

NC IOM Task Force on Covering the Uninsured

June 24, 2005

Cary, NC

Meeting Summary

Members: Tom Lambeth, Andrea Bazan-Manson, Millie Brown, David Bruton, Leah Devlin, Allen Feezor, Charles Frock, Bob Greczyn, Ches Gwinn, Bill Ray Hall, Ann Holton, Rep. Verla Insko, Robert Jackson, Connie Majure-Rhett, John Mills, Graham Moore, Barbara Morales Burke, Barbara Pullen Smith, Lynette Rivenbark Tolson, Jack Rodman, Eric Russman, Randy Rust, Wanda Sandel , Adam Searing, Russ Stephenson, Judith Tintinalli, Leslie Winner, Doug Yarborough

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

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

Guests: Beth Brinkley, Time Doyle, Gustavo Fernandez, Alan Hirsch, Kathy Holladay, Stacey Lampkin, Joy Reed, Kirsten Thompson

WELCOME

Tom Lambeth

Task Force Co-Chair

EMPLOYER SPONSORED INSURANCE IN NORTH CAROLINA

Mark Holmes, PhD

Research Fellow

Cecil G. Sheps Center for Health Services Research

The University of North Carolina at Chapel Hill

The focus of the presentation is on small employers. Dr. Holmes informed the task force that he would review the relationship of firm size and rates of uninsurance, premium costs for various firm sizes, factors that affect offers and take-up rates of employer sponsored health insurance and issues surrounding dependent coverage.

Firm Size and the Uninsured

Firm size is a key factor in employer sponsored insurance (ESI) coverage. On average, only 10% of employees of large firms lack health coverage. Employees of small firms are more likely to be uninsured. About half the uninsured workforce is employed by a small firm (less than 25 employees).

Premiums

There are some important caveats about these analyses. First, the definition of a small firm varies considerably across different datasets, from under 50 employees to under 10 employees. Also, it is difficult to get apples to apples premium comparisons across

states, as we cannot control for differences in the benefits covered, cost of medical services or impact of state regulation. Also, the available premium data reflects information for only those individuals covered by health insurance. Almost no information is known about the premium costs of plans that individuals are choosing not to purchase. For the purposes of this presentation, premiums will be discussed as averages across states in the south Atlantic region.

Total premium costs: North Carolina has the highest premium costs for small firms in the region (those with fewer than 50 employees); only small firms in Delaware pay higher premiums. In contrast, North Carolina has one of the lowest average premium costs for larger firms (50 or more employees). Only Virginia has a lower premium costs than North Carolina for large employer group policies.

On average, the total premium costs for all firms in North Carolina are about the same as other states in the Southeast. The primary reason that North Carolina's overall average premium cost appears more affordable is that the state has more employees in large employers than other states in the region.

Employers' share of premium costs: On average, North Carolina employers pay the third highest average premiums in the region. Small NC employers pay the second highest premium, but large NC firms pay the second lowest.

Employees' share of premium costs: As for employee costs, individuals working for small firms in most of the Southeast states pay a lower premium than employees in large firms, but not in North Carolina. Employees in North Carolina pay about the same amount of premiums independent of firm size. On average, employees in small firms in North Carolina pay 16% of total premium costs.

In sum, small firms face higher premiums. North Carolina small firm premiums are the most expensive in the region. Policy efforts targeting small firms may need to address the problems of both the employer and employee, as both confront comparably higher premium rates in the small group market.

Q: It's important to examine underlying health care costs, and not just health care premiums. Are there any data to see how health care utilization or spending for insured populations in NC compares to other states in the Southeast?

A: That issue can be explored further and findings can be reported back to the task force at a future meeting. There are few data related to this issue available, although we are continuing to look for more.

Q: Is there any way to examine premium costs by industry?

A: Data exist which notes premium trends among various industries, but they are highly protected by the Agency for Healthcare Research and Quality (AHRQ). AHRQ does publish public tables that include general information on industry premium rates. However, with available data, premiums can only be examined using industry averages or firm size data, but not both together.

Comment: The task force keeps referring to 1.4 million uninsured non-elderly individuals in North Carolina. Some portion of this is individuals who are employed but lack health coverage. How many people out of the total number of uninsured work for small firms? How many of the 1.4 million uninsured would be captured by the data in this presentation?

A: The presentation refers to those individuals who are employed, or the state's active workforce. Of the 1.4 million uninsured, approximately 430,000 are employed in a small firm. An additional 230,000 uninsured are in a family with at least one person employed in a small firm. Of course, not all the 230,000 may be eligible (for example, non-elderly parents are included in the 230,000 figure).

Offer and Take-up of Employer Sponsored Insurance (ESI)

The next section of the presentation discusses the relative frequency of ESI coverage among those who are employed. Typically, an individual fits into one of four categories: their firm does not offer health insurance; their firm offers but the employee is ineligible; the employee is eligible but declines coverage; or, the employee is covered by ESI. There are three decision points in the provision of employer sponsored insurance. First, there is the question of whether the employer will offer ESI, which is largely affected by firm size. Second, if offered, which employees will be eligible for coverage. Finally, if offered, does the employee choose coverage ("take up.") The take-up rate is largely influenced by the amount the employer contributes toward employee and dependent coverage, and how much it costs for the employee directly.

North Carolina has a higher rate of enrollment in ESI than any other South Atlantic state: approximately 60% of *all* private employees in North Carolina are enrolled in health insurance coverage. However, this figure masks important differences between large and small firms. Most NC employees at firms with more than 50 employees (65%) are at firms that offer ESI. (More than 95% of these firms offer coverage, about 18% are not eligible for coverage, and another 15% are eligible but do not enroll.) For large firms, the biggest "friction" is not whether to offer ESI, but who will be eligible for it.

For smaller firms, the "offer" decision is more important. Fewer than 60% of individuals who work in NC small firms are offered health insurance coverage. Only SC has a lower offer rate. However, employees who work for small firms that do offer insurance are more likely to be eligible, and more likely to enroll. Thus, NC small firm employees are near the top in terms of enrollment NC employees who work for small firms with fewer than 10 employees are less likely to be offered coverage, and less likely to be enrolled when offered. Only South Carolina has a lower offer or coverage rate than North Carolina.

Q: Does the data presented to the task force refer to coverage for just the employee, or does it also include dependent coverage?

A: It is just targeting employee coverage. Dependent coverage will be discussed later in the presentation, but it should be noted that dependent coverage in general is a bit more difficult to address.

