier to enroll even more physicians as Medicaid providers because this population would not be as sick as the regular Medicaid population.

*Eye exams:* The workgroup suggested including one eye exam/year with prior authorization from the primary care provider. The limited benefit package would not include the cost of glasses.

*Therapy services:* The limited benefit package includes a 25-visit limit/year. Therapy services include speech therapy, physical therapy, occupational therapy and chiropractic services. Therapy services would require prior authorization from the primary care provider.

*Behavioral health services:* The workgroup suggested that a limited number of behavioral health inpatient days should be included, if the Medicaid light plan was built around a \$5,000 deductible plan for inpatient services. Like commercial plans, this would limit the amount of inpatient days covered for behavioral health problems. The work group suggested a 20-day limit on inpatient services with an option to substitute one day of inpatient services for two days of outpatient services, as a means of encouraging the use of less expensive outpatient care. In addition, with prior approval, intensive day treatment is allowed as a substitution for inpatient services. Outpatient behavioral health is limited to 20 visits/year, with prior approval after 8 visits.

*Prescription drugs:* The group decided to further limit pharmacy to two prescriptions per month, with a waiver of that limit for chronic illness maintenance prescription drugs when the patient is enrolled in CCNC disease or care management. Contraceptives are also not included in the two prescription/month limit. Two prescriptions per month would cover most people in the plan, with the exception of the people with chronic conditions. The Division of Medical Assistance cannot establish an exclusive formulary that would limit the drugs available to Medicaid patients, so physicians cannot be required to prescribe the less expensive drugs. However, copay differentials can help provide a financial incentive for patients to voluntarily choose the less expensive drug. Patients with chronic illnesses would be encouraged to get a three month supply at one time to save the state on dispensing fees.

*Maternity services:* Maternity care services would only be provided to fill the gap that Medicaid does not already cover, which includes women between 185% and 200% FPG.

*Durable medical equipment (DME):* DME and supplies would be limited to with a \$500 limit/year and 20% coinsurance. DME would also be subject to prior approval.. Diabetic supplies would be unlimited.

Excluded services: The revised Medicaid light package will exclude home health, personal care services, dental, and podiatry.

*Annual benefit limit:* The group decided on an annual benefit limit of \$1 million because based on the limited benefit package, none of the enrollees would ever reach a million dollar benefit limit. A \$2,500 out-of-pocket co-insurance maximum was also built in because very few people would reach that level, so it wouldn't increase costs very much.

**Table 3: Possible Medicaid Light benefit modifications**

<b>Services</b>	<b>Original Medicaid Light</b>	<b>Possible Medicaid Light modifications to Further Limit Costs</b>
Inpatient hospital (Non-maternity, non-BH)	Covered: \$5,000 deductible or \$10,000 total; 20% coinsurance (only includes facility IP costs)	<i>Add \$100 deductible to \$10,000 plan to discourage inpatient use when outpatient available.</i>
Outpatient hospital	Covered 20% coinsurance	<i>Need to separate outpatient diagnostic from treatment. Want to make sure limits don't drive people into inpatient services.</i>
Skilled nursing	Not covered	<i>No changes recommended.</i>
Emergency room	Covered, \$100 copay (waived if admitted), 20% coinsurance	<i>No changes recommended.</i>
Primary care physician	Covered (sliding scale copay: \$10, \$20 for below/above 150% FPG)(5 visit limit)	<i>Five visit maximum applies to outpatient primary care and specialty (total). Individuals actively participating in care management can have additional visits with prior approval by their primary care providers (PCP). Same limits for outpatient hospital clinics.</i>
Wellness visit	Well visits and immunizations only (not full EPSDT coverage)	<i>One annual visit per year, not included in the doctors visit limit</i>
Specialty physician	Covered (sliding scale copay: \$20, \$40 for below/above 150% FPG)(24 visit limit). Medicaid light package included optometrist, chiropractic, podiatrists in the 24 visit/limit.	<i>Five-visit annual limit applies to primary care and specialty (total). Individuals actively participating in disease management can have additional visits with prior approval by PCP. Optometry, chiropractic and podiatrists not included in this 5 visit limit.</i>
Eye exam		<i>One visit with prior authorization from PCP (no glasses). Podiatrist excluded.</i>
Outpatient therapy	Covered, 20% coinsurance, 25 visit limit for PT, OT, Speech therapy, with PA	<i>25-visit limit applies to all therapy (including chiropractic) but requires prior approval from PCP.</i>
Inpatient behavioral	\$5,000 deductible or \$10,000	<i>In \$5,000 deductible package, should limit</i>

