# NORTH CAROLINA INSTITUTE OF MEDICINE

# Strategic Plan To Assist The Medically Indigent Of North Carolina

## Report of the Task Force on Indigent Care

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## PREFACE

This strategic plan was developed by the North Carolina Institute of Medicine Task Force on Indigent Care to stimulate thinking and discussion on the problem of medical indigency in North Carolina. The North Carolina Institute of Medicine is an independent, non-profit corporation chartered in 1983 by the North Carolina General Assembly. Its mission is to seek constructive solutions to statewide problems that impede the improvement of health and the efficient and effective delivery of health care for all citizens of North Carolina. The problem of indigent care and the uninsured poor have been identified as a major health policy concern by members of the Institute. Consequently, a Task Force was created to address the issue.

At the time this project was undertaken, a number of different groups in North Carolina were working on various aspects of this problem. These included the Indigent Health Care Study Commission (created by the North Carolina General Assembly in 1985), the Health Insurance Trust Commission (created by statute in 1987), and the North Carolina Medical Society Indigent Care Subcommittee. A number of local task forces on indigent care were also at work, including, for example, the Guilford County Indigent Care Task Force, the Mecklenburg County Task Force on Improving Access to Medical Care, and the Pitt County Medical Society Indigent Care Committee.

The IOM Task Force wished to avoid duplicating the efforts of these various groups. It decided, therefore, to concentrate on a task which none of the others appeared to have undertaken: the development of a long-range plan for assisting the medically indigent. This entailed formulating some basic principles regarding individual and social responsibility for health care and making specific recommendations on the basis of these general principles. **The purpose of this project was to design a system that would provide access to an adequate level of health care at an affordable cost to all persons living in North Carolina, with the burden of paying for such care distributed in an equitable manner across individuals and institutions.**

The Task Force recognizes that some aspects of what has been proposed might be rejected by some as not being politically feasible. The Task Force hopes that, by outlining a system that is a major improvement over the current patchwork system of care for the medically indigent, the Institute of Medicine can play an important leadership role in shaping a plan that might prove politically feasible in the future.

The Task Force confronted some challenging philosophical issues in its efforts to define the boundaries of individual, institutional and social responsibilities for care of the medically indigent. The Task Force members hope that their efforts will encourage others in the state to grapple with the same issues. If so, the resultant dialogue and debate might produce consensus on one of the most complicated issues facing state government today.

## SUMMARY

The problem of health care for the medically indigent is large and complex. There is no simple or inexpensive solution to this problem. If there were, it would have been solved a long time ago. Instead, it is a long term problem that cannot be solved in a single year, but instead requires a viable long term strategy that takes into account the complexities involved. North Carolina is in urgent need of a strategic plan to assist the medically indigent because this problem will not go away on its own: it will get worse. Likewise, the state cannot afford to wait for a federal solution that may only slowly emerge, if ever.

This report contains such a strategic plan, designed to address the issue of obtaining adequate health care at an affordable cost.

Three conclusions lie at the heart of this strategic plan:

- **First, that the State of North Carolina has an obligation to ensure that all citizens have access to an adequate level of health care without excessive financial burdens; and**
- **Second, that all citizens should be given universal access to minimum essential health insurance benefits.**
- **Third, that all reasonable cost containment strategies be employed in the provision of care to ensure fiscal responsibility in meeting the goal of the plan.**

The Task Force recognizes that because of its size and complexity, the medically indigent problem cannot be solved either by the public sector or private sector working alone. The strategy proposed here combines public and private sector cooperation in an integrated plan to reduce the size of the population "at risk." If everyone does their share, universal health insurance coverage is possible for all North Carolina citizens. The Task Force believes that a sustained partnership between the public and private sector is a crucial ingredient in any viable long term approach to solving this problem in the years ahead.

The Task Force developed a proposed **minimum essential health benefits plan** (The Benefits Plan) which consists of basic primary care services, including preventive services for all age groups. It also includes 10 days of inpatient hospital coverage and optional coverage for prescription drugs, mental health benefits and convalescent care.

To hold down the premium cost, The Benefits Plan limits inpatient benefits and includes modest deductibles and 20 percent cost-sharing on all services. However, there would be no lifetime maximum on benefits offered and annual out-of-pocket expenses would be limited to $1,500 for individuals and $2,500 for families (or 10 percent of family income, whichever is less). Furthermore, for those below poverty, cost-sharing would be limited to the nominal amounts now used in the Medicaid program.

The Task Force obtained actuarial estimates which showed that The Benefits Plan could be offered at a cost of roughly $77 per month for single coverage and $200 per month for families. The Task Force believes that The Benefits Plan represents a reasonable trade-off between comprehensive benefits and affordability.

In its remaining recommendations, the Task Force has elaborated a system of universal access to minimum essential health insurance benefits.

- **First, with few exceptions, employers would be required to provide health insurance coverage to employees and dependents.**

- **Second, a high risk pool for the medically uninsurable would be created to provide comprehensive coverage at an affordable cost to individuals who otherwise might be denied coverage due to poor health.**

- **Third, Medicaid would be expanded to cover most people below poverty who otherwise could not obtain coverage.**

- **Fourth, a state health insurance pool would be created for those who could not obtain coverage elsewhere at an affordable cost.**

To finance this proposed system, the Task Force outlined some basic principles:

- **The healthy should share in the cost of adequate care for the less healthy. The cost of illness should be spread broadly without regard to people's actual or probable use of care.**

- **People with greater financial resources should share the cost of adequate care for those with fewer financial resources.**

- **The cost of achieving equitable access to health care ought to be shared fairly. The cost should be shared broadly within society and not solely among health care providers. It should not be allowed to fall more heavily on particular practitioners, institutions, or residents of different localities.**

- **Out of pocket costs should be minimized for those unable to pay and health premiums or taxes should be independent of a person's state of health.**

Employers would be expected to pay for 80 percent of employee costs and 50 percent of dependent costs, with the remaining amounts paid by employees. The smallest employers would not be required to provide coverage to employees or dependents, but would be expected to pay an equivalent share of the premium cost for their employees to join either the state health insurance pool or high risk pool.

Premiums for participation in the high risk pool for the medically uninsurable would be based on income, with those below poverty paying no premiums to obtain coverage. Half of the losses on this high risk pool would be paid by insurers and the remainder would be paid by employers.

The federal government would pay for two thirds of the cost of Medicaid and state and local government would share the remainder. Finally, premiums for the state health insurance pool also would be based on a sliding scale, with state government absorbing any losses generated by this pool. Regardless of where people obtained coverage, state government would ensure that the burden on families of paying for essential health care would not exceed 10 percent of family income (and the fraction paid by families with the lowest incomes would be even less).

**The final sections of the report contain recommendations regarding financing the state and local share of health care for the medically indigent.** The Task Force recommendations would require new spending of roughly $1.4 billion a year in North Carolina. However, given the large amount now spent on the medically indigent through the current patchwork system of care and the efficiency savings that would result from individuals having access to timely and adequate primary care, the net amount of new funding required would be $700 million a year. However, more than one third of this amount is for increased cash assistance to AFDC families and a large fraction of the remaining medical costs would be paid by the federal government.

All told, the plan would require a net increase in state expenditures of roughly $200 million a year. The Task Force concluded that in finding ways to pay for such care, more attention needs to be paid to revenue sources which are fair to families at all income levels.The Task Force believes that such additional funding should be used to provide affordable health care for all citizens of this state.

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# I. POLICY GOALS AND OBJECTIVES

## OVERVIEW

The Task Force began its work by agreeing on broad policy goals and objectives. The goals and objectives provide the philosophical framework for the specific recommendations which follow in subsequent sections. In doing so, the Task Force attempted to go beyond the philosophical principles expressed by other groups which have deliberated about the problem of access to adequate health care.

## POLICY GOAL

*RECOMMENDATION 1: The State of North Carolina should adopt the following policy goal: to ensure that all citizens are able to secure an adequate level of health care without excessive financial burdens.*

This parallels the normative standard proposed in 1983 by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1983).[1] However, the Commission did not define explicitly the terms "adequate level of health care" or "excessive burdens". The Task Force has operationally defined both terms below.

### Defining Adequate Level of Health Care

*RECOMMENDATION 2: The State of North Carolina should define "adequate level of health care" as medically necessary care for which expected medical benefits exceed the expected medical harms and for which the expected social benefits exceed expected social costs.*

This minimum standard includes all costworthy care that can effectively prevent or cure disease, relieve suffering, and correct dysfunction (Enthoven, 1988). The Task Force believes that this standard should be thought of as a floor below which no one ought to fall, not a ceiling above which no one may rise. The determination of this level of care should take into account the value of various types of health care in relation to each other as well as the value of health care in relation to other important goods for which societal resources are needed. Furthermore, the total fraction of societal resources that "ought" to be devoted to health cannot and should not be specified in a plan since total health spending results from individual decisions in the health market.

**Defining Excessive Financial Burdens**

*RECOMMENDATION 3: The State of North Carolina should define "excessive burden" in terms of the fraction of annual family income devoted to obtaining adequate health care, including family expenditures for health insurance premiums and out-of-pocket medical expenses, but excluding indirect costs such as transportation, child care or other support services used to obtain adequate health care.*

The Task Force believes that only direct health costs--including family expenditures for health insurance premiums and for out-of-pocket medical costs--should be counted in determining the fraction of family income devoted to health. However, other indirect costs--such as for transportation, child care or other support services required to allow a patient to obtain adequate health care--should not be included.

**Defining Other Excessive Burdens**

The Task Force recognizes that aside from excessive financial burdens, there are other types of burdens that prevent some individuals from obtaining an adequate level of health care. These include time burdens (either travel or waiting times), and lack of support services (such as transportation or child care). The Task Force does think that it is important that the public and private sector address these broader access issues, including the accessibility and affordability of support services needed to obtain adequate health care. However, in this plan, the Task Force is concerned with ensuring that *financial* burdens are not excessive. Therefore, a definition of what non-financial burdens might be considered excessive is beyond the scope of this report.

However, the Task Force is optimistic that by giving individuals and families the means to obtain adequate health care at an affordable cost, other barriers to access may diminish. For example, as health coverage improves for low income individuals in isolated areas, providers may be more willing to practice in such areas, thereby improving geographic access. Similarly, as coverage for primary care services improves, this may result in more medical students electing to become primary care physicians rather than specialists and induce a greater supply of non-physicians such as nurse practitioners.

## POLICY OBJECTIVES

*RECOMMENDATION 4: The State of North Carolina should adopt the following policy objective: to guarantee that all individuals have universal access to minimum essential health benefits.*

The Task Force believes that in order to achieve the policy goal of adequate health care at an affordable cost, universal access to minimum essential health benefits is critical. This approach is a consistent extension of the original goal of Medicaid: ensuring that needy persons receive adequate access to high quality medical care (Davis, 1976).

Universal access to essential health benefits would assist not only the nearly 1.2 million citizens of North Carolina who are uninsured at least some time during the year, but also the 750,000 who are underinsured.[2]

## RESPONSIBILITY FOR MEETING GOALS AND OBJECTIVES

*RECOMMENDATION 5: The public and private sector should share in the responsibility for attaining the objective that all individuals have universal access to minimum essential health benefits.*

The Task Force supports a pluralistic approach in which responsibility is shared among individuals, employers, insurers, providers, as well as local, state and federal government. The private sector alone cannot do the job because there are too many people who do not have access to employer-provided health benefits, which has been the principal vehicle for providing coverage through the private sector. Likewise, however, the public sector cannot do it alone because of federal restrictions on Medicaid eligibility and because it would be both very expensive and unfair for the state to underwrite the entire cost of expanding coverage for the nearly one third of the state's population which is either uninsured or underinsured each year.

In assigning responsibilities, the Task Force has distinguished between a) making available *health insurance coverage*; b) making available *health services*; and c) *financing* either health insurance coverage or health services. The Sections which follow outline The Benefits Plan recommended by the Task Force and detail the recommended allocation of responsibilities for making available health coverage, making available health services, and financing coverage and services.

## IMPLEMENTATION TIMETABLE

The Task Force recognizes that the medically indigent problem cannot be solved overnight. It is a long term problem which can be addressed in incremental steps in the years ahead.[3] The members believe that the appropriate timing of steps to expand access to care for the medically indigent depends on political factors and fiscal constraints that are beyond their capacity to predict. However, they are optimistic that this document can serve as a framework for taking appropriate steps in a systematic and coherent fashion as opportunities arise in future years.

## II. MINIMUM ESSENTIAL HEALTH BENEFITS

### OVERVIEW

The Task Force has developed a health insurance benefits plan (The Benefits Plan) which contains the minimum essential health benefits that should be available to all citizens. The resulting package represents a trade-off between comprehensive benefits and affordability.

To develop The Benefits Plan, the Task Force reviewed a number of potential models. Ultimately, they modelled the plan after a similar "basic benefits package" proposed by the national Health Policy Agenda for the American People. The Task Force modified this basic benefits package based on a review of a number of other potential models. There were five different types of potential models, as follows:

- Recommended minimum benefit proposals developed by other groups, including one developed by Roche Laboratories (Sudovar and Feldstein, 1979) and the minimum standards for major medical policies approved in 1980 by the National Association of Insurance Commissioners (reported in State of Wisconsin Council on the Uninsured, 1980).

- Existing statutory requirements for minimum benefits, such as the minimum benefit requirements for federally qualified HMOs (OHMO, 1982), minimum benefit standards established for group and individuals policies in Connecticut (reported in Van Ellet, 1981); minimum benefits to be made available by carriers in Minnesota (reported in Van Ellet, 1981).

- Minimum health benefits requirements in various employer-mandated benefits plans, including that now in operation in Hawaii (reported in Van Ellet, 1981); the newly-passed program in Massachusetts (House Bill H5210); and the proposed Kennedy plan (Alpha Center, 1988).

- Health benefits provisions of state health insurance pools proposed in Washington state (Roberts, 1986) and Wisconsin (State of Wisconsin Council on the Uninsured, 1987).

- Health benefits now being offered to North Carolina teachers and state employees through the Comprehensive Major Medical Plan and the Blue Cross and Blue Shield of North Carolina Personal Care Plan.

## RECOMMENDED MINIMUM ESSENTIAL HEALTH BENEFITS PLAN

### Summary

The Benefits Plan recommended by the Task Force covers basic primary care services, including age-specific preventive care services developed through Project INSURE (Logsdon, Rosen and Demak, 1982) and the Canadian Periodic Health Examination Task Force (1984). The plan includes 10 days of inpatient hospital coverage and optional coverage for prescription drugs, mental health benefits and convalescent care.

To hold down the premium cost, the plan includes modest deductibles and 20 percent cost-sharing on all services. However, there would be no lifetime maximum on benefits offered and out-of-pocket expenses are limited to $1,500 for individuals and $2,500 for families (or 10 percent of family income, whichever is less). Furthermore, for those below poverty, cost-sharing would be limited to the nominal amounts of cost-sharing now used in the Medicaid program.

### Detailed Benefit Provisions

Most covered medical expenses are subject to an annual deductible and coinsurance:

- **Deductible**--deductibles may not exceed $200 per person ($400 per family) per calendar year for inpatient hospital care; $100 per person ($250 per family) for all other care. A separate deductible of up to $75 is permitted for each emergency room visit (this can be waived for medically necessary visits). For those below poverty, no deductible may be required.

