

North Carolina Institute of Medicine
TASK FORCE ON COVERING THE UNINSURED
March 18, 2005
North Carolina Medical Society, Raleigh, NC

Meeting Summary

ATTENDANCE

Task Force Members: Carmen Hooker Odom, Tom Lambeth, Andrea Bazan-Manson, Mark Benton, Millie Brown, David Bruton, Allen Dobson, Alan Feezor, Charles Frock, Bill Ray Hall, Rep. Verla Insko, Connie Majure-Rhett, John McMillan, John Mills, David Moore, Graham Moore, David Moore, Barbara Morales Burke, Peg O'Connell, Rep. Karen Ray, Lynette Rivenbark Tolson, Randy Rust, Adam Searing, Stephen Smith, Russ Stephenson, Judith Tintinalli, Charles Willson

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

Staff: Gordon DeFriese, Pam Silberman, Kristen Dubay, Thalia Fuller, Jaime Jenkins, Adrienne Parker, Kristie Weisner Thompson

Guests: Walker Armfield, Jason Baisden, N. Collins, Alan Hirsch, Kathy Holladay, Ginny Klarman, Stacey Lampkin, Aaron McKethan, Andrea Radford, Eric Russman, Helen Savage, Carol Scheele, Jeff Spade, Jeff Smith, Pam Sutton Wallace

WELCOME

Gordon DeFriese
President
North Carolina Institute of Medicine

Dr. DeFriese gave introductory remarks and thanked everyone for participating in the Task Force.

Tom Lambeth
Co-Chair of the Task Force

Carmen Hooker Odom
Co-Chair of the Task Force
Secretary, NC Department of Health and Human Services

Secretary Hooker Odom reiterated the importance of addressing this problem, with the growing numbers of uninsured in the state. She noted that the task force has a challenge; to try to develop solutions that can provide meaningful coverage to the uninsured while at the same time, considering the state's budgetary crisis. Secretary Hooker Odom also thanked everyone for participating in the Task Force

DRIVERS OF RISING HEALTH CARE COSTS

Sandra Greene, DrPH

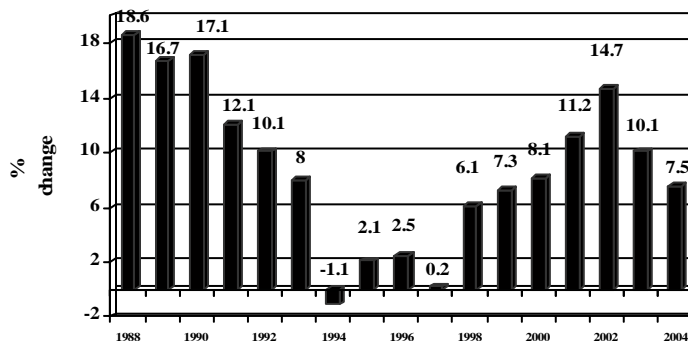
Senior Research Fellow

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University of North Carolina at Chapel Hill

Dr. Greene began by outlining the cost drivers in healthcare: framing the healthcare trends, understanding cost drivers, and employer reactions to recent increases. Except for the period from 1994 to 1997, healthcare costs have increased in excess of inflation each year since 1988. Evidence from a national Mercer/Foster Higgins survey of both public plans and private employer plans (representing more than 90 million) in Table 1 show that, while increases were still high each year, they were trending downward from 1988 (18.6%) to 1993 (8.0%). In 1994, healthcare costs actually decreased 1.1%. Cost increases remained relatively low from 1995 until 1998, but began to rise steadily until 2002 when they had increased 14.7%. Cost increases dropped in 2003 and 2004, to 10.1% and 7.5%, respectively.

Table 1: Trends in Healthcare Costs

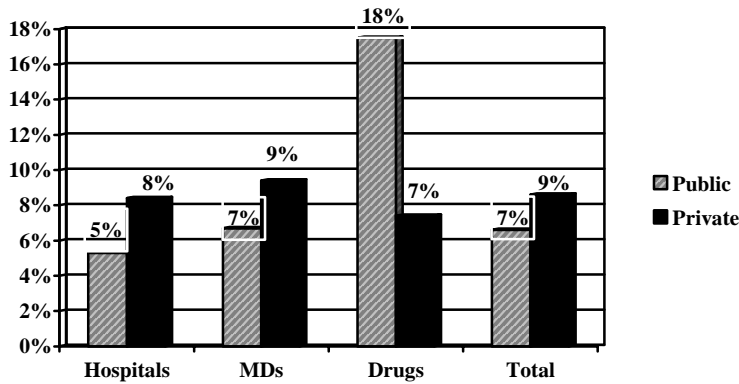


Source: Mercer/Foster Higgins National Survey

According to Mercer's national survey of employer-sponsored health plans, the total health benefit cost per employee continues to rise steadily (from \$3,644 in 1994 to \$6,679 in 2004). The total cost of health benefits includes premiums that the employer and employee pay. Employee out-of-pocket costs are not included in these figures.

National health expenditures increased in 2003 for both public and private payers. Table 2 shows that overall public expenditures increased by 7%, with the largest increase in expenses due to prescription drugs. Increases in public expenditures for hospitals were 5%, physicians 7%, and prescription drugs 18%. Private expenditures increased by 9%, with a relatively even distribution among hospitals (8%), physicians (9%), and prescription drugs (7%).

Table 2: National Health Expenditures: 2003 Increases



Source: NHE data as presented in Smith, et al, Health Affairs, Jan-Feb 2005.

The distribution of health expenditures is uneven among the population. A small percentage of the population accounts for the majority of all spending. Five percent of the population accounts for 55% of all healthcare expenditures, according to the Medical Expenditure Panel Survey—and this has remained steady for decades. A large percentage of the population spends very little on healthcare.

Distribution of Health Expenditures in the United States, 1996

Population	Healthcare Spending
Top 1%	27%
Top 2%	38%
Top 5%	55%
Top 10%	69%
Top 30%	90%

In 2003, the distribution of healthcare expenses was divided among:

- Hospital care (31%)
- Physician and clinical services (22%)
- Prescription drugs (11%)
- Dental/other professionals (10%)
- Administration (7%)
- Nursing home/home healthcare (9%)
- Other (10%)

Cost Drivers

Cost is derived from two variables: (1) unit price and (2) the number of units purchased. The question that arises is, which variable is driving the cost increase? Knowing which variable is driving the increase will help explain what we can do to control cost increases. In that past, controls have been focused on unit price because it is easier to adjust. The

more recent trend toward cost-sharing on consumers is designed to reduce the numbers of units purchased (i.e., to control utilization).

Dr. Greene addressed five key questions: (1) What categories of care are increasing? (2) What are the underlying factors that are driving the increases? (3) How do the drivers change over time? (4) What drivers lend themselves to control? (5) Are there positive trade-offs for increases in some areas of healthcare?

Categories of care are increasing

- hospital inpatient utilization and the expense of this care;
- hospital outpatient utilization (and to some extent the expense of this care);
- use of technology (imaging, in particular); and
- prescription drug prices and utilization.

Hospital inpatient costs have been increasing. Utilization has been relatively flat after a number of years of decline. People spend less time in the hospital than they did in the past, but the cost per day has increased. On the outpatient side, the increase in utilization is a bigger factor than the increase in unit costs in explaining the rising health care expenditures. Hospital outpatient utilization and to some extent costs are also increasing. The use of technology, particularly imaging, has increased. The use and costs of prescription drugs have also increased.

In 2001-2002, the factors that drove rising healthcare costs were:

- Drugs, medical devices, other medical advances (22%)
- Rising provider expenses (18%)
- Government mandates and regulation (15%)
- Increased consumer demand (15%)
- Litigation and risk management (7%)
- General inflation (18%)
- Other (5%)

Many believe that major factors driving increase healthcare costs are the aging population and malpractice; but neither of these two factors is truly causing a significant increase. Data from PricewaterhouseCoopers report that only 7% of annual increases are from litigation. Malpractice costs account for a very small proportion of healthcare dollars. With respect to aging, a good body of evidence debunks the myth that aging is a major cost driver in annual increases. While the average per capita spending on adults older than age 65 is three times the spending for adults ages 34-44, the aging of the overall population is modest from one year to the next. Factors other than aging explain far more of the increases in spending from year-to-year.¹

Underlying factors that are driving the increases

Hospital inpatient utilization and costs. Why have costs increased for hospital inpatients? Admission rates have stopped declining, due to loosening of managed care controls. The complexity and cost of a day in hospital is increasing due to technology.

The unit price of care has also risen due to provider consolidation and new bargaining clout.

In North Carolina, acute care admissions between 1989 and 2003 increased by 30%. In that time, the average length of stay dropped by 29% from seven days to five days (hospital discharge surveys); and the average length of stay is unlikely to decrease further. The best measure of how we use hospitals is a day rate (days per 1,000 persons). The number of days spent in the hospital has declined from 752 to 542 per 1,000 persons. This decline started to level off in 1999 and has been seen among all age groups. The decline has been most dramatic among the elderly—more evidence supporting the assertion that the elderly are not one of the major contributors to annual cost increases. We have seen about five years with little change in the numbers of in-patient hospital days. This leveling of utilization is not unique to North Carolina because it has also been experienced in other states.

Q: Considering that the intensity of services and the duration of hospital stays is shorter, is there anything that would allow us to understand the impact?

