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STATE OF NEW JERSEY

ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

INTERIM REPORT

November 28, 1990

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Chairman

Robbie Miller
Aide to the Commission
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New Jersey State Legislature
ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION
STATE HOUSE ANNEX, CN-068
TRENTON, NEW JERSEY 08625-0068
(609) 292-1646

Honorable Joseph V. Doria, Jr.
Speaker of the General Assembly

Dear Mr. Speaker:

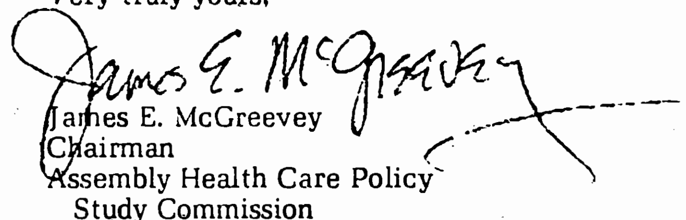
I am pleased to transmit with this letter the interim report of the findings and recommendations of the Assembly Health Care Policy Study Commission.

The Assembly Health Care Policy Study Commission, established in March of this year, has studied the various issues related to the existence of the Uncompensated Care Trust Fund. The Commission held four public hearings to consider recommendations regarding the reduction or elimination of the costs of uncompensated care in New Jersey.

On behalf of the Commission, I would like to express our appreciation and special thanks to Office of Legislative Services staff person, Robbie Miller, who served as aide to the Commission and significantly assisted the Commission's efforts.

I am hopeful that the Commission's continuing study of health care policy in the State will prove useful to the Assembly members. I am also hopeful that the recommendations contained in this interim report will be of value in pursuing the goals of universal access to health care and cost containment.

Very truly yours,



James E. McGreevey
Chairman
Assembly Health Care Policy
Study Commission

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INTRODUCTION

The Assembly Health Care Policy Study Commission was established on March 8, 1990 by Assembly Speaker Joseph V. Doria, Jr. as a bi-partisan commission to examine health care policies in New Jersey and to develop initiatives regarding more affordable and accessible health care for all residents of the State. The formation of the Commission was prompted by the recognition that costs of health care are skyrocketing and demands on the system are escalating. The commission will span the 1990-1991 legislative session and will explore three major issues: the Uncompensated Care Trust Fund; health care planning and reimbursement; and long-term health care.

This interim report covers the initial issue regarding the Uncompensated Care Trust Fund, specifically, the possible options with respect to how to reduce or eliminate the costs of uncompensated care in New Jersey.

After hearing valuable testimony from numerous witnesses, which is fully detailed later in this report, the Commission makes the following recommendations:

1. Make health care more affordable and accessible to all through universal health care directed by a single payer authority.

2. Expand Medicaid eligibility groups to maximum allowable federal levels to bring in matching federal funds.

3. Expand the Garden State Health Plan to Medicaid & non-Medicaid eligibles (uninsured and underinsured).

4. Refocus health care on preventive medicine, wellness and managed care services as opposed to acute care; encourage providers to establish experimental programs to achieve these goals.

BACKGROUND

The health care system in the State and the nation is in a crisis situation with rapidly rising medical costs causing an increasing number of people to be without health care coverage. A recent study indicates that the average health care cost per person in New Jersey rose from $930 in 1980 to $2,224 in 1990 and may reach $5,056 by the year 2000. Additionally, overall health care spending in New Jersey rose from $6.8 billion in 1980, to $17.4 billion in 1990 and may be as much as $42.5 billion by the year 2000.

The U.S. Bi-partisan Commission on Comprehensive Health Care (the Pepper Commission) reports that nearly 32 million citizens in the United States under the age of 65 are uninsured and another 20 million have inadequate health care coverage. In New Jersey the number of citizens who are uninsured is approaching 900,000.

Generally, people obtain health care coverage through their employment. However, a growing number of people do not have such job based coverage and may also be unable to obtain coverage through Medicaid or other public programs. Traditionally, gaps in health insurance protection are found among part-time workers, young workers and the working poor who cannot qualify for Medicaid or afford the cost of health insurance. In New Jersey approximately 75% of the uninsured population are working or dependents of working individuals. Furthermore, an Eagleton Institute survey of small businesses indicates that 55% of employers with 3 or less employees, 43% of employers with 4-6 employees and 34% of employers with 7-11 employees did not offer insurance to their full time employees. Overall, 40% of employers do not offer insurance to their full time employees. Of those who do not provide insurance, the main reason given is that insurance is/was too expensive.*

As health care costs increase due to, among other things, expanding medical technology and higher medical fees, health insurance premiums rise. Small businesses, in turn, cannot or will not pay for health insurance for their employees and the uninsured population rises. Thus, reliance on the Uncompensated Care Trust Fund increases.

The Uncompensated Care Trust Fund was established in 1987 to guarantee access to quality health care to all residents of the State. The Legislature recognized that many residents of the State cannot pay for necessary hospital care and the fund was established to be the mechanism for payment of uncompensated

*See Appendix A

hospital care. The fund is financed through a surcharge on hospital bills of approximately 19%. Uncompensated care costs in New Jersey have risen dramatically from $233 million in 1983 to more than $700 million estimated for 1990.* In 1991 the cost of providing uncompensated care could reach $1 billion.

Another source for payment of health care costs is the Medicaid program, a federal-state entitlement program administered by the State to provide medical assistance to persons with inadequate resources to secure quality medical care at their own expense. The federal government provides matching funds to the State for provision of health care to qualified individuals. Unfortunately, very often Medicaid reaches only a small portion of the eligible population due partly to inadequate eligibility procedures and requirements. Often Medicaid eligibles access the system and their hospital costs are charged to uncompensated care (as indigent care). Had those individuals qualified for Medicaid, the State would have received matching funds and one-half of the individual's hospital bills would have been paid.

In 1990 New Jersey Medicaid costs consumed $2 billion, approximately $1 billion from the State General Fund and $1 billion from federal matching funds. This represents about 9.2% of the overall State budget. Additionally, the eligible Medicaid population is over 530,000, which includes pregnant women and children, the aged, and the blind and disabled.

*See Appendix A

COMMISSION PROCEEDINGS

The Assembly Health Care Policy Study Commission listened to testimony from numerous witnesses at four public hearings held at various locations in the State. Witnesses included members of the administration, representatives from hospitals, insurance companies, business and labor organizations, private social service agencies, professionals and private individuals. All participants expressed concern over the problem of access to health care in the State. The following discussion includes highlights of the testimony heard at each public hearing.

The first public hearing was held on *April 16, 1990* and focused on the availability of health care insurance for employed and unemployed persons in New Jersey.

The Commissioner of Labor, Raymond Bramucci, noted that the gaps in health insurance coverage, which cause workers to be uninsured, are a national problem that ideally should be addressed at the national level. However, since that has not occurred, and is not likely to occur in the near future, the State has been forced to deal with the problem. The result is the Uncompensated Care Trust Fund, which is overburdened and is unfair to those employers and individuals who purchase health care insurance. Surcharges which support the fund have hastened the trend of rising insurance costs, forcing employers to reconsider whether to provide health insurance to employees. As a result, disputes over health benefits are the single biggest issue in collective bargaining; approximately three-fourths of recent labor disputes focused on health care benefits because workers were asked to absorb an increased share of health care costs or were asked to make concessions to make up for employer costs.

One of the major health insurance companies in the State, Blue Cross and Blue Shield of New Jersey, reported that in 1989 the company's health care costs increased by 23% compared to the approximate 4.8% increase for all consumer prices. This was apparently due to a variety of factors including new technology, increase hospital costs, increased utilization and increased malpractice costs. Additionally, the goal of the Uncompensated Care Trust Fund of providing access to health care to all residents has resulted in higher health insurance premiums for purchasers of health care. This is based on the rapid growth of the Fund and the fact that it is supported by a surcharge on hospital bills. Some recommendations included: using general revenues to fund the Uncompensated Care Trust Fund; creating a high risk pool in the State; encouraging small businesses to provide insurance; and discouraging mandated benefits.

Representatives of the business and industry community in the State presented testimony regarding the impact of rising health care costs, particularly on small businesses. The average per employee health plan cost in New Jersey is approximately $2,800 with costs ranging from $2,000 for single coverage to $5,000 for family coverage. Such an expense greatly impacts small businesses. Additionally, small businesses are at a disadvantage in the insurance market because they pay more for insurance (10%-40%) since there are a smaller number of employees among whom the cost can be spread.

Another problem noted was the federal tax law which permits a corporation to deduct the full cost of premiums as a business expense while a sole proprietor can deduct only 25% of his premium cost.

With respect to the Uncompensated Care Trust Fund, it was recommended that uncompensated care be funded through a broad based mechanism and not a surcharge on premiums and patients' bills.

The second public hearing was held on ***May 24, 1990*** and focused on recommendations of hospitals and health care professionals regarding how to offset the Uncompensated Care Trust Fund.

The New Jersey Hospital Association noted that New Jersey has been creative in dealing with hospital cost containment while providing medical care for its indigent population. The Association advocates the retention of the Uncompensated Care Trust Fund because its premise, providing medical care for the indigent and access to all, is both fair and sound. Also, the fund protects hospitals with high uncompensated care case loads from financial insolvency. Broader based funding was urged to support the fund and to unburden the hospitalized patient.

The Association recognizes that the State and the private sector must make commitments to reduce the number of uninsured persons in New Jersey. The State could expand Medicaid eligibility requirements to qualify uninsured individuals for Medicaid, and bring in more federal matching money. The private sector (small employers) could be encouraged to provide insurance to employees, by making it affordable and providing incentives such as State or federal tax credits. The focus should be on wellness and preventive care.

Various hospital executives and health care providers also testified about the need to establish equitable, stable, broad based alternatives to funding the Uncompensated Care Trust Fund instead of funding from the shrinking insurance base which is paying more to cover the uninsured population. Some noted that the definition of medical indigency needs to be reexamined since the use of the Uncompensated Care Trust Fund is disproportionately weighted to bad debt, funding more bad debt than medical indigency, which is not what the fund was intended to cover.

Urged was universal coverage financed through an employer/employee tax on wages. Again, it was urged that the focus should be on managed care systems which define a minimum level of benefits and emphasize primary care, prevention and wellness. Also, managed care systems provide links to providers and properly reimburse for the care they deliver.

Again, the expansion of Medicaid eligibility was urged since not all individuals who are currently eligible are enrolled. It was recommended that a mechanism be established where each hospital could complete Medicaid applications while the patient is at the hospital to assure full enrollment of eligibles.

The third public hearing was held on ***July 18, 1990*** and focused on organized labor's, the State's and private industry's recommendations regarding providing health insurance to employees.

A representative from Allied Signal made a presentation on the successful managed care program the company has offered to its employees since 1987. One of the objectives of the program has been to keep health care cost increases below 10% and, so far, this goal has been met. The program provides coverage focused on wellness with a network or providers to choose from, similar to a health maintenance organization. Allied Signal has had the opportunity to negotiate with unions who have accepted the managed care program.

Labor representatives indicated that the Uncompensated Care Trust Fund relies too heavily on surcharges which results in responsible employers (those who provide insurance to employees) subsidizing irresponsible employers (those who do not provide insurance to employees and whose employees access the fund). They recommended encouraging employment based insurance coverage with a State mandated level of employee coverage. Again, wellness and preventive care, as opposed to inpatient acute care were urged.

Business representatives, also concerned with the growing problem of uncompensated care, suggested that the Uncompensated Care Trust Fund may be more appropriately supported from general revenues instead of the surcharge on hospital bills. While some opposed mandatory employer provided insurance, they did support incentives, such as tax credits, for employers providing insurance to employees. With respect to small businesses, it was suggested that these groups should be exempt from providing coverage for mandated benefits, which increase the costs of coverage for these employers.

The fourth public hearing was held on ***October 9, 1990*** and focused on Medicaid issues including expansion of Medicaid eligibility and availability of community based services for Medicaid eligible individuals.

