

NC IOM Task Force on Covering the Uninsured

July 15, 2005

Cary, NC

Meeting Summary

Members: Carmen Hooker Odom, Tom Lambeth, Sonya Bruton, Allen Dobson, Allen Feezor, Charles Frock, Bob Greczyn, Ches Gwinn, Robert Jackson, John Mills, Barbara Morales Burke, Peg O'Connell, William Pully, Eric Russman, Randy Rust, Adam Searing, Stephen Smith, Torlen Wade, Charles Willson, Leslie Winner

Steering Committee: Mark Holmes, Stephanie Poley, Dennis Williams

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

Guests: Chris Fitzsimons, Alan Hirsch, Kathy Holladay, Aaron McKethan, Rick Mumford, Andrea Radford, Pam Sutton Wallace, Phil Telfer, Kenya Villines, Walker Wilson, Bethany Woomer

WELCOME

Carmen Hooker Odom

Co-Chair

Secretary

NC Department of Health and Human Services

Tom Lambeth

Co-Chair

RESULTS FROM THE FOCUS GROUPS

Kathleen Holladay

Senior Project Manager

FGI Research

At the beginning of her presentation Kathleen Holladay reminded the Task Force that focus groups are solely a qualitative source and they do not provide quantitative data. They are designed to help people understand how others feel and what they are doing in a very broad way. Focus groups are helpful for generating hypotheses that can suggest new directions or offer reality checks and they are good for generating impressions of program services and institutions. I

Most of the focus groups conducted by FGI for the State Planning Grant consisted of between six and 12 people. FGI Consulting conducted 15 focus groups across North Carolina between March and May of 2005. Five focus groups were conducted with the uninsured; four with small employers (1-49 employees), two with medium-sized

employers (25-99 employees), two with large employers (more than 100 employees), and two with insurance agents and brokers.

The purpose of these focus groups was to learn how decisions are made by individuals and employers with regard to seeking and offering health insurance, and what policy options are favored to expand coverage by each group. The uninsured individuals were recruited from a random sample of telephone numbers within a 35-mile radius of the group location. Qualifying individuals had to answer “no” to the following question:

“Do you currently have any form of health insurance? (This includes employer-based health insurance, private health insurance you buy yourself, Medicaid or Medicare, CHAMPUS or other health insurance coverage)?”

Employers were recruited from lists of businesses, based on the size of the businesses. The large and small employers were recruited from within a 35-mile radius of the focus group location. This radius had to be extended to a 50-mile radius for mediums sized employers, because there were fewer that fell into the size category. All business representatives were either responsible for managing their company’s healthcare benefits or responsible for making decisions regarding whether or not to offer health insurance to employees.

Agents and brokers were recruited from a listed sample within a 35-mile radius of the focus group location. Qualifying participants had to sell health insurance as a major line of business and sell to the small group market, individuals, or both.

Discussion topics for the focus groups included factors in deciding whether to get/offer health insurance, consequences of being uninsured/not offering insurance, willingness to pay for insurance, possible trade-offs for more affordability, and policy preferences.

Key Findings

The key findings indicated that cost is the main concern in decisions to buy health insurance for both individuals and employers.

Other key findings include:

- Low-wage individuals don’t see how they could pay much more than \$50 a month for health insurance. However, some were also reluctant to trade small luxuries like cable TV or cell phones for health insurance.
- The emergency department is seen as the safety net for the uninsured. While many participants recognize that the use of the ED for primary healthcare is a driver in rising healthcare costs, the uninsured often view this as a viable healthcare choice.
- Young people don’t value health insurance; older people can’t afford it.
- People with pre-existing health problems are priced out of the individual market and create higher costs for groups.
- Whether buying as an individual or through a group, people pay more for less coverage than they had five years ago.

- Few people want restrictions on their ability to utilize healthcare, although many see that difficult choices will have to be made if more people are to have access to health insurance.
- People need more education to empower them to make wise healthcare choices.
- There is recognition for increased government involvement in healthcare, although a sizable number of people express fear of a National Healthcare Plan.
- Many people see a need for more regulation of healthcare costs, including doctors, hospitals, pharmaceuticals, and insurance companies.

Q: Did the uninsured accept the idea that they may have to give up some options in order to get some care?

A: Yes- at least some of them. The younger folks were willing to accept a limited benefit plan, while the older adults seemed to prefer catastrophic care plans.

Agents and Brokers

Trends in coverage noted by the agents and brokers include:

- Lack of competition across the state is driving cost upwards
- Problems getting small groups covered. There were a lot of complaints about underwriting. The rates come the agents are given by insurers are so high that they have nothing to sell to the group.
- Smaller groups dropping coverage altogether
- Insurance companies are raising the required participation rates, which is making it hard to keep coverage.
- Both employers and individuals are reducing benefits to keep costs down.
- Older individuals or those with health problems send costs skyrocketing in both the group and individual markets.

Q: What did the agents and brokers mean by lack of competition?

A: They told us that there used to be 20 insurance agencies around the state that offered coverage, but that now there are only four.

Comment: When there were 20 insurance agencies, there was always someone trying to give away the product, which would then force them to increase the premiums much more the following year. What you are seeing now is a rational underwriting based on the rules in the small market. Cost increases are being driven by the rising medical costs.

Comment: About 20 companies left the North Carolina market in 1988. Then, a number of large companies began merging. The fewer number of companies limited the price gaming. The producers left in the market re more realistic about their pricing, so agents don't have the same ability to shop around to find insurers who are willing to undercut prices to gain market share. Although agents may not have as many companies to go to, there still may be competition for the agents, which makes it harder for them to keep their clients.

Comment: Over the course of ten years, the landscape of insurance and healthcare has changed in many other ways. The costs of services have continued to rise, and the way people get care has changed, irrespective of the number of insurers in the market. There could be a lot of other reasons that explain the rising premium costs aside from lack of competition among insurers.

Q: What about the commission rate differences between large and small insurance companies?

A: We didn't discuss that in the focus groups.

Comment: I don't think the differences are big now. I think they are pretty close.

Employers

The majority of employers participating in the focus groups are still offering health insurance. All of the large employers (15) surveyed offer health insurance, most of the medium employers (21 of 22) offer it, but the small employers were struggling to offer it (19 of 29). We drew employers from a range of industries, including agriculture, construction, communications, distribution, government, health services, hospitality/service, manufacturing, and professional services.

The reasons employers gave for offering health insurance included retaining and attracting employees and doing so because it is the ethical choice. They felt it was the traditional way people accessed health insurance in the United States and they want to continue that tradition. However, employers also noted a number of barriers to providing healthcare, including the costs of pre-existing conditions and older employees, cost of catastrophic or on-going health issues, and the rising costs and participation requirements for health insurance. There was a lot of discussion about utilization and how health insurance prices skyrocketed after one participant had a major medical need.

Comment: Was it the chronic health concerns that increased the prices, or were there catastrophic problems?

A: I think the majority of the problems were chronic health problems.

Comment: In the small group market, the costs are spread over the whole small group market pool. It is important to understand how that is done. In the small group market with \$1 million, you might get \$50,000 applied towards the individual group in setting their premium price and the rest of it is a pooling charge applied across all small groups.

A: What we heard from employers was that the age banding was a way of charging them for the perceived utilization.

Comment: I wouldn't say perceived. The age-band rate for smaller groups is used because experience indicates that older people are more expensive.

Comment: The employers wanted to see more pooling, so it wouldn't just be them being held solely accountable for the utilization costs.

Comment: The product that they have is pooled already. Health insurance companies are limited in how much they can vary the costs by plus or minus 20% of the rate within the band.

Comment: The process for setting small group-market rates is as follows: The insurer takes a total block of small group experience. The insurer's total block of small group business, maybe 20,000 small businesses, are studied in their entirety to determine a rate for the whole segment. That is the "community rate." Then, individual groups are adjusted from that community rate based on the age, gender, geographic location and family composition of that specific small group and the benefit design. The insurer can then adjust that rate up or down by 20%, based on the perceived health insurance costs and utilization patterns. This process is repeated annually to determine rates for the year; however, the small group can never be more than 50% higher than the lowest cost group (with similar demographics, geographic location and plan design). (Note: a 20% range up or down off the middle produces a 50% spread).

Q: So the maximum swing is plus or minus 15% and then plus or minus 20% after that?

A: From one year to the next, rates can vary drastically. If the group composition changes, the rate could double from one year to the next.

