

Closing the Gap: Insuring the
Uninsured in West Virginia
West Virginia State Planning Grant

October 15th Health Advisory Council
Subcommittee Recommendations

Accountability Subcommittee
Joint Benefits & Finance Subcommittee
Communications Subcommittee

Accountability Subcommittee

Recommendations

Subcommittee's Goal

Come up with recommendations that would provide basic services in a cost-effective manner in order to make the program as practical and as least costly as possible

Who should be held accountable in this plan?

- Consumers
- Employers
- Insurers
- State
- Providers

Consumers

- Consumers who smoke should pay higher premiums since smokers incur higher healthcare costs and change can be accomplished in a relatively short time, if desired.
- Consumers with significantly above average risk assessment scores should pay higher premiums.

Consumers

- Consumers should use the provider network, preferable made up of in-state providers, except in emergencies. Network providers will accept program fees, thus reducing costs.
- Consumers should be expected to provide partial payment of premiums.

Consumers

- Consumers should be expected to pay some reasonable co-payments and/or deductibles. This may, at times, cause patients not to seek care. However, a trade-off of controlling utilization is more important, particularly upon initial implementation of the program in order to control costs.

Employers

- The employer and employee should make equal contributions to the cost of premiums.
- The employer should payroll deduct the employee's share of the premium.
- Incentives should be provided for the employer to offer a wellness program – reduced premiums or tax credit. These programs may help reduce costs over time.

Insurers

- The insurer should provide an adequate network of in-state providers.
- The insurer should pay providers a reasonable fee in order to recruit providers into the network.
- The insurer should provide timely payment with minimal paperwork. This will help recruit providers and minimize overhead costs.
- The insurer should provide a timely appeals process.

State

- The state should provide a dedicated, stable funding source for the government's share of costs, if the state participates in the funding.
- The state should monitor employers, insurers, and providers to ensure their compliance with the program.

State

- The state should take a leadership role in designing the program to assure that an affordable program is offered.
- The state should measure the program impact - both in reducing the number of uninsured and improving their overall healthcare status.
- The state should serve as an insurer - by utilizing either PEIA or Medicaid – of other private insurers are not available.

Providers

- Providers should accept the rates of the plan, recognizing that the rates must be reasonable, but should reduce their overall level of uncompensated care
- Providers should submit accurate bills in a timely manner
- A provider panel should be accessible to patients in a reasonable timeframe for appointments

Joint Benefits & Finance Subcommittee

Recommendations

Background of the Subcommittees

- Began meeting individually as separate subcommittees
- Overlapping missions of what should be covered and how to finance led to a merger in May
- Joint subcommittee has met 1-2 times per month
- Reviewed focus group & interview results
- Input was gathered from all segments: the healthcare system, business, industry, consumers, lawmakers, etc
- Reviewed other states' programs
- Completed an extensive literature review on topic

Subcommittee Membership

Interests represented

- Hospital
- Labor
- Consumer
- Legislative staffers
- Insurance
- Academia
- Business
- Agency representatives
 - PEIA
 - HCA
 - CHIP

State Planning Grant Goals

- To assure that the current levels of coverage in West Virginia's public and private healthcare programs are maintained "Do No Harm"
- To cover 50% of uninsured adults ages 19 to 64 within 5 years – approximately 110,000 people

Subcommittee Charges

- What should be covered by insurance?
 - What is in the benefits package(s)?
 - Is it a product that people would be willing to purchase?
- How will the new insurance package(s) be financed?
 - Things to keep in mind:
 - Self-funded
 - No cost to state
 - No new taxes