A: The number of days is declining, the utilization is declining, but what we do in a day in a hospital is so intense; that is the cost driver. I don't quite know how to quantify it.

Seeing these increases prompted this quote by Stuart Altman of Brandeis University,

“Managed care has been defanged, and the leverage providers have gained will not be easily reversed. This should send a chill down the backs of employers, public purchasers and consumers because we can expect our premiums to surge.”

Hospital outpatient utilization and expense of care. The increases in the costs of hospital outpatient care are due to a combination of utilization and price. North Carolina has seen double digit rates of increase for a number of years. This is a reflection of more services and procedures that can be provided safely to patients on an outpatient basis (e.g., biopsies, surgeries, chemotherapy, etc.).

Use of technology. As we focus on what costs are increasing, we must examine technology and, specifically, imaging. The use of various imaging modalities, such as x-rays (introduced in 1895), CT scans (introduced in 1972), MRIs (introduced in 1983), and PET scans (introduced in 1985) have increased, and continue to do so. CT scans cost around \$1,200. PET scans are the newest and most expensive imaging modality, ranging in cost from \$2,300-\$2,500. For 15 years North Carolina only had three PET scans.

Demand for the PET scan is increasing. The state has approved 18 more in the last few years for a total of 21, and there are applications to the state for more.¹

Given the expense of this technology, we have to ask if it brings any cost savings. Are better treatment choices made as a result of the new technology? Do patients have better outcomes? The data on this is increasing, but difficult to find. Imaging is often performed as a progression or add-on-cost, rather than as a substitution for other technologies. Two studies have looked at the costs. Baker et al., using national data from 1998 to 2000, analyzed the relationship between the supply of new technology and healthcare utilization and spending for four medical innovations: diagnostic imaging, and cardiac, cancer, and newborn technologies. They found increases in the supply of technology are related to higher utilization and spending. For diagnostic imaging, increases in availability are associated with incremental utilization rather than substitution.ⁱⁱ Other research has shown new technologies for heart attacks (e.g., catheterization, angioplasty, and coronary artery bypass grafting (CABG), low-birth weight infants (e.g., ventilators, monitoring, medication), depression (new medications), and cataracts (significant improvements in surgical procedure) to be cost-effective. The same research found that changes in surgery and chemotherapy regimens for breast cancer were not cost-effective because of conflicting evidence for breast cancer treatments.

Prescription drugs. One-third of the increase in healthcare spending for prescription drugs is unit cost, and the remaining two thirds is due to drug utilization. Between 1989 and 2000, there were 1,035 new drug applications (NDAs) sent to the FDA. NDAs were reviewed on two dimensions: (1) whether the new drug has new active ingredients versus existing active ingredients, and (2) whether it provides significant clinical improvement over an existing drug. Only 35% of the new drugs had new active ingredients. Only 24% of the new drugs offer clinical improvement, and only 15% of the new drugs are highly innovative (i.e., have new active ingredients and also provide significant clinical improvement). Examples of these drugs include: Viagra[®], Fosamax[®], Avandia[®], Actos[®], and Plavix[®]. A majority of new drugs offer little improvement from existing drugs.

Q: A few years ago, only a small percentage of our costs were prescription drugs and now they account for 12% of costs. Is the increase in cost because of the unit price or more units being bought?

A: More units being bought.

There are concerns about direct-to-consumer (DTC) advertising (e.g., TV, radio, and print ads), which has increased dramatically since 1996 to over three billion dollars

¹ “The North Carolina Certificate of Need Law prohibits health care providers from acquiring, replacing, or adding to their facilities and equipment, except in specified circumstances, without the prior approval of the Department of Health and Human Services. Prior approval is also required for the initiation of certain medical services. The law restricts unnecessary increases in health care costs and limits unnecessary health services and facilities based on geographic, demographic and economic considerations.” North Carolina Division of Facility Services, Certificate of Need Section. For more information visit <http://facility-services.state.nc.us/conpage.htm>.

annually. DTC advertising is an effective marketing tool. Studies indicate that drugs that are heavily advertised have a significant increase in the number of users. Unfortunately, these advertisements often do not convey sufficient information concerning side effects. Due to the advertising, patients exert pressure on physicians to prescribe certain medications, which may lead to inappropriate clinical use. DTC advertisements also promote expensive brand name drugs over generics.

Reaction of employers to recent insurance premium increases

Employers have reacted to recent insurance premium increases in several ways. Some of the reactions include:

- reducing the employer contribution to the employee's healthcare premium,
- increasing deductibles and copays,
- changing the drug benefit,
- moving from Health Maintenance Organizations (HMOs) and Point-of-Service plans (POs) to Preferred Provider Organizations (PPOs), with fewer administrative costs (not as relevant in North Carolina due to low HMO membership in the state),
- empowering employees to choose less costly providers and plans [not as relevant in North Carolina because in some areas (primarily rural) there are few providers to compete], and
- offering defined contribution benefit plans.

Employers have no confidence in market forces to slow premium growth in the future and have limited ideas on effective strategies, other than cost-shifting and reducing benefits. More than 20% of employers believe disease management will save money, but there is little evidence to support this for the commercial population (although there are other good reasons to support disease management).

Forecast

Significant healthcare cost increases are likely to continue. Some employers who now provide health insurance will be priced out of the market, thus increasing the number of uninsured. There will be more underinsured due to higher cost-sharing and defined contribution benefit plans, and, in turn, there will be a greater reliance on public programs.

We don't know how employers will react to the current round of cost increases. In the early 1990s, they responded by promoting managed care. Will employers embrace defined contribution plans or will they simply increase deductibles and copays to the employees?

Questions and Comments

Q: Medical malpractice premiums are a small amount of overall healthcare costs; but how does defensive medicine affect overall health care cost inflation? Defensive medicine leads to increased use of technology. For example, physicians may order an MRI or other imaging technology to ratchet up his/her

certainty in a diagnostic situation. Also, how much will unhealthy lifestyles affect the cost of healthcare?

A: We are still looking for good studies on the issue of defensive medicine. The US General Accounting Office report may not have included all of the aspects of defensive medicine. It is difficult to measure and know what the impact is. We are beginning to see more studies about the obesity problems and how much those will cost us.

Comment: The real problem is it that defensive medicine is becoming accepted as appropriate clinical practice, or standard of care, and cannot be recognized. Due to the malpractice climate, physicians won't take the risk of making appropriate judgments, especially when they have technology to help with a more specific diagnosis and also reduce legal risks.

Q: You cite data that shows that the top 5% of healthcare consumers uses over half of US health expenditures. Have you done any longitudinal studies to show if this 5% is the same population over time? Are chronic diseases more of a driver of that group?

A: There is some proportion that is consistently high utilizers, but the mix does change.

Q: Why doesn't aging play a more significant role in increasing healthcare costs.

A: If you are trying to assess what is driving the cost from year-to-year, the analysis shows that the aging effect is not driving the cost up from year-to-year. It is a factor over time, but not from year-to-year.

Q: Even though the difference in costs between the youngest and oldest population groups is significant, is the fact that the oldest are growing in such small increments the reason why they are not contributing to the cost increases?

A: The point is what is driving costs from year-to-year. If you take costs from this year to the last, the fact that the population aged a very small amount since last year is not a big factor. Many people dismiss the healthcare cost increases, because they believe they are a result of our aging population and we cannot change our demographics. This view is unfounded.

Comment: Regarding disease management, 15-20% of large employers are implementing disease management programs, and they are getting some return on their investment.

Comment: There are also North Carolina-based disease management programs that have shown a return on investment for employers, such as the Asheville project. The project included the two largest employers and, thus, could invest more for the long-term. The turnover of employees also affects outcomes.

Comment: The Asheville project statistics show that there are significant savings from disease management.

A: There are a lot of reports that show good savings; however, there are also a lot that show no savings.

Q: The factor that made the Asheville project work was that the two largest employers could make long-term investments. With other employer populations, particularly smaller employers, they have a different insurance company every 12 months, so there is no incentive for the company to invest in a group of members who are not going to be there in 12 months.

A: Good point. If people are turning over, you don't have the benefit of a management program. There are all sorts of disease management programs so you can expect many different kinds of results.

Comment: Carolina Access has saved a lot of money for the state because it provides people with a primary care medical home. Carolina Access patients seek medical care early in the disease stage; and this is much less expensive treating them at later, more advanced disease stages or treating them in the emergency department. Success has come from coordinating this locally. In addition, using local providers, instead of external contracting agencies was important.

Comment: It strikes me that defensive medicine gets wrapped up in consumer demand. Doctors don't have any incentive to not prescribe, because this is perceived as being more risky. In an economic sense, when you have a high-priced or high-technology program in the market, after a year or two of having competing products, it plummets. We don't see that in healthcare; you have more suppliers and consumers, but the price does not come down. The laws of economics don't work well in the healthcare field.

Q: We talked about a couple things as we look at the economics of healthcare and payment. Our whole health insurance model is more of a prepaid healthcare model than an insurance model. We have debated about reimposing a more classic insurance model. An observation about economic forces: some say that we have a third-party payments system because people cannot pay for all of the healthcare costs on their own. It was a good point that society needs to think about prepayment. In North Carolina, I think there is a solid backing for a good health planning basis because we are a state that is more rural, and less populated places need resources. We bought into a healthy planning model, so we still think of regulating and controlling healthcare resources as a primary means of controlling costs, yet all of our discussions are replete with how we can get competition to work better. Competition should be between competing healthcare plans, but there aren't as many in our state to compete. Are there any models in other states where there is a significant portion of the population that is regulated, but has some components, like outpatient services, where there is viable market competition?