Comment: There are provisions in the law to use age ratings for an age band up to five years. Even if you don't have a change in your employee group, moving from one age band to another (e.g., because the average age of the group is aging), can cause significant rate increases.

Comment: Age bands are based on confirmed characteristics of a wide spectrum of people in that age band, rather than on the health status of individuals within an organization.

Comment: The current small group market is a compromise. It begins with a pooled, community rate, and offers some variation from that rate. Before the small group laws were implemented each group stood on its own, so really healthy groups had terrific rates and groups with higher risk employees were either refused coverage or paid really high rates. A complete community rating system would benefit the higher cost groups, but lower prices for them would come at the expense of the small, healthy groups who would have to pay substantially more. As a result, if the healthy groups chose not to have insurance at those higher rates, it would drive up the cost within the community rating system.

Q: What is the maximum increase for a group in the small group market?

A: Plus or minus 20%, for a group that stays the same from year to year. But it can vary more than that if the employee mix of the group changes.

Comment: This is a zero sum game. As the rules change, the costs will shift to a different group.

Comment: Affordability is an issue. If the small group is rated too high, younger employees with families can go to the individual market and find a better rate,

which could cause their employer to face problems meeting the participation requirements. It is necessary to incentivize and educate younger employees to stay in the system, in order to keep the group rates affordable. It is for this reason that it makes such a big difference when the employer contributes to the premium costs. Employer contributions often keep the young people in the pool.

Comment: In fact, some of the employers in the focus groups mentioned having to pay a percentage of the employee coverage to keep employees participating in the program.

Q: Are there enough small businesses that each insurer can develop a true community rate? Is the problem that some insurers don't have enough small employers to get a really effective community rate?

A: There are definitely enough small businesses for a good community rate, but no matter how big the group is, some people who otherwise would be paying more will pay less, while the majority who were paying less will pay more.

Q: How many small businesses do you need to have for an effective community rate?

A: Probably around 2,000 would be enough. Large numbers don't necessarily make a cheaper product. It really comes down to the group mix.

Q: How much variation in price is there based on geography in the state? 40%?

A: Easily. For each insurance company, there are some counties where the company has good arrangements, and some where it does not. And, some insurance companies do not believe that it is appropriate to underwrite counties with higher costs by charging more to counties with lower costs.

Comment: In the 90s, there was an effort to reduce the variation in the small group market between high and lower cost groups. Small group reform has stabilized the market and taken out some of the companies that were playing games in the market. North Carolina was the model of this type of reform. But, it gets back to the idea that for every person staying in the pool because higher costs are being lowered, it is hard to know how many people are leaving because of increased costs.

Q: What are the factors that play into the geographic rating? Whether there is a full array of providers?

A: There are numerous factors. Two major ones include utilization and cost per service in a particular area. Areas of the state have different provider practice patterns, which results in procedures having different costs and utilization rates depending on the area.

Comment: If we could get those differentials changed, we might be able to have an affect on the geographic differences. For back fusion surgery, there is a 500% range in costs across the state.

Comment: Every physician practices differently. What drives that regionally is exactly what makes one doctor better than another or makes one doctor different from another. It would be impossible to make all the doctors practice the same way.

Comment: Another thing is that individuals consume healthcare differently. People in a rural area may say they can't leave their farms for an appointment, while some urban workers can leave work for appointments more easily. A larger piece is cost per service. There are some areas where you have one medical provider and there is no competition, so costs are higher than in areas with a lot of competition. We have providers that charge significantly different rates for services than others. There are also differences in costs per case, which can be about six to seven times different. There are many factors that contribute to those differences, but it is hard to quantify them and understand specific cost per case differences.

Comment: If you look at the Medicaid program, we can normalize for price because we pay the same across the state. It would be interesting to compare the Medicaid data to private cost data to see how they overlap.

Comment: Public perception is that deductibles should stay the same and costs should not increase with inflation. People's perceptions don't match with reality.

Solutions

Solutions recommended by participants in the focus groups included: regulation, education, individual responsibility, tax credits, government subsidies/insurance, small business purchasing pools, high risk purchasing pools, premium assistance, and safety net approaches.

The conclusions of the focus groups, compiled by FGI Research included the following:

- Health insurance costs keep rising. All parties, including agents, employers, and the uninsured are concerned about affordability.
- There is recognition that the cost of healthcare for the uninsured has an adverse impact on insurance costs.
- Those needing the most immediate help with the cost of insurance include people with pre-existing conditions, dependent spouses and children, low-wage workers, and employees and owners of small businesses.
- All parties recognize that real solutions must involve all interested factions, including individuals, employers, healthcare providers, hospital administrators, pharmaceutical manufacturers, insurance companies, trial lawyers, and the government.

SMALL GROUP BREAKOUTS

PUBLIC OPTIONS

Pam Silberman, JD, DrPH

Facilitator

President and CEO, NC Institute of Medicine

Discussion topics:

- 1) Outreach and simplification
- 2) Review of Mercer actuarial analyses of public expansion options for adults and children
- 3) Discussion of Medicaid/SCHIP waiver options

- 4) Combining Medicaid expansion with premium assistance
- 5) Ways to encourage personal responsibility for health in publicly-funded insurance
- 6) Other options to expand publicly-subsidized health insurance coverage

PRIVATE INSURANCE OPTIONS

Barbara Morales Burke, MHA

Facilitator

Assistant Commissioner, NC Department of Insurance

Barbara Morales Burke reminded the group that the Task Force met last time, the private insurance ideas that seemed to have resonance among the group included tiered benefit plans in the small group and non-group market; the reinsurance approach, modeled on the Healthy NY plan; and the high risk pool. She noted that, as a result, these are the ideas that Mercer will analyze and cost out. Therefore, the group was tasked with providing Mercer with more specific parameters from which to cost the ideas. Beyond those ideas, the group can also discuss the rate band, encouraging personal responsibility for healthcare, and tax incentives if there is time. It may be possible to ask Mercer to look at those ideas later.

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

Regarding tiered benefit plans in the small group and non-group market, the idea is to provide Mercer with some guidance regarding the following:

- a. Price points (e.g., base at \$50/mo., additional options at approximately \$X/mo.)
- b. Should base package emphasize catastrophic, primary care, or both (with significantly reduced coverage)?
- c. How would this be operationalized (e.g., through pooled structure or as requirement that carriers provide choices to small employers)?
- d. What about mandated benefits? Should we recommend that the NC General Statutes be amended to give Insurance Commissioner the authority to approve products without mandated benefits (or with modified mandated benefits). If so, should that be limited to products offered to groups that did not have prior health insurance coverage)?

The idea here is that small employers would have access to an array of products from their employers. There could be different plan options for employees to choose from, but the idea is for employers to offer a base plan and then the opportunity for each employee to buy up from the base to get a different, enhanced package.

Ms. Morales Burke turned the group's attention to an example of a medical benefits tiered plan sheet, which offered three levels of medical benefits with weekly premiums ranging from \$1.80 for the employee and \$16.75 for the family per week to \$16.75 for the employee and \$81.95 for the family per week.

Comment: We offer a policy very similar to this. We have 275 employees and we have 5 people that are willing to take it. It costs them \$20 per week and the only reason they buy the insurance is because they are being forced to buy it for their children.

Comment: At least one insurance company in the area offers multiple options like this to large employers, but not for small employers. There is a lot of anti-selection within groups with fewer than 25 lives and it is very difficult to average the rates. In North Carolina, whatever a company offers to a 30-life group, it must offer to all similarly sized employers.

Comment: This example is an association product.

Q: For this example, is the employer contribution the same?

A: Yes

Q: What were the take-up rates where this is offered?

A: We haven't asked that.

Comment: Many of the decisions made by employees offered multiple choices are highly dependent on what the organization offered before they went into a multi-option product and what level the employer contributes.

Comment: In each of these options, it appears that the in-hospital benefit is capped.

A: Yes, that is true. This is not a catastrophic coverage plan.

Comment: There are probably at least two ways to come at developing a product. One would be having a catastrophic base coverage and allowing individuals to pay more to get others benefits. The other idea would be to offer a product with a base of services focused on lower-level chronic conditions and preventive care and then allowing the individual to pay more to get the catastrophic coverage. It would depend on what focus you would like to emphasize.

Comment: One insurance agent informed me that some carriers in North Carolina do offer this in the small group market. I don't know what approach (primary care or catastrophic) those carriers emphasize.