The Commissioner of Human Services, Alan J. Gibbs, gave an overview of the New Jersey Medicaid program, indicating that State funds for Medicaid represent 45% of the Department of Human Services' budget and 9.2% of the Fiscal Year 1990 budget. The Commissioner expressed concern over growing Medicaid expenditures due, in part, to the rising cost of inpatient institutional services and the use of hospital outpatient services by Medicaid eligible persons for their primary care. Recommendations included extending Medicaid to all optionally eligible groups allowed under federal law; providing incentives to make participation by providers more attractive; expanding and enhancing community based long-term care services and a move toward managed care.

In connection with the managed care recommendation, the Commissioner explained the existing Garden State Health Plan, the first Medicaid operated health maintenance organization in the country. The program has demonstrated that it is possible to provide reasonable reimbursement to providers while maintaining access to health care and controlling costs. Currently there are 4,200 enrollees in 10 counties throughout the State..

Representatives from various medical centers in the State testified regarding the expansion of Medicaid eligibility to allowable federal limits. Additionally, they stressed the need to streamline the system to provide for on site enrollment and user friendly services, instead of the lengthy, confusing forms presently used. A more streamlined system would result in more Medicaid enrollments and bring in matching federal dollars.

Again, the focus on managed care was urged with incentives offered to providers to join. Timely reimbursement would serve as a good incentive to providers. Additionally, it was noted that health maintenance organizations should enroll Medicaid clients.

The home health care agencies testified that reimbursement rates for home health services need to be adjusted. They indicated that since 1984 home health care agencies have received reimbursement rate increases averaging 4.2%, although hospital and nursing rate increases were double that amount. The agencies encouraged the development of a reimbursement policy which assures parity between institutional care and community based care.

COMMISSION RECOMMENDATIONS

Universal Access to Health Care

1. The Assembly Health Care Policy Study Commission urges the United States Congress to establish a national health insurance system based on the fact that the health care problem exists on a national level.

However, since the Commission recognizes that it is unlikely that the federal government will act in this area in the near future, the State must take the initiative in providing access to all residents. Therefore, the Commission calls for legislation that would guarantee health care coverage to all residents of New Jersey within a system that ensures quality and contains costs.

2. The Commission supports the idea of a single payer system similar to the Universal New York Health Care (UNY*Care) proposal* advocated by the Commissioner of Health of the State of New York. The central and unique feature of the UNY*Care proposal is the interposing of a single payer (the State) between third party payers and providers of health care to buy and regulate the delivery of health care. The single payer authority would maintain a centralized billing system to receive bills from providers, to pay providers and to bill third party payers. The authority would also establish a uniform rate of reimbursement for all providers and covered services.

This comprehensive health care package would also require the State to regulate programs of health insurance for residents who are not otherwise covered by an insurance plan. The State insurance plan would include a reasonable range of health care services, ensure access to a range of providers and include any benefits mandated by law. Managed health care services, with a focus on wellness and preventive care, would be required to be used wherever practicable. Funding for the program would come from employer contributions.

Medicaid Expansion

3. The Commission recommends expanding Medicaid eligibility to the allowable federal limits in order to draw down federal matching funds. This expansion will reduce the use of the Uncompensated Care Trust Fund by Medicaid eligibles since they will no longer access the fund as indigent care but will become Medicaid patients with hospital reimbursement through the Medicaid program.

*See Appendix B

The Commission recommends expansion to at least the following:

- Pregnant women and children up to age 6 in families with income below 133% of the federal poverty level (required by federal law effective 4/1/91).

- Pregnant women and infants up to age 1 in families with income below 185% of the federal poverty level.

- Children between ages 6 and 8 in families with income up to 100% of the federal poverty level.

Once Medicaid eligibility is expanded, enrollment must be aggressive. The Commission recommends that the Department of Human Services develop procedures to provide on site eligibility determinations (at selected health care facilities), and simplification and reduction of lengthy application forms. Medicaid eligibility determinations must be simplified in order to make the system more efficient.

4. The Commission also recommends expanding the Garden State Health Plan to all Medicaid eligibles. There are presently 4,200 enrollees in the Plan throughout 10 counties. The Garden State Health Plan represents a managed care plan for Medicaid eligible individuals. It is a voluntary physician case management program which is an alternative to the existing Medicaid fee-for-service program in the State. Members of the Plan receive, in addition to other Medicaid benefits, a managed care package of services. The Plan is cost effective because it links patients to providers, with a focus on primary care, which ensures early treatment rather than the use of acute care hospitals.

The Commission would like to see mandatory expansion of the Garden State Health Plan to all Medicaid eligibles but recognizes the problems associated with such a mandate, including the necessity of obtaining federal waivers and the overburdening of a small system without adequate participating providers. Therefore, the Commission urges voluntary enrollment of all Medicaid eligibles which should be accomplished by a phase-in by county. In this way the Garden State Health Plan can build a Statewide provider network and encourage Statewide provider participation in the program.

The administrators of the Garden State Health Plan envision enrolling approximately 25,000 new members per year with a five year target of approximately 125,000 new members under such a phase-in program.* No federal waivers would be needed for the voluntary expansion of the Plan. Perhaps, within five years, if the expansion has proved successful, the State will move to make enrollment in the Plan by all Medicaid eligible individuals mandatory.

*See Appendix C

5. The Commission also encourages the health maintenance organizations in the State to develop plans to accept and enroll Medicaid eligible individuals in order to provide a variety of managed care options.

6. The Commission further recommends that the Garden State Health Plan develop a program to enroll non-Medicaid individuals in order to bring in the underinsured and uninsured. Additionally, the program should permit small businesses to buy into the Garden State Health Plan on a sliding scale fee basis or with a matching State subsidy.

Demonstration Projects

7. In order to reduce the burden on the Uncompensated Care Trust Fund, and with its eventual elimination in sight, the Commission encourages providers in the State to establish managed care experiments that account for their special patient and provider populations.* These experiments should be targeted to Medicaid eligibles and the working uninsured (small businesses not offering health insurance). A special commission should be established to oversee these experiments and to collect data regarding their success in reducing costs. The Shared Cost Option for Private Employers (SCOPE) program in Denver, Colorado represents a good model for these experiments.

The SCOPE program is a low-cost, indemnity program which is targeted at small businesses (50 or fewer employees) who do not provide health benefits to their employees, and is funded with the support of several private organizations. The program offers coverage in a managed care framework, focusing on primary and preventive care with a network of participating providers. By restricting providers, the program is able to offer a comprehensive benefit package and more affordable premiums. The unique feature of the SCOPE program is the requirement of major cost sharing of those in the plan; substantial deductibles and co-payments are charged for inpatient care. This is done to encourage enrollees to seek preventive care services, with little or no deductible or co-payment, before they need more expensive hospital care.

The New Jersey managed care experiments should be patterned on the SCOPE program. The experiments should focus away from acute care to managed care plans to encourage wellness, to provide continuity in the provision of health care and to reduce costs and unnecessary utilization of health care services.

*See Appendix D

In the case of experiments serving the working uninsured, shared premiums and/or a sliding scale of co-payment fees should be developed. In the case of experiments serving the Medicaid population, deductibles and co-payments should be made from a State controlled Medicaid fund established for that purpose. The State should consider funding these experiments at least in part by the Uncompensated Care Trust Fund since they will be covering clients who would otherwise be using the acute care setting and accessing the Uncompensated Care Trust Fund.

Other Recommendations

8. The Commission recommends that the Uncompensated Care Trust Fund law be reexamined regarding the definitions of charity care and bad debt. Bad debt represents the unpaid hospital bills of a person who is assumed to be able to pay (because his income exceeds the charity care level) and accounts for 62% of the fund. Charity care accounts for a disproportionate 38% of the fund. The Commission recognizes that hospital collection practices, specifically obtaining adequate patient information as a person accesses the system, must be improved to relieve this problem.

9. The Commission also recommends that existing limits on insurance policies for preexisting conditions should be eliminated. Because of this limitation, many individuals lose valuable coverage when they change jobs. Often those who lack coverage are victims of serious illnesses and those most in need of coverage.

10. The Commission further recommends that the use of community based programs should be expanded. New Jersey presently has eight community based health centers in Atlantic, Camden, Cumberland, Essex, Hudson, Mercer, Passaic, and Union counties which are predominantly funded by the federal government. The use of these centers, to encourage preventive care in community based settings, should be expanded with increased State and federal participation.

Future Considerations

The Commission will next consider issues related to health planning and reimbursement. Specifically, the need for the planning, developing and financing of a comprehensive State plan, the Diagnostic Related Group (DRG) system; certificate of need process; and hospital rate setting will be reviewed.

The Commission will thereafter consider issues related to long-term health care and catastrophic illness. Included topics will be an examination of who pays for long-term care, private coverage vs. Medicaid; alternatives to long-term care such as home health care and day care centers; and an examination of the requisite level of long-term care and funding for that care.

CONCLUSION

In conclusion, the Assembly Health Care Policy Study Commission has presented viable recommendations which respond to the health care crisis being experienced in this State. To not act on these recommendations and accept the status quo, is to surrender the residents of New Jersey to a health care disaster.

Time is simply running out on our health care delivery system. The dilemma worsens daily as a growing number of the working middle class find themselves unable to afford the most meager of health insurance programs. With the Uncompensated Care Trust Fund surcharge on every hospital bill expected to rise to 23% next year and the concomitant 1990 Blue Cross/Blue Shield 47% rate request increase, health insurance is no longer affordable for the majority of New Jersey families.

To break the self fulfilling prophecy of the Uncompensated Care Trust Fund of fewer insured covering a growing percentage of the uninsured, New Jersey must immediately provide incentives for a greater number of businesses to provide health insurance. Concurrently, health care providers need to be assured of stable and equitable reimbursement for services, while individuals and business access affordable coverage.

There also exists the immediate need for the State to expand its Medicaid program to cover the maximum permissible population. Furthermore, the State needs to develop the ability for small businesses to buy into the Garden State Health Plan.

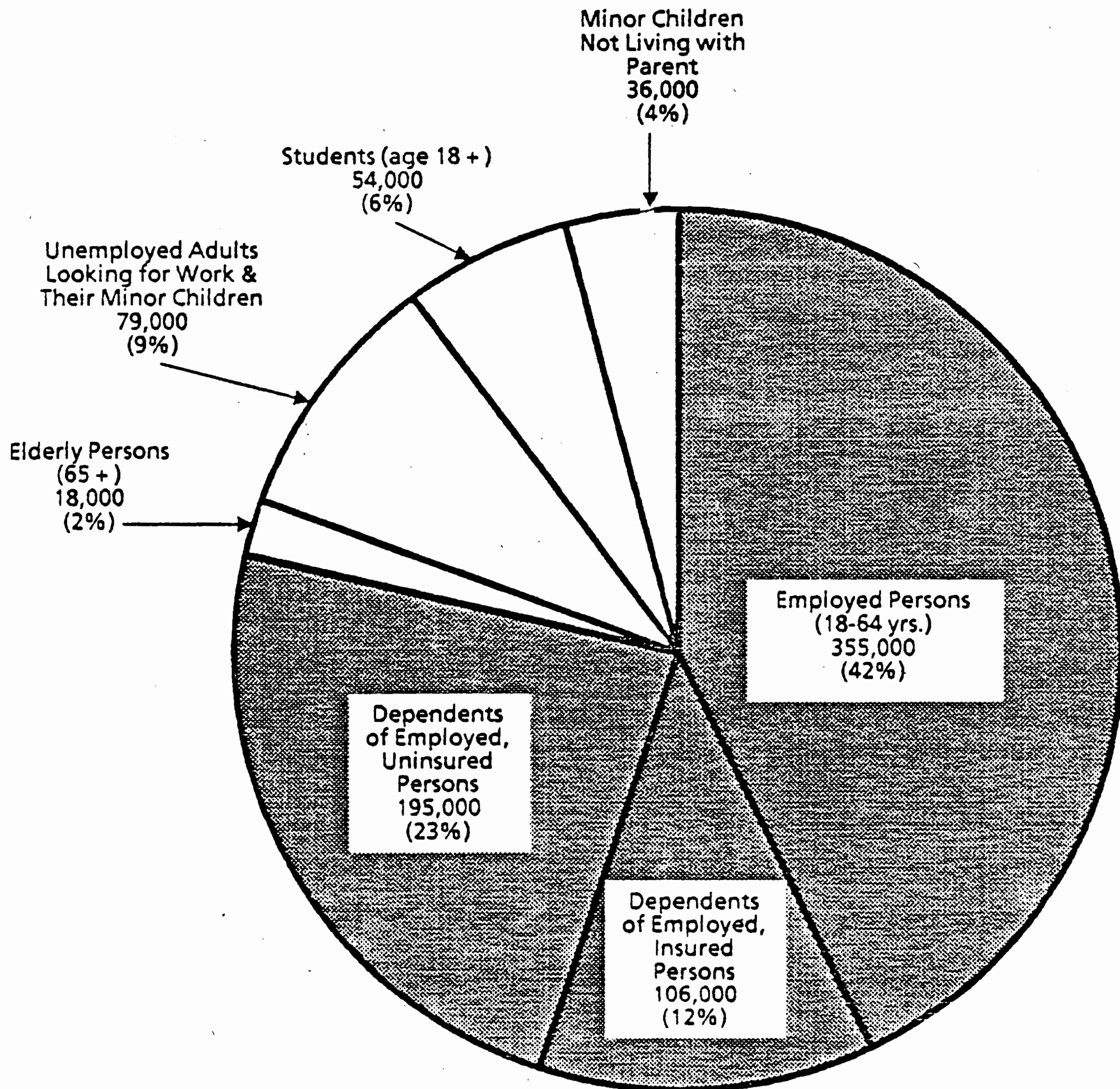
The business community ought to participate responsibly in the one year experimental projects recommended in this report. These experiments focus on the managed delivery of preventive and primary health care. New Jersey must break its institutional bias on the excessive utilization and reimbursement of acute hospital care. Tragically, if the maxim holds true that "health care follows the dollars" and not the inverse, we must begin to encourage appropriate compensation to providers for primary services delivered in the most compassionate and cost effective setting.

