NC IOM Task Force on Covering the Uninsured
NC Hospital Association
September 14, 2005

MEETING SUMMARY

ATTENDANCE
Task Force Members: Tom Lambeth, Charles Frock, Verla Insko, John Mills, David Moore, Barbara Morales Burke, Aaron Nelson, Margaret O'Connell, Senator William Purcell, Adam Searing, Charles Willson, Leslie Winner

Staff and Interested Persons: Tim Carey, Kristen Dubay, Thalia Fuller, Chris Fitzsimmons, John Frank, Sandra Greene, Ches Gwinn, Nancy Henley, Mark Holmes, Henry Landberger, Kathryn Millican, Jeremy Moseley, Rick Mumford, Maureen O'Connor, Adrienne Parker, Stephanie Poley, Ben Popkin, Gail Pruett, Roland Stephens, Cathy Wright, Pam Silberman, Pam Sutton Wallace, Phil Telpher, Walker Wilson

WELCOME
Tom Lambeth
Co-Chair

CONTINUATION OF SMALL GROUP DISCUSSIONS

Private Insurance Options
Sandra Greene, DrPH
Facilitator
Senior Research Fellow
Cecil G. Sheps Center for Health Services Research

Dr. Sandra Greene noted that the recommendations for the private insurance options were drafted and grouped into three main sections: 1) the Healthy NC program, 2) small-group reforms/ratings, and 3) tiered benefit packages. The goal of this meeting is to review the draft recommendations and make changes based on the group's feedback.

Healthy North Carolina
Background. Healthy NC was extensively discussed in previous meetings, however, a summary of the program is provided in Appendix 1, which highlights the differences between the Healthy NY and Healthy NC plans. A number of differences between the programs were discussed in the previous meeting and several recommendations were formed as a result of those discussions.

Draft Recommendation 1.1:
> **The North Carolina General Assembly should consider adopting a Healthy North Carolina program that makes available affordable health insurance in North Carolina.**

Draft Recommendation 1.2:

The plan should be designed so that the benefits and associated cost-sharing to be offered should be closely aligned with current small group products in the commercial market. The benefit packages should include mental health services and an option for prescription drug coverage.

The first recommendation was that the NC General Assembly should consider adopting a Healthy NC program that makes affordable health insurance available in North Carolina. There have been a number of concerns about the first recommendation, as well as the benefit design outlined in the second recommendation. The issue that has been raised is concern that the Health NY program is resource rich compared to plans being offered in the group market in North Carolina. Dr. Greene then asked the group for their reactions to the recommendations and asked how the group felt North Carolina could support the benefits proposed in the second recommendation.

Q: Did Mercer come back with rates for this plan that were affordable?
A: The rates were not priced out because Mercer is working on pricing the tiered benefit package. We thought it would make sense to make the benefits similar to what are currently available in NC.

Comment: Barbara Morales Burke is comfortable with the proposed recommendations.

Comment: It is safe to assume that services not covered by Healthy NC would be accessed, and thus paid for, through emergency services? This would be considered bad debt on behalf of the consumer. Does this mean that ultimately, this would be cost-shifting, rather than cost- saving? Being underinsured does not save money compared to being uninsured.

A: The idea is to make insurance coverage available to those who otherwise could not afford it, by offering them less coverage. For many, having some healthcare coverage is better than having no coverage. We are not necessarily limiting classes of coverage, but we are increasing cost sharing so that copays and deductibles would be higher for certain services.

Dr. Greene pointed out that the coverage plan being considered with the Healthy NC program has more benefits than most current commercial insurance coverage products in available in the state.

The group discussion then focused on preventive care and the group agreed that there should be a focus on preventive care within certain parameters. The general feeling was that promoting healthy lifestyles and covering preventive care would offer the most cost-savings over time. One suggestion included that the Healthy NC plan cover the cost of one preventive visit and preventive visit co-pays, as well as smoking cessation or exercise programs. However, there was disagreement within the group regarding whether or not co-pays should be waived for preventive visits. The group agreed that it would be helpful to have evidence on the long-term savings that would result from one annual preventive visit to determine whether or not that should be provided as a no-cost covered service in

the plan. One group member suggested the idea of introducing a primary care medical home in the program because Community Care of North Carolina, which assigned participants to a medical home, increased the number of well-visits for children by 33% and the number of sick visits by 63%, and total costs dropped 4%.

Dr. Greene noted that preventive care would play a different role in each of the three topics and that there are certain areas in which the law will not allow some types of preventive care incentives. She also noted that Mark Holmes provided a background paper to the Task Force in April on the impact of premiums and cost sharing. That document included some statistics regarding changing utilization. Dr. Greene then asked the group if they were more concerned about preventive care for children and adults and then general consensus was that children were more likely to receive preventive care because it is often provided in conjunction with required immunization shots. The group felt it was important for adults to play an active role in addressing their healthcare and lifestyles.

The group agreed that providing participants with one co-pay free physician's visit upon joining Healthy NC would be a good compromise that could minimize the cost impact to the program, but encourage participants to utilize preventative care services.