A: There is so much variation from state-to-state. Ohio is the model that did away with their certificate of need. It is interesting to look at what has happened with the tremendous competition between all of the outpatient facilities; so much so, that there are not enough patients and many of them are going out of business. That is extreme. There are other states that have loosened up regulations, but more states are going the other way—putting more things under certificate of need.

Q: What happened to the costs in Ohio?

A: They are going up, way up.

OVERVIEW OF SOURCES OF HEALTH INSURANCE AND HEALTH CARE FOR UNINSURED

Pam Silberman, JD, DrPH

Vice President

NC Institute of Medicine

The common perception is that a person with low income can qualify for Medicaid. That is not the case unless the person falls into one of five categories. Medicaid is a publicly-funded, entitlement program that provides health insurance to some low-income individuals and families, but it does not cover all low-income families. In 2004, Medicaid covered 1.5 million North Carolinians. Medicaid is counter cyclical—when the economy declines, enrollment grows. Thus, when the state budget is experiencing its hardest time financially, Medicaid grows. For 2004, Medicaid program expenditures totaled \$8.15 billion. In North Carolina, the federal, state, and county governments pay for program costs (63.4%, 31.1%, and 5.5%, respectively).

To qualify for Medicaid, a person must meet three basic tests: categorical eligibility requirements, income limits, and resource limits. *Categorical eligibility*: Categories of eligible individuals include: pregnant women, child under age 21, family with dependent children, people with disabilities, or older adults (age 65 or older). These categorical restrictions are set by federal Medicaid law. Federal law also permits states to cover certain individuals—such as women diagnosed with breast or cervical cancer—who would not otherwise meet the categorical eligibility requirements. But, a childless adult who is not disabled or elderly will not qualify for Medicaid regardless of whether or not they are living on the street—being poor is not sufficient; you have to meet one of the criteria.

Income eligibility: After meeting the categorical eligibility requirements, a person must also meet income (and sometimes) resource restrictions. Medicaid income limits vary by program category (e.g., categorical eligibility), and for children, by the age of the child. For example:

- ✓ Pregnant women and infants under age one can have incomes no greater than 185% of the Federal Poverty Guidelines (FPG)
- ✓ Children ages 1-5 can have family incomes no greater than 133% FPG
- ✓ Children ages 6-18 can have family incomes no greater than 100% FPG

- ✓ Families (including parents) can qualify if their income is no greater than about 37% of the FPG (slightly higher incomes of up to 57% of the FPG are permitted for working families);
- ✓ People with disabilities and/or people who are elderly (65 or older) can qualify if their income is no more than 100% of the FPG

(The 2005 FPG is \$19,350/year for a family of four).

Resource eligibility: Medicaid resource limits vary by program category. There is no resource limit for pregnant women or children. The resource limit is \$3,000 for families (e.g., parents with dependent children), \$2,000 for an individual, and \$4,000 for a couple if elderly, blind, or disabled (\$4,000/\$6,000 for Medicaid enrollees who also qualify for Medicare). Not all resources are counted in determining eligibility. For example, most Medicaid recipients are allowed to own their home, one car, and personal belongings. However, savings accounts or other liquid assets, or other real property may be counted in determining eligibility.

Medicaid covered over 1.1 million people in North Carolina on a monthly basis (based on people eligible in March 2005). Most of these individuals are in families with children. As a general rule, families and children constitute about 70% of Medicaid recipients but account for 30% of Medicaid expenditures. The elderly and disabled constitute about 30% of Medicaid recipients but spend about 70% of the Medicaid dollars.

Medicaid's covered services are relatively comprehensive, including hospital, physician visits, prescription drugs, diagnostic, mental health and substance abuse, therapy, dental, vision, hearing, family planning, and long-term care services. The major distinction between this and the traditional insurance plan is the long-term care. Medicaid is the major third-party payer of nursing home care. Federal law prohibits cost sharing for certain categories of individuals, including children, pregnant women, and individuals in nursing facilities; and puts limits on the amount of cost sharing for other populations. The law also prohibits states from limiting the services covered for children. For example, states must cover dental care for children even if they choose not to cover dental services for adults (dental is an optional benefit for adults).

Provider payments are considered payment in full, with the exception of cost-sharing. Although Medicaid compensation rates in North Carolina are relatively high compared to other states, rates are still well below the commercial rates. Providers are not required to accept Medicaid patients, with certain exceptions (including community health centers, rural health centers and clinics, health departments, and most hospitals). The Medicaid program in North Carolina is unique in that there is wide primary care provider participation.

Community Care of NC (CCNC) is a Medicaid primary care case management program. Medicaid recipients choose a primary care provider who will serve as the patient's medical home. Providers are paid \$2.50 per member, per month to manage all of the patient's care (e.g., be available 24 hours-a-day, seven days-a-week, 365 days-a-year,

coordinate referrals, etc.). Community networks of primary care providers, hospitals, departments of social services, and health departments provide disease management and case management services to help patients manage chronic or high-cost health conditions. Networks receive an additional \$2.50 per member, per month. A network of providers improves care by using a team of providers to coordinate referrals at the local level, and also by becoming part of the statewide medical management team. Two studies have determined that CCNC saves the state money through improved management of patients' chronic health problems.

Medicaid: A Program for the Poor?

Is Medicaid really a program for the poor? Because of the categorical and resource restrictions, Medicaid covers less than half of all poor people.

Three reasons are cited for why people do not enroll in the Medicaid program: they do not understand eligibility requirements, the application process is complicated (the NC Medicaid application used to be 48 pages, but many states have shorted the form and increased its simplicity; for children, it is now a two-page application), and they do not want to enroll because of the welfare stigma.

NC Health Choice (NCHC) is North Carolina's State Children's Health Insurance Program (SCHIP). It was created in 1998 for children in families who make too much money to qualify for Medicaid, but too little to afford health insurance. Unlike Medicaid (which is an entitlement program), NCHC is a block-grant program. The federal government pays each state a fixed amount for each year, which rolls over; but if a state runs out of money, state funds must be allocated to cover services, or services are cut off. Another difference is that the federal government pays a higher matching rate than under the Medicaid program—73.5% federal, 26.5 % state, and counties are not required to share costs of NCHC. NCHC covers uninsured children under 200% of the federal poverty guidelines. First children are screened to determine Medicaid eligibility. Children are eligible for NCHC only if the family income is too high for Medicaid—In North Carolina the program is administered monthly between NC DHHS and the NC Teachers' and State Employees' Comprehensive Major Medical Plan (the State Employees' Health Plan or "SEHP"). The State Employees' Health Plan administers the benefits, but NCHC coverage is more comprehensive than the SEHP as it covers dental, vision and hearing. The goal was to make the NCHC program comparable to Medicaid, particularly for children with special health needs. Cost-sharing is higher in NCHC than in traditional Medicaid. For families with incomes about 150% of FPG, there is a one-time enrollment fee of \$50 for one child and \$100 for two or more children (per year). In addition, there are co-payments. NCHC has been successful in enrolling uninsured children; enrollment grew beyond the early projections. As a result, North Carolina was the first state to impose an enrollment cap. In January 2001, the program stopped taking new applications, and 34,000 children were placed on a waiting list. Once the cap was lifted, the program began growing again, with growth around 1% per month. There are now over 120,000 children in the program.

Without Medicaid, CCNC, and NCHC, many of the individuals covered by these programs would be uninsured. Given the income guidelines, many would not be able to afford insurance in the private market. Medicaid is an option for expanding coverage because it is an entitlement program. It is a way of bringing in federal monies to help offset the state costs of the uninsured.

North Carolina Healthcare Safety Net

There are also safety net organizations throughout the state where the uninsured can receive care. Safety net providers offer a significant level of healthcare and other health-related services to the uninsured, Medicaid, and other vulnerable populations. They often have a legal obligation or mission to provide services regardless of the patient's ability to pay. They often provide services free of charge or on a sliding-fee scale.

Federally qualified health centers (FQHCs): There are 23 federally funded grantees in the state with 76 service delivery sites. In 2003, state FQHCs served more than 272,000 patients in 54 counties, 122,457 of whom were uninsured.

State-funded rural health centers (RHCs): RHCs obtain state funds based on providing care to uninsured individuals below 200% of FPG. The Office of Research, Demonstrations and Rural Health Development helped create 81 rural health centers and, of these, 32 receive state funding to provide care to uninsured with incomes below 200% FPG. In 2003, RHCs served 21,252 uninsured, low-income patients.

Local health departments: Local health departments cover all 100 counties in North Carolina. Some health departments, like the one in Asheville, have comprehensive primary care services, but many limit services to more traditional public health services, such as immunizations, well-child visits, care for STDs. Our best estimate is that there are 39 health departments with the capacity to provide comprehensive care. They are involved in CCNC, and therefore, meet the same requirements of other primary care providers.