- **Coinsurance**--the individual or family share of expenses may not exceed 20% of allowable charges for covered expenses, up to the maximum out-of-pocket limit.[4] For those below poverty, copayments should not exceed those in effect for Medicaid eligibles in North Carolina.[5]

- **Maximum Out-of-Pocket**--Out-of-pocket expenses would be limited to $1,500 per person and $2,500 per family or 10 percent of family income, whichever is lower.

Minimum benefit plans would have to be offered without a waiting period or exclusions for medical conditions. The following medical expenses must be covered. All plans may permit pre-certification of selected benefits as noted. Those covered through subsidized risk pools proposed by the Task Force would have benefit plans which include such cost containment features (Recommendation 23).

- **Inpatient Hospital Services**--full coverage of semi-private room and board for a minimum of 10 days per year[6]; all intensive care unit costs; radiology services; laboratory tests; medical supplies; operating/recovery room for all surgery and anesthesia (transplants are excluded); and drugs/medicines (plans may restrict use of such drugs to a formulary if non-formulary drugs can be substituted at the request of the attending physician). Private duty nursing would not be covered. Pre-certification of all inpatient services is permitted.

- **Outpatient Services**--full coverage of pre-admission tests; radiology, pathology; outpatient surgery (pre-certification is permitted) and emergency room.

- **Ambulance Services**--full coverage of ambulance/rescue squad services for medical emergencies (excluding air ambulance).

- **Medical Supplies/Equipment**--full coverage in inpatient and outpatient settings of blood/plasma; medical supplies; prosthetic/orthopedic/durable medical equipment (pre-certification is permitted); medications; casts and dressings.

- **Therapy Services**--full coverage in inpatient and outpatient settings of physical therapy; inhalation therapy; speech therapy; and radiation therapy. Cardiac rehabilitation therapy is not covered. Pre-certification is permitted for all therapy services.

- **Physician Services**--full coverage of inpatient visits; all surgery and anesthesia (excluding organ transplants); office visits; specialty care; X-ray and laboratory services. Chiropractic and podiatry services are not covered.

- **Preventive Services**--full coverage of periodic physical examinations, including immunizations, ear examinations and vision screening for children, as recommended in the Health Policy Agenda for America Basic Benefits Package (1988).[7]

- **Pregnancy-Related Services**--full coverage, with no copayments, of maternity care (pre-natal and post-natal) and well-baby care.

The following are *optional* coverages that must be offered in all health benefit plans (if elected, the insured may be required to pay the full amount of any additional premium costs related to these optional services). The optional coverages listed below would be subject to the same cost-sharing provisions of the minimum essential health benefits plan, except where noted. Nothing would prevent a carrier from offering optional benefits in addition to those shown.

- **Chronic/Extended Services**--full coverage for 30 days of short-term rehabilitative care in a skilled nursing facility; and 30 days of home health services related to short-term rehabilitation.

- **Prescription Drugs**--full coverage of all prescription drugs, with no more than a $500 deductible and 20 percent copayment. Any cost-sharing requirements must be waived in the case of life-saving drugs when they are pre-certified.

- **Mental Health**--full coverage for 60 days of inpatient psychiatric care. Up to 50 percent copayment may be required for outpatient benefits and such benefits may be limited to an annual maximum of $1,000.

- **Chemical Dependency**--full coverage for services related to alcohol or drug dependency. Maximum benefits may not be limited to less than $6,000 annually or $12,000 lifetime.

- **Sterilization, contraceptives and family planning services**--full coverage subject to regular deductibles and cost-sharing.

## ASSESSMENT OF MINIMUM ESSENTIAL BENEFITS PLAN

In developing The Benefits Plan, the Task Force balanced affordability with comprehensiveness of coverage. As one illustration, the Task Force was concerned about the high cost of adding an annual physical examination to the minimum benefits plan. Some believe that such exams are cost-effective since they can assist in early detection of disease and thereby reduce preventable hospitalizations. However, the carefully controlled Rand Health Insurance Study showed that there is no significant difference in overall health expenditures or health status for those who received a randomly assigned physical exam and those who did not (Lillard, *et al.*, 1986). Therefore, the Task Force selected more conservative preventive care recommendations developed by groups which had studied the problem for years.

There are two ways of assessing the recommended minimum essential benefits plan: by examining its cost and by comparing it to what typical health plans now offer. After assessing the plan as described below, the Task Force is satisfied that their proposed plan represents a reasonable balance between comprehensive benefits and affordability.

### Estimated Premium Cost

In order to estimate accurately the cost impact of the strategic plan, the Task Force obtained an actuarial estimate of the cost of offering The Benefits Plan through a state health insurance pool. The premium cost for single coverage in

1988 would be roughly $77 per month and the family rate would be roughly $200 per month. If optional coverages are included, the single rate would increase by $40 per month and the family rate would increase slightly more than $100. The Task Force believes that the rate for The Benefits Plan (without optional coverage) represents a reasonable trade-off between comprehensive benefits and affordability.

This computation was based on several key assumptions:

- Hospitals are paid using Medicaid reimbursement rates for hospitals (see Recommendation 37).

- Physicians are paid using the new relative-value scale developed at Harvard for use by Medicare (Hsiao, *et al.*, 1988). Fees would be adjusted using this scale so that the average fee equals roughly 80 percent of the typical fee under usual, customary and reasonable (UCR) reimbursement (see Recommendation 36).

- Maximum allowable cost-sharing limits also were assumed (e.g., a separate $75 deductible per emergency room visit) along with full use of pre-certification, where permitted (see Recommendation 22).

- No optional services were included (see Recommendation 22).

- Administrative costs of 8 percent were assumed.[8]

**Comparison With Other Minimum Benefit Proposals**

The estimated premium is very similar to that of the proposed state health insurance pool in Washington state ($70 per month in 1986 dollars, excluding administrative costs; Claxton, 1986). Estimates of the Kennedy-Waxman mandated benefits bill range from $59 to $100 per month (Haislmaier, 1988). Moreover, $77 a month probably is at the upper end of what firms which now do not offer plans might regard as affordable. A recent North Carolina survey found that cost of insurance is the overwhelming reason offered by small employers for not offering coverage (Wade, 1988). This particular survey was unable to assess how much small employers might be willing to pay for health insurance. However, a recent Tennessee survey of small employers showed that the combined amount that small companies and their employees were willing to pay is only $30 to $35 per month (Alpha Center, 1988b).

This is consistent with a Washington state survey of individuals which showed that those below poverty would be willing to pay $21 per month for health coverage, those between 100 and 149 percent of poverty would be willing to pay $33 per month and those between 150 and 199 percent of poverty would pay up to $44 per month (Claxton, 1986). Since at least two thirds of the uninsured in North Carolina have incomes below 200 percent of poverty, these survey figures suggest that a premium level much above $75 would not be viewed as very attractive by those who most need help.

Another way to compare the premium is by relating it to wage levels. More than half of North Carolina's working uninsured have hourly earnings below 125 percent of minimum wage. For a full-time minimum wage worker, a $75 per month premium would represent 13 percent of hourly earnings, while the family premium would represent more than one third of hourly earnings. As a comparison, in 1986, U.S. employer contributions for group health insurance--including both employee and dependent coverage--averaged only 5.2 percent of all wages and salaries (EBRI, 1988).

**Comparison of Recommendations with Current Health Benefits**

An alternative way to assess The Benefits Plan is to compare it to what is now offered by employers. As an example, the proposed plan prohibits exclusions for pre-existing conditions. However, roughly two thirds of the employers with health plans currently do not provide coverage for treatment of pre-existing conditions (TPF&C, 1987), so this feature of the proposed plan would affect a large number of employers even if their plans otherwise met or exceeded those in the minimum essential benefits plan. The Kennedy-Waxman proposal also prohibits exclusions for pre-existing conditions, whereas the Massachusetts mandated health benefits law does not (Alpha Center, 1988b). Normally, such a provision protects employers against adverse selection, since those in worse health would tend to gravitate towards plans which have no exclusions. However, with universal access to coverage, adverse selection should no longer be a major concern, so the Task Force thought this provision would not be particularly onerous.

Likewise, the Task Force plan would allow no waiting period before benefits could begin: an employee would be covered from the first day of employment. Yet currently, two-thirds of firms with plans require waiting periods which range from 1 month to 12 months: a typical waiting period is two to three months (Chollet, 1984). The Kennedy-Waxman bill uses a thirty day waiting period (Haislmaier, 1988), while the Massachusetts plan uses a 90 day waiting period for full-time employees or part-time employees who are heads of households or a six month waiting period for other part-time workers (McGovern, 1988). Again, waiting periods are most needed when there are concerns about adverse selection. But if everyone has equitable access to health benefits, this no longer should be a problem.

As shown in Table 1, a large fraction of employers already cover services included in the required benefits recommended by the Task Force: of the services for which data is available, at least 80 percent of employer plans already cover those required services. (There is no way of telling from available data whether the detailed coverage provisions for each of these services would meet the Task Force minimum requirements). For the optional services, at least 75 percent of employers already offer some coverage. These figures suggest that the selected levels of benefits do in fact represent what most employers regard as essential health benefits and that large numbers of employers would not be forced to upgrade their plans in order to comply with the requirements recommended by the Task Force.

## Table 1

### Comparison of Minimum Essential Health Benefits Recommendation With Current Employer Coverage

| BENEFIT PROVISION | TOTAL | PERCENT OF EMPLOYERS OFFERING COVERAGE, BY SIZE OF FIRM 1 to 9 | 10 to 24 | 25 to 99 | 100 to 499 | 500 & Up |
|---|---|---|---|---|---|---|
| REQUIRED BENEFITS | | | | | | |
| $2,500 Maximum Out of Pocket* | 82 % | 80 % | 80 % | 88 % | 89 % | 91 % |
| Hospital Room & Board/Surgical | 100 | 100 | 100 | 100 | 100 | 100 |
| Outpatient Care | 99 | 98 | 99 | 100 | 100 | 100 |
| Physician Hospital Visits | 99 | 100 | 97 | 100 | 100 | 100 |
| Physician Office Visits | 83 | 82 | 81 | 95 | 95 | 97 |
| X-ray and Lab | 99 | 98 | 99 | 100 | 100 | 100 |
| Maternity | 84 | 82 | 82 | 90 | 95 | 97 |
| OPTIONAL BENEFITS | | | | | | |
| Home Health/Extended Care | 76 | 76 | 70 | 83 | 85 | 91 |
| Outpatient Prescriptions | 87 | 89 | 81 | 82 | 85 | 94 |
| Mental Health | 82 | 82 | 71 | 92 | 93 | 88 |
| BENEFITS NOT REQUIRED | | | | | | |
| Private Duty Nursing | 66 | 68 | 55 | 72 | 70 | 79 |
| Dental | 33 | 36 | 20 | 33 | 41 | 51 |
| Vision | 20 | 23 | 14 | 14 | 12 | 15 |

NOTE: All percentages shown are based on employers who currently offer health coverage.

* Percentages shown include estimated fraction of firms which have out-of-pocket maximum which is less than the required level. Figures are reported for out-of-pocket maximum of $2,000-4,999. For all firm sizes, only 4 to 6 percent fell into this range: it was assumed that only one fifth of these firms had an out-of-pocket maximum below $2,500. Separate figures were not reported for firm sizes of 1 to 9 and 10 to 24.

SOURCE: ICF analysis of Small Business Administration, Office of Advocacy, Health Benefits Data Base, 1986 (ICF, 1987, p. IV-6).

## III. RESPONSIBILITY FOR MAKING AVAILABLE HEALTH INSURANCE COVERAGE

### OVERVIEW

The Task Force concluded that responsibility for making available coverage had to be shared among several groups, including insurers, employers, individuals, and state government. Everyone would have access to minimum essential coverage through one of five sources:

- Employer-based group plans would cover the majority of people (as they do now).
- Medicare would cover most elderly and disabled and would be supplemented by employer-based coverage for many retirees, and by Medicaid for those with the lowest incomes.
- Medicaid would cover most people below poverty who could not otherwise obtain employer-based coverage.
- A state health insurance pool would be created to assist anyone who otherwise could not obtain coverage, including those below poverty.
- A separate high risk pool for the medically uninsurable would be created for high risk individuals who might otherwise drive up the cost of small employer plans or the state health insurance pool.

Most people would have benefits beyond those included in the minimum essential health benefits plan (as they do today). But unlike the current patchwork system of care for the medically indigent, no one would be permitted to "fall through the cracks." Everyone would be assured a minimum level of health coverage. The responsibility for making available coverage does not necessarily coincide with the responsibility to finance the coverage which is offered. Section V addresses the issue of how the responsibility of paying for universal health coverage should be divided.

### RESPONSIBILITY OF THE FEDERAL GOVERNMENT

The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research concluded that "the Federal government has the ultimate responsibility for seeing that health care is available to all when the market, private charity, and government efforts at the state and local level are insufficient in achieving equity (President's Commission, 1983, p. 5).

There are enormous inequities in the availability of care nationally, as documented by that Commission and the evidence suggests that there are equally disturbing inequities in the distribution of care available to the medically indigent in North Carolina (Danzon and Conover, 1985; CHPRE, 1986a; CHPRE, 1986b; CHPRE, 1986c). There are more than 50 million people in the U.S. who are inadequately protected against large medical bills (Farley, 1985) and extensive evidence that many individuals defer or are denied needed medical services because of inability to pay (see Section VII).

A federal solution to this problem is unlikely to emerge during the next four years, given the federal deficit problem. The Task Force believes that in the absence of federal action, North Carolina cannot and should not wait to address the medically indigent problem because it is too large to ignore. If left unattended, this problem is likely to worsen rather than improve.

The Task Force concluded that the Federal government should make changes to support state initiatives to ensure universal access, including removing certain statutory barriers which impair the ability of states to address this problem equitably.

**Lift Restrictions on High Risk Pools**

> *RECOMMENDATION 6: The Federal government should amend the Employee Retirement and Income Security Act of 1974 (ERISA) to permit states to require self-insured employers to participate in high risk pools for the medically uninsurable.*

ERISA currently allows states to require health insurance companies to participate in high risk pools for the medically uninsurable, including participating financially in the losses from such pools. However, ERISA prohibits states from including self-insured employers in such pools. This is inequitable since it allows the largest firms (which are most likely to self-insure) to avoid paying this obligation. It raises the cost of insurance for the remaining firms and thereby increases the incentive to self-insure, resulting in an even greater burden on small and middle size firms which are not in a position to self-insure.

One possible way around this barrier is to impose an excise tax on health spending for self-insurers who do not participate in the pool (Amkraut, 1986). However, the legality of such an approach has not yet been tested. Administratively, it would be simpler to have all self-insured firms be included in the pool without resorting to such a "pay-or-play" device. The Task Force recommendation is consistent with draft legislation recently developed by the AMA (Council on Medical Service, 1988). Washington state recently created a high risk pool with an express statutory provision to include self-insured plans if ERISA is amended.