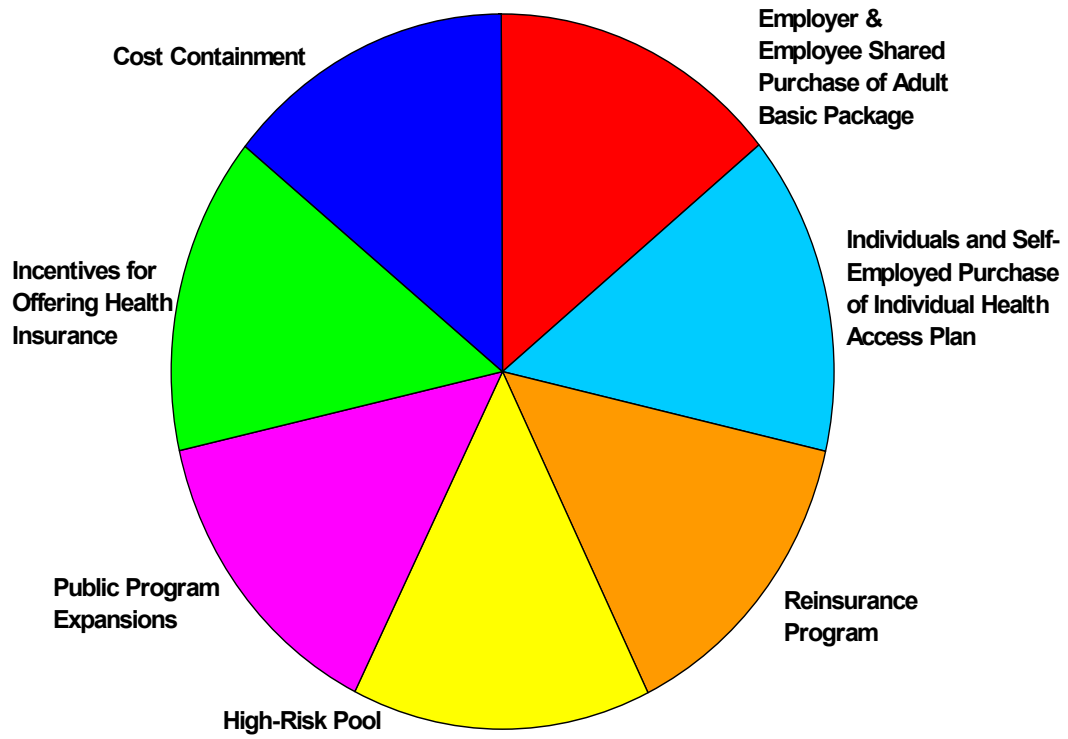
Steps to Achieve Goal #1

- Protecting all interested parties; try to minimize the crowd-out
 - Crowd-out is an insurance phenomenon when people switch from private insurance to insurance paid for with public monies
 - Protect the currently covered populations (i.e., commercially & publicly covered children and adults)

Steps to Achieve Goal #2

- Using the *WV Healthcare Survey 2001*, subcommittee identified the largest segments of the uninsured population
- Identified priority populations as:
 - Employed, self-employed, homemaker
 - Married
- Covering all of these population will achieve approximately 80.3% of goal #2
- Keep in mind that “priority” does **NOT** eliminate any group

Recommendations



Option #1

Employer & Employee Shared Purchase of an Adult Basic Package

Employer & Employee Shared Purchase of Adult Basic Package

- Follows PEIA PPB Plan B for non-state employees
- Available to employers with between 2 & 50 employees
- A public-private partnership approach: all carriers will use PEIA's reimbursement rates
- Allows package to be offered by private market and/or PEIA
- Will have a look-back provision of 12 months
- No pre-existing condition limits will apply
- Will be a guarantee-issue plan
- Minimum employee participation of 75% with spouse taken out of equation if they have insurance available through their work

Employer & Employee Shared Purchase of Adult Basic Package

- Minimum employer contribution to the premium is 50%
- During the focus groups, small business owners responded that they were willing to contribute approximately \$100 per employee per month
- Employer and employee share the cost; no state involvement in premiums
- Minimum threshold defined as at least 20 hrs/wk but let the employer determine how much they will pay for less than full-time workers
- Open-enrollment tied to the plan anniversary date, with exceptions tied to IRS & market standards (e.g., change in status: baby, divorce, etc, new employees, spouse loses job and/or previous coverage)

Additional Details of Adult Basic Package

- Benefit provisions that differ from those of the PEIA plan are underlined in the following tables
- Approximately 8.5 percent of enrollees would hit the annual cap of \$15,000