Q: Does the data on the number of private sector employees enrolled in ESI include those who work part-time?

A: Yes.

Q: In terms of coverage rates, does that data refer to percentage of employees covered or percentage of firms that offer coverage?

A: It refers to percentage of employees covered.

Comment: North Carolina appears to be good from the average standpoint, because North Carolina is a large firm state, according to the categories of the data used in this analysis.

Nationally, approximately 32% of employees are not offered ESI through their current main job, but this varies widely by firm size. Of those who are offered coverage, 92% accept it. Of those who refuse coverage, roughly half are covered by some other source.

Previous task force presentations provided data focusing on North Carolina, but the ability to do that in terms of health insurance premiums is much more limited. The Medical Expenditure Panel Survey, the primary dataset used for this analysis, does not identify states to the public. This information can be obtained, but it is highly guarded and it requires formal approval. From the limited analysis that has been conducted on North Carolina data only, trends are not significantly out of line with those at the national and regional levels.

Employees in all sizes of small firms are much less likely to be offered ESI coverage. Only about one third in the 1-9 firm size group are offered insurance coverage, versus 80% in the 100 or more group. This is presumably the result of higher premium costs in the small group market. Not only are employees of small firms less likely to be offered insurance, they are less likely to accept it (11% of employees in firms with 1-9 employees decline coverage versus 4.8% in firms with 100 or employees). Put another way, employees in very small firms are twice as likely to decline coverage offers.

Comment: The take-up rate will be skewed by the firm's participation rate. There is no data on firms that do not offer coverage because they are unable to meet participation rate requirements. This provides some information about the behavior of those firms that offer ESI, not those that do not. Small firms may simply have a preference against offering health insurance coverage.

Q: The presentation includes information on firms with greater than 50 employees and firms with fewer than 50 employees. Are premiums considerably higher for the smaller firms?

A: Yes, the smaller the firm, the higher the premium will be. Nationally, there may be a 10% difference in premium costs for "larger" small firms and those that are smaller. For example, the national average employee-only premium in 2002 was \$3133 for firms with 50 or more employees, \$3375 for firms with fewer than 50

(7% more than the large firm premium) and \$3565 for firms with fewer than 10 employees (13% more than the large firm premium).

A: Carriers calculate a small firm's premium costs based upon a three step process. The carrier first develops a community rate, for all their covered lives in the small group market. This pure community rate can be adjusted based on specific characteristics of a firm's employees, such as age, gender, family composition and geography. . North Carolina law then allows an insurer to vary this rate up or down by 20%, based on the firms expected use of services.

Comment: Our firm has approximately 23 employees and 10 of those chose to enroll in the firm's policy. Each of those employees cost the firm \$300. The policy was subsequently adjusted which led to the enrollment of 5 additional employees. This caused costs to drop to around \$200 per person. Even a small number of employees choosing to enroll in a small firm's plan can result in significant changes in costs.

The data show that for those employees who are offered coverage, most are taking it. We see this even in smaller firms, but at a lower rate than in large firms. The problem of uninsurance for small firm employees is driven in part by a smaller percentage of small firms offering coverage, and a greater percentage of small firm employees choosing to decline offers.

If we disaggregate these data by wage and firm size, three distinct groups emerge. Within each, workers for larger firms are more likely to accept firm offers of health insurance. Regardless of firm size, employees with lower wages are less likely to take-up coverage. This indicates that both wage and firm size affect employee decisions to accept offers of insurance. Firm size matters much more for lower wage groups.

Q: Would these data account for cases when an employee declines coverage because he/she receives dependent coverage through a spouse?

A: This does include those individuals who decline coverage because they have coverage through a spouse.

Employees in small firms also have less access to ESI through other household members. Although most employees have someone in the household who is offered ESI (including possibly the employee), employees at small firms (1-9 employees) are six times as likely to have no one in the household offered ESI than employees in large firms. A clear pattern of diminished access exists in small firms, even when dependent coverage is considered.

There are (at least) two reasons employees at small firms may be less likely to have someone in the household who has been offered ESI: they are less likely to be offered ESI themselves, and others in the household are less likely to be offered ESI. The first reason is supported by data. The second can only be explored by considering small firm employees who are not offered ESI through their job.

One question to explore is whether spouses of small firm employees work at big firms (and thus more likely to have access to health insurance coverage). Data for the Southeast region suggest that spouses tend to work in similarly sized firms. For example, 40% of the spouses of small firm employees work in small firms; 50% of spouses of large firm employees work in large firms. Even if you consider only those who are not offered ESI, small firm employees are less likely to have someone else in their household who is offered insurance. It is not the case that uninsured small firm employees can simply rely on their spouse for dependent coverage.

There is some evidence to suggest that employees who are offered coverage, but choose not to enroll are more likely to think that they do not need insurance or that insurance is not worth the cost, versus those who accept coverage.

In sum, among small firms, the employer decision of whether to offer ESI has the greatest impact on the number of employees not covered. Most NC small firm employees who are eligible for ESI (82%) enroll in it. However, the wage effect on take-up is more pronounced in smaller firms and workers in small firms less likely to have coverage available from other sources. Costs remain the driving factor in both employer decisions to offer coverage and employee decisions to accept it. If premiums paid by small firms were reduced by \$100, offer rates would increase by 2-3%.

Dependent Coverage

In general, North Carolina workers tend to have a decent rate of insurance coverage from their employers. However, when you consider the entire population, the state has a lower average rate of ESI coverage (58.5% versus 63.8% nationally). One fact that could reconcile these facts is if NC dependents are less likely to be covered by ESI than dependents in other states. This may be driven, in part, by costs. In general, employees in North Carolina pay a higher premium for family coverage than most other states in the South Atlantic region. Data show that states with higher than average premium costs for family coverage have lower rates of family coverage.