The group then discussed the issue of affordability, as expressed in Draft Recommendation 1.1. One person suggested using the affordable housing guidelines to determine affordability for the program. The group felt it was difficult to divide income levels and attach monetary costs for the program according to those delineations. Instead, they felt this recommendation was really aimed at suggesting that there should be health insurance plans available that are lower cost than the plans currently found in the private marketplace. As a result, the group decided to modify the language of the draft recommendation to add the word "more," reading:

Draft Recommendation 1.1:

> **The North Carolina General Assembly should consider adopting a Healthy North Carolina program that makes available more affordable health insurance in North Carolina.**

The group then began to discuss Draft Recommendation 1.3. Dr. Greene posed the questions: How do we want to deal with the issue of providing coverage and dividing the cost of coverage? Do we want to set limits on those who are really eligible? If a person has worked a week, should they be eligible? Do we want to restrict eligibility? The Healthy NY program requires that an individual have employment experience within the previous 12 months, while the current NC legislation doesn't require any work experience.

Recommendation 1.3

> **Eligibility criteria should be modified to target low income residents of North Carolina, and to more clearly define the period of employment an individual must document in order to qualify for enrollment. The program design should incorporate a mechanism to prevent crowd-out via employers dropping coverage.**

The group felt that by making the program more restrictive, like Healthy NY, it would lower costs requested from the legislature and could increase the program's chances of being launched. The group generally felt that the person must be employed at the point of enrollment in the Healthy NC program and should already have worked for a minimum of 90 days within the past 12 months.

Comment: The problem I see with such broad eligibility is that unhealthier individuals who could not get affordable insurance on the private market would be attracted to this product because it would be less costly. In contrast, the healthy people may not find the Healthy NC option very attractive compared to what they can get on the private market. This is the idea of adverse selection and it could lead to excessively high costs to this program, and the state.
A: Cost containment would be addressed by the creation of a high risk pool. If the state also developed a high risk pool, they could put the most costly individuals into that program, rather than the Healthy NC program. In addition, including the work requirement helps to somewhat address the issue of insuring high risk persons at a low-cost rate.

Q: How would rates be determined?
A: From the way the bill was written, it would be based on a community rate. The intention was that it would not be subject to the small group rating laws, so it would be community rated for everyone.

For small employer groups, insurance eligibility, as outlined in Senate Bill 255, is based on 50% of employees participating. Some group members felt that the participation requirement should be greater than 50% to encourage a greater percentage of the firm to participate. Such a requirement would make the plan more attractive because the greater the number of people covered, the lower the unit costs. A small health plan with First Health found that incentives worked. The insurance company said it needed 75% participation from employer groups.

The group felt that individuals who worked for multiple employers within the past year could still qualify for the program as long as all of their days working added up to the minimum of 90 qualifying days of work. Therefore, those 90 days do not have to be with one employer.

Comment: Currently, there is no disincentive to being uninsured because individuals can always go to the emergency department. Those costs are being distributed to all taxpayers. I think there should be a private/public partnership, which would mandate that everyone have coverage. This would eliminate the cost shift of those who are uninsured. It is the same theoretical base as car insurance.

Recommendation 1.4

Experiences with prior health insurance programs suggests that low incentives for brokers will lead to little enrollment in the program. Therefore, the state should develop incentives that encourage brokers to sell the Healthy North Carolina product.

Other states that are trying these types of programs/products have noted the importance of finding a way to make this program attractive to the brokers. Some people feel that the reason the Carolinas program failed was because it wanted brokers to reduce their commissions. Some incentives will need to be provided in order to get the program launched. One previously recommended incentive was to allow brokers to avoid paying sales tax on the Healthy NC product. There could be concern that this could reduce state revenues, but if the program helps to insure a large number of uninsured individuals and small businesses, there could be long-term saving to the state.

Comment: It isn't just brokers who can promote the product. Another idea is for Chambers of Commerce to work together by providing incentives for each person that signs on for the Healthy NC program. In the past, Chambers of Commerce have organized negotiated discounts for participating employers to market products.

Comment: It is not a good idea for the Chambers of Commerce to get the benefit of a feedback percentage. The public should be informed through local agents. If the public is in favor of the program and its benefits, then there should be no problem selling it.

The group felt that as a general rule, it was better not to open up the incentives to too many groups, but rather to focus on those that are most directly involved with selling the product, such as brokers.

Q: Would it be possible to build in cost for a higher percentage of the first year's premium to help cover the cost of selling the product?

A: That concept has been done, but it hasn't been too successful. The second and third years are just as involved as the first year in terms of services.

Comment: The wording of the recommendation makes it sound like the state should develop incentives to facilitate launching the program, but I thought the vision was for private health plans to develop this product. Whose role should it be to develop the product? Alternative language could be, "the state should encourage the development of ...."

A: The state would be the high-risk secondary insurer of the program, so it should not be involved up front.

Comment: If Healthy NC is a viable product, the insurers will launch it. But the targeted employers and population groups are particularly expensive in terms of selling the idea to, which is linked to including prevention and wellness.

Q: How does the state encourage a low cost health coverage program? Through tax policy? Is that what we really mean?

A: Obviously the state could say require companies that develop this product to include a commission of X% premium, or something that is in relation to its other products, so it would be seen as encouragement from the state. But, there is a big difference between mandating and encouraging.