Comment: The spread in benefits is pretty much 15% or less for United. United does more business in the 25-50 employee sized market.

Comment: United also looks at a couple different options that focus on those ideas. It harkens back to the old cafeteria plan rules. You can pick a plan that focuses on catastrophic coverage or on one that emphasizes well-visits. You pick. That is not to say that these options are available everywhere. It gets into mandates- what you can and cannot cover. The bottom line for the consumer is, "I am willing to pay \$X per month, above that, it isn't worth it to me." That is the general response we get from most people. Based on income, that X changes. We are trying to figure out which benefits people in those strata most want. Then you have to reconcile that with offering a product/policy at a cost they can afford. Or are there barriers to

offering that product/policy because of state regulations? We can build something that follows state regulations, but it may price people out of the market.

Q: Where is the cost shifting occurring most? Is it at the catastrophic level or is it at primary care? We want to provide everyone with some base of care.

Comment: For low income people, paying for a health insurance plan with a \$5,000 deductible is not valuable because those individuals would be paying for something they wouldn't use. If they did have to use the plan, and pay the \$5,000 deductible, they would have to declare bankruptcy, anyway, and wouldn't pay for the healthcare services. Therefore, high deductible plans aren't attractive to low-income populations.

Comment: Yes, the plans we are offering aren't high deductible because they are mostly 80/20 plans. You also see the pool of people making more money, but without health insurance growing. That is why we are trying to focus on a whole range of product designs for people with different income levels.

Q: You are in the process of designing these?

A: We have some small group products already available. We developed National Health Access for larger employers in the HR policy association and the only people eligible for these plans are the currently uninsured (e.g., employees who are not currently eligible for coverage, such as part-time or contract workers). We are trying not to encourage employers to drop existing more comprehensive coverage, but to offer this to employees who are not currently covered under existing plans. What we were trying to do is to have the same target- the uninsured- in both the large and small employers. In most of these cases, the employers aren't necessarily contributing any costs to the insurance. We designed the plan assuming the employer contributes nothing. We are meeting with governors and regulators of different states trying to discuss with them how this is a good idea. Universally, every regulator and governor has said they love the idea and would support it, but some say they can't do it because their legislative or regulatory framework doesn't allow them to provide a plan that doesn't offer a certain set of services. The first level in the plan that we have designed is a discount card, which allows individuals to access the discounts that we already offer. The second level is primary care. We do not cover inpatient hospital care until the individual buys up to level three. The response from the regulators is that they think it is a great idea, but they can't necessarily do it. Some states that are highly regulated have figured out a way to approve it. We have not come to North Carolina, yet.

Q: What would be in our regulatory environment that would keep North Carolina from developing this type of plan?

Comment: The effort is for a finite group of the left-out employees within the GEs and GMs of the world. Can we bring that to the market for the general population? If so, do you then create a problem of the uninsured being replaced by the woefully underinsured?

Comment: Whether or not mandates are included, North Carolina is a low to medium mandate state. Some of our mandates are more essential services and others are less essential services that a very low percentage of the uninsured would use. Mandates may not ensure that a person will not become underinsured because it is still possible that one could be very disadvantaged, even in light of existing mandates. Lacking mandates doesn't mean that individuals will be underinsured.

Q: At what point is someone underinsured?

A: It is individual-specific and it depends on the point of time. They usually look at it within the past year.

Comment: You could define it somehow by taking some normal group of people, and determining that a chunk of them aren't going to be able to pay for the level of healthcare that they will need.

Comment: As we look at this approach, one of the problems is that there are different goals of insuring the uninsured. One is a social goal that we would like people to be insured so they can get needed services; the other is a fiscal goal, which is to protect the rest of us from the distribution of costs of their uninsurance. If you are trying to address the first, you want to focus on primary care, while if it is the second, you really want to cover the catastrophic interests.

Comment: Mercer developed a model product with an array of options for us to present at the focus groups. Within those options, some people combined the catastrophic plan with a limited benefit plan. This gets at people having wellness and protecting the rest of population through the catastrophic part.

Comment: The idea we are working towards is giving the employee the choice.

Q: How do you prevent adverse selection within a product like this?

A: Our underwriter would be able to explain it better, but essentially, an individual can buy into the lowest levels of the plan immediately, but cannot purchase the more comprehensive coverage levels until he/she has been in a lower level plan for one or two years. It focuses on having the client participate over a longer period of time.

Comment: A similar system is what helps large employers offer dental insurance- they obligate employee to participate for two or three years.

Q: How do we address Randy's situation, where a product is offered and no one chooses it?

A: The only way you will make this work is to make it mandatory. That is what Massachusetts is trying to do.

Comment: We need to give some targeting for cost for the product, direction to the base plan.

Q: Are there some kinds of health services that we know will lower the cost of healthcare for those who receive them?

A: We know that access to prescription services for individuals with chronic problems helps keep them out of the emergency department. Preventive services generally save costs.

Comment: Then, those services should be included in whichever product we recommend.

Comment: It is also a matter of getting people to go to a doctor's office for that service, rather than to the emergency department. Transportation is one of thing that has been a problem in the past. For an hourly employee, how do you get them to leave work, and thereby lose income, to get care?

Comment: It makes sense to build this product with a hole in the middle and have buying up in the tiers shrink the hole in the middle.

Comment: Similarly, if we are trying to price products and levels of coverage, I would like to start out with some payment towards a physician office visit and some equal coverage of those preventive services that have been shown to be cost-saving. Call those a health assurance package. Then, I would suggest we try to come up with a health insurance package that would be 80 or 90% of seven or ten days of inpatient hospital care. Cover the front end and back end. Then move up to high end surgical fees and put in a maximum. Suggest a single index of the mandates in North Carolina and price the mandates separately.

Q: What about prescription drugs?

Comment: Highly favored towards generic- two tiers with \$15 and \$25 copays and then with a third tier, a \$50 co-pay.

Comment: There are three buckets: The high users, chronic users, and low users. With the tiered concept, we would probably want the option for people to buy into it to close that gap.

Q: Can we price a product focusing on catastrophic and one on prevention separately and together? It may be worth looking at whether or not the preventive option works for some groups.

Q: Is there any sensitivity for universal coverage? Maybe attitudes towards mandated coverage would be different if we could quantify the savings of covering everyone.

Comment: \$50 doesn't necessarily have to be what we tell them is the target monthly cost. In 1988 and 1989 when we did focus groups, they also said that \$50 is what they could afford. This could really be higher.

Comment: We really need a partnership on this product, such that providers would accept lower reimbursement rates for care to individuals with this insurance product. Could you develop a situation where a provider would take less money than they do today for service coverage, in exchange for having protection on the other side? We need to protect the provider from the person who currently has no

coverage.

Comment: That is already being modeled in North Carolina through First Health of the Carolinas. Providers are accepting lower reimbursement rates for lower income patients. The hospital people are willing to invest on the insurance side. They have probably reduced the rate of uninsured by 10% in the entire county. There is a premium subsidy coming in from a grant and there is also a 100% participation requirement, which provides some protection.

Q: Would we want to put those types of provisions in our plan?

A: Yes, it would be helpful to price something like this.

Comment: It would be possible to do a pricing point at prevailing Medicaid rates to see what kind of flux there is on that.

Comment: It is hard to see why an individual would want to buy a product that would be a stretch financially, if it didn't provide a measure of comfort. The product offered needs to be valuable if you expect people to buy it. A lot of this conversation is technical, rather than looking at what consumers would want.

Comment: When we did focus groups in the early 1990s, employers said they wouldn't offer their employees an option for only a seven-day hospital stay, even though that would cover most of the average hospital stays.

Comment: If you have an average hospital and physician cost of \$10,000, which is low, that really comes to \$50 a month.

Comment: On the lower level plans of the tiered options being developed, there is no hospital coverage provided. If you want hospital coverage, that is a higher level. \$50 is for basic physician services.

Q: How do you keep people from buying down to this plan?

A: That is probably already happening because costs are increasing so much for insurance plans.

Q: Can you put a cap on who is allowed to buy this?

A: You could offer it only to employers with an average employee income below a certain level or you could put in participation type requirement.

The qualifiers should be that it is only available to employees working for small employers, with a maximum income.

Comment: We could make a recommendation to provide tax credits for individuals who fall into the group in the middle that wouldn't benefit from help on either end.

Comment: There may have been up-take in people buying insurance who didn't have it previously because of the price point. We think that people with somewhat worse

risks bought it because it was finally something they could afford. The average deductible is \$1500. In Kansas, \$1000 would be a large deductible, in North Carolina it is not.