The State, after a year of observing these experiments, has the obligation to legislatively reaffirm its commitment to residents for access to affordable quality health care. Universal health care coverage, as recommended in this report, must be passed into law within two years. Such coverage will enhance accountability of individual access to services; encourage the delivery of preventive and primary health care services; and centralize presently conflicting reimbursement schedules and methodologies.

Most importantly, universal health care would provide New Jersey with the ability to cogently plan and deliver quality health care to all residents. This State has before it perhaps no greater moral or policy challenge than to ensure its residents the ability to preserve and enhance individual health. Delay of these institutional reforms will only deeply worsen a terrible crisis. The State Legislature must review the adoption or status of these recommendations within two years to determine our success or failure in rising to the health care challenge.

NEW JERSEY
UNINSURED BY EMPLOYMENT STATUS
(ALL AGES), 1986

Total Number Uninsured in New Jersey 843,000



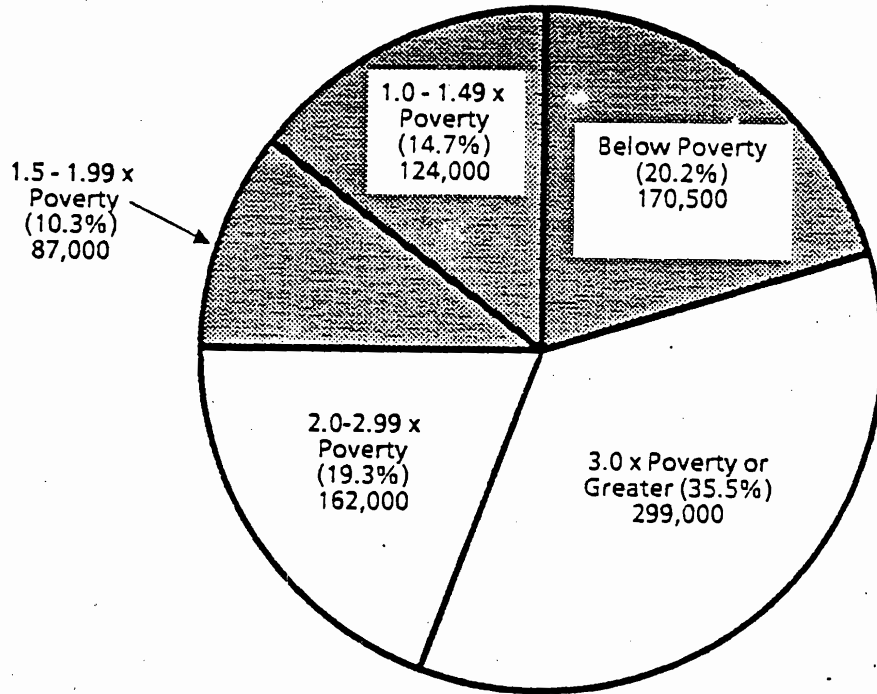
NOTE:

- Over three-quarters of the uninsured (77%) are employed or the dependent of an employed person.

Source: NJ Subsample from the March 1986 Current Population Survey

NEW JERSEY
UNINSURED BY FAMILY INCOME RELATIVE TO THE POVERTY LEVEL (ALL AGES), 1986

Total Number Uninsured in New Jersey 843,000



NOTE:

- Almost half of the uninsured (45.2%) have incomes below twice the federal poverty level.
- Almost two-thirds of the uninsured (64.5%) have incomes below three times the federal poverty level.

Source: NJ Subsample from the March 1986 Current Population Survey

Does Employer Offer Health Insurance

To Full-Time Employees

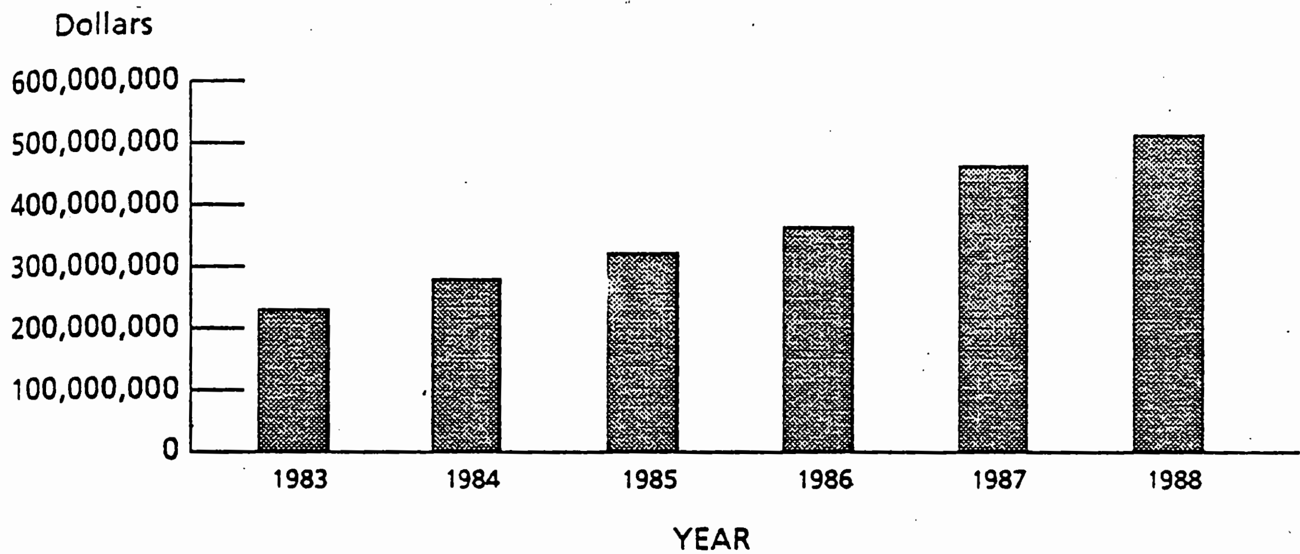
	Yes	No	Don't Know	Total	(n)
All Respondents	59%	40%	0	99%	(1,002)
Type of Business [1]					
--Construction	60	41	0	101	(112)
--Manufacturing	82	18	0	100	(66) [2]
--Wholesale Trade	81	18	0	99	(86)
--Retail Trade	49	51	0	100	(218)
--Finance, Real Estate, Insurance	58	42	0	100	(64) [2]
--Services	56	43	1	100	(401)
--Other	60	40	0	100	(55)
Number of Years Company In Operation					
--1 - 4	46	54	0	100	(131)
--5 - 7	61	39	0	100	(123)
--8 - 10	55	44	1	100	(117)
--11 - 15	63	37	0	100	(143)
--16 - 24	60	40	1	101	(135)
--25 - 30	62	38	0	100	(134)
--more than 30	66	34	0	100	(201)
Total Number of Employees					
--3 or less	45	55	0	100	(293)
--4 - 6	56	43	1	100	(316)
--7 - 11	66	34	0	100	(219)
--12 or more	81	20	0	101	(174)
How Many Full-Time Employees Have Insurance From Somewhere Else					
--All or Most	20	80	0	100	(329)
--Few or None	89	10	0	99	(289)

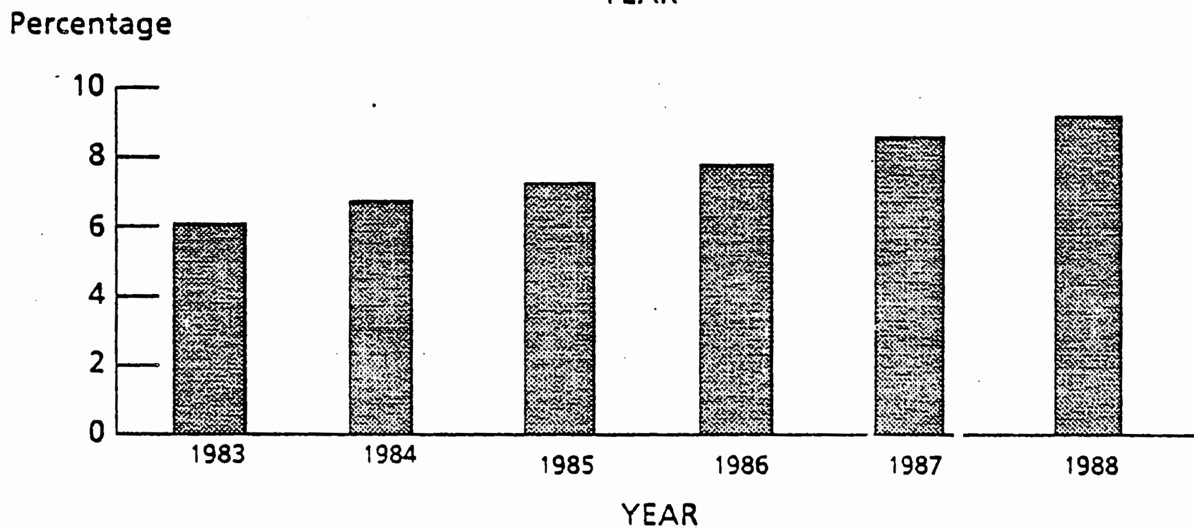
1. *Classifications are based on SIC codes. The category "other" includes agriculture, transportation and communication.*

2. *Percentages are based on very small numbers of respondents, and should be interpreted cautiously.*