The group further discussed state mandates versus encouraging insurance companies/brokers to sell the product. Some people felt that the state could play a role in mandating or encouraging the sale of the product because of the reinsurance it would provide as a subsidy for the product. However, others felt that it would be up tot the market to sell the product and that incentives would not succeed in affecting a change if the product was not popular.

Recommendation 1.5

> **Funding for Healthy North Carolina should be adequately appropriated, so that confidence can be instilled among insurers of the program's solvency. Appropriation should be multi-year. This would encourage plans to invest in the development of products. The reinsurance corridor should implemented.**

One suggestion for augmenting the language in Recommendation 1.5 was to change the wording to read, "to allow the existence of reinsurance to have a meaningful impact on premiums."

Dr. Greene asked the group if they felt it should suggest a specific corridor or an impact on cost. One group member suggested that if there was a goal to reduce premiums by a certain percentage, there could be a number of ways to arrange a corridor to accomplish the goal.

Q: Do you know what the Healthy NY objective was for their corridor?
A: They decreased it to specifically help drop the costs. It required the state to provide significantly higher state funding.

The group agreed that the idea was to make the Healthy NC premiums less expensive than comparable products currently available in the marketplace. However, the group felt that it would require detailed analyses to determine the exact corridor necessary for reducing premiums and, thus, the group suggested that the recommendation not identify an exact corridor at this time. However, the group felt that the recommendation would play an important role in assuring insurance companies that this funding would support the product that they are selling. For example, the $15,000-$75,000 corridor initially chosen by the Healthy NY program was unable to reduce premiums significantly, so it was adjusted to $5,000-$75,000.

Q: Do we want to include a clause suggesting that the state should levy some kind of fee on the providers because they are benefiting from the state's financial contribution to the program?
A: Maybe there should be some kind of requirement that involves provider reimbursement for someone that is covered under this program.
Comment: While that is a good idea, there is concern that provider reimbursement would make selling the product more difficult and minimize the free market aspect of the approach, in terms of providers and health coverage.

Q: What percentage of healthcare costs fall between $5,000 and $75,000?

A: Per member cost of reinsurance would vary for different corridors. For example, our estimates indicate that a corridor in the $15,000-$75,000 range would cost about $400 per member per year. This would be roughly one sixth of the annual premium. Mercer did a similar analysis and found that for a $5,000 to $75,000 corridor (the current Healthy NY corridor), the reinsurance would cover about 32% of the premium. In the Healthy NY program, the cost was about $300 per member per year and they said it was rising annually at a set percentage. That is $33/month, per person.

Q: Is the state going to promote the product? If so, insurance companies might be more attracted to offering it.
A: This is limited to a pretty select marketplace. The insurance companies will be advertising the general product, and then they will offer the whole range of products.
A: There could be a recommendation that the state put some portion of the funding to marketing the product. Business groups could be helpful in getting the word out about the product, which was the expectation at Carolinas, but that didn't work and most businesses did not market the product.
Comment: North Carolina led the nation in enrolling members into the state Children's Health Insurance Plan- Health Choice. The Healthy NC program could follow the Health Choice enrollment model.

Rating Bands

Small group reform was instituted in North Carolina in the 1990s. The current rating method is one of "adjusted community rating with rate bands." The "community rate" is the statewide expected per-person annual claims cost for an insurer's entire book of small group business. The "adjusted community rate" is the differentiation in premium costs from the community rate for a particular small group, based on the small group's characteristics, including age, sex, family composition, and geographic location. Small group rating bands then limit the insurer from charging more or less than 20% of the adjusted community rate based on an independent small group's healthcare utilization rates and administrative costs.

Recommendation 2.1

A study should be undertaken to examine the impact of the Small Group Reform (of the 1990s) in North Carolina. In particular, it is important to understand how these reforms have affected insurance coverage in North Carolina with respect to premiums and equity in the cost and availability of group insurance with respect to an employer's industry, size, and geographic location.

The issue regarding small group rating is the impact on cost and take-up rates for insurance. We need to know if we have a smaller percentage of people accessing small group insurance since the introduction of small group reform, or if access has increased. It would also be valuable to know how our experience with small group rule setting and coverage rates compares to other states that have different sets of rules.

Comment: We should compare the percentage of small employers in our state who are not covered relative to small employers in other states.

The group agreed that a group should be assembled to evaluate the impact of rating bands. The group would research best practices among the states and make recommendations about changes in the rate bands or other regulations that might improve access to health insurance by small group employers.

Q: Who should do this?
A: It should be the Department of Insurance (DOI).

Q: Should we say that the NC General Assembly should task DOI to do this and provide financing?
A: There is an existing group in the state, The NC Health Insurance Innovations Commission- developed in July 2004 that could help with this effort. Ches Gwinn was appointed the first co-chair in March. Hopefully, the government is now appointing the second chair. Hopefully, the group will be in a position to start working. There are a lot of interested players and many of the issues addressed here are also being discussed by that group. If that group were fully assembled, there could be some collaboration and mutual encouragement.

The group agreed that it would make sense for the DOI to share ideas with representatives from the business community, the NC Health Innovations Commission, and other interested parties. It would be best if that information sharing occur between the groups before the ideas are formulated and presented to the General Assembly.