Comment: We want to include some qualifiers to limit eligibility and benefit designs going up and down from the bottom and top with hole in the middle.

2) Healthy North Carolina (reinsurance)

Ms. Morales Burke explained that the basic idea behind a reinsurance product would be to sell a plan that would offer more basic benefits than what is currently available in the private market. Reinsurance would be funded by the state. Claims within a certain range would be eligible to be reimbursed. That would allow insurers to factor in the reinsurance, in order to reduce premiums and help with the affordability of the product.

This idea is currently being discussed in the North Carolina Senate. There is a draft recommendation developed by legislative staff based on the Healthy NY program, which has been in existence for five years. Many people feel it is a good concept that is worth adapting to North Carolina. When we talked about this last time, we discussed working through some of the fundamentals so that Mercer would know how to work up some cost estimates. In our discussion, we should answer the following questions:

- a. Should Healthy North Carolina be limited to employers or self-employed who had previously not offered health insurance? If so, how long should they have been without insurance coverage?
- b. Should Healthy NC be limited to employers with low-wage workforce? If so, how should we define low-wage workforce? What about participation requirements for low-wage workers?
- c. Should HNC be offered to solo-proprietors and/or uninsured individuals with a connection to the workforce? If so, how do we prevent adverse selection? (Is the current exclusion for pre-existing conditions sufficient or can we expand it?)
- d. What are the risk corridors that should be priced out? (NY is \$5,000-\$75,000).
- e. What benefits should be offered? If limited, how would it be limited? (e.g., mandate light? Annual or lifetime limits? Similar to the proposed limited benefit package developed for Medicaid?)
- f. Should there be limits to the length of time for which groups or individuals could receive the subsidized coverage?

In the New York model, the product is available to all small employers who have a certain percentage of their employees with incomes below \$34,000. That employer also must not have offered coverage within the last 12 months. Additionally, employees cannot have coverage through another source. Sole proprietors who haven't had insurance for the last 12 months are also eligible. In NC, the draft plan has no limitations to target small employers with fewer than 50 employees.

Comment: Do we know how much income the state receives annually through the premium tax on health insurance? I would propose reallocating income from the premium tax to support a reinsurance pool subsidy that would make this product more stable. How much revenue would that be?

Comment: The problem with that is that those paying the tax will be covering the costs for those who do not pay the tax because they don't offer insurance.

Comment: In addition, if we use the premium tax income to pay for the reinsurance, how do we pay for the programs/services that tax is currently being used to cover?

Q: What portion of small groups would qualify if it was 300% FPG (employee only, not family)? At various reinsurance levels, what is the percentage of claims would that generate?

Q: Why wouldn't you combine this with the tiered approach?

Comment: On the tiered approach, the catastrophic would match right into this.

Comment: The tiered product would have an annual maximum and this product would kick in above that maximum.

Comment: It would make sense to make the eligibility for the low cost, tiered plan the same as that for reinsurance. There could be some combination of the employer and employee paying the limited in-patient care portion. Once they get to some high costs level, state subsidized reinsurance would kick in.

Comment: The mandates in North Carolina allow for a lot of flexibility in terms of a tiered product. So, I am not sure how the tiered approach would benefit this, unless you say the state reinsurance would only apply to a certain level of the tiered product. We want Mercer to price the building blocks.

Q: What about the price corridor?

Comment: New York moved their corridor to attract more people because it had a greater impact on the premium.

Comment: If we are pricing something for \$50 this year, it will really cost us \$65 by the time it is implemented.

Comment: There are some things we can do to help healthcare costs go down, such as helping people manage chronic conditions. Whatever we design, I would like those things included in this model.

Comment: The Blue Cross Blue Shield Healthy Dividends model has five gauges, such as the body mass index, cholesterol level, and smoking status. On each of the five gauges, if the employee doesn't make a certain level, he must agree to do something to improve his health status in that area. This program says that if you are willing to take some responsibility, the employer will contribute more money towards your healthcare costs.

Q: Is there a statistic on what impact it would have on healthcare costs if each North Carolina resident had a physical?

A: No.

Q: Regarding the risk corridor: What level of claims do we think are reasonable and appropriate for asking the state to pick up the costs?

A: \$5,000 is too low.

Q: Do we know what our average costs are?

A: I think they are about \$25,000.

Comment: \$25K should be the lower end for the risk corridor. Benefits should be limited comprehensive. It would be good to price those out with and without prescription drugs and splits with generic and brand.

Comment: Generic drugs should be included in a tiered plan, with the ability to buy up to a richer tier with brand pharmaceutical benefits.

Ms. Morales Burke pointed out that the group would not have time to discuss the other topics on their list, including high risk pools, potential to change small group rating bands, and ways to encourage personal responsibility in the private market. However, she opened the floor up to quick comments on those issues and, particularly, any private option ideas that were not included in the workgroups discussion outline.

Comment: What about health savings accounts (HSA)? Instead of offering a specific number of office visits, you would put cash in an HSA and then it would be a matter of a person managing what they use their money on. An HSA combined with a high deductible plan.

A: HSAs do not work well with low-income populations.

Comment: We are not talking about attacking the uninsured issue through public education and public marketing. For any product to work, we will also have to start tackling these issues of public education and targeting a specific demographic or health issue. Lack of insurance is not just a product issue; it is also a public education issue.

PUBLIC OPTIONS TO EXPAND HEALTH INSURANCE COVERAGE

Pam Silberman, JD, DrPH

Facilitator

President and CEO

North Carolina Institute of Medicine

Dr. Silberman began the discussion by review Medicaid and NC Health Choice eligibility. Medicaid provides coverage to people who fall into the following categories

(pregnant women; children; aged, blind or disabled; caretakers, and medically needy) and also meet certain income and resource restrictions. Specifically, some of the major groups of people that North Carolina covers includes:

- Infants less than one year old with family incomes at or below 185% FPG
- Children ages one-to-five years old with family incomes at or below 133% FPG
- Children ages six-to-18 with family incomes at or below 100% FPG
- Pregnant women with incomes at or below 185% FPG
- Parents of dependent children with incomes at or below 37% FPG (TANF related individuals; TANF is Temporary Aid to Needy Families)
- People who are aged, blind, or disabled and have incomes at or below 100% FPG

NC does not cover childless adults regardless of low-income status.

In North Carolina Medicaid currently covers 1,138,352 individuals. Of this number, 412,470 are children, 22,850 are pregnant women, 316,143 are TANF recipients (children and caretaker relatives), 26,531 are aged, 217,882 are disabled or blind, 37,878 are under Medicare catastrophic care, and 4,598 are either in foster care, are refugees, or have breast and cervical cancer. NC Health Choice covers 130,694 children.

North Carolina could choose to cover children, pregnant women and parents with higher income limits. The following chart shows North Carolina income eligibility criteria as compared to other states:

State Medicaid income limits for children and pregnant women			
Medicaid income limits	Less than 200% FPG	At 200% FPG	More than 200% FPG
Children	CO (185%) ID (185%) MT (150%) ND (140%) OR (185%) WY (185%)	AL, AZ, DE, FL, IL, IN, IA, KS, KY, ME, MA, MI, MS, NE, <u>NC</u> , PA, SD, TX, UT, VA, WV	CA (250%) VT (300%) CT (300%) WA (250%) GA (235%) MD (300%) NH (300%) NJ (350%) NY (250%)
Pregnant women	AL (175%) SD (133%) AK (175%) UT (133%) AZ (133%) VA (133%) ID (133%) WV (150%) IN (150%) WY (133%) KS (150%) MT (133%) NV (133%) ND (133%)	CO, CT, FL, HI, KY, MI, MS, MO, NE, NH, NM, <u>NC</u> , OK, OR, PA, SC, TN, TX, WA, WI	AR (200%) MA (200%) CA (200%) MN (275%) DE (185%) NJ (200%) DC (200%) NY (200%) GA (200%) RI (250%) IL (200%) VT (200%) IA (200%) LA (200%) ME (200%)

State Medicaid income limits for children and pregnant women			
	OH (150%)		MD (250%)

State Medicaid income limits for working parents*				
Medicaid income limits	Less than 50% FPG	50-75% FPG	75-100% FPG	Greater than 100%
Working parents	AL (19%)	FL (62%)	AK (81%)	AZ (200%)
	AR (20%)	GA (58%)	HI (100%)	CA (107%)
	CO (39%)	KY (70%)	IA (82%)	CT (107%)
	ID (31%)	MI (59%)	MO (82%)	DE (117%)
	IN (29%)	MT (65%)	NV (87%)	DC (200%)
	KS (38%)	NE (56%)	OH (100%)	IL (140%)
	LA (20%)	NH (60%)	OR (100%)	ME (157%)
	MD (40%)	NM (69%)	SC (97%)	MA (133%)
	MS (35%)	NC (57%)	TN (100%)	MN (275%)
	NJ (41%)	ND (69%)		NY (150%)
	OK (45%)	SD (61%)		PA (200%)
	TX (33%)	WY (60%)		RI (192%)
	VA (36%)			UT (150%)
	WV (38%)			VT (192%)
				WA (200%)
				WI (192%)

* This is based on a parent's gross income.