### Lift Restrictions on Mandating Benefits

*RECOMMENDATION 7: The Federal government should amend the Employee Retirement and Income Security Act of 1974 (ERISA) to permit states to require all employers to provide minimum essential health benefits to employees and their dependents.*

Again, ERISA allows states to impose mandated benefits on insurance companies, but preempts states from imposing the equivalent requirements on self-insured employers. If states establish extensive minimum benefits requirements on insurance companies, the added cost of such benefits may be an inducement for employers to self-insure to avoid such requirements. The only state which has been given an exemption from ERISA is Hawaii, which has had mandated employer-based coverage since 1975. The recent Massachusetts mandated coverage statute avoids ERISA restrictions by using a "pay-or-play" mechanism. All employers must pay a surcharge of 12 percent of each full-time worker's first $14,000 in annual wages--up to a maximum of $1,680 per employee. Businesses that provide insurance to their workers may deduct their premium expenses from the surcharge payment, while companies that do not provide coverage must pay the full amount (Alpha Center, 1988b).

## RESPONSIBILITY OF INSURERS

### Availability of Group Health Benefits

*RECOMMENDATION 8: The State of North Carolina should require all health insurers to make available, at the lowest possible premium cost, at least one group health benefits plan which contains minimum essential health benefits for subscribers and their dependents.*

This requirement would apply to roughly 280 commercial health insurance companies and health maintenance organizations operating in the state, as well as to Blue Cross and Blue Shield of North Carolina.

### Participation in High Risk Pool for the Medically Uninsurable

*RECOMMENDATION 9: The State of North Carolina should require all health insurers to participate in a statewide high risk pool for the medically uninsurable.*

There may be as many as 100,000 individuals in North Carolina who are "medically uninsurable." These individuals are unable to obtain health insurance coverage due to medical conditions such as diabetes, hypertension, or kidney disease. They may be denied coverage altogether or rated as "substandard", in which case they receive policies which specifically exclude services related to their condition or must pay higher premiums, or both (OTA, 1988).[9]

Currently, Blue Cross and Blue Shield of North Carolina offers a "Special Non-Group Application Policy" (SNAP) plan for those who have been denied coverage elsewhere.[10] Certain limitations in the SNAP plan, however, make creation of a statewide high risk pool desirable.

First, the SNAP plan is too expensive for precisely those who need it. The current average SNAP premium is $187 per month for one person, which is roughly 140 percent of the average non-group premium rate.[11] For a typical poverty family with three people, this premium is nearly one fourth of family income. Because an estimated four fifths of the medically uninsurable have incomes below poverty, it is not surprising that the SNAP plan has only been able to enroll less than 2 percent of those who could otherwise qualify. If Medicaid is expanded as the Task Force recommends, many of the medically uninsurable would qualify. But fully one fourth of the poor would continue to be ineligible for Medicaid (including some who are medically uninsurable), because they do not meet federal categorical requirements.

Second, although the SNAP plan offers comprehensive benefits, they are subject to a $500 deductible and 20 percent copayment, including for hospital services. These exceed the Task Force-recommended cost-sharing limits that would be used in a statewide high risk pool.

Third, SNAP benefits are subject to a one year waiting period on pre-existing conditions. In contrast, nearly every statewide risk pool now in place uses a six month waiting period on pre-existing conditions and Maine offers only a 3 month waiting period (GAO, 1988).

Fourth, pooling all medically uninsurables--not just a few thousand--into a single risk pool could trim premium costs substantially. Nationally, 10 percent of non-institutionalized patients generate 75 percent of health costs (Garfinkel *et al.*, 1988). Many of the medically uninsurable are among this high-user group. By pooling them, the opportunity exists to use case management and other effective cost containment techniques to trim medically unnecessary services. In addition, at the rates now being charged through SNAP, it would cost more than $200 million to cover all medically uninsurable individuals. Whether the pool is managed by the state (which is already a major health purchaser through Medicaid and the health insurance plan for teachers and state employees) or through a private carrier, this enormous claims volume offers the opportunity to negotiate reimbursement rates (e.g., Medicaid rates for hospitals) that are lower than those paid by BCBSNC and to reduce the costs of covering such individuals accordingly.

Finally, the Task Force believes that on equity grounds, all health insurers--not just BCBSNC--should share in the financial losses associated with a high risk pool. State high risk pools for the medically uninsurable are endorsed by the North Carolina Medical Society (NCMS, 1988) and the North Carolina Hospital Association (NCHA, 1987).[12]

## RESPONSIBILITY OF EMPLOYERS

### Mandated Coverage Requirement

Mandated Coverage for Employees and Dependents

> *RECOMMENDATION 10: The State of North Carolina should require all public and private employers, except new firms and those with fewer than six workers, to offer minimum essential health benefits to all full- and part-time employees and their dependents.*

Nearly 70 percent of the uninsured are full- or part-time workers or dependents of such workers. Since 75 percent of North Carolina workers already obtain health coverage through an employer, it is sensible to explore ways of getting similar coverage for the remaining 25 percent. This mandate would apply to all employees working at least 17.5 hours per week, excluding temporary and seasonal employees (see Recommendation 14).

The Task Force considered voluntary approaches which rely on incentives. However, the best available evidence suggests that even if a 30 percent tax credit were offered to businesses as an inducement to offer health insurance, no more than 15 percent of firms without plans would begin to offer them (Danzon, 1987b). As a result, the Task Force concluded that a purely incentive-based approach to expanding health insurance coverage would be an expensive impracticality.

Further, the Task Force believes that such a mandate is more equitable than the current system. In the current system, large employers usually pay twice for health care: once for their own employees and then again to cover hospital cost-shifting that is caused largely by the employees and dependents of small firms, who are less likely to have health coverage. The Task Force believes that imposing minimum standards for health benefits is no different than other minimum standards which have been established for business, including unemployment insurance, the Social Security payroll tax and minimum wage standards established by both the state and Federal government.

Certain issues would need to be addressed, however, to implement this approach. First, as noted earlier, unless ERISA is amended, federal restrictions would require North Carolina to adopt a "pay-or-play" approach to obtaining mandated employer-based coverage. Under "pay-or-play", all employers would be required to pay a tax surcharge, but firms which already offer plans could deduct their contributions for health benefits from the amount of the surcharge. Thus, firms which elected not to offer health benefits would pay the full tax, while most employers offering plans would pay nothing. Should Congress remove the ERISA restrictions, the Task Forces would prefer a direct mandate requiring firms to offer coverage to the "pay-or-play" approach which allows firms to opt out of offering coverage.

Although this recommendation may be controversial, this idea has been tried with success in Hawaii, where mandated employer-based coverage for employees (but not dependents) has resulted in a 60 percent decline in the uninsured rate (Van Ellet, 1981).[13]

*RECOMMENDATION 11: The State of North Carolina should permit all employees and working dependents who could be covered either through their own employer or as dependents on another plan to select which plan from which to obtain minimum essential health benefits.*

The Task Force believes that sufficient flexibility should be built into the system to allow individuals to decide the best arrangement for themselves, to avoid forcing all employees to obtain primary coverage from their employer when they could be covered as a dependent under a family plan.

Mandated Coverage for Retirees

*RECOMMENDATION 12: The State of North Carolina should require all public and private employers, except new firms and those with fewer than six employees, to offer minimum essential health benefits to all retirees and their dependents.*

Nearly all elderly persons--particularly retirees--qualify for Medicare coverage. However, because of numerous gaps in Medicare coverage, more than three fourths of the elderly purchase some sort of supplemental coverage which will cover copayments and deductibles and certain services not provided through Medicare (Garfinkel, Corder and Dobson, 1986). This recommendation allows retirees who wish to supplement Medicare access to group health insurance rates, which on average would be lower than purchasing comparable coverage through an individual policy.

This recommendation is an extension of existing federal laws which require firms with 20 or more employees and which offer a health benefits plan to offer the equivalent coverage to workers and their spouses who are 65 and over even if they could qualify for Medicare (SBA, 1987). This recommendation largely conforms to current practice among employers. Nationally, for workers in medium and large firms, 75 percent of workers have retiree health coverage under age 65 and 68 percent have retiree health coverage after age 65. For smaller firms, rates of retiree coverage probably are less (EBRI, 1988).

Mandated Coverage for College Students

*RECOMMENDATION 13: The State of North Carolina should require all public and private colleges and universities in North Carolina to ensure that all full- and three-quarter time students have minimum essential health benefits.*

National figures show that students comprise 7 percent of all adults 18 to 64 who are uninsured: the rate of being uninsured among students (29.8%) is twice as high as for other non-elderly adults who are employed (13.5%; see Sulvetta and Swartz, 1986). This recommendation would apply to the roughly 250,000 students of higher education in North Carolina--of whom roughly 75,000 are uninsured.[19]

**Exemptions from Mandated Coverage Requirements**

The Task Force is aware that mandated employer-based coverage might result in a particular hardship for certain types of employees or employers. Therefore, it recommended the following exceptions to the employer coverage mandate.

Exemption for Part-time/Seasonal Workers

> *RECOMMENDATION 14: The State of North Carolina should exempt all firms from having to offer minimum essential health benefits to either part-time workers who are employed fewer than 17.5 hours per week or seasonal/temporary workers.*

National data show that 74 percent of employers with health plans do not provide coverage for part-time workers working as few as 17.5 hours (TPF&C, 1987). As a result, setting the threshold at this level potentially will affect many firms. Nevertheless, in terms of *workers*, this exclusion would affect only about 5 percent of uninsured workers who are employed fewer than 17.5 hours a week.[14]

The rationale for selecting this threshold was to balance two concerns: if set too high (e.g., 32 hours per week), employers could avoid the mandate by converting full-time workers into part-time workers just below the threshold. But if it were set too low (e.g., 10 hours/week), the cost of the health benefit relative to the worker's wages would be high and could result in substantially reduced employment opportunities for such individuals. The threshold selected is low enough to minimize employers' conversion of full-time jobs into two part-time jobs.

Since any part-time workers not covered through employers will be able to join a state health insurance pool, this will ensure that their health needs are met adequately. Even though employers would not be required to offer a plan to such workers, they would be expected to contribute a portion of premiums costs of the state health insurance pool.

The Task Force deliberately excluded seasonal workers from the mandate, in part because migrant farm workers already have a publicly financed system of care.[15] But not all migrant workers have adequate access to services (Quillin, 1988). Because migrant workers are not state residents, they would not qualify for participation in the state health insurance pool. Therefore, in a later section, the Task Force recommends expansion of health services to such migrant workers (see Recommendation 26).

Exemption for Small Firms

*RECOMMENDATION 15: The State of North Carolina should exempt all firms with fewer than six workers, including the self-employed, from having to offer minimum essential health benefits to any employees.*

This exclusion would affect almost 120,000 uninsured workers in North Carolina--nearly one third of the total number of working uninsured.[16] Since most insurance companies would not give such firms a group rate, there is no particular advantage to requiring that employees in such firms be given coverage. Instead, such employees and their dependents would be eligible to obtain coverage through the state health insurance pool. Even though employers would not be required to offer a plan to such workers, they would be expected to contribute a portion of premiums costs of the state health insurance pool.

Exemption for New Firms

*RECOMMENDATION 16: The State of North Carolina should exempt all firms with fewer than 20 employees which have been in operation for five years or less from having to offer minimum essential health benefits to any employees.*

The Task Force recommendation would exempt new firms from having to offer coverage, but would require financial participation (on a phased-in basis) for firms whose employees elect to join the high risk pool, state health insurance pool, or Medicaid (Recommendations 30 through 32).[17]

The specific threshold selected by the Task Force is based on the rate of small business closure. The Task Force favored the phased-in approach, but wished to ensure that full participation by new firms did not occur until after the point at which most small businesses appear able to survive financially. A recent study shows that the cumulative fraction of small firms which fail rises steeply during the first five years, but levels off after that time.[18]

Although the Task Force recognizes that an exemption for new firms may provide an incentive for firms to dissolve and re-incorporate periodically, this possibility would have to be carefully monitored to avoid this type of "gaming." Corrective steps could be taken in the future if a significant number of firms were attempting to obtain an exemption in this fashion.

## RESPONSIBILITY OF INDIVIDUALS

*RECOMMENDATION 17: The State of North Carolina should require all legally responsible adults to cover themselves and their dependents through whatever health plan with minimum essential health benefits is available to them.*

This requirement extends to all individuals, including all types of workers, unemployed workers and those not in the labor force. This requirement would not penalize individuals who could not find any source of coverage because anyone who otherwise is without a potential source of coverage can join the state health insurance pool as a last resort. The Task Force recommends this approach to ensure that individuals or families do not opt to be uncovered to avoid paying their share of premium costs.

1977 data for the U.S. show that among those who are uninsured all year, 11.1 percent declined to enroll in a plan made available to them (Monheit, 1985). More recent data show that the percent of employees who refused employer-based coverage ranges from 7 percent in the largest firms to 14 percent in the smallest (HIAA, 1988), but it is not known how many of those who decline had coverage elsewhere. Non-participation in Medicaid also is a large problem. On average, roughly 10 percent of North Carolina's poor are eligible for, but do not participate in Medicaid.[20]

The Task Force believes that citizens should not be allowed to choose not to protect themselves against financially catastrophic illness and then expect to be given free health care when their medical needs exceed their ability to pay. A requirement to purchase adequate health insurance (or participate in Medicaid) is consistent with the principle of mandatory Social Security deductions or mandatory purchase of a minimum level of automobile liability coverage.

## RESPONSIBILITY OF STATE GOVERNMENT

### Expansion of Medicaid

#### Expand Categorical Eligibility

*RECOMMENDATION 18: The State of North Carolina should expand Medicaid eligibility as much as federal categorical rules allow.*

In 1987, the state of North Carolina substantially expanded its Medicaid program by taking advantage of a number of options to extend coverage to certain population groups. The most optimistic estimates suggest that once these expansions are fully implemented, the number eligible for Medicaid will increase by 125,000--an increase of nearly 30 percent over the number previously eligible. Even though this expansion would reduce the number of uninsured poor by nearly 100,000, there would continue to be more than 300,000 uninsured poor.

Roughly one-fifth of these are individuals who could qualify under current eligibility standards, but who for various reasons do not do so. Efforts to expand outreach or streamline eligibility procedures might be useful in pulling more of these non-participants into the program.

Current federal eligibility rules allow several options for expanding Medicaid eligibility without requiring an increase in eligibility standards: a) increase coverage for all *pregnant women and infants* up to 185 percent of poverty; b) increase coverage for all *children age 5 through 7* up to 100 percent of poverty; c) increase coverage for all *aged, blind and disabled* individuals up to 100 percent of poverty (the recent Medicare Catastrophic Coverage Act requires states to pay for Medicare cost sharing amounts through Medicaid for such individuals, but not to provide them with full Medicaid benefits); d) extend automatic eligibility to all *aged, blind and disabled individuals who qualify for Supplemental Security Income* (SSI). The Task Force endorses all of these options. These options would reach more than 200,000 new eligibles, of which roughly 40,000 would be uninsured poor.

These recommendations parallel those endorsed by the Indigent Health Care Study Commission in 1987. The Commission recommended the first two options and an expansion to all aged, blind and disabled individuals below 75 percent of poverty. The North Carolina Medical Society is on record as supporting these Commission-recommended expansions (NCMS, 1988). The North Carolina Hospital Association also supports maximum possible expansion of Medicaid (NCHA, 1987). If universal coverage is the desired policy objective, the Task Force believes it makes little sense not to cover as many as possible through Medicaid, since this will allow those at highest risk to obtain the most comprehensive coverage, but at a very low cost to the state, since federal matching funds will cover two-thirds of the cost of these expansions.