Q: Does the NC Health Insurance Innovations Commission contain worker representatives?
A: Yes. The law was specific about physicians, providers, brokers, small businesses, large businesses, and workers. All have been appointed but the group has not yet met.

The group decided that a separate recommendation should be developed to express support for the NC Health Insurance Innovations Commission (NCHIIC) to continue the work of this Task Force. There was discussion about collaboration between the NCHIIC and the DOI and the group decided that they should work together, but that DOI should be charged with evaluating the small group reform. In addition, it was suggested that the NCHIIC might be able to work more expeditiously if it was supported with proper funding from the General Assembly.

Tiered Benefits

Employer focus group participants expressed interest in limited benefit health insurance plans. Tiered benefit plans can be developed in a number of different ways, but the most common design includes a “base plan,” which has a very limited benefit package that is available at low cost compared to what is available in the private marketplace.

Commonly, the cost of the base plan is covered by the employer. There are also more comprehensive benefit package levels, offered at increasing price ranges. Within a traditional tiered benefit package, the employee would have the option of contributing to his/her health plan in order to receive more comprehensive coverage. A tiered benefit plan can have any number of different tiers, but three or four tiers, each with increasing benefits and costs, are most common. Tiered benefit plans would provide employers with lower cost options to offer employees (since the benefits are lower than those conventionally provided in comprehensive plans), but allow employees to purchase a richer set of benefits if they desire. Such "tiered benefit" plans are currently limited in North Carolina.

Table 1. Hypothetical Tiered Insurance Benefit Package

	Tier 1 Plan	Tier 2 Plan	Tier 3 Plan
Physician Visits	4 Office visits/year with $25/visit copay. Maximum of $500 per year	8 Office visits/year with $25/visit copay. Maximum of $1,000 per year	Unlimited office visits with $25/visit copay. Maximum of $2,000 per year
Inpatient Hospital Care	80% coverage, subject to $500 deductible. $10,000/year max	80% coverage, subject to $500 deductible. $25,000 max.	80% Coverage, subject to $500 deductible, $50,000 max.
Diagnostic Testing	80% coverage; subject to $250/year max	80% coverage; subject to $500/year max	80% coverage; subject to $1000/year max
ER	$150/year max, subject to $75 copay. Waived if admitted	$150/year max, subject to $75 copay. Waived if admitted.	$150/year max, subject to $75 copay. Waived if admitted.
Prescription Drug Benefit	3 Tier Copay: $15 generic; $30 brand name when generic not available; $50 brand name when generic available. Annual max $1,000/year.	3 Tier Copay: $15 generic; $30 brand name when generic not available; $50 brand name when generic available. Annual max $2,000/year.	3 Tier Copay: $15 generic; $30 brand name when generic not available; $50 brand name when generic available. Annual max $4,000/year.
Mental/Behavioral Health Services	N/A	12 office visits/year with $35/visit copay. Maximum of $1,000 per year.	24 office visits/year with $35/visit copay. Maximum of $2,000 per year.
Other	N/A	Disease management services for select conditions.	Same as Tier 2.
Monthly Premium Estimates			
Adult	**$150**	**$232**	**$270**
Child	**$92**	**$99**	**$107**
Member	**$130**	**$186**	**$213**

Assumptions:

1. Provider rates are based on those paid by operating commercial insurers in NC
2. Estimates based on inclusion of entire NC population
3. The product would be administered by a commercial insurance carriers currently operating in NC
4. The State of North Carolina would waive mandated benefits and approve this type of insurance product.

Dr. Greene noted that there was some discussion about making changes to the benefits outlined in Appendix 3. Suggested changes to benefits include: instituting a hospital maximum, no annual maximum on generic drugs in any tier, and subjecting only name-brand drugs to a maximum. The group avoided adding further benefits because doing so

would move the product further away from being a lower-cost option that the group is trying to introduce on the market.

There was also some discussion at the last meeting about changes in the age cohorts. One suggestion was to present the benefit packages by age cohorts. Mercer evaluated the product based on their standard age cohorts, but Dr. Greene noted that those estimates weren't provided to the group because they were based on a dramatically different benefits package than the one currently being considered. Appendix 3 is just a hypothetical package. Insurers will do their own pricing of the product and they will have different prices for different age cohorts.

Comment: Increasing the tiers, rather than increasing the amount of coverage, may be better. It may help more to decreasing the co-pay amount. For example, instead of increasing physician visits to an unlimited number and keeping the $25 copay, it may be a better benefit to decrease or eliminate the copays and limit the number of visits. Evidence indicates that primary care physician visit copays prohibits people accessing services, particularly when they are sick. Four office visits with $10 copays each could be an improvement for both cost and the individuals' ability to pay the copay.

Comment: The problem with that suggestion is that, for the person with diabetes, you want to incentivize the individual to keep their appointments and be seen regularly. When we look at disease management services, there are none in tier one.

Q: Does the evidence show that disease programs save more money than they cost?
A: A lot of disease management programs focus on avoiding hospitalization. We believe that they are cost effective with the tradeoff of more ambulatory costs, which reduces hospitalization costs.
A: That may be the case, but the costs for tiers 2 and 3 increased when Mercer added disease management.
Comment: Some of the more recent research is showing equivocal results in terms of the cost benefit analysis. The most effective ones tend to be for patients with multiple chronic conditions. But for those that have a single chronic disease, disease management programs may not save money. You may, however, be able to provide better care for the same amount of money.