Many eligible people do not enroll in Medicaid. Of the approximately 1.4 million uninsured people in North Carolina, an estimated 192,000 are children, 46,000 are uninsured adults with dependent children, 13,000 are uninsured pregnant women, and 4,000 are uninsured people with disabilities.¹ Many of these people may be eligible for Medicaid (or NC Health Choice), but have not enrolled in the program. These numbers are probably an overestimate of potential eligibles; but it is safe to assume that there are thousands of uninsured individuals who are eligible, but not enrolled. Every state has this situation. North Carolina is not unique in this regard.

Q: What are the federal rules around presumptive eligibility? Can you use presumptive eligibility to treat patients?

A: Presumptive Eligibility is used most for pregnant women and occasionally for children. Presumptive Eligibility the term used to describe the situation when impromptu Medicaid or NC Health Choice assessments are done in a clinic so people can receive treatment. Has there been any attempt to broaden this? Presumptive Eligibility is only allowed in certain eligibility categories. Is it

¹ Holmes M. Presentation to NC IOM Covering Uninsured Task Force, Apr. 2005. Based on 2001-03 CPS data.

limited by the provider types that can certify whether or not some is eligible for Medicaid or NC Health Choice (i.e. only public providers, community health centers etc.)

Review of Options:

Some of the possible public options to expand coverage to more uninsured individuals include:

- Providing outreach to and simplify the application process for those who are currently eligible for Medicaid or NC Health Choice.
- Utilizing Medicaid expansion options that do not require a waiver.
- Expand Medicaid of NC Health Choice through a waiver program.
- Providing premium assistance for private insurance policies to uninsured parents who fall within the income limits.
- Encouraging Medicaid recipients to take better care of their own health (“personal responsibility”)

Outreach and Simplification: There are a number of ways to expand outreach or simplify the program to make it easier for eligible people to enroll. One way would be to *increase the number of outreach workers* stationed at federally qualified health centers (FQHCs), local health departments, etc. Having more outreach workers in these locations could help identify eligibles as they seek care. Another way to simplify the application process would be to *eliminate the requirement for face-to-face application interviews* for adult coverage (i.e. for people who are blind or have disabilities and elderly people). The requirement to apply in person has already been eliminated it for children, pregnant women, and caretakers. Aged, blind and disabled still have to go to the county Department of Social Services to apply in person. *The application form for adults could also be simplified.* There is already a simplified four-page application form for children, pregnant women, and caretaker adults. There is a 14-page application for adults with larger type and more space between text for easier reading. The NC DHHS is pilot testing the simplified adult application and mail-in applications in the following counties: Cleveland, Duplin, Granville, Guilford, Forsyth, Onslow, and Wake. NC DHHS hopes to implement the process statewide in 2005.

Eliminating the asset (resource) test for low-income parents would also simplify the application process. People with low income typically do not have many assets. This option may also save the state money by decreasing the administrative burden in verifying the applicants’ resources. Countable resources include: bank accounts, stocks and bonds, real estate (home sites are excluded), cars (one car is excluded). There is no resource eligibility test for children or pregnant women. To qualify a family must have assets totaling no more than \$3,000. Twenty-two states have eliminated the asset test for parents. These states include: AL, AZ, CT, DE, DC, IL, KS, LA, MA, MS, MO, NJ, NM, ND, OH, PA, RI, SC, VT, VA, WI, and, WY. Most states have maintained asset requirements for the elderly and people with disabilities; as they are more likely to have accumulated assets than are low-income parents. In North Carolina, elderly or disabled

individuals can have no more than \$2,000 in countable assets, and couples may have no more than \$4,000.

Expanding the eligibility time frame from six months to 12 months is another way to simplify the process. This reduces the time and effort needed to recertify eligibility every six months. The state already provides continuous eligibility for children for 12 months, and for pregnant women (from the date that pregnancy is verified through two-months post partum). However, other groups (such as the aged, blind or disabled) have to be recertified every six months. The state could extend the eligibility period from six months to one year. Medicaid recipients would still need to report changes (for example, a change in income or family composition). But absent a change, the caseworkers would not need to recheck eligibility for a year.

Many states have also taken steps to *streamline the recertification process*. Instead of sending families a blank application (or recertification form), some states have moved to sending out pre-printed forms that ask the family to note any changes. Other states are attempting to have a passive re-enrollment (e.g., asking families to notify the state if they no longer want assistance or if their income or other eligibility factors have changed). Otherwise, the state provides ongoing coverage. North Carolina could look at ways to simplify the recertification process to make it easier for children, families, the elderly and disabled individuals to maintain coverage.

In states with passive reenrollment, the agency checks the state's employment and social security records to see if anything appears that the family not reporting. Georgia is using mail-in renewal forms for their S-CHIP program. Utah implemented a mail-in renewal process in Medicaid and S-CHIP for families who have steady employment (vs. fluctuating income). Hawaii has also implemented a mail-in renewal process now for Medicaid.

Most states (37) have implemented a 12-month eligibility period for families: AL, AZ, AK, CA, CO, CT, DE, DC, FL, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MS, MO, MT, NV, NJ, NY, OR, PA, RI, SC, SD, TN, VA, WV, WI, and WY.

Q: Does this work group want to address ideas to improve outreach and education?

A: The good thing about addressing this piece is that it will not require a lot of administrative money to implement these changes. However, cost increases would come because the more people would enroll.

Q: If you increase the resource limits for parents, would that help?

A: Not really, most people in these income categories don't have that many resources, so it won't necessarily help them by raising the resource limits. The savings come from eliminating the resource test for these individuals; as then the county agencies do not need to spend the time or resources trying to verify resource/asset eligibility. The current resource limit does not exclude many families/parents from coverage; its mostly an administrative burden to counties.

Comment: S-CHIP has had success with a 12-month period of enrollment. However, there are two types of 12 month enrollment. States have the option of providing 12-month continuous coverage to children (and to pregnant women throughout the pregnancy and for two months post-partum). States that provide continuous eligibility guarantee coverage to these individuals, even if their income fluctuates. However, a 12-month certification period only means that a person must come in and have their eligibility re-checked every 12 months (instead of every 6 months). However, they still need to report changes in their income (or household composition) if the change occurs sometime in the 12 month period. If a change occurs, a person may lose their eligibility. Its not clear whether the state could provide 12-month continuous eligibility to parents, or just a 12 month certification period. Children would be guaranteed eligibility, but parents wouldn't if their income level changed.

Comment: What if we recommended passive renewal (e.g., preprinted forms), and that the initial application didn't have to be done face-to-face. For parents and kids, it doesn't have to be done face-to-face, but it does for aged, blind and disabled do.

The work group was comfortable with most of the options for outreach and simplification.

Medicaid Expansion

Medicaid expansion without a waiver: States can increase the Medicaid income and/or resource eligibility limits to cover more children, families, pregnant women, and working disabled. Generally, the program must provide all the same services and be subject to same cost-sharing rules as for lower-income Medicaid eligibles. Enrolling new eligibles with a limited benefit package and/or charging higher cost-sharing would require a waiver.

Medicaid 1115 Waivers: Sec. 1115 of the Social Security Act gives the Secretary of Health and Human Services broad authority to waive SCHIP and Medicaid laws for the purpose of conducting pilot, experimental, or demonstration projects which are “likely to promote the objectives” of the program. States can seek healthcare reform demonstrations and use the savings to expand Medicaid coverage to additional people who would not traditionally be eligible for Medicaid (e.g., childless adults). However, 1115 waivers must be budget neutral to the federal government.