Increase Income Standards

> *RECOMMENDATION 19: The State of North Carolina should raise AFDC payment levels to 75 percent of poverty, resulting in an increase in Medicaid medically needy income standards to 100 percent of poverty.*

Under current federal eligibility rules, the maximum income level used to determine Medicaid eligibility cannot exceed 133 percent of the state's AFDC payment standard. This means that with the exceptions noted above, North Carolina cannot raise income standards unless it is willing to increase cash payments made to single parent families with dependent children. Historically, AFDC payment standards as a percent of poverty have been set very low: the standard for a family of four is only 30 percent of poverty. Thus, to increase medically needy income standards to 100 percent of poverty would require AFDC payment standards to be set at 75 percent of poverty--more than double the current levels. This has made policymakers reluctant to expand Medicaid, since the state would have to find a way to pay for both expanded health benefits and higher welfare payments.

The Task Force believes that Medicaid should be available to all persons below poverty. The least expensive approach to achieving this objective would be if the Federal government lifted all categorical restrictions and expanded

Medicaid to all individuals below poverty regardless of family structure or employment status. The Task Force would support expanding Medicaid in this fashion if such federal changes were made.[22]

However, the Task Force also feels that the objective of reaching as many below poverty as possible through Medicaid is sufficiently important to warrant an increase in income standards--even if this means increased payments to AFDC families. The Task Force recognizes that poverty itself also has an impact on health status (Luft, 1978) and that helping people out of poverty would give them the means for better health. This proposed increase is consistent with a recent recommendation of the the Indigent Health Care Study Commission to increase AFDC payment standards by 10 percent.[23]

Medicaid Buy-in for Employers

> *RECOMMENDATION 20: The State of North Carolina should permit employers to purchase Medicaid coverage for any employee or dependent who is Medicaid eligible, in lieu of such individuals being covered through the employer's group health plan.*

Nationally, about 8 percent of Medicaid recipients also are covered by an employer-based health insurance plan (U.S. Bureau of the Census, 1987a). Starting on April 1, 1990, federal law requires states to provide a 12 month "work transition" period for anyone who would be disqualified from AFDC due to an increase in hours or income, so long as they had been enrolled in AFDC for at least three of the previous six months.[21]

The Task Force thinks that a Medicaid buy-in would have several benefits. First, it would benefit employees by giving those who are Medicaid eligible much more comprehensive coverage than they otherwise could have obtained through their employer plan. The employee also would benefit by not having to contribute the 20 percent of group premiums that generally would be required for the employer plan.

Second, it would benefit state government by allowing employer premium contributions on behalf of eligible employees to replace state general funds that otherwise would have been used to obtain federal matching dollars to pay for Medicaid benefits for covered employees. This would allow an expansion of Medicaid at no cost to the state. It also would encourage much greater participation in "work transition" programs since employers would have an incentive to ensure that all eligible employees were aware of their potential eligibility for the program. In contrast, a study in Maine showed that only 5 percent of employed former AFDC recipients received extended Medicaid coverage, principally because new employees were not aware of their eligibility under the "work transition" program.

Third, it would benefit North Carolina in general since federal funds cover two-thirds of Medicaid and would replace expenditures that otherwise would have been made by the employer plan. Finally, it would benefit employers by allowing them to purchase much more comprehensive coverage for the same premium contribution that would otherwise have been required for the employer plan.

**High Risk Pool for Medically Uninsurable**

*RECOMMENDATION 21: The State of North Carolina should permit all firms with 20 employees or less to enroll their "high risk" employees and dependents in the statewide high risk pool for the medically uninsurable.*

Of approximately 100,000 high risk individuals who might be considered medically uninsurable, about 38,000 are employed. Of these, nearly three fifths are in small firms with fewer than 25 employees. Opening up the high risk pool to employees of small firms would have two advantages.[24] First, it would allow some firms to obtain group coverage that they are now denied because of the poor health of one or more employees. Nationally, among commercial insurers, ten percent of small group applications are judged uninsurable and denied coverage. For Blue Cross and Blue Shield plans, up to 25 percent of small group applications were denied coverage due to medical uninsurability (OTA, 1988).

Second, it would make coverage more affordable for small firms. Commercial insurers currently rate 15 percent of small group members as "substandard" and issue policies that either exclude preexisting medical conditions, had higher than standard premiums, or both. Among Blue Cross and Blue Shield plans, an even higher percentage of small group applications are rated as substandard (OTA, 1988). On average, a high risk individual will cost at least 2.75 times as much to insure than a typical employee.[25] Among uninsured employees in small firms, high risk individuals account for roughly 10 percent of the total, but would generate roughly 25 percent of health claims. By removing the high risk employees, small firms could lower premiums to the remaining 90 percent of employees by almost 20 percent.

**State Health Insurance Pool**

*RECOMMENDATION 22: The State of North Carolina should develop a state health insurance pool which provides minimum essential health benefits to state residents who otherwise could not obtain such coverage. Employers with fewer than 20 employees also should be permitted to use this pool in lieu of offering their own health benefits plan.*

Even when both Medicaid and employer-based coverage are expanded as much as possible, there still will be many uninsured who could not obtain coverage except through private individual policies. These include a) part-time workers

working fewer than 17.5 hours and their dependents; b) seasonal and temporary workers and their dependents; c) all employees and their dependents in exempted firms with fewer than six employees or which have been operating less than five years; d) nonworkers below poverty and categorically ineligible for Medicaid and e) nonworkers above poverty who otherwise do not have access to employer-based coverage. Of necessity, to avoid subsidizing residents in neighboring states who commute to North Carolina or encouraging a glut of migrant workers, this pool would only be open to state residents.

Those without access to employer-based coverage or Medicaid could be required to obtain coverage through private individual health insurance policies. However, because of the marketing costs involved, individual policies tend to be very expensive compared to the equivalent level of coverage obtained through a group policy. For example, administrative costs for individual policies are as high as 50 percent (Blair and Vogel, 1975). Therefore, it would be unnecessarily expensive to require individuals to purchase their own coverage when they could obtain lower premiums through a state health insurance pool.

The Task Force also recognizes the special difficulty that small firms have in obtaining adequate coverage. On average, small employers must pay 10 to 40 percent more for health insurance compared to large firms (SBA, 1987). The Task Force concluded that rather than have a separate pool (MET) for small employers in addition to the state health insurance pool, it would be more efficient to use one pool for the same purpose.[26] Use of the state health insurance pool as a way of levelling the playing field between small and large employers also seemed preferable to using a tax credit since the latter requires additional state expenditures, while the former does not.[27]

The recommendation that state government create the state health insurance pool does not mean that the Task Force believes that such a pool must be administered by the state. The Task Force has not had time to explore all the implications of various administrative arrangements; these are details that can be worked out at a later time if the state pursues development of a state health insurance pool.

**Cost Containment Measures**

> *RECOMMENDATION 23: The State of North Carolina should include prudent cost containment measures in both the state health insurance pool and high risk pool for the medically uninsurable to avoid expenditures for medically unnecessary health care.*

The Task Force believes that all optional cost containment features included in the minimum essential health benefits package should be included in the package offered through the state health insurance pool and the high risk pool for the medically uninsurable. These include maximum use of cost-sharing where

permitted (such as a separate deductible of $75 for each emergency room visit). The Task Force also endorses use of pre-certification for selected services, including all inpatient admissions, outpatient surgery, prosthetic/orthopedic/durable medical equipment purchases, and therapy services. Pre-certification of hospital admissions is highly effective: a recent controlled study showed a reduction in total medical expenditures of 8.3 percent attributable to hospital utilization review (principally, pre-certification; see Feldstein, Wickizer and Wheeler, 1988).

The Task Force also endorses the use of some sort of case management for high cost cases. Blue Cross and Blue Shield of North Carolina currently has a case management system which is triggered either by particular diagnoses known to be very expensive to treat (e.g., AIDs) or when patient expenditures exceed a certain threshold.

## IV RESPONSIBILITY FOR MAKING AVAILABLE HEALTH SERVICES

### OVERVIEW

The Task Force concluded that responsibility for making available health services also should be divided among several groups. The following provides recommendations regarding responsibility for both health services and for support services needed to have adequate access to care without excessive burdens. As in the case of providing coverage, those who are responsible for making available services are *not* necessarily responsible for financing those services.

### RESPONSIBILITY OF PROVIDERS

*RECOMMENDATION 24: The State of North Carolina should increase its efforts to ensure that all providers licensed by the state provide care to patients without regard to their income or insurance status.*

The Hill-Burton Act requires hospitals with Hill-Burton obligations to provide emergency care to all who reside within a community and to provide a specified dollar amount of uncompensated care to low income patients. Federal civil rights statutes prohibit discriminatory treatment based on race, handicap, or national origin. In addition, federal law (COBRA) now requires hospitals to accept patients with medical emergencies (including those in active labor). Such patients cannot be transferred until they are stabilized and the receiving facility has been notified. Transfers for economic reasons alone are not permitted: the only grounds for transfer has to be a hospital's lack of needed services to assist the patient.

Currently, only about half of North Carolina physicians accept Medicaid patients, leading the Task Force to conclude that unless providers were required to accept medically indigent patient, expanded access to health benefits still might leave many patients unable to obtain needed care due to lack of availability of sufficient participating providers. For this reason, they decided to extend the current federals restrictions governing hospital emergency care to all providers, for both emergency and non-emergency care. Since universal access to minimum essential health coverage should ensure that providers are compensated for most care, the Task Force believes that this should ease provider reluctance to treat all patients.

The Task Force is optimistic that with universal health coverage, economic motivations to refuse care will be minimal and that providers will cooperate in seeing that all patients receive the same quality of care regardless of patient economic status.

*Recommendation 25: After universal access to minimum health benefits has been implemented, the State of North Carolina should evaluate whether there is a need to establish a "fair share" requirement on health providers.*

In the context of the previous recommendation, the Task Force concluded it was not necessary to impose "fair share" requirements on either hospitals or physicians at this time. Instead, the state should evaluate the impact of Recommendation 24 to determine whether there remain sufficient access barriers that would warrant imposition of fair share norms. The Task Force is optimistic that providers will voluntarily share the burden of caring for indigent patients in an equitable fashion. For example, the North Carolina Medical Society recently recommended taking steps to encourage its members to accept Medicare assignment for those with incomes below 200 percent of poverty and to develop model referral programs for medically indigent and Medicaid patients (NCMS, 1988). If implemented, these voluntary efforts will improve access to care for the medically indigent.

## RESPONSIBILITY OF STATE GOVERNMENT

### Basic Medical Services

*RECOMMENDATION 26: The State of North Carolina should ensure the availability of all components of essential medical care to all residents, including primary care, specialty care, emergency medical services, secondary and tertiary care, and long term care.*

The Task Force believes that ultimate responsibility for ensuring the availability of basic health services should rest with the state rather than with counties. This is because the fiscal capacity of the counties, the distribution of services and the distribution of the population in need of care--particularly the medically indigent--is too uneven for this function to be performed well at the county level. Counties with the fewest doctors and hospital beds often have the largest populations with inadequate health insurance coverage.

While universal coverage will help provide dollars to expand services in certain areas of need, there still may be disparities that result either in underservice in particular counties or an unfair tax burden on residents in those counties. To illustrate, under the current patchwork system, the total amount of local indigent care funding per resident below poverty ranges from less than $26 in one county to more than $645 in another; the local tax burden to finance indigent care ranges from $7.50 per resident to as much as $150 per resident.

Local input will continue to be essential for planning and development, although the Task Force believes that the state must play a major role in

evaluating where gaps in services are and take whatever actions are necessary to fill those gaps. Further, enhanced state activities are not intended to displace the more than $100 million in local funding now invested in indigent-related health care each year.

The Task Force recommendation is consistent with the North Carolina Hospital Association proposal that there be an expansion of state funding for primary care to ensure a minimum level of primary care services in all counties (NCHA, 1987). The Task Force is particularly concerned that the current system of care for migrant workers be improved since they cannot qualify for inclusion in the state health insurance pool.

**Public Medical Programs**

> *RECOMMENDATION 30: After universal access to minimum health benefits has been implemented, the State of North Carolina should evaluate whether there is a need to overhaul the current system of public medical programs for the medically indigent.*

Currently, there are more than 30 different health programs in North Carolina which provide direct health services to the medically indigent. Income eligibility criteria for these programs vary widely, from as low as 40 percent of poverty in one program to 185 percent of poverty in others. In addition, many programs allow counties to establish eligibility criteria, so that an individual eligible for a particular program in one county may not be eligible in another county. In contrast, of the 34 states which have statewide indigent care programs, more than three fourths establish statewide eligibility standards to ensure uniformity. South Carolina is similar to North Carolina in not having a statewide indigent care program. Nevertheless, the state does standardize eligibility criteria so that most public programs offered through local health departments provide free care to anyone below 150 percent of poverty.

North Carolina's programs target very specific diseases, types of services, or categories of patients (e.g., some programs allow screening but not treatment; others allow inpatient care, but not prevention). This inhibits the ability of local health departments to effectively target resources for an individual with a problem that does not fit into the appropriate categories.

The Task Force concluded that this issue merited detailed study after assessing the actual impact of universal coverage on use of these programs. Such an evaluation can determine whether there are gaps left to be filled. For example, since prescription drugs are excluded from the minimum essential benefits plan, and since the new Medicare catastrophic law offers drug coverage for those on Medicare only after a $600 deductible is met, there may be a need for a state drug program that would fill this gap.

## V. RESPONSIBILITY FOR FINANCING

### OVERVIEW

The Task Force developed four basic principles which underlie their recommendations regarding financing of both health insurance coverage and health services.

- The healthy should share in the cost of adequate care for the less healthy. The cost of illness should be spread broadly without regard to people's actual or probable use of care.

- People with greater financial resources should share the cost of adequate care for those with fewer financial resources.

- The cost of achieving equitable access to health care ought to be shared fairly. The cost should be shared broadly within society and not solely among health care providers. It should not be allowed to fall more heavily on particular practitioners, institutions, or residents of different localities.

- Out of pocket costs should be minimized for those unable to pay, and health premiums or taxes should be independent of a person's state of health.

### RESPONSIBILITY OF EMPLOYERS

The Task Force believes that employers have a major responsibility for financing adequate health coverage, but recognizes that the nature of this responsibility differs depending on the characteristics of the employer and its employees.