Q: Can people make choices to move between tiers 1 and 2 based on changes in their health status?
A: The representative from UnitedHealthcare stated that their tier products had restrictions governing moving between tiers. You could only move one tier per year. It depends on how the rules are set up.
A: Some insurance companies allow individuals to move down in coverage without cost, but a cost is associated with increased coverage.

Recommendation 3.1

Low-cost insurance products should be developed in response to focus group interest in insurance products that are more affordable, yet offer some primary care, hospitalization, and drug coverage.

Q: Do you think this is more of a group product or an individual product?
A: This is a group product for employers who are currently not offering insurance or who can't continue to offer insurance.

Comment: In our focus groups, some employers mentioned the idea of the employer purchasing the base product and then allowing employees to buy more services.

The tiered product in the individual market reflects that an individual wants more limited benefits than what is currently on the market. Blue Cross Blue Shield feels that it should only offer full coverage, so that individuals don't find themselves stuck in the hospital without insurance coverage.

Comment: There are two views of health insurance: prepaid health insurance or catastrophic coverage. This is the prepaid health insurance idea. It is the poorest individuals, who are going to buy this coverage, although they are the most likely to have the higher costs.

Q: Is there a way to study coverage in terms of what is more affordable?
A: This option allows lower-income people to have some coverage, rather than none. It provides some coverage, as well as access. This would allow them to budget their healthcare expenditures.

Q: Does Tier 1 ever become so limited that we are giving them a false sense of insurance?
A: There are small returns on the costs. It is prepaid healthcare. Someone budgets the expenses. They pay about $1500/year and the total benefit looks to be about $12,000/year. By contrast, someone with more coverage may pay $4,000/year and have benefits up to $1 million.

Comment: If someone has a catastrophe and only 10% of it is insured, then that would be a major problem.
A: There is very little interest in a catastrophic plan for low income people. It does not give them access to care- it only protects them from bankruptcy. This option gives an individual a budget. If the individual doesn't pay the premium, then they know a doctor's visit would cost a certain amount. They have a benefit so they don't have to pay out of pocket for those certain costs. Ideally, we would want the tier 1 package to have more services, but it would cost more.

Q: Is there some other way to do it?
A: We could use medical care as a tax deduction like the federal government does. We would have to lower the cost of care that individuals would receive.

Q: Are there other options that would make the tier 1 package more affordable and have more services?
A: This is the best Mercer could come up as administrative costs are between 20% and 25%.

Comment: I like the idea of offering one free physician's visit per year. Here are some options of the types of plans and the types of costs that we would like to recommend. They maybe be doable and if specific insurance companies want to have incentives, that would be fine. We are just trying to give ideas for tiered benefits for the private marketplace.

Recommendation 3.2 (Plan approval)
The NC Department of Insurance should approve the development and sale of alternative products by private commercial insurance carriers such as limited benefit packages or tiered health insurance benefit packages. To allow development of these products, the North Carolina General Assembly should enact legislation waiving certain mandatory benefits for tiered benefit products.

Q: If we are going to encourage private insurers to provide these plans, what do we do about mandated benefits?
A: The Department of Insurance does not currently have the latitude to approve a product that doesn't have mandated benefits.

We must determine if this option would encourage people to move from full coverage to low coverage; what its eventual impact would be on the public sector; how many of the uninsured this would actually serve; if there a sufficient number of uninsured would be served to justify waiving mandated benefits.

Comment: If the private sector doesn't cover people for insurance, then the public sector will. Pilot projects that assess how waived mandates would work, would be ideal in this situation.

Recommendation 3.3
Commercial insurance carriers are encouraged to develop incentives for agents/brokers to sell tiered insurance benefit products.

Comment: If insurance companies can develop a product, then they will have to determine what type of compensation structure will sell it. Therefore, we do not need to include this recommendation. An insurance company is not going to put a developed product on the shelf because that would be a waste of money.

Q: We need to ask Mercer what costs would be associated with including maternity services in the plan.
A: The concern is selection for the non-group if maternity would be built-in coverage.

Public Insurance Options
Pam Silberman, JD, DrPH
Facilitator
President & CEO
North Carolina Institute of Medicine

The August 11, 2005 task force meeting on covering the uninsured resulted in two general recommendations: (1) further the outreach and simplification of the application process to encourage individuals currently eligible to apply and maintain eligibility and (2) recommend that the General Assembly expand Medicaid; the top priority is to cover all working parents with incomes up to 200% FPG under Medicaid benefits light package.

Outreach and Simplification

The Division of Medical Assistance (DMA) should increase outreach and further simplify the Medicaid application and recertification process to encourage those who are currently eligible to apply and maintain their eligibility. DMA should consider, but not be limited to increasing the number of outstationed eligibility workers, eliminating the requirement of a face-to-face application interview for adult coverage (i.e., for people who are blind or have disabilities and elderly people), simplifying the adult application form, and streamlining the recertification process. Because some recommendations require legislative approval and can not be implemented by DMA, the recommendations are divided into two groups, those requiring legislative approval, and those within the domain of DMA. Another potential recommendation of the group was that the NC General Assembly should enact legislation to reduce administrative barriers and increase processing efficiency. This could potentially include eliminating the asset (resource) test for low-income parents and expanding the eligibility certification period from six months to 12 months.