States with 1115 waivers include (2003):			
State	Who	Number with Traditional Coverage	Number with Expansion
AZ	Adults with incomes less than 100% FPG	904,209	122,998
DE	Childless adults age 50-64 and with	123,660	12,735

States with 1115 waivers include (2003):			
	incomes less than 50% FPG		
HI	Adults <100% FPG	183,613	20,679
MA	Children, families, and disabled with incomes less than 150% FPG, long-term unemployed >12 mos, childless adults with incomes less than 133% FPG	928,186	89,358
MN	Parents and children with incomes less than 275% FPG	546,752	87,033
MO	Adults transitioning off welfare who are not otherwise eligible for Medicaid with incomes less than 300% FPG, uninsured custodial parents with incomes less than 100% FPG, certain uninsured non-custodial parents with incomes less than 125% FPG	980,455	101,386
NY	Parents up to 150% FPG, childless adults with incomes less than 100% FPG	3,743,119	346,392
OR	Uninsured adults with incomes less than 100% FPG	410,312	49,067
RI	Children up to 250% FPG	181,432	18,453
TN	Uninsured adults up to 100% FPG, others(adults and children) may be eligible at higher income limits if medically uninsurable	1,326,453	261,447
UT	Adults 19-64 who have been uninsured for 6 months, annual income with incomes less than 150% FPG eligible for limited benefit package	195,793	18,879
VT	Uninsured adults with incomes less than 150%, children b/t 225-300% FPG	128,954	32,900
WI	Uninsured children and parents with incomes less than 185% FPG	772,282	114,222

Source: CMS. States with Comprehensive Statewide Health Care Reform Demonstrations as of Dec. 31, 2003.

In 2003, individuals covered under the 1115 expanded coverage equalled between 8-20% of all Medicaid eligibles in the state.

Q: Are other states getting people into these programs?

A: Yes, but none of the states have had huge expansions. These demonstrations have not been operational long. Utah has a more recent expansion that provides a very limited primary care package to new eligibles. Some of the recent expansions have been financed by cutting services to existing eligibility groups.

Q: Has being uninsured become a norm and not considered a risk to people?

A: There is probably is a subset of people who would choose not to buy health insurance, we but think most would buy a product if they could afford it.

Health Insurance Flexibility and Accountability (HIFA) waivers are a subset of 1115 waivers. States can use HIFA waivers to limit coverage or charge additional costs (premiums, copays, etc.) to optional groups. However, states must continue to cover mandatory populations and offer mandatory services, with limited cost sharing. Any savings from reduced benefits or additional cost sharing can be used to expand Medicaid to cover additional populations, however, the focus of the expansion should be to people with incomes less than 200% FPG. The expansion must also operate statewide, and must be cost-neutral to the federal government.

CMS requires states to explore premium assistance programs in approving HIFA waivers. (Premium assistance programs use Medicaid and/or SCHIP funds to help pay the individuals premium costs for private insurance coverage). As of March 2004, nine states had HIFA waivers that covered additional eligibles.

The 1115 waiver cost neutrality can be determined either on a projected per-person-cost basis or a global cap basis. Waivers that are used to expand Medicaid to groups that could otherwise be covered under traditional Medicaid (e.g., pregnant women, children, parents, elderly or disabled with higher incomes) are determined based on a per-person cost-basis; the per person costs for the Medicaid-eligible individuals may not exceed the amount the state would have spent for groups covered by Medicaid prior to the waiver (plus an agreed upon trend factor). Federal funds are limited to the amount per Medicaid eligible that has been negotiated with the federal government (for example, if the approved waiver assumes the state would spend \$3,000 per eligible individual, then the federal government will contribute its share of the per-person amount). The total amount the federal government contributes is based on the total number of eligibles—if the number of eligibles increases, the federal government pays more. In contrast, cost-neutrality for 1115 waivers that are used to expand Medicaid to cover non-traditional groups is determined based on a global cap. With the global cap basis, CMS will determine how much the program would have spent in total costs over five years. States potentially are more at risk through the global cap, as the state does not receive more money if the number of traditional Medicaid eligibles grows. Further, states do not receive any additional federal funds for expansion groups (e.g., non-Medicaid eligibles) covered by the waiver. The state must use program savings to cover these costs.).

Review of Mercer actuarial analysis of expansion options

Mercer developed cost estimates for two expansion options: (1) Medicaid full-benefit expansion option, and (2) a Medicaid limited-benefit option. Mercer estimated costs for expanding the program to cover parents who have incomes between 37-100%, 101-200%, and 201-300% FPG and for children with family incomes between 201-300% FPG (as NC Health Choice already covers children with incomes up to 200% FPG).

The full Medicaid coverage would include a sliding-scale premium capped at 1-4% of income for individuals and 2-8% of income for families. We didn't feel like we could ask the NC General Assembly for an expansion without also including a premium for the beneficiaries. The sliding scale would have people with the lowest incomes paying the least (both in actual dollar amount and in proportion to their income).

The Medicaid limited-benefit plan would provide less comprehensive benefits and greater cost sharing. The limited-benefit plan estimated costs would include behavioral health and offers two alternatives: (1) an inpatient deductible of \$5,000 annually and (2) an inpatient limit of \$10,000 annually. Because the benefits are less comprehensive and there was greater cost sharing, the premium was capped at: 0.5-2% percent of income for individuals and 1-4% of income for families.

Q: Do these estimates include ways to further reduce health care costs? A: No. These estimates are based on 2001-2003 Medicaid data, which are trended forward. It includes some limited cost-savings from CCNC, however, CCNC was relatively new and was not operational statewide. Thus, this estimate does not capture all of the potential savings from statewide implementation of CCNC. Nor does it include other cost-savings mechanisms (such as strict formularies or more intensive utilization review).

Q: Will these additional items be considered as part of final package?

A: Yes they can.

Covered Services		
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)
Specialty physician	Covered (\$3 copay) (24 visit limit/yr)*	Covered (sliding scale copay: \$20, \$40 for below/above 150% FPG)(24 visit limit)
Inpatient behavioral health hospital	Covered (no copay) (excludes state psych hospitals for adults 21-64)	\$5,000 deductible or \$10,000 total; 20% coinsurance
Outpatient behavioral health	Covered (\$3 copay for private psychiatrists), prior approval after 8 visits (adults), 26th visit (children)	Covered. Sliding scale copay (\$20, \$40 for below/above 150% FPG) 20% coinsurance, 20 visit limit/yr.
Behavioral health other	Covered	Not covered

Covered Services		
Pharmacy	Covered (Copay for adults: \$1 generic/ \$3 brand); 6 script/mo. Limit*	Covered: \$15 copay (generic), \$25 (brand), \$60 (brand, non-formulary)(6 script limit/mo.)*
Family planning	Covered (no copay)	Contraceptives only
Case management	Covered	Community Care of North Carolina only
Home health	Covered	Not covered
Personal care	Covered (3.5 hrs/day or 60 days/mo.)	Not covered
School based health services	Covered	Yes, to extent school is provider of covered services, same cost sharing as with primary care physician
Lab & radiology	Covered, no copay	Covered, 20% coinsurance; requires pre-authorization of MRI/PET scan
Dental	Covered, no copay	Not covered
DME/Supplies	Covered (prosthetics/ orthotics for children <21 only)	Covered, 20% coinsurance. \$500 limit (diabetic supplies unlimited)
EPSDT	Covered, no cost sharing for any services to children	Well visits and immunizations only
Ambulance	Covered, no copay	Covered, \$150 copay (waived if admitted), 20% coinsurance
Maternity	Covered, no cost sharing for pregnant women	Covered prenatal care only for adult women with incomes >185% FPG (<185% covered by Medicaid); not covered dependents (already covered by Medicaid).
Annual benefit limit	None	\$1 million
Out-of-pocket maximum	Limited, because limited cost sharing allowed in traditional Medicaid	None

* 24-visit limit includes physician visits, outpatient clinics, optometrists, chiropractics, podiatrists. Exceptions made for life threatening or certain other chronic conditions (uncontrolled diabetes, sickle cell, chemo, end stage renal or lung disease, hemophilia.) Copay and visit limits only apply to adults.

*6-prescription/limit per month for adults. Exceptions for life threatening conditions or chronic conditions (same as for ambulatory visits).