#### Full-time Employees and Dependents

*RECOMMENDATION 28: The State of North Carolina should require all employers who offer minimum essential health benefits to full-time employees who work 30 or more hours a week to contribute at least 80 percent of the premium cost for employee coverage and at least 50 percent of the premium cost for dependent coverage.*

Surveys by the Small Business Administration (SBA, 1987) and Health Insurance Association of America (HIAA, 1988) show that in 1986, the average employer contribution to employee coverage was 86% (SBA) to 88% (HIAA). Therefore, an 80 percent contribution requirement appeared reasonable. Although these same surveys show that the average contribution to family coverage is 71% (HIAA) to

74% (SBA), the Task Force learned that in North Carolina, the typical employer contribution to family coverage was lower and therefore opted for a lower premium contribution for family coverage.[28]

Although the Task Force favors easing the burden on low income workers, full payment of premiums for minimum wage workers is an inefficient and inequitable way to achieve this objective. Partial payment is consistent with existing employer practices. Less than one fifth of all minimum wage workers live in poverty families (CBO, 1986). Therefore, an employer subsidy targetted at minimum wage workers would inadvertently benefit many in families above poverty. Moreover, for each minimum wage worker in a below poverty family, there are nearly twice as many below poverty workers whose wages exceed the minimum wage. These individuals are deserving of help, yet they would not benefit from 100 percent employer-financed health insurance premiums. Since Recommendation 38 ensures that all families, regardless of income, will be spared from excessive financial burdens, the Task Force saw no need for the employer premium contribution to be higher for low wage workers.[29]

**Part-time Workers and Dependents**

> *RECOMMENDATION 29: The State of North Carolina should require all employers who offer minimum health benefits to part-time workers who work fewer than 30 hours a week to contribute the same share of employee compensation as is spent on full-time workers who work 30 or more hours a week.*

The recommendation adopted represents a neutral position designed to make an employer indifferent about hiring two part-time workers at 17.5 hours or one full-time worker at 35 hours. The Task Force did not want the mandated health benefits requirement to result in distortions of employer hiring practices. For a minimum wage worker who is employed only 17.5 hours a week, the employer contribution to a minimum essential benefits plan would represent nearly a 25 percent increase in the cost of employing that individual. This could substantially erode work opportunities for such individuals. On the other hand, other distortions are possible by exempting employers from having to contribute anything towards health coverage for their part-time workers.

The 30 hour threshold is based on an HIAA survey which shows that firms typically define full-time workers as those employed more than 30 hours a week (HIAA, 1988). This requirement extends to all part-time workers--not just to those working 17.5 to 30 hours a week. Even though employers are not required to offer coverage to part-time workers employed less than 17.5 hours a week, the amount that they contribute on behalf of those workers to the state health insurance pool or high risk pool is governed by the same pro-rata principle.

**Employees in High Risk Pool for the Medically Uninsurable**

*RECOMMENDATION 30: The State of North Carolina should require premium contributions from all employers whose employees or their dependents enroll in the state high risk pool for the medically uninsurable in lieu of obtaining employer-provided coverage. Such employers and their employees should contribute the same premium amount as they contribute towards a group health benefits plan or the state health insurance pool for other employees and dependents.*

Small firms would be allowed to put their high risk employees in the state risk pool for the medically uninsurable. The Task Force believes that it is equitable to require employers who take advantage of the pool to make some contribution to it. The high risk pool premiums would be 50 percent higher than those being charged in the state health insurance pool, raising the possibility of employment discrimination if employers were required to pay 50 percent more than they would for other workers. Since high risk individuals already face some discrimination barriers in employment (Griffin, 1987), the Task Force decided to allow employers to pay the same dollar amount that they otherwise would have contributed rather than the same fraction of premiums.

**Employees in State Health Insurance Pool**

*RECOMMENDATION 31: The State of North Carolina should require premium contributions from all employers whose employees or their dependents enroll in the state health insurance pool in lieu of obtaining employer-provided coverage. Such employers should contribute the same fraction of state health insurance pool premiums as each would have otherwise been required to contribute to a minimum health benefits plan.*

The Task Force has exempted several categories of firms from the requirement to offer health insurance, including very small firms and new firms. All firms are exempt from offering health benefits plans to certain categories of workers, such as seasonal and part-time employees below 17.5 hours a week. Employees for whom no employer-based plan must be offered are eligible to enroll in the state health insurance pool. In lieu of having to offer a plan, these employers would be expected to contribute 80 percent of premium costs (or a pro-rated fraction of such costs in the case of new firms, as per Recommendation 33).

For part-time employees, the fraction would be computed based on the average fraction of wages being contributed on behalf of full-time employees. An equivalent approach would be used to determine the contribution for dependent coverage, which would not exceed 50 percent (as per Recommendation 29).

**Employees Enrolled in Medicaid**

*RECOMMENDATION 32: The State of North Carolina should require premium contributions from all employers whose employees or their dependents enroll in Medicaid in lieu of obtaining employer-provided coverage or who are migrant farm workers. Such employers should contribute the same premium amount as they contribute towards a group health benefits plan or the state health insurance pool for other employees and dependents.*

Employers should neither be rewarded nor penalized for hiring Medicaid-eligible workers; requiring the same premium contribution whether or not the employee joins Medicaid would achieve this effect. Since Medicaid costs for certain categories of individuals (e.g., the disabled) may be quite different than premium costs for employees, it is more equitable that the premium contribution be expressed in terms of dollars rather than the fraction of premiums for which an employer normally would be liable.[30]

Employers of migrant farmworkers would participate financially in their care. Premiums collected on behalf of such workers would be used to fund the state's Migrant Health program.

**Employees in New Firms**

*RECOMMENDATION 33: The State of North Carolina should require limited premium contributions from firms with fewer than 20 employees and which are five years old or less, if they elect not to offer a health benefits plan and their employees and dependents instead join the state health insurance pool, Medicaid or the high risk pool for the medically uninsurable. This contribution should be in the form of an income tax surcharge that does not exceed a certain fraction of the premium amount that normally would be required of employers. This surcharge should not exceed 25 percent of the normal contribution amount for firms during their third year of operation; 50 percent during their fourth year of operation; and 80 percent during their fifth year of operation.*

The Task Force intends to minimize the impact of the mandated health benefits requirement on the rate of failure among new firms. The use of an income tax surcharge would guarantee that only firms with profits to pay for health benefits would do so: contribution requirements therefore would not cause any employer to incur operating losses.

After five years, however, new firms should be sufficiently stable financially to absorb the same financial burden as their more established competitors of providing health insurance to workers and dependents.[31]

**Retired Employees**

*RECOMMENDATION 34: The State of North Carolina should require all employers to offer retirees minimum essential health benefits at rates not to exceed the premium cost of equivalent coverage for workers and their dependents, but employers may elect not to pay any portion of the premium cost for such coverage.*

This provision ensures that retirees have access to group-based coverage at reasonable premium rates. Such access is important since group-based coverage gives the elderly much greater protection. The elderly who have group-based health insurance to supplement Medicare pay an average of 17 percent of their income on health; those with individual Medicare supplement policies spend 28 percent of income (U.S. Senate, 1986).

On average, the premium cost for retiree health benefits is 40% *lower* than the premium cost for workers age 62 to 64 (Short and Monheit, 1987)--principally because the employer plan is secondary to Medicare. Therefore, the Task Force is satisfied that this recommendation will impose no financial hardship on employers. Given that individuals are protected against excessive burdens, all retirees should be able to afford to pay for an employer-based supplement to their Medicare coverage.

**High Risk Pool for the Medically Uninsurable**

*RECOMMENDATION 35: The State of North Carolina should require all employers to share equitably in one half of the losses on the high risk pool for the medically uninsurable.*

There are many ways to finance the losses on a high risk pool. Of the 13 states with pools in operation during 1987, none rely on explicitly on employer contributions. However, all but two (Illinois and Maine) rely on assessments of insurers to cover losses. Since 90 percent of those covered by private health insurance are covered through employer-sponsored plans (HIAA, 1988), this is nearly equivalent to taxing employers, who pay the tax in the form of higher health insurance premiums. The Task Force believes that a tax on employers is appropriate since 38,000 of the 100,000 medically uninsurable in North Carolina are individuals who are employed.

## RESPONSIBILITY OF PROVIDERS

The Task Force believes that universal access to minimum essential health benefits will diminish substantially the current burden on providers of uncompensated care. Therefore, it is appropriate for providers to share in the burden of holding down the costs of a state health insurance pool and high risk pool for the medically uninsurable by accepting reimbursement that is lower than they would expect from a typical insured patient. Some other states are

obtaining deep discounts from providers for pools which expand coverage to uninsured individuals who typically have been the source of much uncompensated care (Alpha Center, 1988b).

**Physician Reimbursement**

> *RECOMMENDATION 36: Physician reimbursement for the state health insurance pool and high risk pool for the medically uninsurable should be based on the Harvard relative value scale developed for use by Medicare. Using this scale, average reimbursement across all physicians should be adjusted downward so that it equals 80 percent of the average reimbursement based on usual, customary and reasonable fees.*

The Task Force believes that the newly developed resource-based relative value scale provides a more equitable basis for setting physician fees than the current method of usual, customary and reasonable (UCR) payment. The new scale will provide relatively greater compensation for primary care physicians and relatively lower compensation for surgery compared to the current system (Hsiao, *et al.*, 1988). This is consistent with Medicaid payment of hospitals at about 72 percent of charges (HFMA, 1986).

**Hospital Reimbursement**

> *RECOMMENDATION 37: Hospital reimbursement for the state health insurance pool and high risk pool for the medically uninsurable should be limited to prevailing Medicaid reimbursement rates.*

The Task Force concluded that with universal health coverage in place, the amount of hospital uncompensated care should drop dramatically. Hospitals now receive only 31 percent of charges for their self-pay patients (HFMA, 1985). Under the plan they will be receiving substantially higher reimbursement on pool patients than they otherwise would have obtained.[32] In this context, the Task Force is comfortable that the proposed reimbursement amount is equitable, though they recognize that current Medicaid reimbursement averages only 90 percent of hospital costs.

## RESPONSIBILITY OF INDIVIDUALS

Although the overall strategic plan substantially protects individuals and families from incurring excessive burdens in paying for health care, it does not eliminate their financial responsibilities. For a typical family, the Task Force believes that workers should cover 20 percent of their own premium costs and 50 percent of the premium costs of covering their dependents. The Task Force also recognizes that cost-sharing for health services is an important means of curtailing unnecessary expenditures and it would be imprudent to insulate consumers against all such cost-sharing.

What families do need protection against are catastrophic costs which absorb a high fraction of family income. The Task Force recommendations are designed to ensure that consumers pay a reasonable share of their own front-end costs but are insulated against the full burden of catastrophic costs.

**Protection Against Catastrophic Health Costs**

> *RECOMMENDATION 38: All individuals should be responsible for paying their share of health insurance premiums and maximum allowable out-of-pocket payments for minimum essential health benefits, so long as these do not exceed a certain fraction of income. Families below poverty should not be expected to pay any portion of their annual income on health care (except for nominal copayments); those above 200 percent of poverty should not pay more than 10 percent; and those between 100 and 200 percent of poverty should pay not more than a sliding scale percentage of income ranging between zero and ten percent.*

The Task Force is aware that for a number of low income families, out-of-pocket expenses now exceed the maximums recommended by the Task Force (the figures shown in Table 2 are conservative, since they do not take into account family payments for health insurance premiums). Nevertheless, the Task Force members believe that the maximums which they have selected represent a reasonable compromise between theoretically recommended amounts and the actual amounts being spent by families at various poverty levels. However, they also recognize that these catastrophic limits would have to be evaluated carefully after being implemented to ensure that families at particular poverty thresholds are not unduly burdened by health expenses.

**Table 2**

**Comparison of Recommended Catastrophic Cost Thresholds With Actual Family Health Expense Burdens**

| FAMILY INCOME AS PERCENT OF POVERTY | ILLUSTRATIVE MAXIMUM FAMILY HEALTH EXPENSES AS PERCENT OF INCOME | PERCENT WITH HEALTH EXPENSES ABOVE MAXIMUM OP Costs Only* | All Costs** |
|---|---|---|---|
| 0 to 100 Percent | 0.0 % | 82 % | 89 % |
| 101 to 150 Percent | 2.5 | 47 | 75 |
| 151 to 200 Percent | 7.5 | 18 | 40 |
| More than 200 Percent | 10.0 | 3 | 10 |

* Out-of-pocket costs only.

** Out-of-pocket costs and family outlays for health insurance premiums.

SOURCE: Howell and Dobson, 1985 (OP costs only). Distribution of all costs estimated by Center for Health Policy Research and Education using 1977 National Medical Care Expenditure Survey data.

Note that the limits on catastrophic expenses do not include any amounts paid for benefits not included in the minimum essential benefits package (e.g., prescription drugs) or for services which exceed the minimum benefit plan limits (e.g., hospital stays in excess of 10 days).

**Coverage Through Employer-based Plans**

*RECOMMENDATION 39: Workers enrolled in employer-provided minimum essential health benefits plans should pay for all premium amounts not covered by their employers.*

For most workers, this will mean paying 20 percent of premium costs on employee coverage and 50 percent of premium costs on dependent coverage. For part-time workers who work 17.5 to 30 hours, however, employer premium contributions will be less than for the average full-time worker. More than half of part-time workers live in families with full-time workers, so in many cases, these workers would simply obtain coverage less expensively by obtaining family coverage through the full-time worker. The remaining part-time workers who must pick up the full premium cost difference not paid by the employer are protected against excessive financial burdens by Recommendation 38.

**Coverage Through State Health Insurance Pool**

*RECOMMENDATION 40: The State of North Carolina should require individuals who enroll in the state health insurance pool to pay a sliding scale premium based on income. Individuals are responsible only for premiums not covered by an employer.*

The enrollee would be responsible for any premium amounts not already contributed by an employer (see Recommendation 31). The sliding scale used to determine premium payments would be identical to the thresholds established in recommendation 38. The family must pay any net premium amounts owed so long as they do not exceed these thresholds.[33]

**Coverage Through High Risk Pool for Medically Uninsurable**

*RECOMMENDATION 41: The State of North Carolina should limit premiums charged in the high risk pool to 150 percent of the average premium for the state health insurance pool. The State should require individuals who enroll in this pool to pay a sliding scale premium based on income. Individuals are responsible only for premiums not covered by an employer.*

The Task Force recommends for administrative simplicity that the cap on premiums should be based on the average premium charged through the state health insurance pool.[34] At this level, the pool would pay benefits of roughly $1.66 per $1.00 of premium income--compared to $1.60 paid per $1.00 in premiums for other states with pools[35].

This recommendation is analogous to the situation for those joining the state health insurance pool except that the dollar amount for premiums generally would be higher. However, an estimated four fifths of the medically uninsurable who are now without coverage have incomes below poverty. This means that they would have no premium payment to make.

**Coverage Through Medicaid**

*RECOMMENDATION 42: The State of North Carolina should require individuals who enroll in Medicaid to pay premiums where federal regulations permit, except for pregnant women.*

Federal rules allow premiums to be charged to families between 150 and 185 percent of poverty (this would apply only if eligibility were extended to all pregnant women and infants up to 185 percent of poverty). These premiums cannot exceed ten percent of additional income (i.e., income above 150 percent of poverty) for such families (AHA, 1988b). For a family of four at 185 percent of poverty, this would allow premium payments of roughly $400 a year (less than $35 per month). For those above poverty who are in the second 6 month period of a work transition period (see Recommendation 18), federal rules permit charging a premium not to exceed three percent of family income. For a family of four at 200 percent of poverty, such premium payments would amount to roughly $700 a year (less than $60 per month).

This recommendation would help ease the burden on state government of financing Medicaid. The Task Force believes it is fair to expect premium payments from Medicaid eligibles in this income category since there are so many working poor at the same income level who would be having to pay a portion of premiums to obtain employer coverage that is much less comprehensive than Medicaid. However, due to the great importance of timely and adequate prenatal care in preventing poor birth outcomes, the Task Force wished to avoid erecting any barriers which might lead pregnant women to forego seeking qualification for Medicaid coverage. Recommendation 38 protects families again any excessive burdens that this requirement might otherwise pose.