> ***Medicaid Expansion Potential Recommendation:*** **The NC General Assembly should enact legislation to reduce administrative barriers and increase processing efficiency, including elimination of the asset (resource) test for low-income parents and expansion of the eligibility criteria period from six months to 12 months.**

Medicaid Expansion: Limited Benefit Package

The group discussed the pros and cons of adopting a hospital inpatient plan based on a $5,000 deductible, versus a plan with no deductible and a $10,000 benefit cap. The group decided that a package with a $5,000 deductible was a better option than the $10,000 maximum package. While a $10,000 package would cover most expenses for the low-income population, this package would exclude catastrophic care. The $5,000 deductible plan includes catastrophic care and is similar to packages offered in the private market. A $10,000 package would also be the more expensive option based on Mercer cost estimates.

Comment: A $10,000 maximum package excluding catastrophic care seems as if it could potentially leave many patients exposed after the $10,000 limit is reached because it is fairly easy to accumulate a $10,000 bill in the hospital. An example of which is having a child. The average hospitalization period of 2-3 days would easily surpass the $10,000 cap.

Q: Would the $10,000 plan encourage people to get earlier treatment?
A: It would appear that this would not be a major concern because the patient does not make the decision to be hospitalized; physicians determine who is admitted. It depends on hospital behavior. Will the hospital go after the money they lose to people who cannot pay? Would the hospital rather risk losing $5,000, or would they rather risk losing anything over $10,000 (depending on what they can recover)? Hospital charges will likely surpass the $5,000 deductible for hospitalizations.

Outpatient primary care and specialty visits

Hospital outpatient care is an area for consideration of cost containment.

Q: Do we require diagnostic imaging to have certified radiology technicians so we know that the first film is a good film?
A: One way to reduce the costs is to avoid multiple requests for re-imaging, since the film for CTs and MRIs is expensive.

A suggestion has been made that would limit outpatient hospital expenditures to $5,000. Chemotherapy and radiation therapy would not be included in this limit. However, they would be subject to prior approval. The southeastern United States has higher imaging rates compared to the rest of the United States. The higher imaging rates may be due to conflict of interest problems as well as to clinical diagnosis uncertainty, which could be a result of defensive medicine and other factors.

Q: Are there standards of care for diagnostic imaging?
A: It's a difficult question to answer because there are so many situations. It would be controversial to implement standards for diagnostic imaging. In addition, there is not an existing mechanism for prior approval of diagnostic imaging. We could cap diagnostic imaging at $10,000.

Q: Would the $10,000 cap on imaging be a more effective way to reduce unnecessary diagnostic tests than prior approval?
A: If the doctor needs an image for diagnostic purposes, then he/she knows how to get advanced imaging. Physicians' decisions may be influenced by the patient's insurance coverage.

Prior approval may not work very well for diagnostic imaging; therefore, we should consider a separate cap for imaging or just have one cap for outpatient care, which includes imaging.

The group proposed a $10,000 limit for outpatient services, diagnostic imaging and outpatient surgeries included. The $10,000 cap would not be applicable to life-saving therapy, such as chemotherapy and radiation, which both require a 20% coinsurance. Outpatient clinic visits for both primary care and specialty care are limited to five visits per year.

Q: How difficult would it be to administer different rates based on smoking status? Is Blue Cross Blue Shield of NC (BCBS) doing this?
A: Yes.

Q: Does BCBS pay for the smoking cessation program?
A: Sometimes but if not, they offer a discount. They pay for the medication, but on a limited basis.

Q: What does Medicaid pay for?
A: Medicaid has covered the medication in the past, but currently covers over-the-counter medication.

Q: Does Medicaid pay for cessation classes?
A: Medicaid works in conjunction with "Quit Now NC!" to offer cessation programs. [QUIT NOW NC! is a resource for people who want to quit smoking, for their families and friends who want to help, and for health professionals with patients who use tobacco.] Patrons can go to quitnownc.org to locate local programs that would offer cessation classes. Some chapters of the American Lung Association offer classes, but a fee is associated with the classes.

The group was in favor of Medicaid working with *Quit Now NC!* as a means to offer smoking cessation programs.

Potential recommendations

The NC General Assembly should expand Medicaid to cover more uninsured low-income people. First priority should be to cover working parents with incomes below 200% FPG with the limited benefits package.

The NC General Assembly should direct the NC Division of Medical Assistance to seek an 1115 waiver to develop a limited benefit package. As part of the 1115 waiver, the NC General Assembly should: Implement a voluntary premium assistance program, so that those low-income individuals with access to employer sponsored insurance can use Medicaid funds to pay for their share of the premium, if cost effective to the state.

Enroll participants in CCNC and provide incentives to actively participate in disease and case management

Charge a lower premium to non-smokers

The NC General Assembly should cover the county's share of the cost of expansion.

The NC Division of Medical Assistance should pilot the use of a health risk assessment (HRA) in one or more of the CCNC networks to: determine the health risks of the Medicaid population, identify priorities for wellness initiatives, assess the costs of implementing a HRA program statewide or with targeted eligibility groups, and assess the potential cost savings from targeted wellness initiatives.