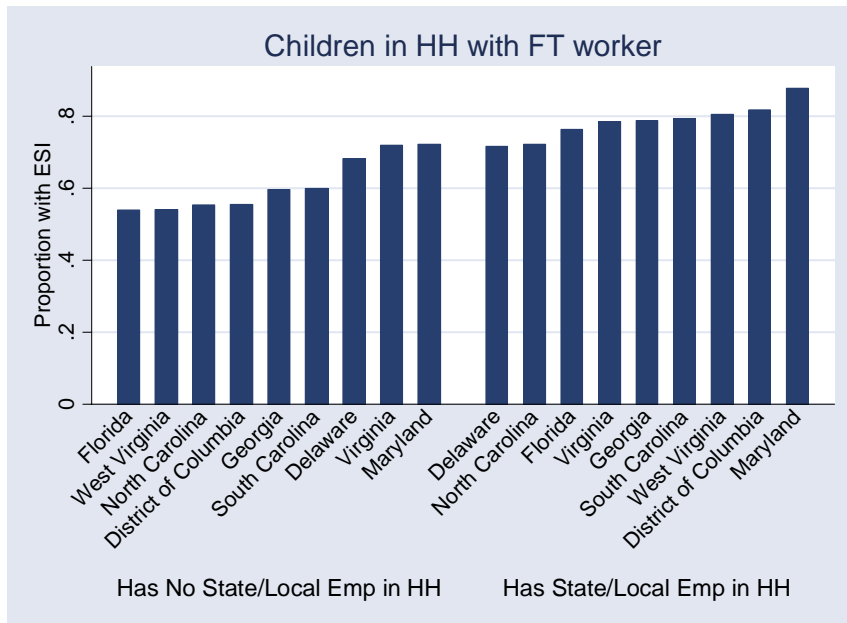
Are the dependents of NC workers less likely to be covered by ESI? Although NC employees have ESI coverage rates slightly above average, North Carolina's rate of coverage originating through another employer in the household is one of the lowest in the region. For example, in the South Atlantic region, only Florida has fewer children covered by employer sponsored insurance than North Carolina. A similar pattern exists among adults who do not work full time (including both part-time and non-workers). Only the District of Columbia has appreciably fewer adults not working full-time covered by ESI. Both of these trends support the assertion that North Carolina has a lower rate of ESI dependent coverage. Overall, although NC employees have a little above average coverage rate from their job directly, then have the lowest dependent coverage rate.

Firm size also plays a key role in dependent coverage. The larger the firm, the more likely dependents are to be covered by ESI. This means that small firms are likely to have very low rates of dependent coverage. In fact, the state's dependent coverage rate (defined as coverage received through another employee) for firms employing 1-24

employees is the lowest in the southeast region. Overall, these data suggest that employee dependents are more at risk of being uninsured in North Carolina than in other states in the southeast region. Those in small firms are at the highest risk of not being covered by ESI.

Q: The state of North Carolina pays 100% of the employee premium but none of the costs of dependent coverage. How would the trends identified be affected if employees for this employer were removed from the data?

A: It may be useful to look at only non-public employees. Many of the statistics presented only refer to private sector employees, but those regarding dependent coverage include public employees. In light of this point, we repeated one graph separately for households in which at least one person works for either the state or a local government. The following graph presents the results. North Carolina has the second lowest coverage rate for children in households (HH) with a state or local government worker, supporting the central point of this comment. Note, however, that children still have low coverage even in the group without government workers.



Comment: North Carolina is one of only two states that contribute nothing to dependent coverage.

Q: To encourage small employers to offer coverage to their employees, are there data that demonstrate that employees who have health insurance coverage are more productive?

A: There may be some empirical data that support that is the case, but very little exists. Preliminary findings from the focus groups indicate that anecdotally, employers believe this to be true. Apart from that, no definitive economic argument supported by quality empirical data has yet to be formulated.

Q: A unique demographic feature of North Carolina is its percentage of the population who resides and works in urban areas. Will any future analyses of these issues compare rural versus urban areas?

A: I am aware of no data comparing premiums by rural/urban status, although anecdotally the rural premiums are thought to be higher. In general, the circumstances tend to be a little more difficult in rural areas. For example, the following graph compares the uninsured rate by rural/urban status. Rural full-time workers are more likely to be uninsured in every firm size category.

Q: If a policy initiative were to target a group of uninsured, such as those in small firms, it would be helpful to consider rural versus urban differences. Some anecdotal evidence suggest that individuals in rural areas encourage spouses to work so they may have access to health insurance and that premium rates are very different in rural as opposed to urban areas.

Comment: In terms of the total number of North Carolinians who are uninsured, how many are employed in a small firm? This is an important question to address as most of the recent economic development in the state is in the small business sector. This would suggest that the state's uninsurance rate is only going to increase if small firms are less likely to offer health insurance to their employees.

A: Of the 1.4 million uninsured, approximately 430,000 are employed in a small firm. An additional 230,000 uninsured are in a family with at least one person employed in a small firm. Of course, not all the 230,000 may be eligible (for example, non-elderly parents are included in the 230,000 figure).

Q: Do you have premium data stratified by age and gender?

A: No.

Q: Do you have any data on how individual health status affects an employee's ability to access health insurance, especially in small firms?

A: No. One problem lies in that most all data sets rely upon self-reported health status, which is often inaccurate. Anecdotal evidence suggests that if one employee in a small firm has a pre-existing health condition, premium rates for the entire firm would be higher so that securing coverage for the entire firm would be more difficult.

Q: Are costs also related to an individual's proximity to a major hospital?

Comment: Blue Cross Blue Shield insures about 20,000 small firms, and clearly, there are significant differences in policy rates across counties, due to varying degrees of facility access and costs of care.

A: Premium costs can be related to a variety of factors, including provider mix, community health status, and rates of utilization. These factors can cause significant variation in policy rates across firms.

Comment: There are many other conditions citizens in rural areas must confront in gaining access to health coverage, in addition to cost of care. For instance, the wage base between rural and urban areas varies significantly. There has also been a consistent migration of young people from rural to urban areas, which affects the overall health status of the rural population. Overall, ESI premiums may be more expensive in rural areas because employers confront an older, less affluent, workforce.

Comment: When considering premium differences between small and large firms, more large firms may be providing coverage at no cost to the employee than small firms. This may be one of the main reasons employees choose to opt out of coverage, a decision that contributes to higher premium rates as a result of adverse selection.

Comment: This is an important issue to the small business community. It has consistently been rated the number one issue on the National Federal of Independent Business member survey.

REVIEW OF PRIVATE INSURANCE OPTIONS

Pam Silberman, JD, DrPH

President Elect

NC Institute of Medicine

As a precursor to her discussion of private insurance options, Dr. Pam Silberman expanded on one of the issues that came up during Mark Holmes presentation regarding the variation in premium rates between rural and urban populations. In the small employer marketplace, the insurer creates a community rate for all its small businesses. That rate can then be varied based on the demographic composition of each individual employer. As a result, a firm located in a rural area that employs all 50 year olds will have a higher premium. The final step allows the insurer to vary the rate up or down, by 20% in either direction, based on utilization. So, the premiums for small employers can vary dramatically when one compares workforces with very different demographics, utilization, and costs.