## RESPONSIBILITY OF STATE GOVERNMENT

Currently, North Carolina is one of only four states which does not explicitly designate whether state or county government ultimately is legally and financially responsible for care of indigents (the other states are Kentucky, South Carolina and Tennessee; see Butler, 1985). In the Task Force strategic plan, state government essentially would serve as payor of last resort for all citizens in North Carolina. Thus, aside from its current investment of more than $200 million a year in Medicaid in FY1989, more than $150 million a year in public medical programs, and roughly $20 million in appropriations to hospitals for indigent care, state government would take on additional

responsibilities. Section VI discusses various methods in which these additional responsibilities might be financed. This Section is devoted exclusively to describing where state responsibility for financing would begin.

**Protection Against Catastrophic Costs**

*RECOMMENDATION 43: The State of North Carolina should fully subsidize all costs of obtaining minimum essential health benefits that are an excessive burden on families.*

This recommendation is a logical adjunct to current federal tax policy, which provides a tax deduction for those with medical expenditures (including health insurance premiums) which exceed 7.5 percent of adjusted gross income.[36]

**State Health Insurance Pool**

*RECOMMENDATION 44: The State of North Carolina should establish a uniform premium amount for the state health insurance pool which is designed to recover all claims and administrative costs. State government should finance all losses from this pool.*

The Task Force believes that a single community rate (for single and family coverage) should be established for the state health insurance pool rather than offering premiums that vary by age, sex or other factors, as so many individual insurance plans do. For those paying full premiums, the rate should recover all costs of the pool, but should not generate a surplus. Since most users would not pay full premiums, the pool would run an annual deficit which should be financed by state government.[37]

**High Risk Pool for the Medically Uninsurable**

*RECOMMENDATION 45: The State of North Carolina should finance half of the losses on the high risk pool for the medically uninsurable.*

Only one state (Illinois) explicitly funds the high risk pool through the state general fund. Nine states implicitly fund part or all of the losses on their high risk pools by assessing insurers and then allowing them a credit against premium or other taxes owed. Only two states (Connecticut and Minnesota) allow insurers to completely absorb all pool losses, while Maine uses a tax on hospital services to finance its pool (AHA, 1988).

The Task Force did not address the issue of whether it would be preferable to finance the state share of losses "up front" through the state general fund or an increase in a specific tax, or through the "backdoor" in the form of a tax credit to compensate insurers for their losses on the pool.

## VI. POTENTIAL IMPACT OF STRATEGIC PLAN TO ASSIST THE MEDICALLY INDIGENT

### ESTIMATED COVERAGE OF THE UNINSURED

Table 3 summarizes how various categories of the uninsured are likely to obtain coverage under the strategic plan proposed by the Task Force. The largest fraction of the uninsured are workers and their dependents. Among this group, less than half would obtain their coverage through an employer-based plan. Roughly one third of those eligible for employer-based coverage would be covered by the state health insurance pool (the majority of these being individuals in new firms less than five years old).

**Table 3**

**Estimated Coverage of the Uninsured Under IOM Strategic Plan to Assist the Medically Indigent (1988 Population Base in Thousands)**

| CHARACTERISTICS OF UNINSURED | EMPLOYER-BASED HEALTH BENEFITS | HIGH RISK POOL FOR MEDICALLY UNINSURABLE | STATE HEALTH INSURANCE POOL | MEDICAID | TOTAL | DISTRI-BUTION |
|---|---|---|---|---|---|---|
| WORKERS AND DEPENDENTS | 235.3 | 28.7 | 190.6 | 114.3 | 569.0 | 70.9% |
| Firm Size 20 workers or more | 179.6 | 0.0 | 0.0 | 45.2 | 224.8 | 28.0% |
| Firm Size 6 to 20 workers | 41.0 | 6.7 | 16.0 | 16.0 | 79.6 | 9.9% |
| Firm Size 5 workers or less | 14.8 | 8.0 | 54.2 | 19.4 | 96.3 | 12.0% |
| New Firms Under 20 workers | 0.0 | 14.0 | 120.4 | 33.8 | 168.3 | 21.0% |
| NON-WORKERS BELOW POVERTY | 0.0 | 8.6 | 34.9 | 81.3 | 124.8 | 15.5% |
| Dependent Children | 0.0 | 0.0 | 0.0 | 32.5 | 32.5 | 4.1% |
| Adults with Families | 0.0 | 0.0 | 0.0 | 12.8 | 12.8 | 1.6% |
| Aged, Blind, Disabled | 0.0 | 0.0 | 0.0 | 35.9 | 35.9 | 4.5% |
| Categorically Ineligible | 0.0 | 8.6 | 34.9 | 0.0 | 43.5 | 5.4% |
| NON-WORKERS 100-200% POVERTY | 0.0 | 5.5 | 61.8 | 11.6 | 78.8 | 9.8% |
| NON-WORKERS OVER 200% POVERTY | 0.0 | 1.3 | 24.6 | 4.5 | 30.4 | 3.8% |
| GRAND TOTAL: | 235.3 | 44.2 | 311.9 | 211.6 | 803.0 | 100.0% |
| DISTRIBUTION | 29.3% | 5.5% | 38.8% | 26.4% | 100.0% | |

NOTE: Figures shown are based on 1988 population total and assume that all Medicaid expansions approved in 1987 have already been fully implemented, which will reduce the estimated average daily number of uninsured by roughly 100,000.

In addition, more than one fifth of those with access to an employer plan could be covered by Medicaid if it were expanded as much as the Task Force recommends. Less than five percent of those with employer-based coverage would be included in the risk pool for the medically uninsurable.

Nearly one sixth of the newly covered uninsured are non-workers below poverty, including both adults and children. Of these, two thirds could be covered through Medicaid and one third would be covered either through the state health insurance plan or the high risk pool. Nearly ten percent of the uninsured are non-workers between 100 and 200 percent of poverty--three quarters of which would be eligible for the state health insurance pool, while the remainder qualify either for Medicaid or the high risk pool. Only a tiny fraction of the uninsured are non-workers above 200 percent of poverty, most of whom also could participate in the state health insurance pool.

All told, roughly 30 percent of the uninsured would be covered through expanded employment based coverage under the proposed IOM plan. Roughly five percent would qualify for the high risk pool, while nearly 40 percent would be included in the statewide health insurance pool. Slightly more than one fourth of the uninsured would be covered through Medicaid expansion under the IOM plan.

## ESTIMATED COST IMPACT

The gross new cost of covering these 800,000 uninsured is nearly $1.4 billion a year. This is a sizable addition to the nearly $8 billion now spent on health care in North Carolina. However, nearly $250 million of this total represents increased welfare costs resulting from increasing the Medicaid medically needy standard to 100 percent of poverty. Moreover, a large fraction of the $1.4 billion merely displaces current health spending by individuals or which is financed through cost-shifting. Once the savings that result from such displacement are taken into account, the net new cost of financing this strategic plan would be much lower. Finally, half of the overall added cost would be financed by the federal government, with the remainder roughly evenly split across employers, state government and individual payments. Local funds would account for less than five percent of the total.

Half of this gross program cost is accounted for by Medicaid expansion, slightly less than one fourth is due to the state health insurance pool and only 10 percent is related to the cost of a high risk pool. The remainder would be accounted for by expansion of employer-based coverage (this is a conservative estimate since it does not include those who already have coverage who are able to obtain improved quality coverage under the plan.

## Table 4

### Estimated Cost Impact of IOM Strategic Plan to Assist the Medically Indigent (1988 Dollars in Millions)

| SOURCE OF REVENUE | CURRENT PATCHWORK SYSTEM | GROSS NEW COSTS IF TASK FORCE RECOMMENDATIONS ADOPTED: Employer-Based Health Benefits | High Risk Pool for Medically Uninsurable | State Health Insurance Pool | Medicaid Expansion | Grand Total | GROSS NEW COSTS AS PERCENT OF PATCHWORK |
|---|---|---|---|---|---|---|---|
| FEDERAL FUNDS | $2,370.5 | $71.3 | $34.4 | $73.5 | $503.8 | $683.0 | 28.8% |
| Direct | $990.0 | $0.0 | $0.0 | $0.0 | $452.8 | $452.8 | |
| Indirect | $1,380.5 | $71.3 | $34.4 | $73.5 | $51.1 | $230.2 | |
| STATE FUNDS | $381.9 | $24.3 | $6.9 | $78.2 | $118.5 | $227.9 | 59.7% |
| Direct | $372.9 | $10.7 | $0.0 | $67.0 | $114.3 | $192.0 | |
| Indirect | $9.0 | $13.7 | $6.9 | $11.2 | $4.2 | $36.0 | |
| LOCAL FUNDS | $104.3 | $5.5 | $0.0 | $0.0 | $52.8 | $58.3 | 55.8% |
| EMPLOYER CONTRIBUTIONS | $1,399.2 | $57.2 | $57.6 | $54.6 | $38.8 | $208.2 | 14.9% |
| Health Plan Contributions | $1,399.2 | $57.2 | $6.5 | $6.2 | $27.4 | $97.3 | |
| Income Tax Surcharge | -------- | $0.0 | $6.0 | $48.3 | $11.5 | $65.9 | |
| High Risk Pool Tax | -------- | $0.0 | $45.0 | $0.0 | $0.0 | $45.0 | |
| PROVIDER CONTRIBUTIONS | $214.5 | $0.0 | **** | **** | **** | **** | 0.0% |
| Hospital Losses | $68.6 | $0.0 | **** | **** | **** | **** | |
| Physician & Other Losses | $145.9 | $0.0 | **** | **** | **** | **** | |
| INDIVIDUALS | $3,729.4 | $80.0 | $31.3 | $90.1 | $0.6 | $202.0 | 5.4% |
| Premium Contributions | $752.8 | $39.6 | $11.8 | $45.6 | $0.6 | $97.6 | |
| Out-of-Pocket | $2,976.7 | $40.4 | $19.5 | $44.5 | $0.0 | $104.4 | |
| GRAND TOTAL | $7,985.4 | $238.3 | $131.9 | $296.3 | $714.6 | $1,379.4 | 17.3% |

NOTE: Figures shown are the gross new costs of implementing the IOM strategic plan for the medically indigent. All long term care costs are excluded. The figures do not take into account any savings from reduced out-of-pocket expenditures for the uninsured, for reduced use of public medical programs or reductions in uncompensated care for providers. Table 5 contains some rough estimates of the size of the savings that would result from the strategic plan.

## ESTIMATED COST SAVINGS

The gross new costs shown in Table 4 overstate the net amount of new funding that would have to be invested in the current system in order to implement the Task Force strategic plan. These savings can be grouped into four basic categories.

**Replacement of Current Patchwork System of Care**

First, the proposed plan would largely displace the current patchwork system of care for the medically indigent, which now provides more than $1.2 billion in subsidized care each year. This includes nearly $500 million in public medical programs and nearly $200 million each for hospital and physician free care. Lower use of all these sources of subsidized care will benefit all levels of government, employers and consumers who now finance private cost-shifting.

Another source of savings will be reduced welfare costs resulting from universal access to health benefits, since there no longer would be any incentive for low wage workers to quit work and become Medicaid eligible in order to have health coverage. One study showed that 20 percent of former welfare recipients who became employed at minimum wage jobs returned to public assistance because their children needed health care (Governor's Commission on Health Care, 1988).

Finally, many uninsured will have reduced out-of-pocket expenditures once they obtain minimum essential health benefits and these savings also need to be taken into account.

**Lower Costs for Employers**

Employers will also enjoy some savings that are not reflected in the gross program cost estimates. First, small employers will be able to shift their high risk employees to the high risk pool for the medically uninsurable, thereby reducing their premium costs for the remaining employees they cover.

Second, small employers which currently offer plans may be able to obtain administrative savings resulting from use of the state health insurance pool. That is, employers with fewer than six employees may find that they can get less expensive coverage through the pool than in the private market where administrative costs for very small plans tend to be very high.

**Improved Primary Care Access**

A strong case can be made that some of the added cost of expanded primary care would pay for itself through reductions in acute or long term costs that could have been prevented through more timely medical attention. There is unequivocable evidence that the medically indigent do not receive adequate health services. Among those who are uninsured, 15 percent of families report not obtaining needed health care during the previous 12 months (RWJ, 1983); 16 percent of adult "heavy users" did not obtain needed health care during the previous 12 months (Equicor, 1986); 31 percent of chronically ill adults did not obtain needed care for financial reasons (Hayward, *et al.*, 1988); and 3.6 percent of families report being refused care for financial reasons (RWJ, 1983).

One major source of potential savings is in the area of prenatal care. Currently, at least 10 percent of uninsured pregnant women start their prenatal care in the third trimester or never (Singh, Gold and Kenney, 1987). It is conservatively estimated that $1 invested in timely and adequate prenatal services yields at least $3 in savings from reduced need for neonatal intensive care and infant rehospitalizations in the first year of birth (IOM, 1985).

Another major source of potential savings will be from preventable hospitalizations. For example, the low income uninsured are 50 to 60 percent more likely not to have obtained medically recommended preventive services (including PAP smears, blood pressure check-ups, glaucoma and clinical breast exams; see Woolhandler and Himmelstein, 1988). The efficacy of such preventive measures in improving health status and/or reducing the need for hospitalization is well-established (see Lillard *et al.*, 1986 and Mandelbrott *et al.*, 1988). The potential magnitude of the preventable hospitalization that results from inadequate preventive care is reflected in findings from a recent study in Washington, D.C.. Excluding obstetric and trauma-related admissions, more than one third of hospital use among the uninsured was medically preventable (Lewin-ICF, 1988).

**Improved Efficiency**

Finally, there should be some efficiency savings that result from better use of health services. For example, an effective system of case management for the medically uninsurable holds the promise of achieving large savings for the small fraction of the population which generates the greatest amount of costs. Improved access to care for the uninsured also can result in less unnecessary emergency room use that would partially offset their greater use of health services in general once financial barriers to access have been removed for them.

Table 5 summarizes these various potential savings, using conservative estimates of the amounts of savings that could result if the IOM plan were implemented. These savings can be deducted from gross program costs to yield net costs of implementing the plan.