<b>Services</b>	<b>Original Medicaid Light</b>	<b>Possible Medicaid Light modifications to Further Limit Costs</b>
health hospital	total; 20% coinsurance	<i>inpatient behavioral health to 20 days, substitution allowed</i>
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	<i>No changes recommended.</i>
Behavioral health other	Not covered	<i>Intensive day treatment allowed as substitution for inpatient with prior approval</i>
Pharmacy	Covered: \$15 copay (generic), \$25 (brand), \$60 (brand, non-preferred)(6 script limit/mo.).	<i>Limit two prescriptions per month; waived for maintenance drugs for chronic illnesses when in CCNC disease or care management. Two-prescription limit does not include contraceptives. Copay modified to: \$5 (Tier 1), \$30 (Tier 2), \$60 (Tier 3) Encourage 3 months supply for chronic medications.</i>
Family planning	Contraceptives only	<i>Contraceptives only, not included in two-prescription limit/month.</i>
Case management	CCNC only	Participation in CCNC required, must select medical home
Home health	Not covered	<i>No changes recommended.</i>
Personal care	Not covered	<i>No changes recommended.</i>
Dental, podiatry	Not covered	<i>Dental and podiatry excluded. (Original Medicaid light proposal only excluded dental)..</i>
Lab & radiology	Covered, 20% coinsurance; requires pre-authorization of MRI/PET scan	<i>No changes recommended.</i>
DME/Supplies	Covered, 20% coinsurance. \$500 limit (includes glasses) (diabetic supplies unlimited)	<i>Glasses not covered; prior approval required for DME. Diabetic supplies unlimited.</i>
Ambulance	Covered, \$150 copay (waived if admitted), 20% coinsurance	<i>No changes recommended.</i>
Maternity	Covered prenatal care only for adult women with incomes >185% FPG (<185% covered by Medicaid); not covered dependents.	<i>No changes recommended.</i>
Annual benefit limit	\$1 million	<i>No changes recommended.</i>
Out-of-pocket maximum	None	<i>\$2,500/person out-of-pocket maximum on coinsurance</i>

### **Personal responsibility**

The workgroup next moved to discuss ways to encourage people to take better care of themselves and participate in CCNC. CCNC provides care and disease management to

individuals with chronic or high cost health problems. Disease management and care management services are offered to target populations, but there is currently no penalty for failing to participate. Currently, Medicaid does not cover: a health risk assessment for every adult or separate payment for counseling around smoking cessation and/or nutritional counseling (included as part of regular reimbursement to primary care provider). The employer population is moving towards using health risk assessments.

Dr. Silberman posed the question of whether or not newly eligible Medicaid enrollees should be charged differential premiums or cost sharing depending on their participation in CCNC or lifestyle behaviors. The idea is to provide incentives to get active participation in CCNC. Some examples include developing a premium differential for non-smokers or smokers participating in smoking cessation program.

Under the HIPAA non-discrimination provisions, premium differentials can be charged as long as people are eligible to avoid the higher premiums by participating in cessation programs. Cessation programs would have to be built into the costs of the Medicaid Light program because those costs are not already included. Generally, the workgroup felt it would be better to charge a specific premium rate and then discount the rate for non-smokers and cessation program participants

Dr. Silberman asked the group if they felt the Medicaid Light program should implement a health risk assessment (HRA) for all new eligibles. Collecting HRAs would provide more information about the prevalence of lifestyle risk factors within the participating population. However, studies from worksite wellness initiatives suggest that these programs are most effective when they get 80% of eligible employees to fill out HRAs.