Q: How often is the community rate calculated?

A: Every year.

Q: Is there any chance to influence that?

A: Only if you bring in healthier people.

Dr. Silberman noted that she will discuss some ideas for encouraging small employers to offer coverage, since small employers are much less likely to offer ESI than large employers. The data suggest that the take-up rate among employees of small firms is relatively high; so the real need is to increase offers for insurance.

Small group market

Private options for the small group market include:

- *Reinsurance.* Healthy New York is one model. There is a bill in the NC General Assembly proposing a similar type program (Healthy North Carolina). It would offer a subsidy to cover some of the higher cost cases, which would help lower premiums for group members. The Healthy New York program covers 90% of claims costs between \$5,000 and \$75,000. Once Healthy New York moved to this reinsurance corridor, premiums for small business were reduced by 17%.
- *Purchasing pools.* The concept is to pool together lots of small employers in order to obtain rates similar to those of large employers. However, the concept has been tried in North Carolina and failed. Therefore, any effort in this direction would need to reflect learning from past mistakes and include new ideas.
- *Small group reform.* Conceptually, there are several possible ways to adjust small group reform laws, although it is unclear what effect these changes could have. For example, North Carolina covers small employers in the 1-50 market, while other states cover them in the 2-50 market. One of the reasons that North Carolina chose to extend its small group laws to self-employed individuals is because we don't have a high risk pool for people with pre-existing conditions. The state requires insurers to offer policies to self-employed individuals on an adjusted community rated basis (using the same rules as apply to the 2-50 group). However, this may lead to adverse selection among solo-proprietors, leading to higher costs in the small group market. So one option would be to exclude groups size one from the small group reform laws (but then this may lead to more uninsurance among solo-proprietors). Another option is to change the adjustments allowed to the community rating rules. The NC Department of Insurance has been talking to other states about small group rating reform and has not learned of much activity in other states.
- *State tax credits or deductions.* There is the possibility that there will be a bill in the NC House of Representative to provide a tax credit to employers offering health insurance to their employees. In past, such proposals haven't been overwhelmingly successful, but the way a program is packaged has a great affect on this.
- *Premium assistance.* The state can use Medicaid or SCHIP funds to help subsidize the employee share of private insurance premium costs for employees who qualify for Medicaid or NC Health Choice. The difficulty of implementing this option in North Carolina is that eligibility is so low that there are few people eligible for Medicaid in the state that are working and have access to ESI. To make this option effective, it would be necessary to first expand the group that qualifies for Medicaid.

Q: Regarding Healthy New York and the 17% premium reduction, was that reduction due to provider discounting or to large insurers getting back into the market? If it is the latter, this might have an initial impact of lowering premiums, but they would probably eventually increase again.

A: What I have been told is that the way they originally set up the program, the reinsurance didn't kick in until \$30,000. The idea was to provide some

financial cushion against very high claims, so that insurers wouldn't have to build a cushion into their premium price. However, the state found that the initial stop-loss threshold of \$30,000 wasn't enough assurance for insurers (to get them to lower their premium prices). The insurers worked with the state to develop the \$5,000-\$75,000 reinsurance corridor, which allowed insurers reduce their premiums for that part of their risk. It is essentially a public subsidy. In North Carolina, we would not necessarily want to choose the \$5,000-\$75,000 just because Healthy NY chose that range. There is a lot of work to look at the relative pros of cons of different ranges. There are many variables. The larger the range, the greater the state subsidy, and the smaller the range, the less the program will attract insurers.

Comment: We should examine the range of insurance product choices that are evolving in the market. There is a consumer-driven model, Health Savings Accounts. They have higher deductibles and may attract certain General Assembly members to support a plan that would include them.

Comment: If a reinsurance model would reduce premiums by 17%, I think it is important to see what that reduction would actually be and what affect that would have on take-up. For example, 17% of a \$3,000 premium would be about \$500. How much would that increase the take-up rate? We need to have a benchmark to consider.

Comment: The other piece would be what amount of state funds would be required to get to that reduction?

Non-group market

There are also individual market options for the non-group marketplace. North Carolina is in the minority of states that does not have a subsidized high risk pool. Blue Cross Blue Shield of North Carolina (BCBS) has one, but there is no public subsidy to make the premium more affordable. Representative Insko introduced a bill to study this issue. States can also offer tax credits or premium assistance to subsidize the cost of private health insurance in the non-group market.

There was mention at a previous meeting about the Trade Adjustment Relocation Act (TAA). North Carolina did a better job than most states in enrolling eligible individuals under the Trade Adjustment Act, but most eligibles didn't enroll. Even though the federal government will subsidize 65% of the premium costs for eligible enrollees, many people who lose their job (therefore making them eligible for the TAA), can't afford the remaining 35%. Additionally, there are a lot of unemployed workers who can't qualify for trade adjustment assistance under the current program rules. There were also some questions raised at a prior meeting about implementing an unemployment tax to help people pay for COBRA coverage. This was done in Massachusetts, but only when there was a surplus in the coverage pool.

Q: How many people would be eligible for a high risk pool?

A: I don't know; it depends on the eligibility criteria. The real issue is how to equitably fund a high risk pool so that its costs don't fall on the backs of those who have made the decision to buy insurance.

Comment: I have seen an estimate for North Carolina that between 20,000 and 25,000 people in the state are medically uninsurable. National data indicate that 1-2% of the uninsured population would be medically uninsurable.

Comment: Blue Cross and Blue Shield of North Carolina has the highest participation in TAA in the country. We made a decision that we would not turn anyone down in the individual market, but by the nature of the market, you can't spread the costs over the healthy market, or they will go somewhere else for coverage, so the high risk coverage tends to be a very expensive. Every other insurer denies coverage for some people in the non-group market. Some people would rather be turned away, than to be charged the high premiums it requires to cover their medical costs.

Reducing premium costs

A major issue that the Task Force needs to explore is how to make premiums more affordable. One option, in addition to public subsidies or reinsurance (discussed previously) is to develop a pared down benefit package. Some states have developed "mandate-light" benefit plans, e.g., insurance products that are not required to cover all of the state's mandated benefits. However, states that have moved in this direction have not had high take-up rates. Some states have tried to develop pared down benefits in Medicaid (for example, primary care only); similar models could be attempted in the private market.