Free Clinics: Unlike the previously described safety net organizations, free clinics usually do not provide continuous care. They are often limited to offering services one or two nights per week and provide care on a first come, first served basis. Sixty free clinics or free pharmacies serve 48 communities in North Carolina (2003), more than any other state in the country. The free clinic system is staffed by a large group of volunteer healthcare professionals and staff. In 2003, free clinics provided care to 69,320 low-income uninsured individuals (59,840 for medical services and 9,480 for pharmacy or behavioral health needs).

Project Access and Healthy Communities Access programs: Many of the safety net organizations provide primary care services; however, there are other initiatives to expand care to the uninsured. More innovative approaches for providing care for the uninsured include Project Access sites or Healthy Communities Access sites. These organizations try to link safety net providers to private practitioners (including specialists), hospitals, and ancillary providers, creating a small network of care for the

uninsured. In Buncombe County where Project Access started, individuals receive insurance-like cards and providers file dummy claims to document the value of services provided to the uninsured. Project Access and free clinics tend to work better in resource rich communities, where there are more providers who can donate their time. They typically do not work as well in rural communities because there are not enough providers to serve even the paying population. Provider volunteerism is a key component in providing care to the uninsured. However, providers may not be able to continue to meet this need as the numbers of uninsured continue to increase.

School-based or school-linked health centers: Most of the children served in school-based or school-linked health centers probably have healthcare coverage. State funds support 31 school-based and three school-linked centers, which provide services to approximately 28,000 children. Twenty-eight other centers do not receive state funds

Q: Does the presence of a nurse make school-based or school-linked centers a center?

A: No, it is a small team that includes a primary care provider, and other providers such as nutritionists, mental health professionals, social workers, etc.

Area Health Education Center (AHEC) programs: AHEC supports five residency programs in family medicine, three in rural family medicine, four in internal medicine, four in OB/GYN, three in pediatrics, and three in surgery. They provided outpatient care to approximately 35,400 uninsured patients in 2003.

Hospitals: Hospitals are a major source of care, particularly non-primary care, for the uninsured. There are 130 acute care hospitals in North Carolina and 109 operate an emergency room. Hospitals that participate in Medicare that have emergency rooms are required by federal law (the Emergency Medical Treatment and Active Labor Act, or EMTALA) to screen anyone who requests treatment at the emergency department, regardless of ability to pay. A 2003 survey of hospitals found that 22% (672,799) of the patients seeking care in the emergency department were uninsured.

Prescription drug assistance programs (PAPs): Pharmaceutical companies offer PAPs that provide free or reduced-cost medications to low-income uninsured individuals. Some of the safety net organizations offer medications through these programs and/or help patients apply for the programs individually.

Private physicians: National studies show that the uninsured often receive care from private physicians. In 2001, approximately half of the uninsured reported receiving care in a physician's office. Some of this care is provided for free or at reduced charge, and some is provided with the expectation of full payment. Nationally, physicians were less likely to report providing charity care in 2001 than in 1997 (71% vs 76%). There are no North Carolina specific data.

Ideally, the uninsured, like others with insurance, should have a primary care provider, who can: (a) provide a wide range of medical services, including preventive, acute care,

and management of chronic conditions; (b) provide or arrange for services 24 hours-a-day, 7 days-a-week; and (c) provide direct patient care at least 30 hours-a-week.

Safety net providers are not available in every community or do not have sufficient capacity to meet the health needs of all the uninsured. Despite the broad array of safety net services, the NC IOM Safety Net Task Force was only able to document that 25% of uninsured received primary care services through safety net organizations in 2003. The uninsured have more difficulty in many communities accessing other services, such as specialty care, behavioral health, or mental health

Insurance coverage from different employer groups

What do we know about employers who offer coverage? North Carolina small employers are less likely to offer health insurance coverage than small employers of comparable size nationally. The biggest difference among employers with fewer than 10 employees; nationally, 36.8% of these employers offer health insurance compared to only 25.1% among these employers in North Carolina. When comparing employers with more than 50 employees, North Carolina employers are a little better (97.2% of NC employers offer health insurance compared to 96.5% nationally), but probably this is not a statistically significant difference.

Smaller employers in the United States, as well as in North Carolina, are less likely to offer insurance. In North Carolina, when employees are offered health insurance they are more likely to be eligible for coverage offered by their small employer, and they are more likely to enroll. The key issue is that a sizable number of small employers do not offer coverage. Insurers also often require that you work a certain number of hours or work for a certain period before you can qualify for the health insurance coverage.

Table 1. When Insurance Offered, NC Employees More Likely to Enroll

Percent of Employees in Private Sector Establishments:	<10 employees	<50 employees	50+ employees	Total
That Offer Insurance				
US	47.3%	63.5%	97.8%	88.3%
NC	35.0%*	55.5*	98.1%	88.0%
Eligible for coverage				
US	81.2%	78.0%	76.8%	77.1%
NC	86.8%*	84.4%*	83.9%*	84.0%*
Enrolled in coverage				
US	65.6%	61.3%	62.7%	62.4%
NC	73.6%*	69.5%*	70.3%*	70.2%*

*NC is statistically different than national estimates.

Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey Data (MEPS)-Insurance Component. 2002. Tables II.B.2.a, II.B.2.b.

According to the NC Department of Insurance, the health insurance industry in North Carolina is fairly concentrated. In 2003, of the 32 small group carriers² (now 29 in 2005), the top five carriers (BlueCross Blue Shield of NC, United Healthcare NC, Mega Life & Health Insurance, MAMSI Life and Health, and Wellpath Select) provided health insurance to 84.6% of the groups. Small group insurers covered over 53,000 groups or more than 547,000 lives. BlueCross Blue Shield of NC provided insurance to 45.6% of the covered groups.

Similar information about covered groups or covered lives is not available for the large group or non-group market; however, rough estimates about the market share of insurers in the group and non-group market are available through financial statements. In 2003, the North Carolina group market as a whole (287 large and small employers and other non-employer groups) reported \$4.5 billion in direct premiums. More than \$10 million in premiums were reported by 39 companies. The top five companies accounted for approximately two-thirds of the premium dollars [BlueCross Blue Shield of NC, United Healthcare of NC (HMO), Cigna Healthcare of NC (HMO), United Healthcare Insurance Co, and Principal Life]. BlueCross Blue Shield of NC accounted for approximately one-third of the premium dollars.

For the non-group (individual) market, 277 companies reported direct premiums totaling \$1.2 billion. Fourteen companies reported over \$10 million in premiums. The top five companies accounted for approximately two-thirds of the premium dollars (BlueCross Blue Shield of NC, AFLAC, Colonial Life & Accident, Mutual of Omaha, Bankers Life & Casualty). BlueCross Blue Shield of NC accounted for more than 40% of the premium dollars.

In North Carolina, 66.5% of private sector enrollees are enrolled in self-insured plans at establishments that offer health insurance, compared to 55.9% nationally. This may be because a higher percentage of North Carolina employees work for very large firms with 1,000 or more employees (54.8% of NC private sector employees vs. 46.5% nationally) and employees in these firms are more likely to be enrolled in a self-insured plan (90.0% in NC vs. 81.4% nationally). According to CPS data from 2004, North Carolinians are more likely to purchase non-group coverage than the national average, with 8.1% of North Carolinians having non-group coverage vs. 6.5% in the United States.

Comment: States that rely heavily on managed care may have lower rates of ERISA plans (as large employers may be purchasing HMO coverage instead of self-insuring).

The slides Mark Holmes presented at the February meeting, showed employer-based coverage is decreasing. We have a slightly higher percentage of individuals who are obtaining coverage through the non-group market.

² Small group carriers cover employers with less than 50 employees.

Q: Are you talking about a comprehensive major medical plan or supplemental coverage in the non-group market?

A: I would need to look back at the CPS definition of coverage. I think they are talking about comprehensive health insurance coverage. The term non-group is being used in two different ways here because the information is from two different sources. The data aren't perfect, but much of it comes from CPS.

North Carolina has much strength that can be built upon on as we move forward to the future and face challenges. It is a state rich in available resources with medical institutions, pharmaceutical companies, and profitable insurers. There is a strong safety net with provider volunteerism. Public businesses and the political infrastructure care about problems of the uninsured. The CCNC disease management and case management system is organized around community networks of providers and agencies. There has also been strong support for Medicaid and NCHC among providers, as well as for CCNC among providers and policymakers. In addition, there is clear support for prevention and personal responsibility. Insurers are building prevention and wellness/disease management into health plans. Some employers are experimenting with models to promote wellness and personal responsibility, for conditions such as obesity and diabetes. These strengths have the ability to bring technology and best practices models to the forefront for improving health and creating efficiencies.

Challenges in developing plans to cover uninsured

As a state, we face a few key challenges in covering the uninsured: the state budget constraints this year (and potentially into the future), the rapid increase in the uninsured, and the steep decline in employer-based coverage. Very small employers are less likely to offer insurance. Job loss and changes in the structure of the employment market contributed to the decline in employer-based coverage. Trends also show that there is less employer-sponsored coverage even in the same industries. Low median wages and an increase in the percentage of families in poverty is another contributing factor because having everyone pay for insurance out-of-pocket is not feasible. There is opposition to entitlements among some in the NC General Assembly. Also the concentration in health plans reduces competition. The low HMO penetration in North Carolina leaves us without the option of expanding HMOs, which many states have tried to use to offer some lower-cost options to their population. Our markets have gone to more open access and less managed care.

Questions and Comments

Q: We have about 750,000 uninsured that are not getting health insurance. Where are they going for their care?