NEW JERSEY UNCOMPENSATED CARE COST AND UNCOMPENSATED CARE AS A PERCENTAGE OF GROSS HOSPITAL REVENUE, 1983-1988

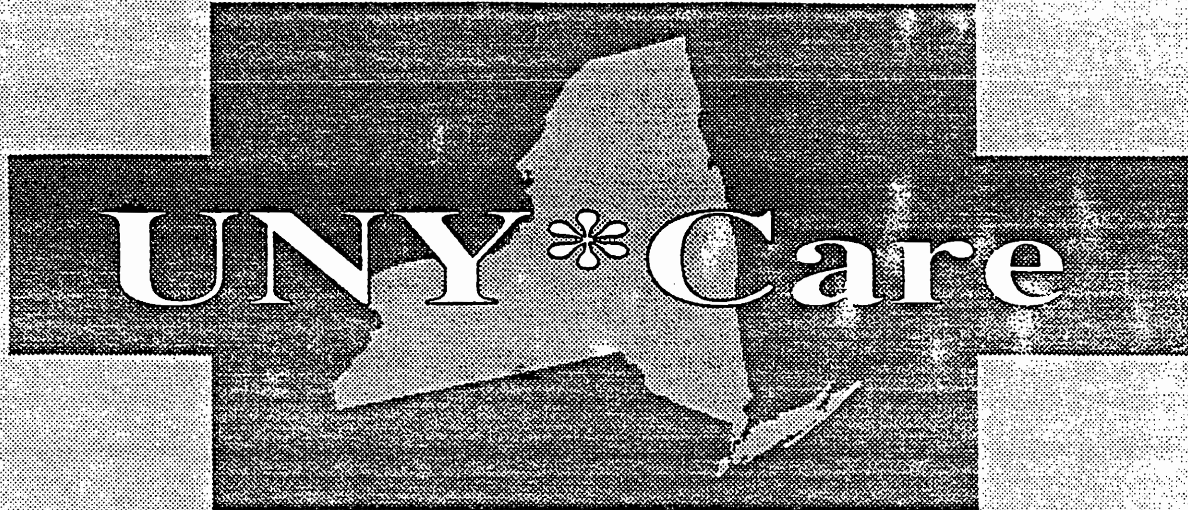
Year	Uncompensated Care Amount	Gross Revenue	Ratio of Uncompensated Care Cost to Gross Revenue
1983	$233 million	$3.8 billion	6.1%
1984	$282 million	$4.1 billion	6.8%
1985	$323 million	$4.4 billion	7.3%
1986	$366 million	$4.7 billion	7.8%
1987	$465 million	$5.2 billion	8.6%
1988	$513 million*	$5.6 billion*	9.2%*





*projected figure

Universal New York Health Care



A Proposal:
Revision I

New York State Department of Health

May 10, 1990

New Jersey State Library

STATE OF NEW YORK
DEPARTMENT OF HEALTH
ALBANY

DAVID AXELROD, M.D.
COMMISSIONER

May 10, 1990

Dear Colleague:

I invite you to read the first revision of the UNY*Care proposal since it was initially released on September 1, 1989. The changes in this version reflect many of the comments of our UNY*Care Advisory Group, which Governor Cuomo directed us to establish. This group, comprised of national and state experts on the issue of universal health insurance coverage, met three times in late 1989. Their review of and deliberations on the proposal are summarized in the back of this document.

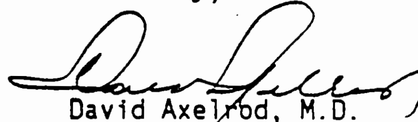
Governor Cuomo has directed us to meet also with interested parties and individuals across the state to obtain their suggestions on how to improve UNY*Care. For the past several months, we have met with hundreds of people who have expressed deep concern for the uninsured, the underinsured, and excessive medical care inflation. Many of their comments parallel those of the Advisory Group, and are also incorporated into this version.

The major revisions included in this version pertain to the following: 1) clarification of the Single Payer's two roles; 2) clarification of employers' responsibilities for purchasing health care coverage for full-time and part-time workers; 3) the form of governance for UNY*Care; 4) the impact of UNY*Care on HMO's; and, 5) the excessive costs of our health care system and the limited success of our multiple payer system in controlling costs.

Governor Cuomo has begun to phase-in certain aspects of the UNY*Care proposal as it relates to coverage for uninsured children and streamlining the cumbersome billing and payment system. We are continuing to meet with interested groups to elicit their suggestions on how to refine and strengthen the proposal. We intend to issue a second revision in late summer or early fall.

For this purpose, we would appreciate having your observations and suggestions regarding this first revision.

Sincerely,



David Axelrod, M.D.
Commissioner of Health

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EXECUTIVE SUMMARY

While New York State remains a leader in health policy, our system has not escaped the gaps in insurance coverage, excessive costs, and other shortcomings that plague health care in the United States generally. Despite our evident achievements, the current system of multiple private and public payers cannot meet the more difficult and complex needs that have evolved in the decades since Medicare and Medicaid were enacted. Gaps in coverage constantly reappear, competitive pressures force insurers to avoid the truly sick, and new challenges like AIDS threaten to overwhelm the system. Without some fundamental new approach the state is not likely to ever eliminate the chronic, recurring inability of the public and private systems to offer comprehensive medical care to the entire population.

This report documents the chronically shifting insurance coverage for millions of New York State residents. While there are approximately 2.5 million New Yorkers without any coverage, millions more have limited coverage for certain types of care. For example, nine out of 10 New Yorkers have minimal long-term care coverage. Primary care insurance for low income women and children is severely lacking. New York's Medicaid funding has risen and fallen over the past decade. The number of uninsured New York workers increased 41 percent between 1980 and 1986.

This report also states the obvious -- medical inflation is excessive and our current methods for controlling cost are not sufficiently comprehensive. Nationally, annual medical care inflation historically has been twice that of the Consumer Price Index, and inflation's price tag of about $4.5 billion this year for New York State alone does nothing to address the problems of the inadequately insured. An increasing amount of our economic output is being consumed by health care. In 1970, 7.4 percent of our economy was devoted to health care. In 1980, the percent was 9.1 percent, and in 1990, the amount is projected to be 12 percent, a one-third increase over 10 years. Canada expends only about 8.5 percent of its GNP on health care, about a third less than us, yet all Canadians are insured and their health status is somewhat better.

The way we pay for health care contributes to medical inflation and recurring gaps in coverage. Our multi-payer system limits our ability to control costs and to manage health care resources. As costs rise, coverage shrinks. Universal access and cost control must be joined in a single framework if success is to be won.

This report outlines a system of stable and affordable health care for all New Yorkers -- Universal New York Health Care -- UNY*Care, combining cost control and expanded tax-based programs and private insurance. While a completely tax-based system might be the most effective and equitable approach to achieving these goals, our proposal concludes that such an approach is not initially feasible. On the other hand, we have rejected using only an employment-based approach as in Massachusetts, because it alone does not reform the payment and enrollment systems. Without linking the two key steps of expanding coverage and controlling costs, affordable universal coverage will likely remain an illusive goal. Therefore, UNY*Care rests on two basic principles: 1) universal coverage can only practically be afforded by accepting and strengthening the system of private, employer-based insurance and by expanding public programs for those not in the work force, and 2) this incremental improvement must be linked to a fundamental reform of the payment system with all providers facing a single payer, and with all residents being assured access to a sufficient level of care.

- All New York residents will be issued a single enrollment card establishing membership in the UNY*Care system. Figure 2 describes this fundamental change in the enrollment system with each resident treated alike in terms of service delivery and billing.

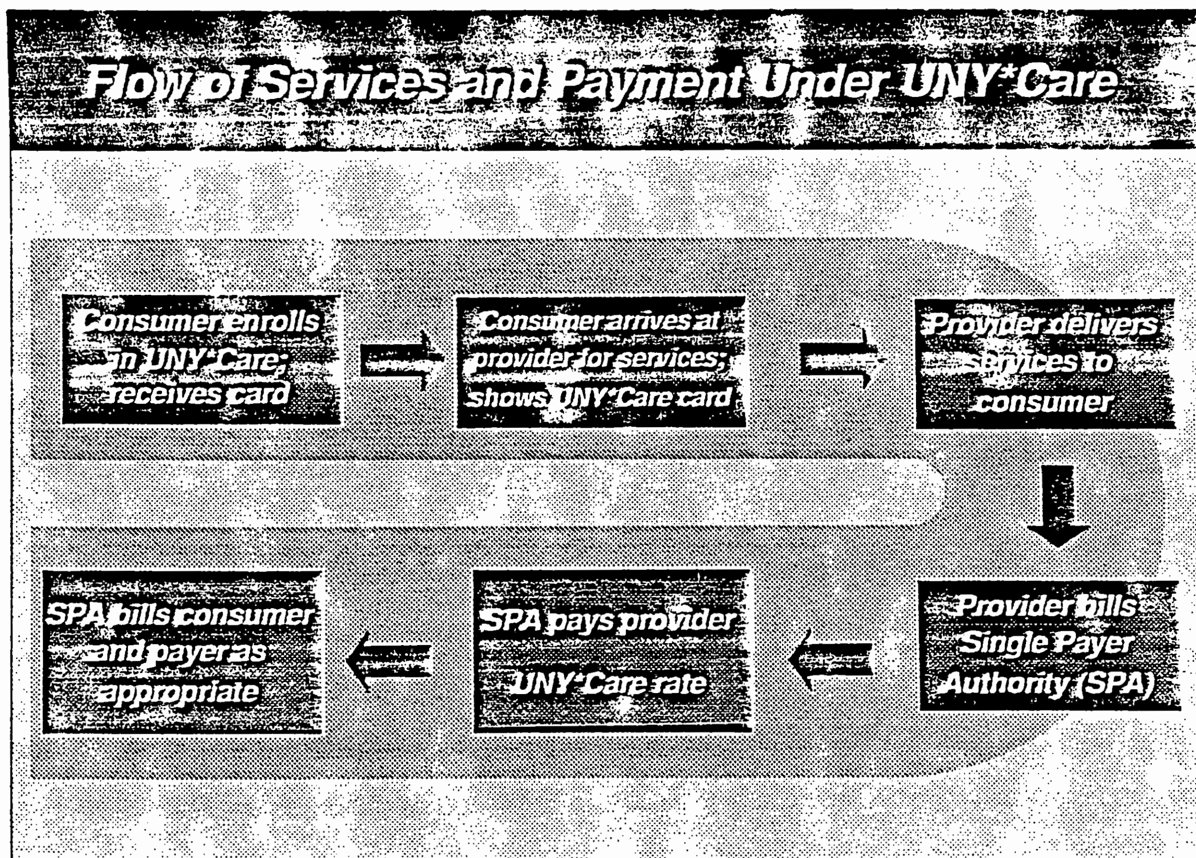

Figure 2

Table 1

	New Public Revenues Beyond $1.1 Billion Bad Debt and Charity Care
I. **Zero Option:** Includes: Insurance for all uninsured persons not in labor force, mandated insurance for employed uninsured, single payer structure, small business subsidy. Stop Loss*. <u>Source of funding</u>: $1.1 billion bad debt and charity care pools, plus up to $100 million in general revenues.	$0 – $100 million
II. **More Access and Limited Economic Incentives:** Includes: **Zero Option** plus limited business subsidy including single payer structure, plus public funding of primary and preventive care program for all women, children, youth to age 17. Stop Loss*. <u>Source of funding</u>: $1.1 billion bad debt and charity care pools plus $250 million in additional general revenues.	$250 million
III. **Full Access and Economic Incentives Option:** All programs under Options 1, 2, single payer structure, plus major subsidies for all business offering insurance for first time. Stop Loss*. <u>Source of funding</u>: $1.1 billion bad debt and charity care pools, plus $700 million general revenues.	$700 million

*Because the stop-loss program is self-financing, it is not entered as requiring new revenues

UNIVERSAL NEW YORK HEALTH CARE (UNY*Care)

The health care system for New York State faces serious and widely acknowledged challenges. The magnitude of public and private resources New Yorkers devote to health care is surpassed by few nations in the world. As the nation's second largest state with its largest city, our health care problems range from recruiting physicians and other personnel for sparsely-populated rural areas and crowded ghettos, to managing the health care systems of a vast metropolitan region containing some of the finest medical centers in the world. New Yorkers spend over $40 billion on health care each year, and are increasing that amount annually by about $4.5 billion; despite our myriad cost control attempts, medical care inflation continues to be double that of the Consumer Price Index and health care costs relentlessly consume a growing proportion of our Gross State Product. Against this backdrop of excessive inflation, public and private managers struggle to find resources to stem the AIDS epidemic, overcome personnel shortages, and to treat the uninsured.