Specifications for Adult Basic

<u>Annual deductible</u>	<u>\$250</u>
Annual out-of-pocket maximum	\$2,000
<u>Annual benefit maximum</u>	<u>\$13,000</u>
Physician Services	
<u>Adult routine physical examinations</u>	<u>\$15 co-pay</u> for office visit; no co-pay for specified preventive services
Diagnostic x-ray, lab, and testing	20% coinsurance
Physician inpatient visits	20% coinsurance
Physician office visits	\$15 co-pay
Prenatal care	Covered in full after deductible
Well child exams and immunizations	Covered in full

Hospital Inpatient Services	
Semi-private room; ancillaries; therapy, maternity, x-ray, lab, surgical, and general nursing services	20% coinsurance
Rehabilitation	20% coinsurance, limited to 150 days per year
Skilled nursing	20% coinsurance, limited to 100 days per year
Hospital Outpatient Services	
Outpatient surgery	\$50 co-pay per visit, then 20% coinsurance
Pre-admission testing; diagnostic x-ray and lab; radiation and chemotherapy	20% coinsurance

Lewin Memo 9/3/03

Specifications for Adult Basic

Mental Health & Chemical Dependency	
Inpatient services, including detoxification and partial hospitalization	20% coinsurance, limited to 30 days per year
Outpatient services	20% coinsurance, limited to 20 visits per year
Outpatient Therapy	
Acupuncture; occupational, physical, and speech therapy	20% coinsurance; benefit limited to \$1000 per year
Chiropractic services	Not covered
Other Medical Services	
Emergency room treatment	\$50 co-pay (if not certified as an emergency), plus deductible and 20% coinsurance
Emergency services and supplies	\$25 co-pay plus deductible and 20% coinsurance; must be certified as an emergency

Specifications for Adult Basic

Durable medical equipment	20% coinsurance; must be medically necessary
Infertility services	Not covered
Other medical services and supplies (if not covered under prescription drug benefit)	20% coinsurance; may be subject to plan guidelines or limitations
Podiatry	\$15 co-pay for office visit; 20% coinsurance for surgery
Dental services/TMJ	Not covered, except for treatment related to accidents or impacted teeth (20% coinsurance)
Hearing exam	Not covered (except under well child benefit)
Vision services	Not covered

Lewin Memo
9/3/03

Specifications for Adult Basic

Prescription Drugs	
<u>Annual deductible</u>	<u>\$75</u>
<u>Annual benefit maximum</u>	<u>\$2,000</u>
Generic drug (mandatory if available)	\$10 co-pay
Formulary brand drug (must be medically necessary per prescribing provider)	\$20 co-pay
Non-formulary brand drug	\$50 co-pay
Diabetic supplies	Covered
Growth hormone	Covered

Lewin Memo
9/3/03

ABP Average Monthly Benefit

Calibrated estimate of monthly benefit cost	\$157.25
Underwriting and selection factor	1.24
Adjusted estimated monthly benefit cost	\$194.99
Administrative & distribution expense and risk & profit margins (as % of gross premium)	6.0%
Gross premium	
Employee Only Coverage	\$207.44
Employee & Spouse Coverage	\$428.72
Family Coverage	\$622.30

Lewin Memo
8/18/03

Next Steps for Adult Basic Package

- Looking to get the premium down to \$199/200 per month
- Blue Cross/ Blue Shield will price package using their risk, profit and administration fees with PEIA reimbursement schedule
- Currently requesting that other carriers (The Health Plan & Carelink) estimate their pricing to see if cost can reach \$199/200
- Need to look at what is necessary to allow commercial carriers to utilize PEIA reimbursement schedule

Option #2

Individuals and Self-Employed Purchase of an Individual Health Access Plan

Individual Health Access Plan

- Individuals and self-employed people are eligible
- Part-time employees without access to employer-sponsored insurance, laid-off workers, unemployed, students, temporary, seasonal workers, etc, are also eligible
- Suggest a 12 month look-back provision
- Lock-in provision, enrolled person must keep the plan for 12 months
- Offered by private market and PEIA
- Allow commercial insurance to utilize PEIA reimbursement schedule