Table 2. Expanded Medicaid Services

Services	**Medicaid Light**	**Modified Medicaid "Light"**
Inpatient hospital (Non-maternity, non-BH)	Covered: $5,000 deductible or $10,000 total; 20% coinsurance (only includes facility IP costs)	Add $100 deductible to $10,000 plan (to discourage inpatient use when outpatient available)
Outpatient hospital	Covered 20% coinsurance	*Suggestion: $5,000 outpatient hospital limit (chemo and radiation therapy not included in limit)* *Outpatient diagnostic imaging subject to prior approval* *Outpatient hospital clinic visit subject to same limits as physicians*
Emergency room	Covered, $100 copay (waived if admitted), 20% coinsurance	Covered, $100 copay (waived if admitted), 20% coinsurance
Skilled nursing	Not covered	Not covered
Primary care physician	Covered (sliding scale copay: $10, $20 for below/above 150% FPG)(5 visit limit)	5 visit applies to outpatient primary care and specialty (total). Individuals actively participating in care management or disease management can have additional visits with prior approval by PCP. Same limits for outpatient hospital clinics
Wellness visit	Well visits and immunizations only (not full EPSDT coverage)	One annual visit per year not included in the doctors visit limit
Specialty physician	Covered (sliding scale copay: $20, $40 for below/above 150% FPG)(24 visit limit)	5 visit applies to primary care and specialty (total). Individuals actively participating in disease or care management can have additional visits with prior approval by PCP.
Eye exam		1 visit with prior auth from PCP (no glasses) Podiatrist excluded
Outpatient therapy	Covered, 20% coinsurance, 25 visit limit for PT, OT, Speech therapy, with PA	Covered, 20% coinsurance, 25 visit limit for PT, OT, ST, chiropractic, with prior approval by primary care provider
Services	Medicaid Light	Modified Medicaid "Light"

Inpatient behavioral health hospital	$5,000 deductible or $10,000 total; 20% coinsurance	In $5,000 deductible package, should limit inpatient behavioral health to 20 days, substitution allowed
Services	**Medicaid Light**	**Modified Medicaid "Light"**
Outpatient behavioral health	Covered. Sliding scale copay ($20, $40 for below/above 150% FPG) 20% coinsurance, 20 visit limit/yr., PA after 8 visits for adults	Covered. Sliding scale copay ($20/$40 for below/above 150% FPG), 20% coinsurance, 20 visit/yr limit. PA after 8 visits.
Behavioral health other	Not covered	Intensive day treatment allowed as substitution for inpatient with prior approval
Pharmacy	Covered: $15 copay (generic), $25 (brand), $60 (brand, non-preferred) (6 script limit/mo.).	2 script/mo. limit; waived for maintenance drugs for chronic illnesses when in CCNC disease or care management. Copay modified to: $5 (Tier 1), $30 (Tier 2), $60 (Tier 3) 2 script limit does not include contraceptives. Encourage 3 months supply for chronic medications
Family planning	Contraceptives only	Contraceptives only, not included in 2 script limit/mo.

High-risk pools

<u>Benefits</u>
The group discussed the benefits and eligibility criteria that should be considered in a state high-risk pool. Suggested benefits include comprehensive, multiple preferred provider organizations (PPOs) with differential deductibles (deductible doesn't apply to doctors' visits) with an HSA option, $2,000 out-of-pocket maximum (over the deductible), $1 million lifetime limit, and disease management and/or case management should be included.

Q: Why should we offer multiple PPOs?
A: So people would have choice.
Q: Why?
A: Because they could chose a less expensive plan or a more expensive plan and pay the difference.

Q: How long do people stay in high-risk pools?
A: About 30 months.

Q: What happens when they leave the high-risk pool?
A: They either become healthier, go back to work, die, or participate in Medicare.

Coinsurance in high-risk pools is typically set 20% for visits with in-network providers and 40% for visits with out-of-network providers.

Q: Do people feel comfortable with offering multiple PPOs?
A: We still need a basis for the cost estimate.

Q: Do we feel comfortable with $1,500 deductible and 80/20 coverage?
A: One thousand dollars is usually the lowest deductible in the high-risk pools of other states.

Q: What should the maximum out-of-pocket expenses be?
A: Other states generally have $1,000-2,000 above the deductible. BCBS thinks the out-of-pocket deductible is higher than $1,000-2,000.

Q: What proportion of people in high-risk pools is in the middle income bracket?
A: Very few. Low-income people can't afford to pay the deductible, and most states don't subsidize the deductible.

People who enter high-risk pools are probably frequent healthcare users, so they will probably gravitate toward the lower deductible. Someone with cancer who is in remission might choose a higher-deductible plan.

Most states with high-risk pools have lifetime limits, up to a million dollars.

Q: What would be reasonable?
A: If one has a diagnosis of cancer that prevails for any length of time, the lifetime limit of one million dollars could be used rather quickly. It is common for people to exhaust the million dollar limit. Some states have two million dollar caps. South Carolina has a one million dollar lifetime cap. We will try to determine the cost if there is no lifetime limit.