Medicaid Expansion: Full Benefit Plan (CY 2006)

	Low Range	Projection Estimate	High Range
37% to 100% FPG			
Adult PMPM	\$492	\$528	\$589
101% to 200% FPG			
Adult PMPM	\$475	\$510	\$570
201% to 300% FPG			
Adult PMPM	\$461	\$494	\$552
Child PMPM	\$240	\$257	\$265

Key drivers of uncertainty: participation level/selection, demographic mix, and workforce effect.

Mercer developed two benefit packages for catastrophic (hospital) coverage: (1) a \$5,000 inpatient (IP) deductible and (2) \$10,000 total inpatient limit. There would be significant coinsurance and cost sharing for the limited plan. See the following tables.

Medicaid Expansion: Limited— \$5,000 IP Deductible

\$5,000 Annual IP Deductible	Low Range	Projection Estimate	High Range
37% to 100% FPG			
Adult PMPM	\$272	\$305	\$346
101% to 200% FPG			
Adult PMPM	\$261	\$292	\$331
201% to 300% FPG			
Adult PMPM	\$250	\$280	\$318
Child PMPM	\$132	\$147	\$155

Key drivers of uncertainty: participation level/selection, cost sharing utilization discouragement, demographic mix, and workforce effect.

Medicaid Expansion: Limited — \$10,000 IP Limit

\$10,000 Annual IP Limit	Low Range	Projection Estimate	High Range
37% to 100% FPG			
Adult PMPM	\$289	\$324	\$367
101% to 200% FPG			
Adult PMPM	\$277	\$310	\$351
201% to 300% FPG			
Adult PMPM	\$266	\$297	\$337
Child PMPM	\$141	\$157	\$165

Key drivers of uncertainty: participation level/selection, cost sharing utilization discouragement, demographic mix, and workforce effect.

Q: Is this an annual benefit of \$1 million? Or is this a lifetime cap?

A: We are not sure. We can check.

Q: Can we be sure the state would not pick up work-related healthcare costs?

A: Medicaid is the payer of last resort.

Q: Is the 24 visits the total for all provider visits? It seems high.

A: Yes, it covers physician visits, outpatient clinics, optometrists, chiropractics, podiatrists. Exceptions are made for life-threatening or certain other conditions (uncontrolled diabetes, sickle cell, chemo, end stage renal or lung disease, hemophilia). The visit limits only apply to adults in the regular Medicaid program.

Q: Do you want to reduce number of visits generally, but allow exceptions for people in CCNC with chronic care?

A: It can be an incentive for people to manage their care better. It works for the asthma management plan at BCBS.

Q: The per member per month estimates look high.

A: This is because this is for the full Medicaid benefit package; not the limited benefit package. Also, it's important to note that the per member per month costs go down as income goes up, because people with higher incomes are generally more healthy.

Comment: In developing their estimates, Mercer identified that male TANF recipients enrolled in Medicaid had higher healthcare costs than Mercer has seen anywhere else. We surmised that some of the TANF males may have substance abuse or

mental health problems, and would not be generally reflective of the costs associated with a working male population. Thus, Mercer used utilization data from a working population in developing the estimates for the expansion group (for the adult men).

Q: The Medicaid limited-benefit program does not offer coverage for dental services, eye glasses, etc. Did Mercer price these items?
A: No. We have no idea how much more it would cost to cover these services. Part of the idea was to develop a product that what the NC General Assembly would support. If people in the regular market don't have vision care, etc., then it will be hard to sell.

Q: Will this also cover out patient hospital care?
A: Yes.

Q: In the limited-benefit plan, how are services covered after the beneficiary pays the deductible?
A: With the \$5,000 deductible plan, the beneficiary would continue to pay the 20% coinsurance. There is no cap on the coinsurance. With the \$10,000 limit plan, the beneficiary would have to pay any medical costs after the \$10,000 limit was met in that year.

Mercer Public Sector Policy Option Cost Estimates: Summary of Results

	Full Benefit Expansion	Limited Benefit Expansion (\$5,000 IP Ded)	Limited Benefit Expansion (\$10,000 IP Limit)
Total Cost Estimate	1,017,655,000	350,123,000	371,866,000
Federal (63%)	641,122,650	220,577,490	234,275,580
State (31.5%)	320,561,325	110,288,745	117,137,790
County (5.5%)	55,971,025	19,256,765	20,452,630
New Eligibles			
Adults	156,000	93,583	93,583
Children	17,583	10,500	10,500

Comment: Regardless of which expansion option we choose, this plan would still add over \$100 million to state costs.

Q: Is it cost neutral per individual for the federal government?
A: For the federal government.

Q: With the full-benefit expansion, is this everyone that would possibly qualify?
A: No. The estimated premiums are based on an assumption that only 50% would participate for the full Medicaid expansion, and only 30% for the limited Medicaid benefit package.

Q: If 50% participate, what percent of the uninsured would this be?

A: If all the estimated adults and children participated and were previously uninsured, it would reduce the numbers of uninsured by 12.4%.

Comment: It's expensive.

Comment: If we do the full expansion, it's still not that much more expensive for the state because the federal government pays the largest share of the costs.

Q: Can we assume this expanded coverage is for people with no coverage?

A: No, but we could have a waiting period to avoid crowd out. Also, we could help reduce crowd-out by simultaneously implementing a premium assistance program (which would help pay the employee's share of an employer sponsored insurance plan).

Comment: In bottom tier you might see spouses move out of the State Health Plan into this plan. We could pay for most of this with 50 cent increase in the cigarette tax.

With the limited \$10,000 IP plan, \$324 is the monthly cost to provide this coverage to one adult beneficiary. The low-income beneficiary would be responsible for a premium that is about 1% of their income on an annual basis for individual coverage, or 2% for family coverage (higher income individuals may have premiums that amounted to 4% of their income, or 8% of their income for family coverage).

Q: So for \$130 million we could cover 100,000 people with a limited benefit package?

A: Yes.

The estimates only include the health care (claims) costs, not the administrative costs. So the total cost would have to be increased by approximately 2%-3% to include administrative costs.

Q: Does the work group want to make a recommendation about expanding Medicaid to parents or children?

Q: What about covering childless adults?

A: If you start covering childless adults, costs will be higher because they will be older and therefore sicker.

Comment: I like concept of limiting physician visits and being able to expand a beneficiary's visit limit based on their participation in disease management efforts. This makes disease management a requirement without making it a requirement.

Q: How many physician visits is ok? Where did the number 24 come from?

A: We really don't have limits anyway because if people need/want it they get exempted.

Q: Does the limit protect program gaming? If it's not a real limit then it doesn't work.

Comment: I think we are better off looking at specific services than at global limits.

Q: If you are a patient with congestive heart failure. Would you go see a doc 24 times a year?

A: No but this is every provider combined together. You might need to make 24 visits to different types of providers.

Comment: Who gets the visits the fastest? It's a competition for who gets patients in more often. If Medicaid fees are low, then providers generate more visits. The decisions we make here will shift costs to the private market. If there is a \$5,000 hospital inpatient deductible, people will not pay their share so then there will be uncompensated care and physicians will shift the costs to insurance company negotiations and so on.

Q: Isn't private sector already paying for this with already uncompensated care for uninsured?

Some adjustment of pent up demand is built into the estimates.

Q: How much of total costs is hospital inpatient care? If you had a \$1,000 deductible for inpatient hosp care how much more would that cost?

Comment: This is really a subsidy. The cost shift will continue, but it's getting harder since there are fewer people to spread costs among. Disease management will have to reduce the number of people who end up in hospital.

Q: What is a reasonable way to address this utilization that make s it harder to game and incentivizes people to participate in disease management?

Comment: If NC wants to go it alone to try to expand coverage in the face of inaction on the federal side, then we will have to make some serious compromises. We can always change it later. Most people with insurance coverage has better benefits than the limited plan, but for someone who has no coverage at all, this is something.

Comment: BCBS data does not support the myth that if you provide people with preventive benefits, they will use them. Only one out of seven of BCBS beneficiaries are using covered preventive services.

Comment: On average, Medicaid beneficiaries turnover after nine months so the state doesn't have long to work on disease management.

Q: DHHS is trying to move 0-5 year olds with family incomes less than 200% FPG from NC Health Choice to Medicaid. Can we recalculate these numbers putting these kids on the full Medicaid instead of in this plan or NC Health Choice? If NC moves these kids to full Medicaid, but offers a limited Medicaid product to their parents, does that make an impact on the limited-benefit plan costs.

A: These estimates are only costing-out children with family incomes between 200-300% FPG so they are not part of the group of children being moved.