*Q: What will the HRA be used for?*

*A: To help the state target incentives and to provide additional information on this health risks of this new population.*

The work group discussed the option of conducting the HRA at annual wellness visits instead of at enrollment because that would tie it more directly with wellness directives. However, other workgroup members suggested including the HRA as part of enrollment because people do not always go to their annual wellness visit. The data could then be sent back to the primary care provider so that he/she would have the information when the individual came in for his/her annual wellness visit.

*Comment: Our systems are filled with information that we gather but cannot use. I recommend the costs for HRAs be included in the estimates and requests, but if there is no system to use the data, HRAs should not be conducted.*

*A: The HRA data system could be built into the CCNC data system, but there would be costs associated with analyzing the data. It is important that we are careful what is asked of DMA given the constraints they already face.*

*Q: What does CCNC do now in this regard?*

*A: When first started in Pitt County, we had amazing compliance using HRAs, but we never did anything with the data.*

The workgroup then discussed whether there was a way to get CCNC enrollees to change their behavior. It was noted that without HRAs, CCNC would not be able to manage the age, blind, and disabled populations because the information allows the case managers to focus on the specific needs of individual patients. Additionally, although CCNC does not currently have an initiative around obesity, that is one of its next three disease management initiatives.

The work group noted that although the majority of employers are basing their wellness initiatives around an HRA, the discussions here surrounded an insurance company setting, rather than an employer setting and there are significant differences when you are considering 77,000 people scattered across the state. However, some workgroup participants felt that it would be a missed opportunity if some front end HRA was not built into the Medicaid Light program because if it is not included initially, it could be difficult to go back and add in.

It was determined that the HRA should not be mandatory until a determination is made regarding how to use the data. However, there is a possibility that someone might pay to work with the database or that analysis could be conducted without a huge capital investment from the state. The workgroup suggested CCNC introduce a voluntary HRA pilot in computerized form.

### **High risk pool**

High risk pools are a way of providing health insurance to people with pre-existing conditions who cannot access health insurance in the private market because the costs are too prohibitive. The Task Force members previously supported the idea of developing a high-risk pool for North Carolina. Dr. Silberman asked the group about what benefits should be covered and how the plan should be structured in a high-risk pool.

*Q: Who would be eligible for the plan?*

*A: The plan is for the non-group market.*

The work group felt the benefits should be comprehensive and include multiple preferred provider organizations (PPOs) with differential deductibles. Deductibles should not apply to doctor's visits. In addition, the group agreed on offering a health savings account option, which would help individuals pay for a high deductible plan by allowing them to pay for it with money from a tax free account. It was also determined that disease management and case management services should be included. All other states that have implemented high risk pools have helped to subsidize them so people can afford to buy the product. In fact most states have several products- a limited and more expansive PPO . More states are moving into disease management and/or case management, as well.

Eligibility is also a question. The work group discussed the fact that qualifying participants must be ineligible for other coverage, including Medicaid, Medicare, and

COBRA. In addition an individual would be eligible if he/she cannot purchase a product for less than what the high risk insurance would cost him/her. There was discussion about allowing certain health conditions to make individuals automatically eligible, but if this were the case, there was concern that private insurers would then price their products to eliminate populations with those conditions.

The work group also agreed upon a six month waiting period for pre-existing conditions unless the individual had continuous coverage. Every state with a high risk pool has a waiting period between six and 12 months. The group also noted that the high-risk pool should serve as the insurance product for the HIPAA individual guaranteed product and the Trade Adjustment Act.

The work group suggested that the state put limit the premium charged to the individuals of 150% of the standard risk, which is common in other states. Some newer pools have gone up to 200%, but data from Blue Cross Blue Shield didn't find much difference between the two. In addition, there should be an additional public subsidy for low income families below 300% FPG on a sliding scale.

A lot of states are subsidizing the high risk pools through state funds, including an assessment on insurers (broadly defined) and capped reimbursement rates to providers. This way, both providers and insurers participate in the financing of this high risk pool.

The work group completed its discussion and the meeting was adjourned.