A: They are going to the hospital emergency rooms. The uninsured are more likely to use it as their source of care. Some people are not receiving care. We can't capture private doctors, so there are some folks that are going to private doctors, but there are no data to document the numbers of uninsured who obtain care through private physicians.

Comment: Small businesses are dropping coverage, and the perception is that those employees are going to the hospital where they are getting care. I don't know if it is accurate. I would be interested to hear from NCHA.

Comment: We don't have a rich data set in a historical trend fashion for emergency care service. We can know the data for 2003 and 2004, but we don't have numbers for 1996 and 1997 to compare. All payer classes are increasing their use of emergency department, reflecting that access points aren't keeping up with growth and demand. If all access points are keeping up with demand, certainly the uninsured are not be able to access them all.

Comment: Parents of children enrolled in Medicaid bring their kids in when they are sick, but the parents sound sicker than the kids. Physicians know the parents aren't going to get care, so they take care of them "off the line." The other option is for parents to go to the emergency department, and they don't get preventive care there. In the private sector, physicians don't normally ask for family income or set sliding-fee scales. The uninsured run up a bill that goes unpaid, bounce around private physicians offices, and/or avoid care.

Q: What would be the explanation for why North Carolina small employers are less likely to provide health insurance, but more likely to make employees eligible?

Comment: It may be a result of having a smaller percentage of the small employers that are offering coverage. Blue collar and white collar offices provide coverage; the ones that don't provide it are the ones that are family-run, and the Mexicans are not offered coverage because they aren't going to take it. In construction and landscaping, they buy non-group individual plans. The poverty level and non-traditional American immigrant population is where the numbers are escalating, and you can't do anything about it.

DIFFERENT APPROACHES TO EXPANDING HEALTH INSURANCE COVERAGE AND TRADE-OFFS

Jeff Smith and Stacey Lampkin, FSA, MAAA

Mercer

Mercer has worked with the state Medicaid program for three or four years. Mercer will be developing actuarial estimates of the costs of different options proposed by the Task Force.

Following up on Mark Holme's presentation from the February Task Force meeting, the uninsured are a disparate group with many similar characteristics and many differences. Most of the uninsured are employed or have a connection or link to employer-provided coverage. They tend to be very young, poor, non-white, employed by small firms, or live in rural areas.

So who pays for their care? We all pay for their care. A study by the Urban Institute in Massachusetts found that uncompensated care for the 450,000 to 650,000 uninsured

ranged between \$900 million and \$1.3 billion in 2004. These costs are borne by federal, state, and local governments. Society pays much of the cost through taxes, charitable contributions, and higher prices paid by the insured. To alleviate some of this expense, states are attempting to lessen the number of uninsured. According to the US Census Bureau, there were 1.4 million uninsured individuals in North Carolina in 2003.

Options for getting coverage for the uninsured

Universal healthcare is politically difficult because it requires new sources of funding. It can take several different forms, but is politically difficult to enact. The European systems use what amounts to sickness funds, and they get their funding through the government and then are responsible to take care of the population. There is also a mandate for employer-based coverage. But, that does not always cover everyone because there is a group with no formal connection to the employers. Attempts for universal coverage in Washington state and Massachusetts are being considered.

There are a lot of different reasons for being uninsured. One reason is that people do not value health insurance coverage. Young people don't want to pay for health insurance coverage because they won't need it. A major reason that people are uninsured is an inability to afford the premiums. A very small percentage of individuals are uninsurable due to medical reasons. Having pre-existing medical conditions may make healthcare premiums prohibitively expensive. It is difficult to apply middle class values to the decision making of the poor. When considering the options, it is important to look at it from the perspective of the uninsured. Since insurance is bought to protect assets, individuals without assets may not see the need or value in having health insurance.

Instead of universal healthcare, many states are designing options that address the problem of the uninsured in chunks. These options may target a subpopulation. The State Children's Health Plan (S-CHIP) is an example because it targets children in a certain income category. There are three different non-mutually exclusive groups of approaches explored here: private sector approaches, publicly-funded options, and public/private partnerships.

Private sector approaches

Private sector approaches are closely connected to market-based solutions. The market has been working on doing this for some time and yet has not solved the problem of the uninsured. After 40 to 50 years of trying to cover the uninsured, the market seems to have made it worse. Insurers fight to insure the 20 to 30 year-old group that is not going to use coverage, leaving the less healthy with a higher bill to pay and making coverage less affordable.

Private sector approaches include managed care, major medical/catastrophic plans, consumer directed health plans, limited benefits packages, and purchasing pools.

Managed care: Managed care is a more comprehensive form of healthcare. HMOs help link consumers to a medical home, and is probably best suited for providing preventive care which can translate into longer-term savings. Managed care systems also help shift

utilization to the lowest cost, appropriate health care setting; and steers consumers to cost efficient providers. However, current managed care systems are limited in terms of their ability to provide significant short-term savings. Any savings that can be attributable to better preventive services take longer to realize. For example, sealants for children have been shown to reduce dental expenses later in life. Unfortunately, children in the Medicaid program are only there seven or eight months, which means that covering sealants is not cost-effective for Medicaid. But, it might be cost-effective for the child's parents because they need to consider long-term health care costs. The cost-effectiveness is difficult to determine for the uninsured, because most of the uninsured come in and out of that status during their lifetime. Managed care ensures that a person receives care at a participating network, but if one does not receive care within the network, her benefits are reduced or eliminated. In addition, managed care shifts utilization to the lowest cost-appropriate care setting.

Major medical and catastrophic plans: Major medical and catastrophic plans are supposed to act as a barrier to care by implementing a high deductible. It forces the consumer to be more judicious with healthcare utilization by having him/her assume higher costs. This option is not very popular in open market and does not stimulate utilization of preventive care. For lower-income families, high-deductible or catastrophic plans may be akin to being uninsured because the family may never be able to meet their deductible.

Consumer-directed health plans: Consumer-directed health plans are some of the newest options, and it is too early to tell if these will work. These plans remove some third party payer responsibility and add defined-contribution style program characteristics. The theory is that this design encourages the judicious use of healthcare purchases, which will lower overall costs. To work, these programs require widespread dissemination of data on cost and quality. This is the biggest limitation to making consumer-directed health plans work right now, and currently, good data are not available. It will be difficult to make a consumer-directed healthcare market work until then. The idea is that the public will embrace these plans because of the slow growth in costs. However, there is some concern that these plans could increase costs for some individuals, particularly those who want to protect assets and put off needed healthcare. In addition, there could be adverse selection and risk pool stratification, as more healthy individuals opt for higher-deductible plans. Lastly, the widespread use of health savings accounts could have an impact on tax revenue, if passed in North Carolina.

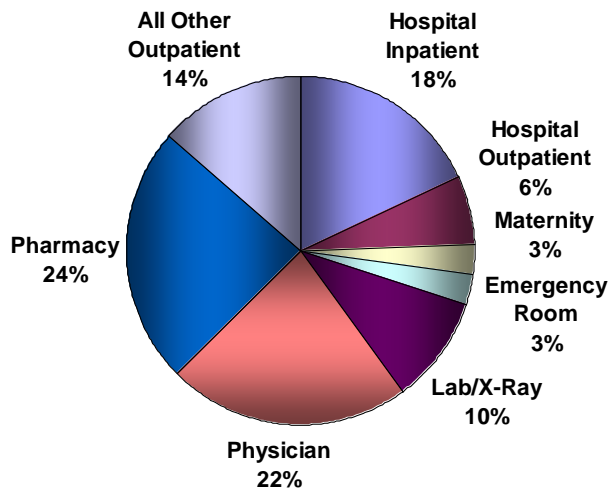
Limited-benefits packages: Limited-benefits packages have been around since the beginning of health insurance, but in a different form. For example, if a person is admitted into a hospital, the plan would pay that person \$100 a day for up to 10 days in the hospital. Limited benefit packages grew to cover doctors' costs, as well. Today's version of a limited-benefit plan concentrates on what services are covered. Many state-mandated services exist. States that have existing or proposed legislation allowing plans that do not meet mandated benefit requirements include Arkansas, Colorado, Florida, Maryland, Minnesota, Montana, New Jersey, North Dakota, Texas, Utah, and Washington. California is currently proposing to allow residents to purchase a

prescription drug discount card for \$15 annual fee. Developing insurance regulations that allow the sale of health plans without the mandated benefits requires regulation changes and applies mostly to small employer groups because the larger employer groups are usually self-funded and therefore are not required to follow state insurance mandates.

Limited-benefit packages also can be for catastrophic or preventative coverage. There is some concern that they will crowd out comprehensive plans and may put more pressure on the safety net. A few states have made these plans available, but not too many carriers are picking up on them. What we are hearing is that the benefit plan without the mandated benefits is not much different from the full comprehensive plan, except the value isn't there—the public does not see value in something that is not a comprehensive benefit package. The consumer response has been very weak.

One of the reasons for the weak consumer response is due to the distribution of healthcare costs. When considering the non-essential healthcare costs, there is not much to consider. Chart 1 of healthcare costs by service category for active employer groups indicates that pharmacy costs (24%), which have risen over time, are the biggest proportion of healthcare costs. In contrast, inpatient hospital costs have decreased and are now only 18%. Some of the drug manufacturers have tried to argue that there is a direct correlation between increased drug use and decreased hospital use, but it is unclear how much, if any, of the decrease in hospital utilization is due to the increased use of prescription medications.