The policy challenge of today's health care system is vastly different from twenty years ago when Medicare and Medicaid were passed for the nation's elderly and the poor. These programs expanded access for millions, and private insurance coverage also continued to expand. Yet this period of growth seems to have reached its limit during the early eighties. We now face a new policy reality. Despite its successes, our current system of private and public programs cannot match the job. Chronic gaps in coverage constantly re-appear, competitive pressures force insurers to avoid the truly sick, and new challenges like AIDS tend to overwhelm the system.

The New York Academy of Medicine, in its August 1988 report advocating universal coverage, sums up the central failures of our present system:

> "In the decade following the Second World War, there was dramatic improvement toward a health care financing system that would cover all Americans. Over the last decade this trend has begun to reverse... The private employment-based insurance structure is fragmented. Medicare...fails to meet the current needs resulting from demographic and technological changes. Medicaid funds intended to protect the poor, have increasingly or disproportionately been diverted to plug the gaps in the federally funded Medicare program.... The private employment-based structure has contributed to an erosion of the essential social risk pool through experience-rated selectivity of coverage. At the same time it has failed to respond to changes in labor market patterns, leaving many members of the increasing part-time work force without any health insurance coverage."

The recurring gaps in coverage are the most visible signs of the system's distress. Gail Wilensky, senior health economist with Project Hope, notes that the number of uninsured tends to rise and fall with the vagaries of political commitment, the business cycle, the structure of available jobs, and so forth. After decades of steady expansion, employment-based insurance has been falling. As Wilensky notes, the "most clear cut decline in coverage has been among workers and their dependents" (Health Affairs, Summer, 1988). Since 1980, 15 million U.S. workers or their dependents have lost job-based health insurance, and the number of uninsured New York workers has increased by 41 percent. Employers who maintain coverage for their workers pay

in coverage and the multiple streams for reimbursing health care, because this fragmentation disperses responsibility among different actors and institutions, leaving no one with responsibility for the needs of the state considered as a whole, as one community. This affects all New Yorkers. There is limited ability to make choices about what purposes our health care resources -- to which we all contribute -- should be put.

These problems have not evolved without warning. For half a century, advocates of universal health coverage at the national level (including many distinguished New Yorkers) have warned that a fragmented system would never be adequate to meet the needs of all citizens. We almost gained universal coverage during the mid-seventies. Then the issue vanished from the political scene.

After a decade of silence, universal access has returned to state and national agendas. Partly it is because, as the New York Academy of Medicine report suggests, there is a growing awareness of the permanent limits of our fragmented system of health care and its inability to assure access to health care for all people. Massachusetts has taken a step toward expanding coverage to all its uninsured. However, the Massachusetts program falls short of a universal system because it does not also make payment and enrollment universal.

New York doesn't need another set of programs to combat specific ills of our current system. What is needed is a universal health system that covers all residents regardless of their employment status and in a way that assures a flexible and rapid response to constantly changing needs and new health technology. At the present time New Yorkers have no adequate way to shape their health care needs as a whole community.

The Universal New York Health Care (UNY*Care) system offers a permanent closing of gaps in coverage for all New York residents, and reforms the present system of reimbursement, insurance, and payment in a way that assures that these gaps will remain closed and new needs met in a rapid, public, and equitable manner. It also assures that quality medical care and workable cost controls can be developed in a way that is equitable for all New Yorkers. Providing universal coverage and improving our health system involves more than plugging gaps. As the Subcommittee on Health Insurance of the New York State Council on Health Care Financing in its January 1988 report on the uninsured noted, "...the foundation of a comprehensive coverage strategy is a system which operationalizes a broad view of social responsibility to address the problem, balancing objectives and roles of all segments of the community."

Perhaps the basic reason New York is seeking to reform its health care system rests in the nature of our life together and our motives for political association. In the sphere of health, as perhaps in no other sphere of life, Americans recognize that we are all bound to one another: the problem of the insurance salesman in Syracuse whose aging mother must enter a nursing home is our problem; the problem of the young mother in Queens who works at a fast food chain that doesn't provide health insurance for its workers is our problem; the problems of children without basic preventive care is our problem; the problem of the addict with AIDS who cannot find treatment for his disease is our problem. All of these are our common problems. Yet without some common framework like UNY*Care we lack effective mechanisms to address these as common problems and to express and show our shared fate and our shared responsibility.

or by HMO enrollment. Yet 40 percent do face deductibles of $540 for acute episodes and many are forced to purchase supplemental policies to cover this cost. UNY*Care will cover this deductible for individuals or families who fall below 200 percent of poverty.

Long-Term Care

Nine out of ten New Yorkers (15.6 million people) have either no long-term care coverage or minimal coverage. Ten percent (1.8 million) have total coverage because they are categorically eligible for Medicaid. Medicare provides almost no long-term care coverage. The basic orientation of Medicare is short-term illness.

Given this limit to Medicare it is not surprising that increasingly Medicaid is being used to finance long-term care, not only for poor New Yorkers but also for middle income residents who spend down to receive Medicaid coverage. This shift in Medicaid's structure seriously undermines its basic purpose of providing complete medical assistance for the state's poor.

The optimal solution to New Yorkers' long-term care needs would be changes in the national Medicare program to include long-term care in its basic provisions and re-orient its priorities to better serve the needs of its aging beneficiaries. This basic change would permit long-term care to be covered through the broad Medicare payroll tax base and would pose the smallest burden on individual beneficiaries, businesses, and taxpayers.

Failing that development, New York State must determine if it will develop a state long-term care insurance program or stimulate the private insurance market for future inclusion in UNY*Care.

Cost Control

The excessive increase in medical care costs are well documented. Health care costs as a percentage of our Gross National Product increased 32 percent in the last ten years. Employers see profit margins eroding and employees see a growing portion of their potential wage increases being diverted to pay for escalating health care costs.

Although many strategies have been used to contain health care costs, they have experienced limited success due to a basic structural flaw – they are all operated within the context of a multiple payer mechanism. Controlling health care costs can be accomplished more effectively under a single payer system, which gives taxpayers and premium payers the necessary market power to arrange for reimbursement levels with providers that are less than double the inflation rate. Problems such as cost-shifting, providers shopping for those payers that offer the highest reimbursement, and payers attempting to outbid one another to enroll providers in their plans will disappear in a system where there is only one payer. Also, the structure for billing and payment can be greatly streamlined.

The structure of governance for UNY*Care is not settled and discussion as to its most appropriate configuration will continue. The creation of a UNY*Care public authority is one option. Others argue for a private rate-setting commission. Others claim that since UNY*Care has such a major public responsibility, it is most appropriately governed by another state agency. What is significant is that most all agree that UNY*Care will require a new organization at the state level with new responsibilities and roles. The nature of this body -- whether a new state executive department, a public benefit corporation, or some other structure -- requires further study and deliberation.

Reimbursing Hospitals

As Figure 4 shows, under the current system providers face multiple payers: Medicare, Medicaid, Blue Cross, HMO's, Worker's Compensation, No-Fault, and commercial insurance companies. These different payers not only present providers with a heavy burden of paperwork, they also encourage discrimination against those with less than adequate coverage. Also, different categories of payers pay differential rates: Blue Cross pays less than commercial insurers because it provides open enrollment, community rates, conversion rights, and Medicare Supplemental Insurance Pools.

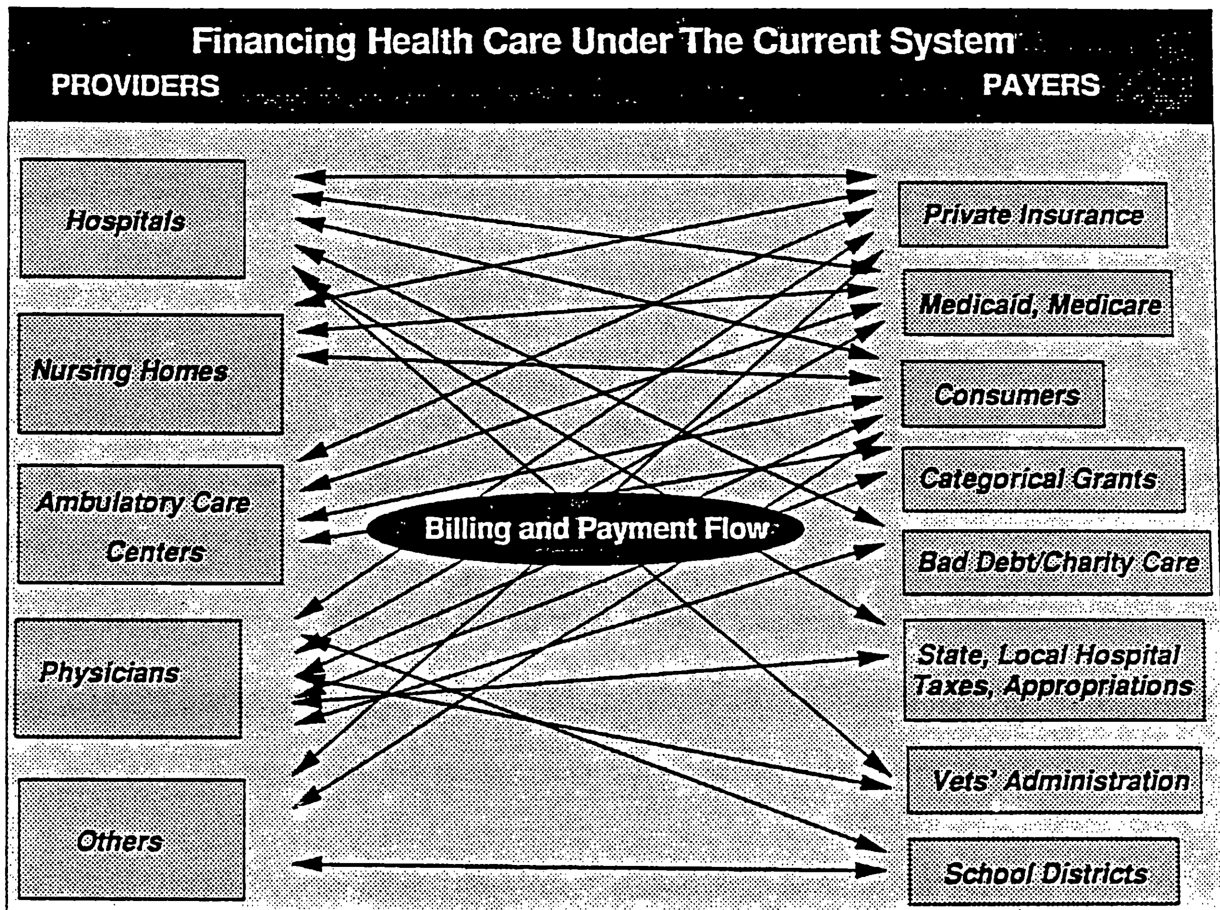

Figure 4

be arrived at in various ways. It can reflect historical charges, that is, the market valuation of services, or actual resource costs. While many physicians are reimbursed in accordance with fee-for-service schedules, a growing number, between 40 and 50 percent, are salaried. Finally, under capitation, a primary care physician receives a set amount to cover the cost of office care he/she provides to a patient, or for services provided by specialists to whom he refers the patient. Thus, the physician is at financial risk for inefficiencies or excess. Capitation, however, encourages the greatest budgeting and prioritizing since income per patient is largely fixed and not associated with utilization.

Given the current preponderance of fee-for-service, and the difficulty of instituting a capitation system statewide, UNY*Care will seek to reimburse physicians on the basis of a negotiated fee schedule possibly based on a relative value scale while also seeking to encourage capitation wherever possible.

Reimbursing Long-Term Care

Residential long-term care facilities in New York State are paid in accordance with a case-mix reimbursement system known as "Resource Utilization Groups" (RUGs). This system, a prospective reimbursement methodology, employs case mix measures and allows facilities to be reimbursed based upon characteristics of their patients as measured by a patient classification system. The RUGs classification system is composed of 16 distinct patient groups, each of which differs in terms of clinical characteristics and resource utilization. The RUGs system categorizes patients into one of these 16 groups and reimburses facilities on the basis of the classification group.