<u>Eligibility</u>
The group discussed the eligibility criteria for high-risk pools. Individuals would be considered ineligible if they had other healthcare coverage (i.e., Medicaid, Medicare, COBRA). To be eligible, individuals must be unable to purchase a policy except with a premium higher than that offered through the pool *or* rejected from other insurer for health problems. Under state law, we also allow a six-month look-back period and a 12-month exclusionary period for pre-existing conditions, unless they have had continuous coverage (i.e., private, COBRA, Medicaid).

The group also discussed what factors could be used to vary rates (e.g., age, sex, geography; and health behaviors). Regarding health behavior, should individuals who do not smoke get a discount? This is only legal if the smokers can also get discount if they participate in smoking cessation. High risk pool administrator should study additional ways to encourage healthy behaviors and report back to the General Assembly about options within one year of program operation.

Q: Are there insurers who would reject people who don't have serious health problems (i.e., hay fever)?
A: Even if they are rejected, they will be covered by BCBS.

Q: Can high-risk pools satisfy other federal requirements?
A: Most states that have high-risk pools use it as their Health Insurance Portability and Accountability (HIPAA) product. Only a handful of states use the pool as their Trade Adjustment Act product.

Q: Is it a good idea to use the pool for both HIPAA and TAA?
A: Yes. Most TAA people are placed in higher-tier plans at BCBS.

Q: Do we want to suggest that tobacco use is a rate variable?
A: Yes. If you are found to be a smoker, you could be dropped from the plan and be required to pay for insurance. It would be considered fraud. This would be hard to prove, but life insurers do it.

Financing

BCBS projects the cost of the high-risk pool would be $43 million/year for claims costs above 150% standard premium rate. This does not include additional costs of subsidy to individuals with incomes less than 300% FPG (using a sliding-fee scale, with 95% subsidy for people with incomes less than or equal to 100% of poverty up to a 0% subsidy at 300% FPG. The state should appropriate funds to help subsidize premiums for-low income individuals. Suggested financing mechanisms include levying an assessment on insurers [broadly defined to include insurers, reinsurers, Multiple Employer Welfare Arrangements (MEWAs), third-party administrators, Administrative Services Only (self-funded) based on covered lives) and establishing lower reimbursement rates for providers (e.g. based on Medicare rates].

In the early 1990s, the outcome of taxing third-party administrators was unclear. The uncertainty dealt with third-party administrator taxations, and if that taxation could stand an Employee Retirement Income Security Act (ERISA) challenge. By taxing the administrator, the cost sharing would be extended to insurance companies as well as to insurers. Some states have used a public subsidy (appropriation) as a means of cost sharing, while others have lower reimbursements for the high-risk pools. Most states that have taxed providers use the generated revenue to fund Medicaid. North Carolina has a provider tax on nursing homes as a means of cost sharing. The Center for Medicare and Medicaid Services (CMS) is in the process of determining how much states can tax providers. Hospitals are more sympathetic to lower reimbursement than a bed tax.

BCBS has historically offered insurance to people who need it, but the price can vary wildly. Costs could be prohibitive. Because BCBS doesn't have a bigger pooling mechanism, the individuals' costs aren't subsidized very much.

BCBS looked at those who applied to Blue Advantage to determine which tiers people would be in, so they could get an estimate of how many people might be eligible for a high-risk pool. Other states are generally limiting the premium cost to 150% of standard risk. BCBS has estimated that approximately 9,000 people would enroll in this plan, and it would cost about $43 million to cover those expenses above 150%. About 1% of the state population is considered uninsurable, but only about 10% of that 1% would enroll, which would cost $4,800 per person per year. This is fairly consistent with what other states have done. North Carolina is in the minority of states that doesn't have a high-risk pool (34 states have a high-risk pool). When this was proposed a year ago, the insurance companies were against it because the plan was going to be financed based on a tax on insurance companies. It wasn't a broad-based way to get funding for the plan. However, it would encourage companies to self-fund because those companies wouldn't have to pay this tax. To make this plan a success, all of the key players must be in favor of its infrastructure and design.

Q: Would it be possible to include the state and local government health plans (BCBS is the third-party administrator for the State Health Plan)?
A: Legislators may not approve the plan if the government health plans are included. It should be logical, but we need to think about it.
Comment: The cost to include governmental health plans is $43 million. The state could appropriate some of this.

Comment: We don't want to create an incentive that would shift people out of the pool because the state is picking up the bill. States whose high-risk pools have been the most successful have include subsidized rates for low-income enrollees.

Comment: BCBS had a $1,500 deductible and 80/20% coverage/copay.

Q: Do we have a mechanism that would estimate the cost of providing the subsidy? Does BCBS have a system to determine the subsidy?
A: Maybe. What percentage of the premium would be subsidized?

Q: At 100% FPG, what is a reasonable cost for people to pay?
A: South Carolina charges $750 for 45 year olds, so asking individuals to pay 90% of their premium would cost $75/month, which is probably too expensive. If we want to make this affordable to people with the lowest income, then our subsidy should start at 95%, and decrease in percentage for individuals with higher incomes. We are already providing an indirect subsidy at 150% standard risk (premium), which is similar to contributions of other states.

Other issues
Our next meeting is November 9th. We will have the final cost estimates and recommendations to report back to the full group.

Adjourn