Comment: There are two ways to look at this. One is to eliminate mandates and another is to allow an insurer to apply a dollar amount and all mandates would be covered up to a certain dollar amount. That is far more consumer driven because it encourages personal responsibility. This allows you to do whatever you want, within certain limits.

Comment: Years ago, we conducted some market testing of pared down packages and we found that employers were reluctant to offer them, and employees agreed these packages shouldn't be offered. There was some discomfort around offering this type of package. It would be interesting to see if that feeling has changed.

Comment: BSBC used to have a "basic care" package and it was an abysmal failure.

Comment: It would be important to make some distinctions between the small group and the individual market. There are certain mandates for small group carriers. All the HMO versions of the basic plan have pared down benefits and the basic plan doesn't include coverage for most state mandates, and

those are terrible sellers. There are different ways a pared down package might get different results. In the individual market, an individual may be willing to make those tradeoffs, whereas an employer in the small group market might not.

Comment: There are a wide range of benefit options in individual market. The package BCBS tried to offer years ago was virtually nothing, so if you did something a little different and put in tradeoffs for disease management, then it might be successful. Generally, people don't take very good care of themselves and the issue of personal responsibility is a much bigger driver of insurance than take notice of.

Personal responsibility is another issue to consider. Task Force members have talked in the past about the importance of encouraging insured individuals to take responsibility for their own health. Under HIPAA (Health Insurance Portability and Accountability Act) insurers are prohibited from discriminating against individuals in the group market based on their health status. However, there are other provisions which enable employers and/or insurers to offer wellness and disease management plans. We need to do more research to see how to design a plan that encourages insured individuals to participate in a disease management plan or use preventive health without violating the anti-discrimination provisions.

Large employers

Beyond the small group market, there is also the question of whether reform is needed in the large group market. Looking at Mark's data, it appears that this may not be as necessary. However, it could be valuable if there is a way to encourage large employers to cover more part-time workers.

TASK FORCE DISCUSSION: PRIVATE INSURANCE OPTIONS

Dr. Silberman noted that she would like to hear feedback on which approaches the Task Force members think are the most promising to consider. In future meetings, she noted that the Task Force will break into small groups to look more in depth at private and public options. Then the Task Force will reconvene as a large group to hear what was discussed in the smaller groups.

Comment: One of the things we have to understand is that most of this coverage is still going to be offered in the private market and the agent's role cannot be ignored. Regardless of which solutions we are considering, getting the agents to promote them will be a formidable task. One idea to consider is whether or not there could be an opportunity to categorize those commission incomes for expandable products or uninsurable individuals as tax-free income for the agents. The state would forego its 7% tax income in exchange for obtaining more interest in the producer community.

Comment: There is no disincentive for a small employer to drop coverage except for losing employees who would prefer to work for employers with ESI. Could

there be a tax on folks who don't offer ESI to help cover those who are uninsured? That would give employers an incentive for thinking of ways to cover their employees.

A: That type of "pay or play" option has been attempted in four states, but it has never been implemented because each time the law was repealed before it was implemented.

Comment: Are you saying pay the whole amount of insurance premiums or just something?

Comment: You would have to look at the numbers and see what was politically doable. But you could have the state match the employer contribution to get to a premium that could be affordable the uninsured employee.

Comment: How do we know that which options are going to be evaluated? I like the proposal for agent tax breaks.

A: We are trying to get a sense of the Task Force's priorities to inform the staff process for getting additional information and analysis.

Comment: What does National Federation of Independent Business (NFIB) recommend, besides lower premiums?

A: They have tried to push association health plans (AHPs) at the federal level. However, one issue with AHPs is that they are completely unregulated at the state level, putting all regulation at the federal level. However, the federal government doesn't have the expertise or staff to evaluate plans at the national level. States (including North Carolina) had very negative experiences in the past with unregulated Multiple Employer Welfare Arrangements (MEWAs) that have gone bankrupt, leaving the insured members and providers in the lurch. As a result of that experience, Congress enacted laws to give states the authority to regulate and oversee MEWAs. The National Association of Insurance Commissioners is concerned that AHPs could repeat this experience if they weren't properly regulated. In addition, AHPs could "cherry pick" healthier small employer groups—which would help ensure lower premiums for those who were in the AHP—but at the expense of other small employers. Ultimately, AHPs may end up covering fewer people because those left in the non-association market would be the worst risk and the costs in that market would escalate and become unaffordable for many. Ultimately we would end up with fewer people insured, not more.

Comment: It would be valuable to at least have information on the association health plans in the Task Force report. If the benefits and disadvantages of that option are not considered, then we will not be prepared for the public debate.

Comment: In the case of association health plans, there should be a national set of common rules that would be enforced by the local insurance department. US Senator Enzi has proposed an idea that an association health plan would

be regulated by the state in which it was developed, even if it offers services to more than one state.

Q: Does the American Association for Retired Persons (AARP) have a national association health plan?

Comment: As a member association, AARP members have health plans and other products available to them so they can purchase health coverage with some insurance companies. The key distinction is that the AARP has been around for a long time, and was not created just to sell insurance. As a result, the organizations can not cherry pick healthier risk individuals; the health insurance is offered to all members. In contrast, there is a fear by many that AHPs will limit membership to healthy groups; excluding any group that might have higher health care costs.

Comment: Intuitively, the idea of pooling sounds like it should save money. However, if you allow pooling of dissimilar interests and you have individuals who can move in and out of that plan, they will naturally select the plan with the lowest premium. As a result, those groups that could get better rates outside the pool leave, only the higher cost groups remain in the pool. Most of the permissible association health plans have closed in North Carolina because their premiums got more and more expensive. There are a few multiple employer associations, but their coverage experiences have been pretty tough. It is very difficult to price a group when you know individuals can choose to purchase the coverage or not, based on the best deal, so companies have to rate the group very conservatively. The insurer may still have to do the administrative work at the individual unit, but if not, and the association does it, they typically skim off some percentage of the premium to cover their administrative costs.

Q: Are there any successful association plans in North Carolina? The concept makes sense.

A: It makes a big difference if it is through an employer association or individual association.

Comment: What was done with small group reform is also a form of pooling. Each insurer starts with a community rate that includes all small employers. Anybody that does this is going to have a corridor around that rate to accommodate for differences in the employees.

Comment: It would be valuable to determine what would happen if we changed the rate bands around the community rate. What if we loosen them by some percent or tighten them by some percent? What we have seems to be a pretty good compromise. But could we get a few more people into the pool? Are we losing those people on another pool?