Subsidizing Policies for the Uninsured

In addition to having the necessary reimbursement structure and authority essentially in place, UNY*Care will benefit from current state initiatives in order to make insurance universally available. The Expanded Health Care Coverage Act of 1988 authorized the implementation of a series of pilot projects to test alternative health coverage models. Nearly $13 million is available to support these pilot projects which are anticipated to assist approximately 14,500 individuals with the purchase of health insurance. Two different types of pilot projects will be developed, each targeted toward a different population. One pilot type will assist low-income individuals and families with the purchase of health insurance while the other will target the employed uninsured by subsidizing employer-based health insurance. The projects began enrolling beneficiaries during June 1989, and will continue until December 31, 1990. These efforts reflect a state commitment to the goal of universal access to health coverage and will provide important lessons and experiences for the implementation of UNY*Care, particularly regarding the subsidization of employer and individual contributions to premium costs. This aspect of UNY*Care, the expanding and financing of coverage, is described in the following section.

- The means for financing expanded coverage under UNY*Care will include restructuring the expenditure of $1.1 billion in bad debt and charity care funds, using a portion of the $4.5 billion annual increase in medical care inflation, assuring that the responsibility for paying for health care is equitably shared and that care is delivered more efficiently and appropriately.

The term "standard package of benefits" or "covered services" deserves elaboration at another time. For the present, the overall structure and fiscal implications of the basic package are sufficient. UNY*Care will specify a basic package of benefits which will serve as a standard for all benefit packages. This standard package of benefits will likely include routine physician visits, physical and occupational therapy, laboratory and diagnostic services, inpatient and catastrophic care. While this coverage will specify a minimum, the minimum will be sufficiently high to encourage acceptance by all parties as the basic standard of care. This package will not only define covered benefits, but will also limit total out-of-pocket expenses of individuals as well as the percentage of the premium costs borne by the employer and employee.

For all types of coverage, several common features emerge. Except for Medicare and Medicaid, all forms of insurance will carry coverage up to roughly $25,000 for both major medical and inpatient care during any given year. For costs beyond these amounts, UNY*Care will be the payer, using a surcharge on employers' health insurance premiums and other funds to finance this change. Also, for persons who fall below 200 percent of poverty, all or most out-of-pocket expenses will be borne by UNY*Care, again using Medicaid, where appropriate, or other state funds. The package described in the following pages is summarized in Figure 5.

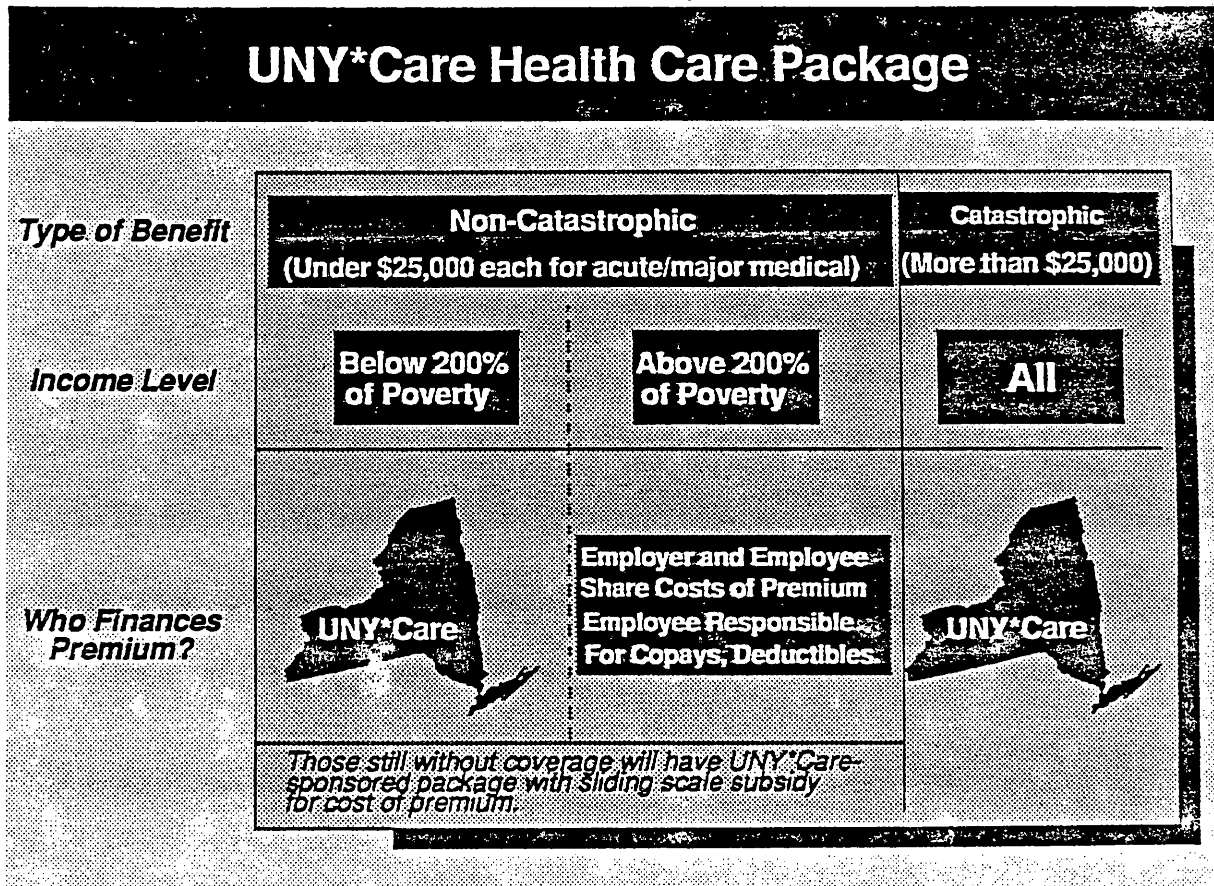

Figure 5

recipients. UNY*Care reimbursement rates for all services will be deemed payment in full; physicians will not be permitted to bill separately. UNY*Care will, for a basic set of services, require mandatory assignment.

Insurance Deductibles Unrelated to Income: A typical large corporate plan provides 80 percent coverage after a $200 deductible, and 100 percent coverage after a $2,000 out-of-pocket cap has been reached. For many low income people, these shared costs can limit utilization. UNY*Care, under the Access Options assures financing of primary care visits for people with incomes below 200 percent of poverty, who represent almost one-third of the state's population.

Uneven and/or Limited Private Insurance Coverage of Primary Care: The primary care benefits of employer-based and individual insurance plans vary significantly. While some of this variety will remain, UNY*Care will be in a far better position to phase in a basic level of primary care and preventive services consistent with acceptable medical standards.

Inpatient, Major Medical, and Catastrophic Coverage

- **UNY*Care will function as a stop/loss source for all inpatient and major medical care insurance policies and self-insurance programs after a standard level of coverage has been exhausted.**

The state stop/loss for inpatient care and major medical expenses recognizes the fact that coverage for these expenses is limited. The only people who have total financial coverage for these events are those who are covered by Medicaid, and some HMOs. These three sources cover only about 37 percent of the State's population or about 6.3 million people. For the remaining 63 percent or 11.3 million people, the coverage varies from none to several hundred days of care or several hospital stays with a deductible and co-payment.

In order to assure catastrophic coverage for all persons enrolled in UNY*Care, a state stop/loss will be available to all employers, insurance companies, HMOs, self-insurance programs, and individual policies. No insurance plan will need to pay beyond a specified amount, for example, $25,000 of coverage each for inpatient care and major medical care. Policies which currently provide coverage beyond these specified amounts can restrict their coverage and their risk to those levels. The stop/loss provisions will not apply to Medicaid which already provides full coverage. Measures to ensure complete coordination of benefits will be implemented so that deductibles and co-payments will be covered by another spouse's policy if one is available.

The services covered beyond the stop/loss will be financed through the use of various funds. However, a large portion of the financing will be derived by assessing employers a surcharge on the health insurance premiums that they pay for the first $25,000 of inpatient care and the first $25,000 of major medical expenses. Employers that provide adequate catastrophic coverage will have the surcharge entirely, or largely, rebated. Conversely, those employers that provide inadequate catastrophic coverage will pay the entire surcharge.

The role of employers in financing health insurance coverage will become more equitable because of the stop/loss provision. This provision means that employers will carry the same high level of catastrophic coverage for each employee. The

Of the 2.5 million people uninsured, about 265,000 are self-employed or a dependent thereof; of this number, about 162,000 are actually employed and 103,000 are dependents. This group comprises about 10 percent of the 2.5 million who are uninsured. UNY*Care will offer the self-employed the opportunity to purchase the same $25,000 inpatient care and major medical policies with the stop/loss benefit that will be offered to employers. Approximately 46 percent of self-employed people and their dependents are below 200 percent of poverty; UNY*Care will offer them a sliding scale subsidy from $2,700 to $0. The exact amount of the subsidy will depend upon the person's income level between 100 percent and 200 percent of poverty and whether the policy holder is purchasing family or individual coverage. The subsidy will be provided to people currently uninsured, as well as those who already have insurance, but who wish to purchase a UNY*Care policy.

- **UNY*Care approved policies of $25,000 of inpatient care and $25,000 of major medical coverage will be made available to the unemployed and those people "not in the labor force." A sliding-scale subsidy will be available for those people below 200 percent of poverty. These policies will also benefit from the stop/loss provisions previously described.**

The uninsured unemployed and the uninsured who are not in the labor force, and their dependents, make up 1.1 million, or 44 percent of the 2.5 million uninsured. UNY*Care approved policies will be available to the unemployed/uninsured and those people otherwise not in the labor force, and this coverage will include the stop/loss benefit. The state will provide subsidies to those currently uninsured (0.7 million people), as well as those who already have private insurance but wish to purchase a UNY*Care approved policy. The assistance will be from $2,700 to $0 and will vary by income from 100 percent to 200 percent of poverty and whether the policy holder is purchasing family or individual coverage.

- **To protect employees below 200 percent of poverty, UNY*Care will provide a tax credit to those low income employees who contribute a relatively large amount through withholding to the employer's purchase of health insurance.**

A tax credit is necessary to protect low income employees from making relatively large contributions toward the employers' purchase of health insurance. Low income employees who work for an employer who just begins to provide coverage under the employer incentive coverage program will contribute a maximum of $500 and $250 for family and individual coverage, respectively, and low income employees who work for an employer already offering a comprehensive plan might be contributing several hundred dollars through payroll withholding. UNY*Care does not provide a maximum cap on their withholding in order to avoid interference with pre-determined labor-management agreements. A contribution of only $500 or $250 can be excessive for extremely low income employees. Therefore, a tax credit will be available to employees below 200 percent.

- **Personal contributions by low income households for their health care will be limited on the basis of income. The maximum contribution will range from $0 for a household at or below poverty to a maximum of $1,000 for those at 200 percent of poverty.**

Personal or out-of-pocket contributions, by low-income households, for their health care, are limited under UNY*Care to protect these individuals and families from impoverishing themselves as a result of their medical care needs. Personal contributions of low-income households (those with income below 200 percent of poverty) are determined on an income-based sliding scale such that households

Despite the benefits of a purely tax-based approach, it also brings certain disadvantages. One of its most notable is the magnitude of tax revenues necessary to support a totally tax-based approach at the state level. For example, the entire amount of revenue collected in 1988 in New York State taxes and fees is $26 billion. Each increase of $1 billion represents an increase of 3.9 percent in total tax and fee revenue. If personal income taxes were excluded, other tax revenues would have to be increased by 8.5 percent for the same $1 billion. The breakdown of components of total state tax revenue is summarized below:

New York State Taxes and Fees Fiscal Year 1988

Tax	Billions of Dollars	Percent of Total
Personal Income	13.9	54.3
Sales and Use	5.3	20.7
Business Taxes	3.5	13.8
Property Transfer	1.2	4.7
User, licenses, fees	1.7	6.5
TOTAL	25.6	100.0

Another option is to raise taxes to replace the employer contribution. The private sector employer's contribution to health care in New York is approximately $9 billion. This sum cannot be easily covered by taxes immediately; however, this sum could be raised gradually over a phase-in period.