Chart 1: Health Care Costs by Service Category, Active Labor Force Population



Purchasing pools/association plans: Another idea that gained ground in 1980s, but lost ground in 1990s, is now being considered again—purchasing pools. Purchasing pools bring small employer groups together to have more bargaining power. These plans have not met a lot of success and are often seen as an insurer of last resort. Adverse selection into these pools have caused costs in these pools to spiral upward. The variety of rules and regulations around small group has kept them from operating in true market fashion. Small group employers are under major cost pressures, typically for the same package of

benefits; costing these employers 10-20% more in premiums. These higher premiums result from the small size and inability to negotiate and comply with state-mandated requirements. In addition, these plans are subject to premium taxes in certain states, such as North Carolina.

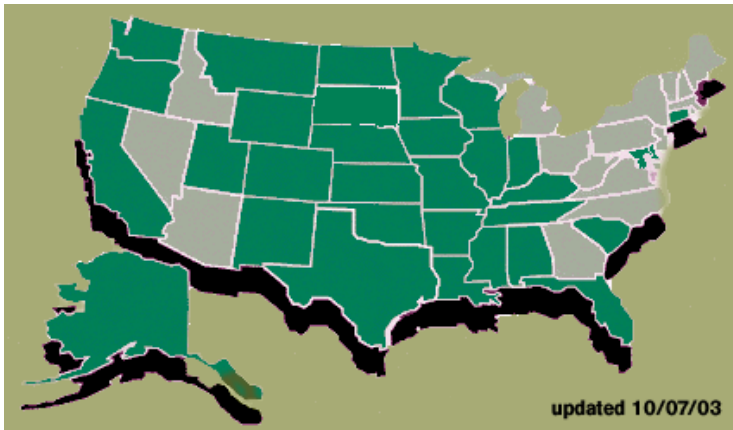
Publicly funded options: What are states doing?

Some publicly-funded options include Medicaid expansions, high-risk pools, and safety net options. Dr. Silberman talked about the Medicaid program and some of the expansion activities related to Medicaid. Medicaid expansions have probably been the most successful in addressing the needs of the uninsured in the last couple years. In Arizona alone, Medicaid spending has increased by 100%, and now serves one in five Arizonans. There is some concern that these expansions are leading to crowd-out on the employer side. For example, Wal-Mart Stores and other employers have said that they don't need to provide healthcare coverage for their employees because employees can get coverage through public programs.

The Health Insurance Flexibility and Accountability (HIFA) is designed to allow states to reduce services for some Medicaid recipients and extend a more modest benefit to the uninsured. The new regulation also allows states to simply reduce Medicaid expenses without expanding coverage. To date, nine states have initiated a waiver application under HIFA. Utah cut benefits to some of its existing Medicaid beneficiaries and extended benefits to some of the formerly uninsured. The Bush administration is touting Utah as an example to follow, but there is no agreement yet that this is a successful model.

High-risk pools: High-risk pools are another method that some states are using to try to cover the uninsured or uninsurable people. High-risk pools try to eliminate some of the cost uncertainty around health insurance for higher-cost individuals. They are generally run as a state non-profit, which is funded by tax dollars. As of October of 2003, over 250,000 people in 30 states had health care coverage from a risk pool. In Map 1, green states had high-risk pools as of October 2003. It is not clear whether or not they are effective programs. High-risk pool costs continue to rise, and they have a lot of adverse selection (i.e., they attract individuals who have higher than average healthcare needs). Many states have had to cap enrollment due to spiraling costs.

States that have high-risk pools, October 2003.



Source: healthinsurance.org/riskpoolinfo.html

Safety Net: Safety net approaches were discussed earlier by Dr. Silberman. As an addition to the information she provided, the Massachusetts governor just announced a new push for a safety net program, and this option may be worth looking into. Many states have some kind of safety net in place.

Public-private partnership approach

The public-private partnership approach attempts to put together the good aspects of both the private market and public funding approaches. This approach is used in many states including New York, Maine, and New Mexico. Three-share programs, which started in Michigan, are getting a lot of attention. The Michigan project was locally funded with healthcare costs shared by the state, the employer, and the employee. The employee would pay a third of the costs and the rest would be split between the employer and a public entity. As a result, one dollar of public funds is able to leverage two dollars of private funds. Three-share approaches are often funded with disproportionate share hospital (DSH) funds. Many employers that expressed an interest in this would like to cover employees if they could come up with a cost-efficient option, but their employees often wouldn't pay to make it work. One legislator from Michigan recommended using a refundable tax credit to encourage employees to participate in a three-share program. That might be another way to get some public funds into such a program. Maine has recently put a three-share program into place. Maine took the concept and applied it to the employer side so that the state picks up the employer contribution and uses that as state share to get it matched by the federal government and then match it with the employee contribution to pay for coverage. Surprisingly, the Office of Management and Budget (OMB) has not yet turned it down.

Premium assistance programs: There are a handful of states with premium assistance programs. In premium assistance programs, the state helps pay some of the cost of the premium for the uninsured. Since about 55% of uninsured families have access to employer-sponsored healthcare coverage, premium assistance programs are usually used to help the low-income uninsured enroll in employer-sponsored coverage. A percentage of the full premium paid could be based on an individual's income level. This option has also been used to expand Medicaid.

Like the high-risk pools, some of the other options, premium assistance programs also have the risk of crowd-out and adverse selection. Sixteen states provide premium assistance and the Dirigo project in Maine is one example. States have found that without an 1115 waiver, enrollment is usually not significant. Generally, there has been a low rate of participation. Program difficulties have included burdensome outreach and administration (trying to reach out to all the people among various employer groups is difficult). Payroll deduction could be another challenge, and there are privacy concerns about employers knowing what is going on with an employee's healthcare.

Comment: The new premium assistance programs have the employee go to the Medicaid agency, so that the employer is not involved and privacy concerns are avoided.

Benefit levels are also less than Medicaid so you have to come up with some way to wrap services around the employer program. There is a confusing array of federal regulations that make premium assistance programs tough to deal with. Mercer helped the state of New Jersey put together an online program, so that the employer could enter the company information and determine if it is cost effective to provide the coverage to employees.

Tax credits: Under a tax credit option, the state subsidizes a tax rate for those who voluntarily enroll in the program. Plans could be purchased through employers, brokers, or in the marketplace. The tax credit approach could utilize a refundable tax credit, direct voucher, or some other tax-related benefit. Financing of program would come from combination of federal and state revenues, individual premiums, and out-of-pocket payments. Over 15 states make tax credits available.

The Bush Administration is proposing refundable tax credits for health insurance, but it has not said what the funding sources would be, so it is not clear if this would be a viable option or not. Should it be implemented so that individuals get the money at the end of year with their taxes or is there a way to provide money monthly so people can meet their premiums? The concern is that employers may eliminate their employer coverage if tax credits become commonplace. In addition, younger, healthier employees may drop coverage in favor of a tax credit that pays for all of their coverage, which would make it more expensive for those requiring more costly healthcare that would not be covered entirely by the tax credit.

Reinsurance: Reinsurance is insurance purchased by an insurer, often to protect against especially large risks or risks correlated to other risks the insurer faces. Under this option, the state would purchase reinsurance, or acts as the reinsurer, for health plans. Another option would be having all insurance carriers in the state pay for reinsurance. Reinsurance is a way to spread risk within the insurance market and induce carriers to underwrite small employers. Larger insurers have not been in favor of reinsurance so many states have made insurer participation in the reinsurance market voluntary. In Arizona, a healthcare group piggybacked off of the health maintenance organization (HMO) networks of Medicaid and offered the HMO network to small employers who

weren't been able to get coverage in the traditional marketplace. The state was, thus, able to subsidize administration costs. The employers would buy in and pay only for costs associated with healthcare. In Arizona costs spiraled upward, so some of the rules were changed, and the number of people covered was cut in half. This kept prices under control, but the state still had to put in money for coverage. Another approach is using state money to try to smooth out some of the bumps in the uninsured market.

State health insurance buy-in: State employee health insurance buy-in programs have been talked about for years, but no state has implemented one yet. Under this option, the state would allow individuals and/or members of small groups to buy into the existing plan for state employees. Some of the benefits to this option are that it would utilize existing networks and allow individuals to join an established population. New Mexico has proposed allowing this and using separate pools. West Virginia is setting up an insurance product using the same negotiated price discounts as offered in their State Employees Health Plan. This would be difficult in North Carolina, as our State Health Plan often pays higher than commercial rates

TRADEOFFS- COVERAGE AND COSTS

Stacey Lampkin, FSA, MAAA
Mercer

Ms. Lampkin noted that her presentation was designed to stimulate conversation among the Task Force members regarding which potential options they would be interested in having priced out. Mercer plans to take the preferences expressed in the meeting and the tradeoffs most interesting to the group and return with more detailed information at the next meeting.

The big tradeoff is between the type of coverage provided and its costs. The key question is what benefits does the uninsured population need the most? What are they interested in, and where do they see gaps in coverage? Ideally, people would be protected from catastrophic financial loss and have basic coverage that encourages the use of preventive care. There may be some populations who think they need protection from catastrophic loss only, because they feel like they can afford some of the basic care. There may be other groups that just want coverage for basic care. That information will come out of the focus groups and will greatly affect program costs.