## Table 5

### Estimated Cost Savings From IOM Strategic Plan to Assist the Medically Indigent (1988 Dollars in Millions)

| SOURCE OF SAVINGS | TOTAL | FEDERAL | STATE | LOCAL | EMPLOYERS | PATIENTS |
|---|---|---|---|---|---|---|
| REDUCTION IN CURRENT PATCHWORK SYSTEM | $600.5 | $48.3 | $23.0 | $13.0 | $25.5 | $451.3 |
| 1. Reduction in Public Medical Program Use | $40.7 | $20.3 | $13.7 | $6.7 | $0.0 | $0.0 |
| 2. Reduction in Hospital Cost-Shifting | $52.2 | $11.2 | $5.9 | $6.3 | $15.0 | $13.8 |
| 3. Reduction in Physician & Other Cost-Shifting | $91.2 | $16.8 | $3.4 | $0.0 | $10.5 | $21.1 |
| 4. Reduction in Out-of-Pocket Expenses | $416.3 | $0.0 | $0.0 | $0.0 | $0.0 | $416.3 |
| LOWER COSTS FOR EMPLOYERS | $38.4 | $0.0 | $0.0 | $0.0 | $38.4 | $9.6 |
| 1. Use of High Risk Pool by Small Employers | $37.1 | $0.0 | $0.0 | $0.0 | $37.1 | $9.3 |
| 2. Administrative Savings Through Pooling | $1.3 | $0.0 | $0.0 | $0.0 | $1.3 | $0.3 |
| IMPROVED PRIMARY CARE ACCESS | $20.1 | $4.6 | $2.4 | $1.8 | $4.7 | $6.5 |
| 1. Better Prenatal Care | $2.7 | $1.3 | $0.7 | $0.0 | $0.3 | $0.3 |
| 2. Reduction in Preventable Hospitalizations | $17.4 | $3.3 | $1.7 | $1.8 | $4.4 | $6.2 |
| IMPROVED EFFICIENCY | $16.2 | $2.3 | $1.2 | $1.3 | $3.0 | $8.4 |
| 1. Case Management for Medically Uninsurable | $10.9 | $1.4 | $0.8 | $0.8 | $1.9 | $6.1 |
| 2. Reduction in Unnecessary Emergency Room Use | $5.2 | $0.8 | $0.4 | $0.5 | $1.1 | $2.3 |
| GRAND TOTAL SAVINGS | $675.1 | $55.2 | $26.6 | $16.1 | $71.7 | $475.7 |
| GROSS PROGRAM COSTS | $1,379.4 | $683.0 | $227.9 | $58.3 | $208.2 | $202.0 |
| NET NEW PROGRAM COSTS | $704.2 | $627.7 | $201.3 | $42.2 | $136.5 | ($273.7) |

# FOOTNOTES

1 The Task Force recommendation is also nearly identical to a proposed mission statement suggested by the Governor's Commission on Health Care in Oregon (1988).

2 The uninsured include all persons who are completely without any sort of third party coverage for health costs, including Medicaid or Medicare. The underinsured include all persons who rely exclusively on Medicare for coverage and those whose private health insurance coverage leaves them at more than a five percent risk of spending more than ten percent of annual income on health care.

3 This reality is reflected in the work of the Oregon Governor's Commission on Health Care (1988), which recommends that equitable access to health care be provided to 90 percent of Oregonians by the year 1995 and to 99 percent by the year 2000.

4 In the plan offered through the state health insurance pool, cost-sharing would not be used for inpatient hospital services because hospital reimbursement would be limited to Medicaid per diem rates. The Task Force concluded that hospitals accepting such low reimbursement should not have to face the prospect of further losses through unpaid copayments. For employer-based plans, however, hospital reimbursement presumably would be higher; therefore cost-sharing up to 20 percent would be permitted.

5 Current Medicaid cost-sharing provisions are as follows: $0.50 per chiropractor visit (pregnant women only); $0.50 per clinic visit and per prescription filled; $1.00 per visit to a physician, optometrist or outpatient clinic; and $2.00 per visit for podiatrists, dental care; non-hospital dialysis services; and for each pair of eyeglasses or eyeglass repair service costing $5.00 or more.

6 Roughly three fourths of non-elderly hospital patients have lengths of stay below this 10 day limit (CBO, 1977). Thus, the floor on coverage would be adequate for most people. Although 60 percent of hospital costs for the non-elderly are accounted for by those with stays above 10 days (CBO, 1977), the Task Force chose not to jeopardize the affordability of their proposed minimum essential health benefits plan in order to include a substantially higher inpatient day limit to benefit a few. Nothing prevents plans from offering higher limits: nationally, more than three-fourths of employers under 50 employees which offer health plans have day limits in excess of 30 days (HIAA, 1981). More importantly, those who have stays that exceed the specified limit and who otherwise would face unaffordable out-of-pocket costs will be protected by Recommendation 38 that ensures that no family would have health expenses that exceed 10 percent of family income.

7 The HPA recommendations for preventive services fall into 3 categories. Maternal and child care includes a) medical examination of mother before birth of child (pre-natal care: number of visits not specified); b) medical examination of mother after birth (post-natal); c) 3 annual physician visits for infants between birth and age one; d) 2 annual physician visits between age one and age two; e) 1 annual physician visit between ages two through six; bi-annual physician visits between ages seven through eighteen. Immunizations include all immunizations at appropriate ages that are health and cost effective, as derived from guidelines from Project INSURE and from the American Academy of Pediatrics. Medical examinations include procedures designed for early identification of potentially serious problems, at the following intervals: a) one visit every five years for those under age 40; one visit every three years for those age 40 through 49; one visit per year for those 50 and over. The specific tests to be covered in these examinations would be based on recommendations contained in Project INSURE and Canadian Periodic Health Examination Task Force.

8 Administrative costs will vary sharply depending on employer size, ranging from as low as 4 percent for the largest groups to as high as 50 percent for very small employers (Trapnell, 1987). If small employers are pooled together into large multiple employer trusts (METs), administrative costs of roughly 14 percent are possible (Trapnell, 1987). Administrative costs for the North Carolina Medicaid program were 4.6 percent in federal FY1986 (HCFA, 1987). For a statewide health insurance pool and for a typical employer, an eight percent figure for administrative costs was used.

9 Sixteen states have created statewide risk pools to allow such individuals to obtain coverage. These states are Connecticut, Florida, Illinois, Indiana, Iowa, Maine, Minnesota, Montana, Nebraska, New Mexico, North Dakota, Oregon, Rhode Island, Tennessee, Washington, and Wisconsin (GAO, 1988).

10 Another twelve states, including North Carolina, have Blue Cross/Blue Shield plans which offer open enrollment to individuals regardless of health status.These states are District of Columbia, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Vermont and Virginia (GAO, 1988).

11 Many statewide risk pools cap their premiums at 150 percent or less of non-group premium rates. However, the AMA recommends that premiums for such risk pools be set no higher than 125 percent of the average premium for group coverage--which would be even lower than comparable premiums for individual coverage (Council on Medical Service, 1988).

12 High risk pools also are supported by the AMA (Council on Medical Service, 1988) and the Health Insurance Association of America (Page, 1988), In 1986, the U.S. House of Representatives approved an amendment to COBRA which would have required states to set up high risk pools, but this provision did not survive in the Senate. Subsequently, there have been several pieces of federal legislation introduced which would encourage states to establish such pools (S. 1634, H.R. 1182).

13 Other states such as Minnesota and Connecticut have mandated minimum benefits plans, although these have not been applied to employers across the board because of concerns about ERISA restrictions. To date, only Massachusetts has attempted to circumvent ERISA by using a "pay-or-play" approach to mandated employer-based coverage for employees and dependents. In the absence of ERISA constraints, more states might well have adopted this approach by now. Nationally, this approach is incorporated by bills introduced by Senator Kennedy (S. 1265) and Rep. Waxman (H.R. 2508). This approach is endorsed by the Health Insurance Association of America (Page, 1988).

14 The exclusion of part-time workers working fewer than 17.5 hours a week mirrors the threshold used in the Kennedy-Waxman proposal. It is the same threshold used for non-discrimination eligibility tests for health benefits under Section 89 of the Tax Reform Act of 1986 (AHA, 1988) and by the state of Oregon in determining eligibility for small employer tax credits (Governor's Commission on Health Care, 1988). It is slightly lower than the 20-hour-per-week threshold used in Hawaii and Massachusetts (McGovern, 1988). It is also lower than the 25-hour-per-week threshold suggested by the Washington Business Group on Health (Goldbeck, 1987).

15 The total number of uninsured workers who are seasonal or temporary is nearly 50,000. The Task Force did not decide on a definition of temporary or seasonal workers, but most firms use a threshold of 12 weeks in defining "temporary" employees for health insurance eligibility purposes (HIAA, 1988). The Massachusetts plan excludes temporary workers who are hired for five months or less (McGovern, 1988).

16 This exemption mirrors the Kennedy-Waxman mandated health benefits bill, as amended, which exempts firms with five or fewer employees for the first three years and only requires them to provide catastrophic coverage for the next three years, after which they would no longer be exempt (AHA, 1988). The Task Force recommendation is nearly identical to the plan in Massachusetts, which permanently exempts firms with six or fewer employees (Alpha Center, 1988b).

17 This exemption is similar to a provision in the Massachusetts statute which exempts all new businesses (not just those under 20 employees) from paying the "pay-or-play" surcharge in their first year and gradually phases in participation until all new firms are fully participating in their fourth year of operation (Alpha Center, 1988b).

18 Specifically, 13 percent of small businesses fail in year 1, 27 percent during the first two years, 32 percent during the first three years, 45 percent during the first four years, 49 percent during the first five years, 50 percent during the first six years and 53 percent during the first seven years (Birch, 1987).

19 This recommendation is identical to a provision in the Massachusetts universal health insurance law.

20 Some argue that participation would increase if state barriers (e.g., lengthy application forms, insufficient eligibility workers) could be eliminated (Crawford, 1988). The Oregon Governor's Commission (1988) recommends eliminating such barriers so that non-participation declines from its current level of 25 to 30 percent of eligibles to only 5 to 10 percent. However, other studies suggest that red tape accounts for less than one quarter of non-participation; in contrast, individual choices (e.g., welfare stigma) accounts for more than one third of non-participants (Bendick, 1980).

21 Aside from the new work transition rules, which apply to all individuals who are disqualified from AFDC, there is also a provision allowing a nine month work transition period for families which otherwise would have been disqualified due to more stringent AFDC eligibility rules passed in 1981. Under this provision, states have the option of providing an additional 6 months of transition coverage. At least 13 states have exercised this latter option to go beyond the federally required work transition requirement (AHA, 1988). The Massachusetts plan for universal coverage extends the AFDC work transition period to 24 months (Alpha Center, 1988b).

A recent Oregon proposal would allow employers who qualify for a tax credit to pay premiums to a state pool on behalf of Medicaid eligibles in this "work transition" period. This pool would then be used to draw down Medicaid funding on behalf of those eligibles (Governor's Commission on Health Care, 1988). Hawaii currently exempts employers from having to provide group coverage to those eligible for Medicaid.

The Task Force recommendation is consistent with federal legislation recently introduced by Senator Quayle to allow pilot projects to let low-wage workers in small businesses buy into Medicaid based on their ability to pay. Similarly, both the Health Insurance Association of America (Page, 1988) and Washington Business Group on Health support changing current regulations in order to allow low income individuals to buy into Medicaid (Goldbeck, 1987).

22 The Health Insurance Association of America endorses expanding Medicaid to all individuals below poverty (Page, 1988).

23 In proposing a much larger increase in income standards, the Task Force recognizes that the total added cost (including higher AFDC payments and Medicaid costs) would amount to roughly $250 million a year and would provide coverage to a maximum of roughly 80,000 new eligibles who otherwise could not have been reached through the increases in categorical eligibility described above. Thus, the added cost per new eligible exceeds $3,000. However, the state and county share of this total would be less than $1,000 per newly covered eligible. This is only slightly more than the state would have had to pay to cover these same individuals through a state health insurance pool. Since Medicaid benefits are appreciably more comprehensive than those provided through the pool, the Task Force considers this net payment amount to be reasonable and well worth undertaking.

24 Both Maine and Wisconsin are now encouraging small employers to put their high risks into a state pool (AHA, 1988).

25 This is based on a recent GAO analysis, which found that for six states which have operated high risk pools for at least five years, $1.60 was paid for each $1.00 of premium income (GAO, 1988). Since a typical pool caps premiums at 150 percent of the standard rate for individuals (which would be higher than group premiums), high risk premiums are probably set at no less than 150 percent of the typical premium charged to groups and claims must average 240 percent of group premiums (150 % x 160%). But for a typical private insurer, claims paid equal 87 percent of premiums, so the overall differential in claims paid for high risk employees compared to average employees would be 275% (240% divided by 87%).

26 Some states--including Florida, Tennessee, West Virginia and Wisconsin--are actively involved in pooling small employers into Multiple Employer Trusts (METs) as a way of reducing premium costs through economies of scale (AHA, 1988). Other states--including Hawaii, Oregon, Massachusetts and Wisconsin--are experimenting with subsidies to either small employers or their employees as a way of reducing this differential (AHA, 1988).

27 For example, the tax credit in Oregon will be up to $25 per month for small firms (25 employeesor less) which have not offered health benefits for at least two years (Governor's Commission on Health Care). In North Carolina, there are 150,000 workers in small firms without health insurance plans (including the self-employed). Even if all self-employed are excluded and only half the remainder have not offered plans for two years, an equivalent program in this state would cost $14 million a year. Massachusetts is offering tax credits of up to $28 per month for firms with 50 or fewer employees which have not offered health insurance in the last three years (Alpha Center, 1988b), so an equivalent program in North Carolina could be even more expensive than the Oregon version. However, the tax credits in Massachusetts are only a temporary inducement to offer coverage prior to the mandatory deadline of January 1, 1992. Tax credits cannot exceed 20 percent of premiums in year 1 and 10 percent of premiums in year 2 (McGovern, 1988).

28 The Kennedy-Waxman proposal requires employers to contribute at least 80 percent of premium costs for both workers and dependents and to contribute the full premium amount for workers earning less than 125 percent of minimum wage. Hawaii requires employers to contribute at least half of premium costs for employees, but nothing for dependents.

29 The Task Force is aware that Hawaii provides a subsidy to employers with fewer than 8 employees if the required employer contributions exceed 1.5 percent of their wage bill. Similarly, Massachusetts has established a hardship fund to finance premium contributions which exceed 5 percent of gross revenues for business with 50 or fewer full-time workers (Alpha Center, 1988b). The Task Force decided against a similar hardship fund in North Carolina.

30 This approach is similar to the Oregon tax credit program, which requires employers with Medicaid eligibles to contribute to a state fund the same premium amount as they otherwise would have paid. This fund is then used to draw down Medicaid dollars on behalf of these individuals (Governor's Commission on Health Care, 1988). It is unclear whether a federal waiver would be required to permit such employer premium contributions.

31 The phase-in of financial participation is similar to that used by Massachusetts (see Footnote 17).

32 Other states have sought and obtained similar hospital discounts in programs targetted at the uninsured. The Michigan Health Care Access Project got hospitals to agree to rates 20 percent below Medicaid. Similarly, the Regional Medical Center in Memphis agreed to accept patients in a plan developed by the Tennessee Association of Primary Health Care Centers for a daily charge equal to only 12 percent of its typical charges (Alpha Center, 1988b).

33 The AMA also endorses an income-related premium for state risk pools, but does not indicate where subsidies should start or stop (Council on Medical Service, 1988). The proposed Washington state health insurance pool disqualifies any enrollees whose gross income exceeds 200 percent of poverty for six consecutive months.

34 Virtually all statewide high risk pools specify a maximum premium amount that can be charged to policyholders, based on the average individual standard rate charged by major insurers with comparable coverage. These maximums range from 125 percent to 200 percent, but by far the most common (used by 9 states) is 150 percent (Trippler, 1987). In contrast, the AMA recommends capping high risk pool premiums at 125 percent of the average rate for group coverage (Council on Medical Service, 1988).