A mixture of tax-based programs and employer-based insurance was chosen for UNY*Care's design because that is the basis of the current system, offering its familiarity and experience, and because the single payer strategy overcomes many of the current system's liabilities. More than 50 percent – about $19 billion of $35 billion – of the current health care delivery system is already tax-based in one way or another (Medicare collects $8 billion from payroll tax, Medicaid collects $10 billion from federal/state/local, etc.). Even the employer-based coverage is tax "assisted." UNY*Care will continue to use this tax-based approach and will even expand upon it somewhat to help finance some of the program's costs.

UNY*Care will also implement various measures to counter-balance certain inequities in the employer-based system of providing health insurance. For example, there is great variance among employers in the amount each one withholds from employees for the purchase of health care. In order to minimize and standardize this variance for low income employees, UNY*Care will provide a tax credit to those low income employees who contribute a large amount through withholding. There is also great variance in the benefits provided by employers in terms of varying levels of deductibles, copayments, covered services, and catastrophic care. UNY*Care will minimize these differences by helping low income people pay for deductibles, copayments, and uncovered but needed services. Furthermore, UNY*Care will standardize catastrophic coverage by providing a stop/loss benefit. The stop/loss will

EFFICIENCY AND QUALITY IN A UNIVERSAL ENVIRONMENT

The rising cost of health care is widely acknowledged and has been addressed by a number of strategies, particularly for hospital-based care. There has been gradual movement towards more uniform payment rates for hospital inpatient services by the various insurers under the leadership of state regulatory authority. Still, government officials and providers face multiple payers, both public and private, leading to fiscal irresponsibility on everyone's part. The arena for generating costs – the hospital or the physician's office – remains local in nature while the sources of payment are spread among all levels of government and among many different private payers. To alleviate these inequities, UNY*Care will concentrate responsibility in the hands of one actor – state government – which will play a larger role in assuring that adequate resources are available to meet the state's needs and that all New Yorkers have access to appropriate health care services.

Several specific ways that UNY*Care will encourage greater efficiency and quality of care are highlighted below:

Efficiency

- A single payer authority responsible for setting rates of reimbursement for all health care services in New York State will be interposed between existing third-party insurers and providers. As the sole entity authorized to set rates of reimbursement, UNY*Care or state government will assume the role of the single buyer of health care rather than continue as one of the many payers of health care. As the single payer, government will have more market power to effectively negotiate reimbursement structures that better promote efficiency and assure quality.

- Shifting government's role from one of many payers of health care to the single payer permits the establishment and enforcement of a "health care budget," which offers the capacity for better and more equitably controlling medical care inflation and for shifting scarce resources to the areas of greatest need. A statewide health budget will allow for system-wide projections of anticipated resource needs, revenues and expenditures. This budget will also allow UNY*Care administrators, elected officials, affected interest groups, and consumer representatives to make recommendations for necessary adjustments in taxes, premiums and reimbursement levels. For the first time, the public and officials will be asked to examine whether the growth in the system is in line with available public and private resources.

- Movement to a single, uniform reimbursement methodology will also help constrain overall health care costs. This is suggested by past experience with hospital reimbursement in New York State. The hospital reimbursement methodology, in effect since 1983, has resulted in inpatient care expenditures lower than the national average. To achieve system-wide savings all payers and all settings must be subject to uniform reimbursement methodologies and rates determined by a single payer, the state.

Equally important, it must be noted that flexibility within the UNY*Care structure regarding HMOs is necessary since HMOs are both providers and insurers and, therefore, require a different stream of payment than other providers and insurers. HMOs actually could accommodate more readily the periodic predetermined transfers of funds envisioned as part of UNY*Care, thereby allowing them continued flexibility.

Quality of Care In a Universal Plan

"Quality" health care is often thought to refer to care provided according to accepted standards of practice with outcomes consistent with a person's condition. There is a wide array of Department of Health surveys, inspections, and other activities for surveillance of the quality of care delivered in most treatment settings and UNY*Care will improve the database needed to perform those activities. In this document we have also been discussing quality as very much tied to access and appropriate, timely use of services. The burdens on hospitals of persons with poor primary care, the persistence of certain causes of morbidity and mortality because of this same deficiency, the need to better target categorical programs and other resources, and so on, are quality issues. Thus, for quality of care, universal coverage must be provided within an overall framework capable of giving us greater ability to use services and resources judiciously and appropriately as part of making them more available. UNY*Care gives us this framework.

Access

An insurance mechanism alone will not overcome the barriers to health care, and will not be sufficient to assure all individuals access to care. In some urban and rural areas of the state, the supply of providers is insufficient and in many cases, inappropriate sites of service delivery offer the only available providers. For example, many inner city residents utilize hospital emergency rooms for primary care and other needs more appropriately met in clinics or physicians' offices. In rural areas, geographical barriers to care exist and providers are not always organized to meet most effectively the needs of the residents.

We recognize that these and other access issues must be addressed concurrently with the development of UNY*Care, and emphasize that the Department of Health will continue its efforts in this regard. UNY*Care's single payer/single buyer and its "health care budget" provide a powerful vehicle for the development of appropriate and organized health care delivery systems in areas with insufficient and ineffective provider supplies.

While UNY*Care is by definition and name a "universal" program, clearly there are a few groups in New York State for which the system may not guarantee access. In particular, questions have been raised about undocumented aliens and those uninsured who do not choose to enroll in UNY*Care or pay for any health care costs. Further discussion with the federal government is needed to most fairly meet the health care needs of undocumented aliens since they are disproportionately represented in New York State. Currently, undocumented aliens can receive Medicaid-covered emergency services, prenatal care and delivery in New York State. It would appear at this time that bad debt and charity care funds will continue to be necessary for their care for services other than those covered by Medicaid.

APPENDIX

UNY*CARE ADVISORY COMMITTEE

SUMMARY OF COMMENTS

The UNY*Care Advisory Committee was created to provide advice and input regarding the September 1st proposal for Universal New York Health Care (UNY*Care), and to recommend changes or alterations where necessary. Committee members are listed below. The Committee, which met three times – September 27, November 2 and December 1 – provided invaluable independent review and criticism of the UNY*Care proposal. In some cases, the committee recommended further research.

Raymond J. Baxter, Ph.D.
Acting President
NYC Health & Hospitals Corp.

Howard Berman
President, CEO
Rochester Blue Cross/Blue Shield

Warren G. Billings
Executive Director, Health Services
State Communities Aid Assn.

Laurence D. Brown, Ph.D.
Professor
Columbia University

Maria Josefa Canino
Assistant Professor
Rutgers University

Alain Enthoven, Ph.D.
Marriner S. Echols Professor
of Public & Private Management
Stanford University

Deborah Freund, Ph.D.
Chair of Faculty of Health
Sciences and Administration
University of Indiana

Rashi Fein, Ph.D.
Professor
Harvard Medical School

Jerome M. Goldsmith, Ed.D.
Executive Vice President
Jewish Board of Family and
Children Services

Robert Gumbs
Executive Director
HSA of New York City, Inc.

Robert Haggerty, M.D.
President
The William T. Grant Foundation

David R. Jones
General Director
Community Service Society

number of important issues and provided suggestions for improvement to the proposal, the group seemed to agree with the statement of one of their colleagues that perfecting the proposal must come to an end. The real challenge is changing the current system.

The following represents a summary of their comments to us on the initial version released September 1, 1989. The Committee was asked to comment on and make changes to this summary; six members did submit comments and the essence of those comments have been added to the summary that follows. We have benefitted greatly from the Committee's input and have incorporated many of their recommendations into the revised UNY*Care proposal of May 10, 1990. We hope that we can call upon them in the future to help us to further refine the proposal.

An additional concern of several committee members related to how out-of-state employers with employees residing in New York State and conversely how New York State employers with out-of-state employees will be dealt with under this program. For employers located outside of New York State, UNY*Care will not have the authority to impose taxes. New York residents who are employees of out-of-state firms that have coverage that meets UNY*Care defined standards will be issued a UNY*Care card and thus be made a part of the overall system. These individuals will be eligible for subsidies if their income is below 200 percent of the federal poverty level. Employees of out-of-state firms that choose not to offer employee health benefits will have the option of purchasing a UNY*Care approved policy and will thus be eligible for subsidies if their income is below 200% of the federal poverty level. New York State employers with workers who reside out-of-state will be required to pay, like all other businesses in the state, the payroll tax for these non-resident employees.

It was suggested that there may be areas of New York State in which an employer will be able to purchase UNY*Care approved policies for less than the estimated policy cost used in the UNY*Care proposal. The concern was that if an employer is able to procure employee health insurance for less than the amount of the payroll tax, some employers would end up being taxed unfairly, in an amount greater than their cost.

The adequacy of the proposed subsidies to businesses was questioned by some committee members. It was suggested that the subsidies must cover a significant portion of the new cost to businesses if they are to support the UNY*Care proposal. Additionally, it was suggested that the subsidy for each employer be phased-out on a flexible schedule that recognizes each employer's financial status.

ACCESS TO HEALTH CARE AND THE HEALTH CARE DELIVERY SYSTEM

A crucial means for assuring access is universal coverage through the use of a universal card. While advisory committee members generally agreed that UNY*Care's insurance vehicle would increase access to health care in general, many members stated strongly that financial access alone would be insufficient to assure all individuals access to care. In some urban and rural areas of the state, the supply of providers is insufficient. In many cases, inappropriate sites of service delivery offer the only available providers. For example, many inner city residents utilize hospital emergency rooms for primary care and other needs more appropriately met in clinics or physicians' offices. In rural areas, geographical barriers to care exist and providers are not organized to most effectively meet the needs of area residents.

The current health care system can only attempt to address service shortages in a limited and piecemeal manner. UNY*Care, with its single payer/single buyer, establishes the framework to more effectively support the development of appropriate and organized health care delivery systems in areas with an insufficient and ineffective provider supply. Attention must be paid to the fact that only paying physicians more will not result in their locating in areas of need unless supported by nurses and ancillary services also. Future versions of the UNY*Care document will be amended to include details on the additional steps the UNY*Care authority must also take to improve access.

Other concerns raised regarding access centered on financial costs to participants and the feasibility of effectively administering the program. Some members felt that the sliding scale, as currently structured, was not generous enough, particularly for those with income at or near 200 percent of poverty. However, others noted that UNY*Care could not resolve all problems of access; perhaps the sliding scale could be made more generous in subsequent years. Concern was raised regarding the administrative feasibility of the program of subsidies and cost of means testing. How would individuals know if they are eligible for a subsidy? What about the "notch-effect?" Members also suggested that the proposal should be more specific regarding explicit sites where individuals can access care (supply patterns).

While acknowledging that insurance coverage alone would not ensure access, committee members urged that the agenda for universal coverage should be moved forward. Universal coverage certainly would not hinder access; at best it could serve as a platform for capturing new resources to pay for improved access.

Accountability was stressed, including a single new agency to administer the program and to avoid inter-agency conflicts. Knowledge of who is accountable is also important for consumers when access to health care is a problem.

mechanisms within that context. Finally, although the issue of utilization control is important, increased demand on the part of the newly insured is desirable as one member stated, and UNY*Care can absorb the demand because its intent is to rationalize the system and allocate resources away from unnecessary care.

Standardization of the insurance package is an integral part of UNY*Care. This standardization shifts the insurance industry more from differentiation by product to price, not unlike many other industries. In addition, UNY*Care would establish a minimum benefit package, not a single policy. Under the regional pilot projects, minimum benefit standards were established, yet five different packages were eventually agreed upon. This experience could certainly be replicated in UNY*Care. The authority will not sell policies, but will determine the benefit package and will contract with insurers for the sale of new UNY*Care approved policies.

Others offered alternatives to the single payer – utilizing Blue Cross open enrollment policies to provide coverage for the uninsured and an option under which the state would set payment rates only for the "UNY*Care plan," which would be made available to all interested individuals. This latter approach would allow for competition between UNY*Care and existing insurance products. Neither of these approaches includes the power of a "single buyer" to control system growth nor the standardization and efficiencies of a "single payer" claims processor.