Q: Is there any interest in the reinsurance model?

Comment: We need to know what the public contribution level would be to even gauge whether or not we want to consider it.

Comment: The legislation doesn't include any actuarial analysis and proposes only providing \$2 million for the program. If they were to pass it as it currently stands, it would fail and people would assume it is a bad model. There is a chance that it will not pass this year, but there is still interest in the issue and we want to know if you want us to see what it would cost.

Comment: It would be fool hearted not to look at this if the Senate leadership has started down this road. Can you provide information about what type of impact we can expect, depending on the way the program is changed?

Comment: What are some of the policy options in there? Are we talking about reinsurance for new products? All products?

Comment: One of policy differences between Healthy NY and Healthy NC is that the NY model is targeted to small employers, solo proprietors, and individuals who cannot get health insurance otherwise. It is also targeted to the low-wage workforce. This was imposed to insure that the program does not displace the private market that already exists. The NC program, as written, does not target low-wage workers. The same three groups are targeted, but it is not limited to the lower-wage workforce. Do you think it makes more sense to look at it broadly or targeted to some kind of workforce that would be less likely to afford coverage? Wage does make a difference in terms of take-up.

Comment: Is there a way to combine things? Look at 1-9 for the Healthy NC approach and consider tax incentives for the larger market. One thing I would like us to look at is an analysis of what can go wrong with these policy options. It is important that whatever we move toward doesn't fail.

Comment: Healthy NC should be targeted to low-wage employees because the data show us that is the area of greatest need. The funding realities also make that important.

Q: Regarding Healthy NC, what is the projected buy-in from small employers? Do you get a sense of their interest and eagerness to go after something like this with premium support?

A: I can't tell you in NC, although I expect there is some buy-in since the Senate is pushing it. In NY, initially the small employer part was the smallest component. However, once they changed the corridor, it is now the fastest growing of the groups, although it is still relatively small. Healthy NY has about 90,000 people covered and it continues to grow, but it is still not a huge number for New York. There are no mandates involved. It is a pared down benefit package that is delivered through HMOs.

Comment: I would like to look at a high risk pool, independent of Healthy NC. What operational changes have been made in high risk pools around the country?

Comment: There is a group that does a report on high risk pools every year.

Comment: BCBS has done a fair amount of work on this and they could talk to someone about it.

Comment: I would support looking at high risk pool. It doesn't cover a large portion of the population, but it does cover a population that we won't be covered any other way.

Comment: There was some interest in the small employer focus groups for tiered options, like those available in some large organizations. They would like a bare-bones package offered, with the potential for employees to buy-up.

Comment: That is in the research that we have, as well. Is there anything in the regulations right now that is prohibiting this tiering? One of the advantages in our pooling effort in California was that you could offer choice. There are some packages that can offer that.

Comment: It is a little more difficult than you think. When you insert choice, you get strange looking results.

Comment: Were employers interested in base-plans that were based on high deductible plans or primary care/prevention?

A: In focus groups, we presented options for both. Some employers said they would like to at least offer the catastrophic and others said they would like to offer a more limited basic preventive care option and then employees could buy up.

A: In looking at the public side, we tried to combine the pared-down primary care package with limited hospitalization. So you still have the primary care, but you only cover the really expensive hospitalizations.

Comment: The wage base makes a difference. Higher deductibles and co-pays would be a disincentive for take up at lower income levels. For this population of the uninsured in small businesses with lower wage rates, it seems like the more you make the employee pay, the less they are going to want coverage.

Comment: There is a tradeoff in what you offer as benefits and what you pay in premium.

Comment: A lot of it comes down to what mandates the insurer must offer. If you have an ability to offer everything but only up to a certain dollar amount, that is easy for the employee to choose. Are we saying that from the mandate perspective we have to cover a large group of services?

Dr. Silberman reviewed the options that came out in discussion:

- Reinsurance model
- High risk pools with different iterations
- Tiered options: start with a pared down benefit package and build up

- Shifting the rate band around community ratings

In addition, the Task Force was also interested in financial incentives (such as tax breaks) to encourage agents to sell the new insurance products to the uninsured.

PRICING PUBLIC SECTOR INSURANCE OPTIONS

Tim Doyle, FSA, MAAA

Stacey Lampkin, FSA, MAAA

Mercer Human Resource Consulting

Tim Doyle noted that as consultants at Mercer, their consulting group has a lot of experience working with Medicaid. They have worked in 35 states and priced programs in a number of those. They were involved in a HIFA (Health Insurance Flexibility and Accountability Medicaid waiver) expansion in New Mexico, the Dirigo program in Maine, and adult Medicaid expansion in New York. For the Task Force, Mr. Doyle highlighted the work that they have done to price a number of different options based on the interests expressed in previous meetings.

With respect to the Medicaid full benefit expansion, Mercer analyzed the costs for adult parents of Medicaid or SCHIP qualified children, with incomes between 37% to 300% of the federal poverty guidelines (FPG) and for children in the 201% to 300% FPG range (as children with incomes up to 200% FPG can already receive coverage under NC Health Choice). The Medicaid limited benefit option was also evaluated for the same groups. This was what the presentation will refer to as the targeted population.

Medicaid full benefit expansion is the standard Medicaid benefits package with very limited cost sharing. The premium charged would vary depending on income, but would be capped at 1% to 4% of income for individuals and 2% to 8% of income for families. The program was designed to obtain a 50% take-up rate with the targeted populations for the full Medicaid coverage package.

The limited benefit program targets the same population, but offers much less comprehensive benefits. Initially, Mercer priced the limited benefit package with and without behavioral health; but found that the inclusion of behavioral health services didn't add significantly to the price, so left behavioral health services in the limited benefit package. Two specific alternatives were priced. The first benefit package has a \$5,000 inpatient deductible annually, which requires members to pay first \$5,000 of inpatient services, after which point inpatient benefits are covered. The second alternative is an inpatient maximum of \$10,000. The member would receive \$10,000 of covered inpatient care, after which, the individual is responsible for inpatient costs. The sliding scale premium is 0.5% to 2% of income for individuals and 1% to 4% of income for families (half of the premium for the full coverage package). However, because of the more limited benefits, Mercer only estimated a 30% take-up rate.

Methodology of cost estimates

Mercer used the standard actuarial cost estimate approach, which selects a base population similar to the target population to obtain base costs. Then trend adjustments are made for cost changes over the evaluated time period. This helps to project future costs. Adjustments are also made to reflect changes in the benefits, so that each analysis reflects the differences in the benefit packages. Finally, if the target population is different from the base population, you make adjustments based on those differences.