Individual Health Access Plan

- Similar to a plan that Arkansas is pursuing
- 7 inpatient hospital days per year
- 6 outpatient visits per year
- 1 outpatient surgery/procedure per year
- 2 maintenance prescriptions per month
- \$250 medical/surgical deductible
- \$75 drug deductible
- Administrative load is equal to 6% of gross premium
- Cost: \$140 per month
- Cost estimates are based on PEIA's reimbursement rates

Lewin Memo 9/3/03

Next Steps for Individual Health Access Plan

- Blue Cross/Blue Shield will look at impact on the premium if age and gender rated
- Possibly allow medical underwriting/ medical screening
- Need to consider laid-off or fired workers and if the 12 month look-back provision would apply
- Need to look at what legislative and/or regulatory changes are necessary to offer this type of plan & what is necessary to allow commercial carriers access to PEIA reimbursement schedule

Option #3

Develop a Reinsurance Program

Reinsurance Program

- Policy recommendation that the state explore supporting reinsurance covered by public funds
- This program would be available to those who reach the annual cap of their other insurance

Option #4

Develop a High-Risk Pool

High-Risk Pool

- Policy recommendation that the state explore establishing a high-risk pool to cover individuals who cannot get coverage elsewhere. The state should consider the federal grant funds that are available for establishing these types of programs.
- Recommend that the state look to the National Association of Insurance Commissioners (NAIC) for assistance with modeling of program
- Program would be for individuals who have proof that they were turned down by an insurance carrier, are HIPAA-eligible, or who have been diagnosed with certain illnesses

Option #5

Public Program Expansions

Medicaid Expansion to Custodial Adults

Expand Medicaid coverage to custodial parents of Medicaid children up to 100% FPL.

- Currently, if the household income exceeds 29% of the FPL*, custodial adults will not be eligible for Medicaid, even though their children may be eligible
- Option costs an estimated \$9.0 million in state funds or \$5.3 million with \$25 premium contribution (this requires a waiver)
- Subcommittee supports option as a longer-term objective, BUT suggests exploring a HIFA Waiver to restructure the current Medicaid benefit package to reduce benefits to help lower the cost of this type of expansion

*FPL table is attached at end

CHIP Program Expansion I

Expand WVCHIP to uninsured children of families between 200% and 250% of FPL with an individual premium contribution.

- Program would have a \$25/month premium per child charged
- It would follow the CHIP program crowd-out provisions
- Same CHIP benefit package and co-pay structure applies
- Funding would be from an existing federal allotment that was recently received

CHIP Program Expansion II

Implement the above mentioned CHIP expansion, evaluate the results, then consider expanding to CHIP for children of families between 250% and 300% of the FPL.

- Subcommittee supports the consideration of this option after above CHIP program has been implemented and its effects evaluated
- Need to give consideration to where the funding would come from for this option

Additional Steps for Public Program Options

Committee plans to establish a small working group to look at the following two concepts:

- Allow buy-in to the CHIP program for children up to 300% FPL when the parent/guardian has any type of employer-sponsored insurance. The employer, employee or a combination of the two would pay the state's share of the premium for the child(ren)
- As an incentive for the Adult Basic Plan, allow buy-in to the CHIP program for children up to 300% FPL when the parent/guardian employer has the Adult Basic Plan as their insurance. The employer, employee or combination of the two would pay the state's share of the premium for the child(ren)