Comment: The Emergency Department copayment is to discourage utilization, not to penalize the provider. If we include a copayment, we shouldn't penalize hospitals for their inability to collect the copayment, since the hospital is required under federal law to see everyone who comes to the emergency department.

Q: Of the two packages, is there a preference the NC Hospital Association would have?

A: I don't know. If inpatient hospital services are the only service covered then maybe the lower one (e.g., \$5,000 deductible), but if it includes inpatient and outpatient services, then higher (e.g., \$10,000 limit). Currently this population is paying nothing.

Q: What will this do to DSH payments? Would it eliminate the ability to collect DSH?

A: This would reduce Medicaid deficit if we could collect it. I don't know, but we should get that answered. Where it comes from is not important as long as you get paid.

Q: It makes sense to go with one of the packages, and the question is which catastrophic plan should you go for?

Comment: We do not expect a difference in hospital utilization because of this plan since people are not admitted for voluntary reasons.

The group came to a consensus agreement on of the concept of expanding Medicaid to parents in some form. It is not ideal, but it moves us forward.

Q: Should we to recommend full or limited plan?

A: The only way it has a chance is to recommend limited package.

Q: Where do you obtain the cost savings?

Comment: If you recommend full benefit package to the NC General Assembly and use the limited package as an alternative, you can point out what a great deal the limited package. It provides a comparison point.

Comment: The purpose of this Task Force is to reduce the number of uninsured. If you recommend a full-benefit plan, then you can reduce the uninsured by larger numbers. The limited plan reduced the numbers of uninsured, but not as much.

Q: Do you want to make a priority recommendation? If the NC General Assembly has to choose between expanding it to one population versus another, should children be first or parents or should it be income-based? Then we can get to how we can further refine the package to build in more utilization control, etc.

A: We should make it a priority that parents be the first group covered. We should start with lowest income group of parents because it will help the overall compliance of the family.

Comment: We should encourage participation in CCNC, but what is the base point (number of visits)?

Q: Why can't we mandate that beneficiaries enroll in CCNC. What does enroll mean? It really means they have to be compliant. Do you kick them out, charge them more, limit benefits, or what?

A: Kick them out if they don't participate in CCNC.

Comment: BCBS charges no copay for generic drugs. Most BCBS beneficiaries switched to generic drugs when this change occurred. It has been an effective strategy.

Q: Can you waive copays for certain types of visits as an incentive for preventive care or disease management?

Q: Can we get some ideas for these strategies from DMA to think about it and talk about it at next meeting.

Comment: This task force should answer the question of whether or not to mandate CCNC participation.

Comment: We should mandate Medicaid home (CCNC) and disease management and use copays to help create other behaviors we want.

Comment: The Task Force can make the decision but needs some suggestions about what the incentives should be.

Comment: It would be nice to impact the parents of the children because the family needs better health and family involvement might enhance overall compliance. Do the requirements limit the number of people that will be eligible.

Q: Can we require that people not be smokers?

A: No, not under HIPAA—it would be discrimination based on health status and addiction.

Q: Can we mandate they participate in cessation plan?

A: We can probably mandate that they participate in a smoking cessation program, but not that they quit smoking (as addiction to tobacco is a health status factor and plans can't discriminate against individuals based on health status).

Comment: We also need to decide how many physician visits the plan should cover unless the person has an exemption. We could reward beneficiaries for getting an annual physical by waiving the copay or by awarding them additional visits.

Comment: Costs are assuming a 50% participation rate. During the first years, we don't expect to enroll that many. What Mercer has estimated is the mature program in FY 2006. Do we want to add more projections and shape it for what we think the first year would really cost?

A: Yes, but we also want to present both options for maximum number of people.

Comment: We should link the limited-benefit package to required CCNC participation (e.g., the person must pick a medical home and enroll in CCNC, if eligible). We can figure out ways to provide incentives for active participation. We could build in one wellness visit per year with no copay. We can work with CCNC to determine incentive options.

Comment: We should also work with the Task Force to decide on the best physician-visit number, but at some point we will just have to pick a number.

Comment: The priority is to push hard on getting up to 200% for the parents. It works for so many good reasons.

Comment: It would help if we can quantify what these people cost not having insurance. Then we could show the money saved by covering them.

Medicaid/SCHIP Premium Assistance Programs

States can use Medicaid/SCHIP funds to help pay the premium costs to enroll Medicaid or SCHIP eligible individuals/families into employer-sponsored insurance (ESI). Generally, states must “wrap-around” coverage and costs, to ensure that Medicaid/SCHIP eligible individuals receive equal coverage and pay no more than would be required under public insurance (e.g., “hold harmless”). However, states are not required to provide “wrap-around” services or help with additional costs if the premium assistance program is implemented as part of a waiver.

States must show enrollment is cost-effective—e.g., a state must spend no more in a premium assistance program than in their regular Medicaid/SCHIP program. Sixteen states operate premium assistance programs: CA, GA, IA, IL, MA, ME, MI, MO, NJ, NM, OR, PA, RI, TX, UT, VA, and WI.

Q: How do you keep employers from having a perverse incentive to reduce their premiums or decrease benefits?

A: Employers would have to do it across the board to all their employees. An employer cannot discriminate based on income. Employers with a lot of low-

wage workers could make this shift though, but the change would affect all their employees—not just those eligible for premium assistance. Also, if it's not cost effective to the state, then the state can't provide the subsidy.

Q: Is there any reason for us not to offer voluntary choice in a public-private partnership?

A: Yes. This is a subsidy for people who couldn't afford to pay for private coverage on their own, but have the option of getting private insurance.

Q: Can you require a period of ineligibility?

A: Yes, if part of a waiver program. However, it's not clear why a state would choose to do this if the premium assistance program is a cost savings to the state. This is not a problem of "crowd-out" as the employer is still providing health insurance. Premium assistance programs only help pay the employee's share of the employer-sponsored insurance.

Comment: Premium assistance should be voluntary and should not include wrap around. We would need a waiver to do this, because otherwise a state would need to provide wrap around services.

Personal responsibility

CCNC provides care and disease management to individuals with chronic or high-cost health problems. Disease management activities include: asthma, diabetes, high cost/high risk, emergency department, and ambulatory sensitive inpatient utilization. Programs for congestive heart failure (CHF) are being developed, and programs for chronic obstructive pulmonary disease and obesity are in planning for statewide implementation.

CCNC is anticipated to be statewide by the end of 2005. Disease management and care management services are offered to target populations, but there is no penalty for failing to participate. Traditional Medicaid covers: certain smoking cessation drugs, bariatric surgery for obesity (with prior approval). 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).

CCNC had 643,000 enrollees by end of June 2005.

Comment: The military finally requires HRAs (Health Risk Assessments). Maybe regular Medicaid should do this too. The state can loosen some of limits if people have for their wellness visits and an HRA. There is data on this but only in the context of employer wellness plans, not for this population.

Comment: One problem with the existing CCNC program is that you need to wait for claims data to identify people in need of case management or disease management (e.g., to identify people with asthma or diabetes). One of the advantages of a HRA is that you

could identify individuals with health risks earlier, and start providing preventive services. The HRA data would need to stay at the local level.

Q: What does it mean in terms of added costs?

Comment: It's hard to do with a large number of people. Having an HRA for everyone would be administratively difficult.

Q: Will the average length of stay in Medicaid affect the benefit of this?

A: No because they don't leave the community practice. You can still make a difference. Could you do the HRA when you complete the Medicaid application form?

Comment: The State Health Plan is working on an HRA.

Q: Do we want a preferred drug list (PDLs)?

Comment: It would be better to expand PAL (a list of medications, by class of drugs, that gives information to providers on the cost of the different drugs). Most savings on PDLs are on key classes of medications. It has to do with spread on the costs of the drugs in the class. Some classes have larger spreads and that's where you can save a lot of money. The key to cost savings is to get physicians to prescribe lower cost drugs in the same class of medications.

Q: Should we say Medicaid-eligibles don't have to pay the copay for generics in order to encourage use of generic drugs?

Comment: Most of the medications that are prescribed in North Carolina are generics (when generics are available).

Summary

- The group agreed that outreach and enrollment simplification should be used to facilitate people who are already eligible to enroll in Medicaid/SCHIP.
- The group agreed that DHHS should seek a Medicaid expansion waiver to cover parents with incomes up to 200% FPG, with a limited benefit package
- The group agreed that premium assistance should be recommended.
- The group also agreed that there should be a level of personal responsibility.