# Appendix E

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# Evaluation of HRSA Coverage Options: Executive Summary

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Government Human Services Consulting

*A copy of the full Mercer Government Human Services Consulting report on Evaluation of HRSA Coverage Options can be accessed online at: http://www.nciom.org/projects/uninsured/uninsured.html.*

# Executive Summary

Growth in the number of Americans without health insurance coverage has become a significant policy issue across the country. North Carolina is no exception, where the uninsured population has increased from 16 percent of the non-elderly population in 1999-2000 to 18 percent of the non-elderly population in 2003-2004.[1]

To support a Heath Resources and Services Administration (HRSA) State Planning Grant to study policy options for expanding health insurance coverage in the state, the Cecil G. Sheps Center for Health Services Research at the University of North Carolina–Chapel Hill hired Mercer Government Human Resources (Mercer) to assist in option design and pricing. With direction from the Cecil G. Sheps Center for Health Services Research (at the University North Carolina-Chapel Hill) and the Task Force for Covering the Uninsured, Mercer evaluated both public sector- and private sector- sponsored options for expanding coverage. All cost projections are based on coverage for calendar year 2006.

## Public Sector Options

Mercer evaluated three publicly sponsored expansion options; all were Medicaid expansions. The first option is an expansion of the current set of Medicaid covered benefits, and the remaining two are variations on a limited benefit expansion. Children in North Carolina from families with incomes up to 200 percent of FPG are currently eligible either for Medicaid or Health Choice for Children, depending on income level and age. All three expansion options were evaluated for expansion to children from 200 to 300 percent of FPG.

Medicaid currently covers non-pregnant adults with incomes up to 37 percent of the Federal Poverty Guidelines (FPG) and pregnant women with incomes up to 185 percent of FPG. All three expansions were evaluated for parents of children enrolled in Health Choice in the following income bands: 37 to 100 percent, 100 to 150 percent, 150 to 200 percent, and 200 to 300 percent.

Providing full Medicaid benefits to individuals is expensive; the benefits are comprehensive and the member cost sharing is very low. Per person monthly cost projections for adults ranged from $490 to $530, depending on FPG level. Children are less expensive, projected at $257 monthly. The full Medicaid expansion to 300 percent FPG could be expected to cover 174,000 people at a total annual cost of $1 billion. That cost would be shared between the federal government, the State, Counties, and enrollees in the form of a premium contribution.

A limited benefit expansion could provide a less expensive alternative and still provide coverage of key services to some individuals currently without health care coverage. The

[1] Holmes M. Data from the U.S. Census, Current Population Survey: 2004, 2005 (reflecting 2003, 2004 coverage). Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. 2005. The analyses are based on two-year average of 2004, 2005 CPS data weighted more heavily to the most recent year.

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limited benefit options evaluated do not include all the benefits in the regular Medicaid program, and they require significantly more cost sharing on the part of the enrollee.

Mercer evaluated two versions of a limited benefit plan, with the difference between the two being the treatment of hospital inpatient services. In the first alternative, there is a $5,000 hospital inpatient deductible that must be borne out of pocket before the benefit begins. In the second alternative, there is a $100 inpatient hospital deductible, and then 80 percent of costs are covered until the plan has paid out $10,000 in inpatient expenses.

Mercer's analysis showed that the projected costs for the two limited benefit options do not differ much from one another, but are much lower than for the full benefit expansion. Per person monthly cost projections for adults ranged from $270 to $290 for the $5,000 Inpatient Deductible option and from $275 to $300 for the $10,000 Inpatient Limit alternative.

However, this type of plan is likely to attract fewer enrollees than a full expansion. Although the premium charged is lower, many persons are likely to consider the covered benefits and the high cost sharing levels and choose not to enroll. Projections for each of these products were that they might cover approximately 104,000 individuals at a total annual cost of $334 to 344 million. Again, these costs would be shared by the federal, state, and county governments, and by the enrollees through the payment of a monthly premium contribution.

## Private Sector Options

Focus groups conducted in Spring 2005 as part of the HRSA project revealed interest in tiered benefits offered to small employers, particularly in the form of limited benefit plans. This model includes a base plan of benefits and the opportunity to "buy up" to higher levels of benefits. Small employer coverage is regulated by the State, and this option might require statutory and/or regulatory changes. While this type of product would be designed and priced by the private market in North Carolina, the Task Force asked Mercer to produce cost estimates for a sample product, to provide a sense of whether this type of option might provide an attractive cost/benefit alternative that could encourage higher levels of coverage among employees of small employers.

The sample product evaluated covers a core set of services considered to be the most critical: inpatient hospital care (including professional services while admitted), physician office visits, diagnostic testing, emergency room, and prescription drugs. The base plan (Tier 1) covers a low level of these benefits (for example, up to 4 office visits annually), while employees could choose to buy one of two richer versions of the plan (Tier 2 or Tier 3). All three tiers have member cost sharing requirements that are similar to those in standard commercial health insurance products.

These very limited products are projected to be significantly less expensive than comprehensive health insurance products currently available. For instance, the sample product estimated monthly premium cost per adult ranged from $150 (Tier 1) to $270

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(Tier 3). However, despite the interest in this type of product expressed in HRSA focus groups, limited benefit plans have not historically been popular in the private health insurance market. For this reason, cost estimates were developed assuming that 40 percent or fewer eligible individuals would purchase this product.

Other private sector coverage options were considered by the Task Force but were not priced by Mercer.

## Methodology

Mercer used an actuarial pricing approach to project costs for each of the policy options evaluated. This type of approach starts with base data that represents the closest possible match to the target population, covered services, and service delivery method of the option to be priced. That base data is then adjusted for expected differences between the base and the option, including differences in population, covered services, cost sharing elements, and time period.

For the public sector options evaluated, Mercer used North Carolina Medicaid data as the most reasonable available base data source. For the private sector options, North Carolina detail from a large commercial claims data set was used. The adjustments made to those data sources were based on data analysis, other internal and external research, and the judgment of Mercer's actuaries. The adjustments are appropriate for the type of analysis performed; they do, however, rely on assumptions that are selections from ranges of reasonable assumptions. The cost projections that result, and are shared above, are best interpreted as a point estimate within a range of reasonable results.

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