Last year Mercer did work for a foundation, St. Luke's Health Initiatives (SLHI), which provided an excellent framework for this discussion of tradeoffs. SLHI's mission is to improve the health of people and their communities in Arizona, with an emphasis on people in need and building the capacity of communities to help themselves. The framework is called St. Luke's Health Initiative Coverage Models for Arizona. The foundation was looking for information to help inform the debate around coverage models in Arizona. As part of a broad-based public education and advocacy effort to increase health insurance coverage and access, St. Luke's hired Mercer to evaluate four coverage models: public utility, individually-based tax credit system, sliding scale system, and employer mandate. The examples presented here are not as detailed as those

that the Task Force will get from Mercer. These illustrate the issues out there and the problems related to providing insurance to the uninsured.

The public utility model reflects a universal public approach. This is a mandatory approach with a focus on prevention and primary care. The individual tax credit system represents the type of approach that might be characterized as free market. The government may provide a small subsidy but rely on the private market to provide coverage. For the SLHI initiative, we assumed a small subsidy covering about one month of premiums.

The sliding scale model represents a public option, such as a buy-in to the Medicaid managed care option. It is targeted toward the lower-income subpopulation of the uninsured. The employer mandate, or pay-or-play approach, is an example of a broader approach to encourage or mandate employers who do not currently offer coverage to do so. All of the models assumed a comprehensive coverage level.

The table below shows the number of newly insured projected under each model, by income level. Public utility was assumed to cover all of the uninsured. The size of the uninsured pool was 386,000. Employer mandate projected to cover about 48% of people, and it didn't vary much by income level. We assumed all employers had two or more employees, and employers must cover all employees and dependents. Not everybody has access to an employer from whom they can get coverage, and not everyone will choose to take employer-offered insurance. The Medicaid buy-in is targeted more to the low-income uninsured population. It is projected to cover 29% of low-income people, but only 13% of the total uninsured. The tax credit option covers more of the higher-income uninsured than it does the lower-income uninsured.

Table 3: Estimated CY04 Arizona Newly Insured by Delivery Model and by FPL
(to nearest 1,000)

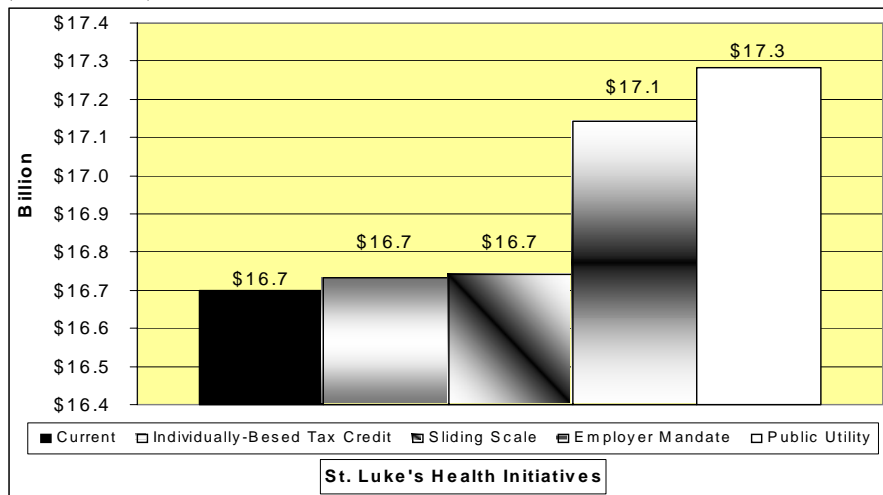
	Individually- Based Tax Credit	Sliding Scale (Medicaid Buy-In)	Employer Mandate	Public Utility
Under 100% FPL	6,000 (2%)	111,000 (29%)	186,000 (48%)	386,000 (100%)
100-199% FPL	8,000 (2%)	18,000 (6%)	155,000 (48%)	322,000 (100%)
200% FPL & Over	24,000 (7%)	5,000 (2%)	138,000 (48%)	286,000 (100%)
Total	38,000 (4%)	134,000 (13%)	479,000 (48%)	994,000 (100%)

Whenever you have voluntary programs like the tax credit and sliding scale, it is important to consider the impact on the employer-provided health insurance market. The

term used is the “crowd-out” effect. It may be in a person’s interest to choose the public program, or the employer may feel less responsibility to provide health insurance if there are other options. In addition, sicker people are more likely to take advantage of these programs than healthier people, which will affect the type of enrollment in each program. This is the effect of adverse selection. It is possible to price programs reflecting adverse selection, but there must be good estimates and ideas of who is going to participate in the programs and the cost levels of each program.

Table 4 illustrates the projection of the whole system cost for each of model, according to the current system annual cost in Arizona, in billions. This includes people only under the age of 65. This graph may be misleading because of the scale used. The public utility and employer mandate raise costs by less than a billion dollars, which is not that much in percentage terms. These are system costs, not costs to the state or to any one individual.

Table 4: Estimated CY04 Arizona Overall Program Dollars by Delivery Model (in Billions)



If this model is expected to include this many newly insured individuals, how much are we paying for each newly insured individual? Table 5 shows the projected annual additional cost per newly insured individual, by delivery model. The most expensive model for the state is the tax credit because so few people are covered; the cost to the system is still significant. The sliding scale is the least expensive model for the state because there is a significant premium buy-in from individuals, which helps cover costs. The public utility is somewhere in the middle because it covers so many additional people.

Table 5: Projected Annual Additional Cost per Newly Insured, by Delivery Model

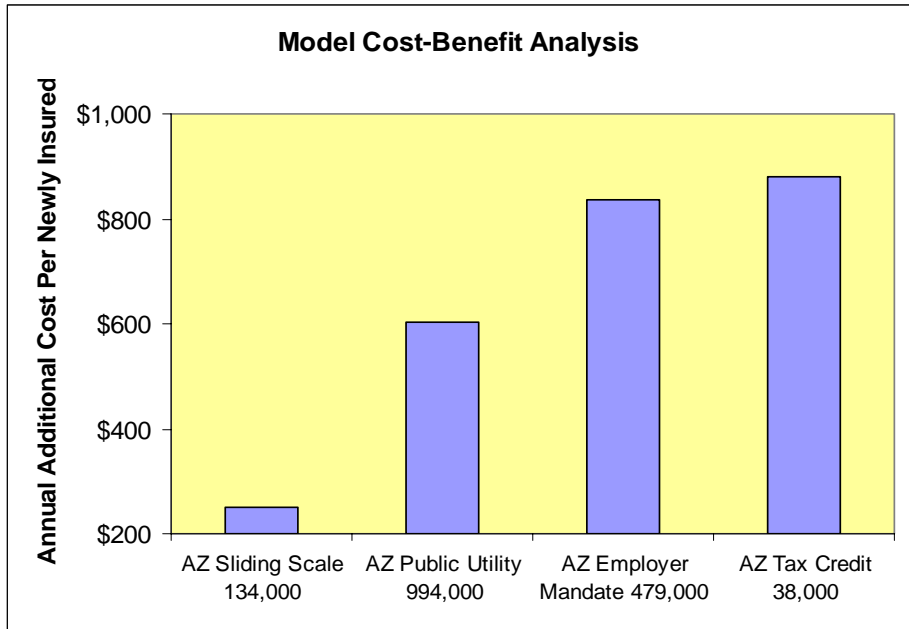
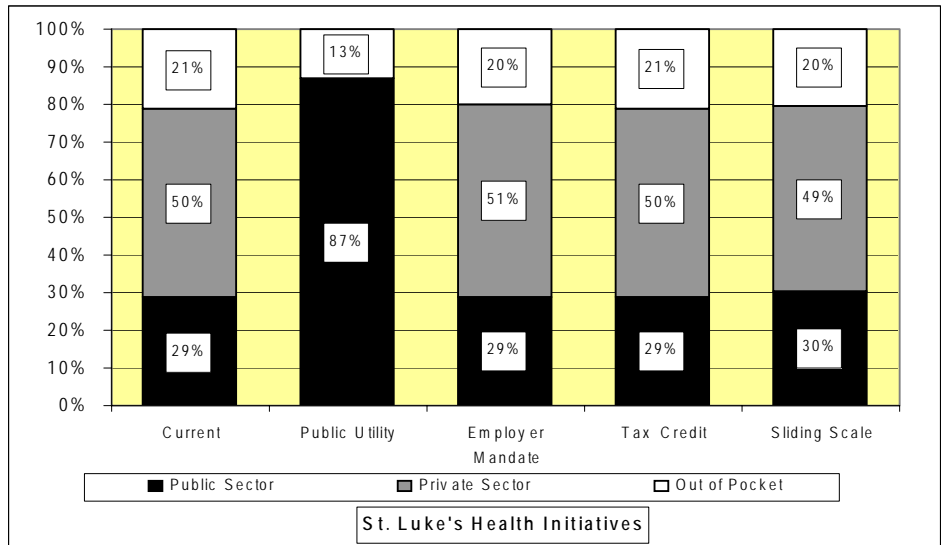


Table 6 shows how the costs within each system are allocated among the public sector, private sector, and individuals. The public utility shares costs only between the government and the individual, whereas in the rest of the models, the proportion covered by the private sector does not change very much. There are only a couple percentage points difference in the private sector contributions of each option.