Mr. Doyle explained that Mercer used the Medicaid fee-for-service data for TANF parents (SFY 2002-2004) as the base. Mercer chose to use multiple years because it provides more credibility and experience to the data. This base was chosen because it was assumed that the TANF adult population would most closely reflect the utilization and costs of the target adult low-income parent population. Mercer reduced the Medicaid fee-for-service base estimates to reflect the drug rebate that the agency receives from the pharmaceutical manufacturers. Mercer used trend factors to increase the base estimate to SFY 2006, and also made changes to reflect differences in the TANF population (largely women) to a more diverse mix of women and men. No adjustment was required for the full benefit package option because it is the same benefit received by NC Medicaid fee for service. However, a number of adjustments were made to account for cost sharing impacts and any dollar limits for the limited benefit packages.

Q: Would dental services be covered?

A: In the full benefit package, yes, but not in the limited benefit package.

Mercer also adjusted for pent-up demand. Pent up demand is the concept that individuals will often delay non-emergent healthcare needs until they are enrolled in a health insurance program. The increased utilization that occurs from pent up demand is usually relatively small, about 5% or less, and typically occurs initially, but decreases as the program matures. It will phase out.

The next adjustment was for the income of the target population. Generally, the greater the income one has, the better one's health. The base population makes a lot less than the targeted population, so this adjustment had to be made.

The last population health status adjustment is the workforce effect. This adjustment is made because people who are employed on an hourly basis use fewer services because they must weigh the costs and benefits of taking time off. This will be very different from the base population, which is predominantly comprised of individuals that don't work and would not have to consider that hours of work lost.

Age and gender are pretty good indicators of cost, so anytime that age/sex mix changes, costs also change. The Medicaid data is mostly a mix of children and women, while the target population will be more males and more adults, so the difference in the population distribution must be accounted for. In the base, because there are a lot of women, there are very high maternity costs and those won't be nearly as high for the target population.

Participation or take-up was discussed a little in Mark’s presentation. Essentially, the premium levels and the cost sharing will drive participation and enrollment. Typically, when the participation is low, the sicker people will be the first to enroll. That may come down as the program matures and more of the healthy to enroll. We assumed that the take up rate of the full benefit package would be 50% and the limited benefit package would be 30%.

The administrative costs have not been included in these estimates, but Medicaid administrative costs would raise these estimates by about 3.2%.

Resulting Cost Estimates

For the full benefit option, the 2006 per member per month (PMPM) projected total costs were \$528 for an adult in the income range of 37% to 100% of the federal poverty guidelines, \$510 for an adult with income between 101% and 200% FPG and \$494 for an adult with income between 201% and 300% FPG. Children with incomes between 201-300% FPG would cost \$257 pmpm (See Table 1 below). Mercer also developed a range of projected costs (which would reflect changes in the underlying assumptions about adverse selection, age/sex differences in enrolled population, etc.). For example, for an adult with income between 201-300% FPG, the projected cost is \$494 pmpm, but it could actually cost from a low of \$461 pmpm to a high of \$589 pmpm. The children’s PMPM projected cost of \$257 is about half of the parents’ cost, which is expected. The effect of the FPG adjustment is also evident in the cost estimates, with the lowest income individuals projected to be the most expensive segment to cover.

Table 1: Medical Cost Estimates for Medicaid Full Benefit Expansion, Calendar Year 2006			
Full benefit package	Low Range	Projection Estimate	High Range
37% to 100% FPG			
Adult PMPM	\$492	\$528	\$589
101% to 200%			
Adult PMPM	\$475	\$510	\$570
201% to 300% FPG			
Adult PMPM	\$461	\$494	\$552
Child PMPM	\$240	\$257	\$265

For the limited benefit plan, costs are about 60% of the costs for the full benefit plan (See Table 2). That is partly due to the enrollee being required to pay the first \$5,000 of all inpatient claims and the exclusion or limitation of certain other benefits. Costs for the limited benefit plan with a \$10,000 inpatient maximum are about 20% higher than those with a \$5,000 deductible because it will cost the plan less if the member pays the initial costs (See Table 3).

Table 2: Medical Cost Estimates for Medicaid Limited Benefit Expansion with a \$5,000 Inpatient Deductible, Calendar Year 2006			
\$5,000 Annual inpatient deductible	Low Range	Projection Estimate	High Range
37% to 100% FPG			
Adult PMPM	\$272	\$305	\$346
101% to 200%			
Adult PMPM	\$261	\$292	\$331
201% to 300% FPG			
Adult PMPM	\$250	\$280	\$318
Child PMPM	\$132	\$147	\$155

Table 3: Medical Cost Estimates for Medicaid Limited Benefit Expansion with a \$10,000 Inpatient Limit, Calendar Year 2006			
\$10,000 Annual inpatient limit	Low Range	Projection Estimate	High Range
37% to 100% FPG			
Adult PMPM	\$289	\$324	\$367
101% to 200%			
Adult PMPM	\$277	\$310	\$351
201% to 300% FPG			
Adult PMPM	\$266	\$297	\$337
Child PMPM	\$141	\$157	\$165

Comment: Imposing a deductible is one method of discouraging unnecessary utilization. But inpatient care is not something people typically avoid because of cost concerns. It is the type of care people must have. A \$5,000 deductible will not make that significant an impact on reducing utilization and overall costs.

A: That is true. The assumptions used for the cost estimates do not include a reduction in utilization due to the deductible for inpatient care.

Q: These estimates include coverage for just the uninsured parents of SCHIP or Medicaid children. How many uninsured does that include?

A: The target population for this particular coverage option is roughly 350,000 people statewide.

Q: Do the estimates assume that the expansion would be administered at the state level and that federal dollars would automatically be drawn down according to current Medicaid law?

A: Yes. In addition, the state and county split of the non-federal share was developed according to current state law, which requires the counties to pay 15% of the non-federal share of Medicaid program costs. The task force could certainly recommend that the state pay the entire cost of the non-federal match.