35 The estimated premium cost for the state health insurance pool will be $77 per month (Section II), so premiums collected by the high risk pool would be 150% x $77 = $116. If the premiums collected under the SNAP program roughly equal claims costs, then the ratio of claims to premiums collected would be $187/$116 = 1.61. The ratio could be much higher. The average BC/BSNC premium for individual coverage is $133 ($187/140%, from footnote 25). On average, states with high risk pools charge 150% of the non-group rate and experience $1.60 in claims per dollar of premiums. If the same occurred in North Carolina, high risk pool costs would equal $133 x 150% x 1.6 = $319 and the claims to premium ratio would climb to 2.76.

36 A bill recently introduced by Senator Durenberger, S. 2486, would raise the federal tax deduction limit to 10 percent). Although several states have had catastrophic health insurance programs in the past, Rhode Island is the only state remaining which provides a state-backed guarantee of covering all bills which exceed a certain amount. For those who have qualified health plans, the Rhode Island Catastrophic Health Insurance Plan (CHIP) will cover all health costs which exceed either $1,118 or 10 to 12.5 percent of allowable income (however, amounts paid by a family to meet deductibles cannot be used towards the CHIP deductible). For those who are uninsured, the deductible requirement is much higher: $11,118 or 50 percent of income. Strictly speaking, the spenddown provision of North Carolina's Medicaid program performs the same function. However, for a middle income family, medical expenses would have to absorb a very high fraction of income (over 80 percent) before an individual could qualify under spend-down. Moreover, due to categorical restrictions, this type of catastrophic protection is not available to roughly one fourth of the population.

37 This is consistent with the AMA view that losses from state pools should be spread over as wide a base as is possible (Council on Medical Service, 1988).

## BIBLIOGRAPHY


AHA. 1988. Promoting Health Insurance in the Workplace: State and Local Initiatives to Increase Private Coverage. Chicago: American Hospital Association.

Alpha Center. 1988a. Health Care for the Uninsured Program Update. Washington, D.C.: Alpha Center, March 1988.

Alpha Center. 1988b. Health Care for the Uninsured Program Update. Washington, D.C.: Alpha Center, July 1988.

Amkraut, Cathy. "Federally Mandated Health Benefits Are a Trend Signifying New Concerns." Business and Health (June, 1986), 54.

Ansberry, Claire. 1988. "Despite Federal Law, Hospitals Still Reject Sick Who Can't Pay." Wall Street Journal. November 29, 1988.

Bendick, Marc, Jr. 1980. "Failure to Enroll in Public Assistance Programs," Social Work (July, 1980), 268-274.

Birch, David L. 1987. Job Creation in America: How Our Smallest Companies Put the Most People to Work. New York: Free Press.

Blair, Roger and Ronald J. Vogel. 1975. The Cost of Health Insurance Administration. Lexington, MA: D.C. Heath and Co.

Butler, Patricia. 1985. "Legal Obligations of State and Local Governments for Indigent Health Care," in Access to Care for the Medically Indigent: A Resource Document for State and Local Officials. Washington, D.C.: Academy for State and Local Government, March 30, 1985.

Canadian Periodic Health Examination Task Force. 1984. "Report of the Periodic Health Examination Task Force." Canadian Health Association Journal. 1984 Supplement.

CBO. 1977. Catastrophic Health Insurance. Washington, D.C.: U.S. Congressional Budget Office, January 1977.

CBO. 1986. The Minimum Wage: Its Relationship to Incomes and Poverty. Washington, D.C.: Congressional Budget Office, Staff Working Paper, June 1986.

CBO. 1988. Congressional Budget Office Responses to Questions About the Effects of S. 1265 from Senator Dan Quayle. Washington, D.C.: Congressional Budget Office. Mimeo.

CHPRE. 1986a. "Who Are the Medically Indigent? and Barriers to Access." Presentation to Indigent Health Care Study Commission. Durham: Duke University, Center for Health Policy Research and Education, March 12, 1986.

CHPRE. 1986b. "Payment and Responsibility for Indigent Health Care." Presentation to Indigent Health Care Study Commission. Durham: Duke University, Center for Health Policy Research and Education, April 22, 1986.

CHPRE. 1986c. North Carolina County Profiles. Durham: Duke University, Center for Health Policy Research and Education, August 1986.

Claxton, Gary. 1986. "States Test Models for the Employed and Unemployed Uninsured." Business and Health (December, 1986), 56.

Council on Medical Service. 1988. "Protecting the Uninsured: Use of State Risk-Pools." Journal of the American Medical Association 260 (July 15, 1988), 373-374.

Crawford, William C. 1988. "N.C.'s Welfare Policy Wastes Taxes and Hurts the Poor." North Carolina Forum. November 10, 1988.

Culhane, Charles. 1988. "Waxman Urges Health Care Benefits for All Workers." American Medical News. May 13, 1988.

Danzon, Patricia. 1987a. State Health Insurance Pools: An Evaluation. Report prepared for North Carolina Hospital Foundation. Philadelphia: University of Pennsylvania, Wharton School, August 1987.

Danzon, Patricia. 1987b. Expanding Employment-Based Health Insurance. Report prepared for North Carolina Hospital Foundation. Philadelphia: University of Pennsylvania, Wharton School, August 1987.

Danzon, Patricia and C. Conover. 1985. Health Care for the Uninsured Poor of North Carolina. Durham: Duke University, Center for Health Policy Research and Education, August 1985.

Davis, Karen. 1976. "Medicaid Payments and Utilization of Medical Services by the Poor." Inquiry 13 (June, 1976), 122-135.

EBRI. 1988. "Questions and Answers About Employee Benefits," EBRI Issue Brief No. 78 (May, 1988).

EBRI. 1988b. Measuring and Funding Corporate Liabilities for Retiree Health Benefits. Washington, D.C.: Employee Benefit Research Institute.

Enthoven, Alain. 1988. "Managed Competition of Alternative Delivery Systems," Journal of Health Politics, Policy and Law 13 (Summer, 1988), 305-322.

Equicor. 1986. Equicor Healthcare Survey-V. New York: Equitable HCA Corporation, July 1986.

Feldstein, Paul J., Thomas M. Wickizer, and John R.C. Wheeler. 1988. "Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures." New England Journal of Medicine 318 (May 19, 1988), 1310-1314.

Fleming, Michael F. and Charles S. Hayak. 1984. "Health Care Planning in North Carolina: Migrant Workers Program." North Carolina Medical Journal 45 (June, 1984), 371-374.

GAO. 1988. Health Insurance: Risk Pools for the Medically Uninsurable. Washington, D.C.: General Accounting Office, April 1988.

Garfinkel, S., L. Corder and A. Dobson. 1986. Health Services Utilization in the U.S. Population by Health Insurance Coverage. National Medical Care Expenditure and Utilization Survey, Series B, Descriptive Report No. 13. DHHS Pub. No. 20213. Office of Research and Demonstrations, Health Care Financing Administration. Washington, D.C.: U.S. Government Printing Office, December 1986.

Garfinkel, Steven A.; Gerald F. Riley and Vincent G. Iannacchione. 1988. "High-Cost Users of Medical Care." Health Care Financing Review 9 (Summer, 1988), 41-52.

Gianelli, Diane M. 1987. "Patient 'Dumping' Problems Explored At Hearing." American Medical News, August 7, 1987.

Goldbeck, Willis. 1987. Testimony provided by the Washington Business Group on Health, in U.S. Senate, Minimum Health Benefits for All Workers Act of 1987, Hearings before the Committe on Labor and Human Resources, 100th Cong., First Session, Part I, June 24, 1987.

Governor's Commission on Health Care. 1988. Report to Governor Neil Goldschmidt on Improving Access to Health Care for All Oregonians. Salem: Office of Health Policy, September 1, 1988.

Greene, Leonard M. "Controlling Medical Costs With Tax Surcharge Plan." State Journal. February 10, 1983.

Griffin, Katherine. 1987. American Medical News, April 10, 1987, p. 35.

Hayward, Rodney A.; Martin F. Shapiro; Howard E. Freeman; and Christopher R. Corey. 1988. "Inequities in Health Services Among Insured Americans: Do Working-Age Adults Have Less Access to Medical Care than the Elderly?" New England Journal of Medicine 318 (June 9, 1988), 1507-1512.

HCFA. 1987. Program Statistics: Analysis of State Medicaid Program Characteristics, 1986. Baltimore: Health Care Financing Administration, Office of the Actuary.

HCFA. 1987b. "National Health Expenditures, 1986-2000." Health Care Financing Review 8 (Summer, 1987), 1-36.

HFMA. 1985. Hospital Billing and Collection Analysis in North Carolina. Durham: North Carolina Chapter Healthcare Financial Management Association.

HIAA. 1981. A Profile of Group Medical Expense Insurance in the United States. Washington, D.C.: Health Insurance Association of America.

HIAA. 1988. The Uninsured: A Resource Document. Washington, D.C.: Health Insurance Association of America, Research and Policy Development Department.

Howell, E. and L. Corder. 1985. Out-of-Pocket Health Expenses for Medicaid Recipients and Low-Income Persons, 1980. National Medical Care Utilization and Expenditure Survey. Series B, Descriptive Report No. 4. DHHS Pub. No. 85-20204. Office of Research and Demonstrations, Health Care Financing Administration. Washington, D.C.: U.S. Government Printing Office, August 1985.

Hsiao, William C., Peter Braun, Douwe Yntema and Edmund R. Becker. 1988. "Estimating Physicians' Work for a Resource-Based Relative-Value Scale," New England Journal of Medicine 319 (September 29, 1988), 835-841.

Hsiao, William. "Public versus Private Administration of Health Insurance: A Study in Relative Economic Efficiency." Inquiry 15 (December, 1978).

Institute of Medicine. 1985. Preventing Low Birthweight. Washington, D.C.: National Academy Press.

Lewin-ICF. 1988. "Profile of Uninsured Patients Admitted to D.C. Hospitals." Washington, D.C.: Mimeo of results of study performed for District of Columbia Hospital Association.

Lillard, Lee A.; Willard G. Manning; Christine E. Peterson; Nicole Lurie; George A. Goldberg; and Charles E. Phelps. 1986. Preventive Medical Care: Standards, Usage and Efficacy. Santa Monica, CA: Rand Corporation, R-3266-HCFA, August 1986.

Logsdon, Donald N., Matthew A. Rosen and Michele M. Demak. 1982. "The INSURE Project on Lifecycle Preventive Health Services." Public Health Reports 97 (July-August, 1982), 308-317.

Mandelbrott, Jeanne S. and Marianne C. Fahs. "The Cost-Effectiveness of Cervical Cancer Screening for Low-Income Women." Journal of the American Medical Association 259 (April 22/29, 1988), 2409-2413.

McGovern, Patricia. 1988. "Answers to the Most Popular Questions About Universal Health Care in Massachusetts." Commonwealth of Massachusetts: State Senate, Committee on Ways and Means, April 14, 1988.

Meyer, Jack A., William R. Johnson and Sean Sullivan. 1983. Passing the Health Care Buck: Who Pays the Hidden Cost?. Washington, D.C.: American Enterprise Institute.

Monheit, Alan C., Michael M. Hagan, Marc L. Berk, and Pamela J. Farley. 1985. "The Employed Uninsured and the Role of Public Policy." Inquiry 22 (Winter, 1985), 348-364.

NCHA. 1987. Position Statement of the North Carolina Hospital Association On Indigent Health Care. Raleigh: North Carolina Hospital Association.

NCMS. 1988. North Carolina Medical Society Indigent Care Recommendations. Raleigh: North Carolina Medical Society, September, 1988.

Page, Leigh. 1988. "Insurers Propose New Health Care Coverage System." American Medical News, April 1, 1988, 25.

Quillin, Martha. 1988. "N.C. Must Improve Health Conditions of Migrant Workers, U.S. Officials Say." Raleigh News and Observer, April 10, 1988.

Robbins, Aldona and Gary Robbins. 1987. Mandating Health Insurance. Washington, D.C.: Institute for Research on the Economics of Taxation, Economic Report No. 39, July 8, 1987.

Roberts, Stanley. 1986. Washington Health Care Project Commission Actuarial Study. Mimeo. Milliman and Robertson, September 8, 1986.

Rubin, Rita. 1986. "'Dump' Ban Doesn't Halt Transfers." South Florida Medical Review, August 26, 1986.

RWJ. 1983. Updated Report on Access to Health Care for the American People. Princeton, NJ: The Robert Wood Johnson Foundation.

S&J Associates. 1987. The Development of An Affordable Sliding Fee Scale. A Study Prepared for the Consumer Representative to the Study Commission on Health Care Financing and Delivery Reform. Boston: S&J Associates.

SBA. 1987. "Health Care Coverage and Costs in Small and Large Business," in The State of Small Business, 1987 Report. Report from the President to Congress. Washington, D.C.: Small Business Administration.

Seidman, Laurence S. 1977. "Medical Loans and Major-Risk National Health Insurance." Health Services Research (Summer, 1977), 123-128.

Short, Pamela Farley and Alan C. Monheit. 1987. "Employers and Medicare As Partners in Financing Health Care for the Elderly." NCHSR Staff Paper, NCHSR 88-1.

Singh, Suhella; Rachel Benson Gold and Asta-Maria Kenney. 1987. The Financing of Maternity Care in the United States. New York: The Alan Guttmacher Institute, December 1987.

State of Wisconsin Council on the Uninsured. 1987. Report of the Council on Health Care Coverage for the Uninsured: Plan for a State Health Insurance Program. Madison, WI: State of Wisconsin Council on the Uninsured, January 1, 1987.

State of Massachusetts, House Bill H5210. An Act to Make Health Security Available to All Citizens of the Commonwealth and to Improve Hospital Financing. Boston: Commonwealth of Massachusetts.

Sudovar, Stephen G. and Patrice Feinstein. 1979. National Health Issues: The Adequacy of Coverage. Nutley, NJ: Roche Laboratories.

Sulvetta, Margaret B. and Katherine Swartz. 1986. The Uninsured and Uncompensated Care. Prepared for the National Health Policy Forum, June 1986.

Tonsfeldt, Lynne. 1986. "Cost Management Through Case Management." Personnel Management, March 1986, 74-79.

TPF&C. 1987. "Health Benefit Plans Fall Short of Proposed Legislative Requirements." TPF&C Survey of Employers, reported in Medical Benefits, September 30, 1987.

Trippler, Aaron. 1987. Comprehensive Health Insurance for High-Risk Individuals. Minneapolis, MN: Communicating for Agriculture, August 1987.

Trapnell, Gordon. 1987. Letter to Senator Edward M. Kennedy, May 18, 1987. Printed in Congressional Record, May 21, 1987, S-7081.

U.S. Bureau of the Census. 1987a. Consumer Income, Series P-60, No. 155. Receipt of Selected Noncash Benefits: 1985. Washington, D.C.: U.S. Government Printing Office, January 1987.

U.S. Bureau of the Census. 1987. Government Finances, Series GF86, No. 3. State Government Finances in 1986. Washington, D.C.: U.S. Government Printing Office, October 1987.

U.S. Senate. 1986. Retiree Health Benefits: The Fair-Weather Promise, Hearing before the Special Committee on Aging, 99th Cong., Second Sess., August 7, 1986.

Van Ellet, T. 1981. State Comprehensive and Catastrophic Health Insurance Programs: An Overview. Washington, D.C.: Intergovernmental Health Policy Project, October 1, 1981.

Wade, Torlen. 1988. "Small Employer Focus Groups." Presentation to North Carolina Health Insurance Trust Commission. Raleigh: November 22, 1988.