Details of Public Program Options

	Eligible People	Number Enrolled	Reduction in Uninsured	Crowd-out	Total Costs (\$1,000s)	Premium Revenues (\$1,000s)	Costs Less Premium (\$1,000s)	State Costs (\$1,000s)	Federal Costs (\$1,000s)
CHIP I: Children Between 200 Percent and 250 Percent of FPL									
Without Premium	10,490	4,795	2,247	2,548	\$7,881	--	\$7,881	\$1,967	\$5,914
With \$25/Month Premium	10,490	3,117	1,461	1,656	\$4,541	\$701	\$3,840	\$958	\$2,881
Custodial Parents up to 100 Percent of FPL									
Without Premium	25,354	16,723	13,952	2,771	\$36,235	--	\$36,235	\$9,044	\$27,191
With \$25/Month Premium	25,354	10,151	8,425	1,726	\$21,995	\$770	\$21,225	\$5,298	\$15,927
CHIP II: Children Between 250 Percent and 300 Percent of FPL									
Without Premium	12,798	5,514	2,427	3,087	\$9,063	--	\$9,063	\$2,262	\$6,801
With \$25/Month Premium	12,798	3,584	1,579	2,005	\$5,076	\$783	\$4,293	\$1,071	\$3,222

Info from Lewin Memo 9/29/03. Note: Lewin estimates use the maximum crowd-out calculations. Literature indicates that crowd-out is generally 15% to 22%.

Option #6

Develop Incentives for Employers/Businesses Offering Health Insurance to their Employees

Incentives for Offering Health Insurance

- Subcommittee considered a tax rebate program. Cost to state with a 40% rebate = \$58 million
- Subcommittee recommends pursuing the creation of a preference system for companies who want to contract with the state or who receive economic development funds.
- The system will be based on whether the employer provides health insurance coverage for their employees. This system would establish a differential preference system whereby the companies who offer “commercially customary” types of health insurance plans would receive preference points (preference #1). Those employers who buy into the adult basic package would also receive preference points but not as many (preference #2).

Next Steps for Incentives Program

- Need some feedback from state purchasing and economic development on the impact of this type of system
- Look at moving from preference system to eligibility criterion within five years

Option #7

Cost Containment Measures

Cost Containment

- Subcommittee supports the establishment of a group, under the auspices of the State Health Plan process and the HCA, to examine how much we, as a state, can afford to spend on health care.
- The idea is that the group would develop annual baseline cost estimates and projections for each health care sector. It would then examine the actuarial projections quarterly and, if a sector exceeds the budgeted projection, the group would make recommendations.

Cost Containment

The group would include:

- Providers
- Private Insurance Carriers
- The Medical Universities
- Government Payors
- Government Regulators
- Business Leaders
- Consumers

Communications Subcommittee

Town Hall Recommendations & Concerns

General Recommendations and Concerns

Many individuals, especially retirees, would like to know why healthcare costs are increasing at the rate they currently are.

Delegate Ellem, (R) Wood County, posed the question, “Is [expanding insurance coverage] something the states are equipped to handle?”

A significant number of attendees feel preventive medicine is important.

Several attendees expressed the sentiment that persons choosing to live a healthy lifestyle should be rewarded.

Many attendees expressed concern that something be done to control the escalating cost of prescription drugs.

Recommendations and Concerns Regarding Potential Options to Expand Coverage

Several attendees endorse the idea that businesses that offer health insurance should be rewarded with a.) tax credits and b.) preferred vendor status by the State.

Many of those present at the town halls endorse the expansion of public programs (via a change in eligibility standards, as well as through a program that allows individuals/employers to buy into Medicaid). Here, many support this option because of the federal matching dollars the State receives.

Those who do not support expanding Medicaid point to the fact that current Medicaid recipients already face problems accessing care. These individuals feel that if there are more people enrolled, the problem of finding a doctor who accepts Medicaid will only get worse. Others oppose this option because they believe that many West Virginians are too proud to participate in public programs.

In response to the concerns regarding Medicaid patients’ access to care, the idea was put forth that physicians’ assistants and nurse practitioners could serve as suitable (and cheaper) alternatives to physicians.

While several individuals endorse the idea of offering employer tax credits, fewer attendees expressed support for the notion of offering employee tax credits.

Several attendees supported the development of a low-cost catastrophic package, with one individual suggesting that this type of package be augmented with a preventive care component—i.e. screenings and checkups.

Many attendees expressed their desire that mental health and substance abuse not be cast by the wayside, but should be incorporated into any new programs that are developed. Others, primarily physicians, expressed concern over the fact that insurers are less and less willing to cover the long hospital stays that are often required in order to sufficiently treat patients suffering from these types of disorders.