*Q: What is the rationale for estimating a 50% take-up rate for the expansion?
How was that rate calculated?*

A: The 50% take-up rate used for the full-Medicaid expansion was based upon research performed by the Kaiser Foundation, which focused on take-up rates among Medicaid recipients with different premium levels. The 30% take-up estimate for the more limited benefit package involved more judgment on our (Mercer's) part. It is reasonable to assume that the cost sharing in the limited benefit plan is significant enough to discourage more people from enrolling, so a lower participation rate was used for those estimates (30%). The effects of the participation rates on claims costs were accounted for in the development of the cost estimates. In effect, we assumed more adverse selection with lower take-up (participation rates).

Q: Could we change the underlying assumptions about utilization, for example, by building in evidence-based research about pharmaceuticals. Did Mercer include changes that are being made to the Medicaid program—such as disease and case management under CCNC—in projecting expansion costs? Could changes be made within the existing system to control costs, which could reduce the estimates?

A: We did not incorporate any systemic changes into our cost estimates. Generally, these estimates do include a little in terms of technology changes (as that is included in some of the trend data), but we did not include other systemic changes into the estimates.

A: Because the estimates are based upon historical Medicaid data, some of the costs savings from CCNC are accounted for and some are not. The data used are from 2002-04, but as the disease management programs become more established, costs should decrease even more, although that is not reflected in these estimates.

Q: Are the CCNC case management costs included in the cost estimates?

A: yes. Case management is considered part of total medical costs and is accounted for in the cost estimates.

For any new insurance expansion, a contingency margin is typically included to account for the lack of actual experience data available to develop accurate average cost estimates. The estimates presented do not include a contingency margin, but once the program is implemented, it will be much easier to predict average costs. If the expansion initiative were to include all adults, the average population age would be higher, which would in turn increase program costs.

The estimates also assume that cost sharing will be collected under the limited benefit plan, which may drive down program costs and utilization rates. If providers are unable to refuse service if an enrollee is unable to pay for services, though, utilization will be higher and estimated costs will likely increase. Cost sharing for the full benefit plan is consistent with what the federal government will allow in the Medicaid program.

Comment: The federal government allows for some cost-sharing requirements that North Carolina does not currently impose. If those were implemented, they could significantly affect costs and overall coverage take-up rates. The task force should consider imposing the maximum amount of cost sharing the federal government would allow in any expansion effort.

It has been assumed that the insurance expansion would be administered through Community Care of North Carolina, and if it were not, there would be an impact upon the estimated cost. Crowd-out effects have not been accounted for in the estimates, as it is unclear whether there will be a policy enacted as part of the expansion to control possible crowd-out (for example, a required period of uninsurance before enrolling).

Comment: The task force should consider that North Carolina has previously decided to include several optional services in its Medicaid benefit package that may be excluded under a coverage expansion to an optional population. It might be useful to know what those services cost as decisions are made in regards to what services will or will not be included in a recommended benefit package.

Comment: There are several services that have been excluded in the estimate of the limited benefit package, including home health care, personal care services, dental care services, hearing aids, vision coverage and access to skilled nursing facilities. The limited benefit option also includes quite a bit of cost sharing that is not part of the full benefit package. In effect, the limited benefit package does exclude a lot of the optional services.

It should be noted that there is additional information in the presentation's appendix that details how the original costs were adjusted to arrive at the final estimate. The process began with a Medicaid PMPM base of \$411.42 and ended with a PMPM cost of \$494, which is not an enormous difference.

Q: What costs associated with care for uninsured would be eliminated if North Carolina were to expand health coverage?

A: Maine's Dirigo health plan is currently attempting to determine those costs for their state's health care system now that their program has been implemented. Since North Carolina is still at the preliminary stages of the process, and it is still unclear what a final insurance product would look like and who it would target, it is difficult to estimate what potential savings might be realized if health coverage were expanded. It is a very complex undertaking.

Comment: Some sources have estimated the average amount of uncompensated care that a physician offers in a year is \$40,000.

Comment: The task force should consider what a coverage expansion to working parents would save the entire health care system. How much in

uncompensated care costs are currently being passed onto consumers in the commercial market?

Q: Does the proposed expansion have to be administered through Community Care of North Carolina to draw down federal funding? Can private funds be used to draw down federal dollars?

A: To draw down federal dollars, the state must provide its required share of costs. The state match may be drawn from several sources, including tax revenues, but not donations. Premium revenues cannot be used as a portion of the state match. They may only be used to reduce the total costs coverage, which would benefit both the state and federal government.

A: Indiana is considering imposing a tax on the all individuals who would be targeted by a coverage expansion, whether or not they choose to enroll. The tax would be used to pay for the state's share of Medicaid costs. Those who do enroll would receive Medicaid coverage or have their share of employer sponsored insurance subsidized by state/federal funds (through premium assistance).

Comment: The federal government does not allow states to provide Medicaid benefits only to those who pay for them. All individuals who are eligible for coverage are guaranteed access to services, regardless of whether they contribute to costs. A broad based tax to generate new revenues could be used in lieu of county/state dollars to fund the expansion, but it could not target just those who would receive the benefit.

Q: Are there ways to further modify the estimates that were developed to explore how other cost sharing levels would affect projected costs? Also, has there been or will there be any discussion of innovative options to use the state/county Medicaid share with some sort of private expansion option?

A: To support states in their efforts to develop policy options through the Planning Grant process, the federal government has staff who are available to consult with the task force on the technical aspects of proposed expansions.

Comment: These estimates really reflect coverage expansion for a subset of the working uninsured. Single adults are not included. If the problem of uninsurance is to be entirely addressed by the task force, all individuals should be included in the estimates. What would be the costs to cover all of the uninsured through a public option?

Comment: It is important to note that in expanding coverage to working parents, Medicaid enrollment for children already eligible for the program may increase.

Comment: There was a survey done by the county Departments of Social Services at the request of the General Assembly to determine where the parents of the children enrolled in the Medicaid and NC Health Choice programs worked by

type of industry. Most counties did respond and the corresponding data might provide some useful insights for this project.

Comment: Do the estimates for the expansion include administrative costs? If not, why were they not factored into the analysis? There will likely be a significant administrative cost for the state and the counties associated with implementing a Medicaid coverage expansion for uninsured parents.

Comment: Senate Bill 255 (Healthy North Carolina) will be heard in committee next week. Relevant details will be sent to the task force in case any members are interested in attending.

Comment: Next week there will be several people asking the General Assembly to pass a resolution memorializing Congress to expand the existing Trade Adjustment Act (HR 1787). It will specifically ask for the federal government to increase its coverage of health insurance costs for displaced workers, from the current 65% to 80%, and to liberalize the eligibility for coverage to more displaced workers.

Meeting adjourned.