Table 6: Summary of Estimated CY04 Arizona Health Care Dollars by Funding Source

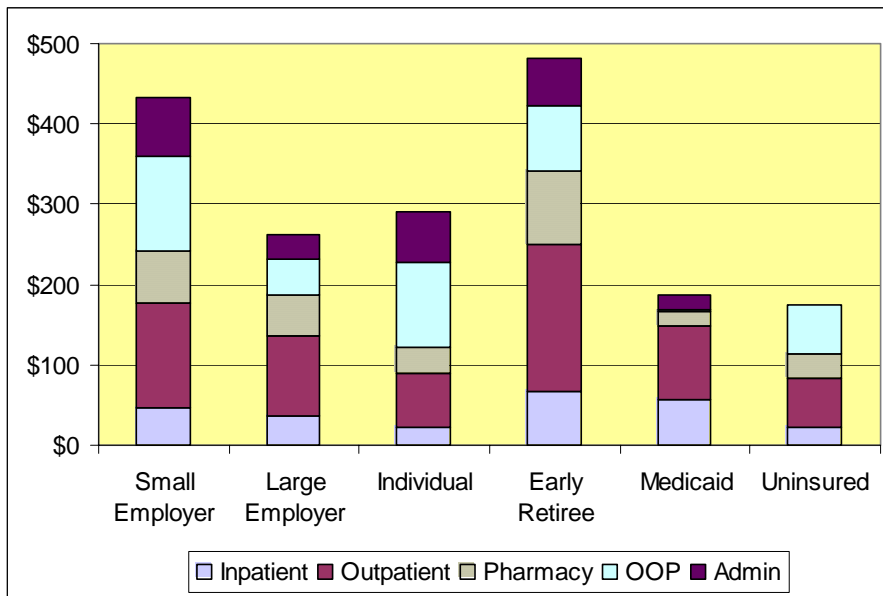


As Mercer prepares to cost-out some of the options for the Task Force, there are a number of interrelated pieces to consider. In order to develop a cost for expanding Medicaid, a target population must be outlined so that information about the population,

such as the morbidity rates, can be factored into the calculations. Information on the covered population, the benefits and the delivery system all influence cost, and the cost also influences those factors in the reverse direction because they are so interrelated. It will be valuable if the Task Force can determine which factors, such as target population, will act as the basis for decision making related to the other factors.

Table 7 illustrates how much the population chosen can affect the costs that are estimated or projected for the program. Table 7 shows six populations of individuals under the age of 65 years. The administration levels vary tremendously depending on the delivery system chosen. Small employers and individuals have high administrative costs, which include claims processing, marketing, profit, and contingency. Large employer costs are usually smaller than small employers because they have lower administrative costs and are often self-insured.

Table 7: CY04 Per Member Per Month (PMPM) Expenditures by Insurance Market Segment and Category of Service (under age 65)



Q: Why is the early retiree cost so disproportionately high?

A: I am not sure.

Other potential policy options

Ms. Lampkin then asked to hear what types of policy options the Task Force would like to know more about and for Mercer to evaluate.

Comment: I would like to see some costs on the three-share program. What are the actual dollar contributions per patient for each of the three shares?

Comment: I am also interested in the three-share costs. In addition, what would be the cost for the reinsurance pool? Try to estimate the number of claims that are really high cost.

Comment: It would be interesting to see if there are some variations of three-share and four-share pricing on the part of providers along the lines of what is going on in Moore County.

Comment: I would be interested in public expansion of Medicaid to parents whose children are already insured under Medicaid and NC Health Choice.

Comment: More exploration of a high-risk pool for North Carolina would be interesting. I would recommend everyone read the February 27, 2005 News and Observer article about high-risk pools and how some insurers declare certain individuals untouchable.

Comment: More information about the range and source of subsidization would be helpful. In addition, I would like more information about greater tax offsets to industry.

Comment: On the issue of a range, what is the maximum premium that can be charged? What about federal funds high-risk pools—didn't legislation cap that at 150%?

Q: What about aggregating small businesses by insurance? Why did that fail? If you can aggregate a healthier population it seems like it should work.

A: One idea is to offer purchasing pools with incentives for the healthy to come into the pool, as well as the unhealthy, who are higher cost. There are some models we could use to try to address the problems that faced purchasing pools in the 1990s.

Q: Has someone looked at variations on the three-share program? FirstHealth did a variation. Are there other models that attempt to hybridize the three-share program, such as through employee-employer-hospital type systems?

A: There are a lot of models, but most are local community initiatives. None are statewide.

A: An example in Florida is that the local hospital got special dispensation to offer a pretty comprehensive coverage program targeted to employers who had not offered insurance in the last 12 months. All the physicians in the hospital agreed to accept Medicaid reimbursement, which made the package much less expensive. Unfortunately, they were unable to get many small employers to sign up to offer the plan.

Q: Has that type of survey of employer interest been done in NC?

A: Insurers may have that data, but it would be about 15 years-old by now.

Q: What state has the smallest percentage of employed uninsured?

A: Minnesota. It has a much higher percentage of employer-based coverage, and it is a healthier state so it can supplement with more public coverage. In addition, its business community is very involved.

Comment: The part about paying Medicaid or Medicare reimbursement rates is very interesting. The question is translating that into getting people to purchase the plan. We need a hybrid approach. It would not be a problem for North Carolina communities to take lower reimbursement, but how are we going to fund it? There is not a lot of appetite for using Medicaid as a vehicle, but we need to find the right Medicaid stream to do it.

Comment: One idea would be to combine, using Community Care of North Carolina (CCNC) as the network and pricing with a premium assistance program where Medicaid pays the employee premium with some private insurers. The private insurer could contract with CCNC to provide the same disease and case management as provided to Medicaid patients.

Q: What is the current tax expenditure for employer-based coverage, in forgone revenues? What proportion of those revenues go to families with incomes above 50% of the federal poverty guidelines compared to some other population subsets?

Q: Was there any discussion about segmenting what it is we are trying to insure? All the emphasis seems to be on keeping people healthy and out of emergency rooms. Is there a step-wise type program for everyone who is uninsured that would cover access to ambulatory care and preventive services? I wonder if it would be a benefit to put this on a matrix to look at what we are covering and what the strategies are for covering different segments of it. We should talk about it based on covering first priorities, then second priorities, and so on.

Comment: In Cabarrus County, they have people with absolutely no insurance, and they convinced providers it wasn't fair for one or two of them to provide charity care. Instead they decided to distribute the burden. If virtually everyone had coverage for the rudimentary stuff, the community could concentrate on how to cover things that are much more expensive.

Comment: If you are going to provide something for free, make it easier for the physician or provider. Putting resources in the community is a key component of making this process work. The idea of a tiered benefit system is a good one.

Comment: At least get everyone access to some basic care, so that reduces the number of services unavailable to the uninsured.

Comment: This idea has been thrown out for years, but the evidence from Florida shows that no one is buying this type of coverage.

Comment: In the private sector, it has not been something that the employers and employees have been interested in. It might work better if it is a service provided by the public sector.

Comment: You could use a HIFA waiver to redirect current funding. That is essentially what Governor Levin has done in Utah. It is cost-neutral. You could do that through redirecting some of your current Medicaid money, but you would have to cut benefits to some segment of your non-categorical group.

Q: Which Medicaid population is getting reduced benefits in Utah?

A: I don't know which group they cut, but it would most likely be the "higher-level" current Medicaid folks.

Comment: Another option is an individual mandate. If everyone would pay in, there wouldn't be such high risk.

A: California has legislation in the General Assembly that requires that individuals to purchase a basic level of coverage, with a premium subsidy for low-income individuals that would be validated at tax return time. I can't remember the enforcement mechanism they propose.

Comment: You have to think of something that brings new money into the system.

Comment: I have big problems with any proposal that would expand limited services by reducing services to very low-income populations. We shouldn't just do it to the poor folks because we can. We need to develop something that people really want to buy. Another idea is related to the money under the Trade Adjustment Act. It is pretty minimal and already does provide some health insurance subsidy, but it hasn't been as widespread as we would like. It could be possible to take some of that money, increase it, or use it in a way to target the displaced workers. It would only affect a fairly small section of the uninsured, but at least there is some money there.

Comment: There is a million dollars for start-up costs of risk pools.

Comment: North Carolina used the Trade Adjustment Act more than other states did, largely because of the work of the Governors' Office with BlueCross BlueShield of NC. Is there a way to combine provider discounts with a 65% subsidy, but working it out so the providers discount the differential? It still doesn't do any thing for the non-dislocated workers, but at least we could use it on some of the uninsured.

Comment: The real problem is that it is such a narrow group of people. There is not enough money there to deal with the bigger issue.

Comment: Thirty-eight states reduced their unemployment tax because the economy was so good. Those funds were over-funded. If we had put in enough just to put a

percentage of that into a health insurance/unemployed-uninsured fund then we could make bridge monies available.

A: Massachusetts did that. I don't know if it is still in existence. They took the unemployment pool and subsidized the whole COBRA buy-in for individuals until they found a job.

Comment: I would like a simple list of the options brought up today.

Meeting Adjourned

ⁱ Reinhardt, Uwe E, Does the aging of the population really drive the demand for healthcare? Health Affairs, Nov/Dec 2003.

ⁱⁱ Baker et al. The relationship between technology availability and healthcare spending. Health Affairs Nov 2003.