Additional questions and concerns raised by committee members regarding the UNY*Care proposal include the following:

Several committee members requested further information regarding the recourse available to the UNY*Care authority in the event of non-payment of premium amounts or other out-of-pocket expenditures by program participants. The most immediate recourse available under this scenario is discontinuation of coverage and/or collecting the balance due through a collection agency or other efforts. It is hoped that the benefits of the program will provide inducement enough for full participation by all New Yorkers. It is recognized, however, that some individuals will "fall through the cracks," choosing not to participate and will remain uninsured. For these individuals it will be necessary to continue a bad debt and charity care pool similar to that which currently exists but of a much lesser magnitude.

Several committee members requested that the benefit package envisioned under UNY*Care be more explicitly defined within the body of the document. Precise definition of the components of the benefit package were purposefully excluded from the document to permit the program future latitude in refining the benefit package.

Other suggestions were made for changes and additions to the UNY*Care document. These include: clear goal statements; inclusion of the points of view and effects of UNY*Care on hospitals, doctors, insurers, etc.; description of phase-in activities and priorities; more specifics on how UNY*Care will affect HMOs; a mechanism independent from UNY*Care that providers can use to appeal utilization control decisions; and, changing the name "single payer authority" to a term implying a broader responsibility. It was also suggested the document stress that the proposal could simplify some of its more onerous tasks with the appropriate changes in Federal law.

PRELIMINARY REPORT
ON
FIVE-YEAR EXPANSION PLAN
FOR THE
GARDEN STATE HEALTH PLAN
1991-1996

TO
GOVERNOR'S COMMISSION ON HEALTH CARE COSTS

FROM
ALAN J. GIBBS, COMMISSIONER
DEPARTMENT OF HUMAN SERVICES
AND
THOMAS M. RUSSO, CHIEF EXECUTIVE OFFICER
GARDEN STATE HEALTH PLAN

SEPTEMBER 1990

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INTRODUCTION AND SUMMARY

In keeping with the request of the Governor's Commission on Health Care Costs, this paper outlines a five-year plan (1991-1996) for expanding the Garden State Health Plan (GSHP) to Medicaid eligibles and to non-Medicaid eligibles in New Jersey.

The GSHP was designed to address certain Medicaid issues, such as improving access, providing primary care in the most appropriate setting, reducing costly hospital use, increasing reimbursement to physicians and lowering Medicaid costs. It is a managed care alternative for those who are Medicaid eligible and was meant to parallel the development of Medicaid contracts with private/commercial health maintenance organizations (HMOs) for the enrollment of Medicaid members.

Because the GSHP has yet to be operated on a large scale, it seems prudent for the State to expand the Plan on a gradual phase-in basis to build a physician network and to target enrollment by counties. This procedure eliminates major risks, does not involve federal waivers, and affords the State with flexibility and the opportunity to evaluate the operation and projected savings of the Plan with a larger enrollment base. It also affords an opportunity to determine how well a Revolving Fund concept will work as a method of financing the Plan and establishing a savings reserve.

However, because of the positive benefits of the GSHP as a Medicaid managed care program, an ambitious expansion schedule should be followed on a voluntary basis to target the enrollment of 25% of the non-institutionalized Medicaid eligibles over the next five years. This would represent an average net enrollment of approximately 25,000 new members per year, with a five-year target of 125,000 new members. Although this is an ambitious objective, it is one that should be achieved if the GSHP is given adequate resources. At the same time, corresponding efforts should be made to maximize the enrollment of Medicaid eligibles with private/commercial HMOs in order to provide choices and a range of managed care options.

Use of the GSHP under a buy-in arrangement for the enrollment of private non-Medicaid and non-Medicare persons represents an exciting new venture for State government. It also should be pursued and the GSHP should make enrollment available to non-Medicaid/Medicare eligibles, such as the underinsured and uninsured. However, it is a major undertaking and should be done cautiously as it is a new area for State public policy. Since the GSHP may be considered a competitor with the private HMO sector, prudence would dictate a methodical approach because of the myriad of policy, legal, regulatory, operational, administrative and resource issues which must be addressed as experience is gained with such a venture.

The Department recommends a flexible and voluntary approach for the GSHP for an initial five-year period to gain additional experience in all areas and to assess the efficacy of the plan when operational on a significantly large scale basis. At the end of the five-year period, a report should be made on the success or non-success of the program, at which time recommendations would be made as to whether it is feasible to pursue

further voluntary expansion of the plan or whether a mandatory approach for the GSHP in New Jersey represents a viable option.

VOLUNTARY VS. MANDATORY PROGRAM

Given what is known about the GSHP at this time, including savings projections and Plan operations, it might appear appropriate to mandate that the maximum number of Medicaid eligibles be required to join the GSHP within the shortest possible time period. However, there are problems associated with this approach, the major one being the ability to establish a large statewide physician network without a significant phase-in period. The only way this could be accomplished would be to require that all physicians in New Jersey with a primary care medical practice participate in the Plan.

Mandatory physician participation would also have to be extended to referral physicians, but a problem would exist because of the low Medicaid reimbursement rates under the fee-for-service program. This is because under the GSHP only primary care physician case managers are paid on a capitation basis, whereas all referral physicians are paid under the regular Medicaid fee schedule.

Compulsory enrollment would also require the match-up of Medicaid eligibles with participating physician case managers within a relatively short period of time. Because of these and other issues, such as the need for State legislation and HCFA waivers and the success of building other managed care options, it is felt that any decision on a mandatory approach be made following five years of experience under an expanded voluntary plan.

Therefore, a voluntary approach to participation by physicians and Medicaid eligibles in the GSHP in the first five years is recommended in order to build the confidence of the physician community in the Plan and in the Medicaid program. This alternative would be preferable to compelling all physicians and Medicaid eligibles to participate in the Medicaid program without a gradual build-up of the physician network.

EXPANSION TO MEDICAID ELIGIBLES

It is believed that the GSHP has the potential to deliver high quality accessible care at moderate program costs with the ability to increase primary care provider participation. It is also believed that the Plan is able to increase reimbursement to selected providers in a controlled, cost-effective fashion. As a result, the GSHP should undertake an effort to enroll a large number of Medicaid clients in managed care plans by 1996. This would entail a multi-year phase-in of the GSHP and other managed care initiatives as provider networks and administrative resources are developed. However, major investments in planning, marketing and provider recruitment and relations will be required for the Plan to achieve these goals.

It is believed that the most prudent method to achieve these goals is the gradual phase in of the Plan to targeted counties on a continued voluntary basis for an initial five-year period (1991-1996). Expansion of the Plan should also utilize the most effective and resource efficient means possible to develop networks of physicians and enrollment patterns on a voluntary basis. This approach enables the State to use the experience gained for the operation of a full scale program and provides for a smoother, orderly, non-disruptive and relatively risk-free expansion.

VOLUNTARY EXPANSION ENROLLMENT PLAN

Expansion of the GSHP is recommended based on the increased voluntary participation by eligibles and physicians in the Plan over a period of five years. The maximum projected penetration rate for the Plan would be 25% of the non-institutional and non-waiver Medicaid eligible population in each of the counties by the end of the five-year period. This process, however, should be flexible to accommodate adjustments as needed. The specifics of the expansion plan follows.

Year 1 - 20.000 New Members (Essex. Middlesex. Camden)

The focus of the first year would be on developing physician networks in the three most populous counties now in the Plan: Essex in the northern part of the State, Middlesex in the central part, and Camden in the south. The division of the State into three geographical areas allows for maximally efficient use of staff and transportation resources.

An enrollment of 20,000 new members is projected in the first year as existing staff train new staff and marketing and enrollment gain momentum.

Year 2 - 25.000 New Members (Essex. Middlesex. Camden. Passaic. Union. Atlantic)

In the second year, marketing and enrollment would continue in the original counties in order to attain the target penetration rate of 25%. Additional counties (Passaic, Union and Atlantic) would be selected for physician and eligible marketing. These counties are selected on the basis of geography, population, and expected strong outcomes from marketing.

Total new enrollment in Year 2 in all six counties would approximate 25,000. Total enrollment in the Plan would reach 45,000.

In addition, during the second year, physician case manager networks would be developed in Hudson County in order to prepare an expansion application for the GSHP's Certificate of Authority from the New Jersey Department of Health. The application is needed since GSHP operates as an HMO and receives its authority to operate through the same process and scrutiny as any commercial HMO in the State.

Year 3 - 30,000 New Members (Essex, Middlesex, Camden, Passaic, Union, Atlantic, Hudson, Mercer, Burlington)

Additional counties would be selected for physician and eligible marketing in the third year: Hudson (the first new county in the Plan since its start of operations), Mercer, and Burlington. These counties are also selected on the basis of geography for logistical efficiency, substantial Medicaid populations, and expected significant enrollment from marketing. Marketing and enrollment would continue in the previously participating counties.

Total new enrollment in Year 3 in the seven counties with expanding enrollment is planned at 30,000. Total enrollment in the Plan would be approximately 75,000.

During the third year, physician case manager networks would be developed in the new counties of Bergen, Monmouth, Ocean, Gloucester, and Cumberland in order to prepare an expansion application for the GSHP's Certificate of Authority.

Year 4 - 25,000 New Members (Essex, Middlesex, Camden, Passaic, Union, Atlantic, Hudson, Mercer, Burlington, Bergen, Morris, Monmouth, Ocean, Gloucester, Cumberland)

In the fourth year, marketing and enrollment would continue in seven of the nine counties from the first three years. It is expected that in the fourth year, Essex and Camden counties would reach their maximum saturation levels of enrollment possible under a voluntary program. Marketing and enrollment activities in these counties would be maintained for the balance of five years at a level sufficient to maintain enrollment.

Additional counties would be selected for physician and eligible marketing in the fourth year: Bergen and Morris in the north, Monmouth and Ocean in the central part of the State, and Gloucester and Cumberland in the south. Although these are counties with modest numbers of Medicaid eligibles, enrollments could exceed those of the preceding counties which would be nearing saturation levels.

Total new enrollment in Year 4 in the thirteen counties with expanding enrollment should reach 25,000. Total enrollment in the Plan should approach 100,000.

During the fourth year, physician case manager networks would be developed in the remaining six counties still outside of the Plan. All except Sussex would be prepared for a Certificate of Authority expansion application.

New Jersey State Library

Year 5 - 25,000 New Members (Essex, Middlesex, Camden, Passaic, Union, Atlantic, Hudson, Mercer, Burlington, Bergen, Morris, Monmouth, Ocean, Gloucester, Cumberland, Sussex, Morris, Hunterdon, Somerset, Cape May, Salem)

In the fifth year, marketing and enrollment would continue in twelve of the fifteen counties from the first four years. In the fifth year, the counties of the first year, Essex, Middlesex, and Camden, would reach their maximum saturation levels of enrollment possible under a voluntary program. Marketing and enrollment activities in these counties would be continued at a level sufficient to maintain enrollment.

The last remaining counties of the State would be added for physician network development and eligible marketing in the fifth and last year of the voluntary phase of Plan expansion: Sussex and Warren in the north, Hunterdon and Somerset in the central part of the State, and Cape May and Salem in the south. Although these are counties with small numbers of Medicaid eligibles, networks should be built nevertheless while enrollment continues in the more populous counties.

Total new enrollment in Year 5 in all of the State's counties should reach almost 25,000. Total enrollment in the Plan should approach 125,000 by 1996. Because of attrition, continued marketing would be necessary to maintain this enrollment level.

METHOD OF VOLUNTARY EXPANSION

The proposed method of expansion is the most effective and resource efficient, and carries the least risk of failure or serious disruption, considering all of the current issues facing the Medicaid program. It develops networks of physicians and enrollment patterns on a voluntary basis.

The following chief features of the expansion plan ensures its maximum efficiency and minimal administrative costs in comparison to other HMO expansion methods:

(1) The highest volume Medicaid physicians are identified in a given county for marketing.

    This approach eliminates the need for promotion and advertising to the entire physician community.

(2) The physician marketing teams present the Plan to the physicians. Repeat visits assure that all questions are answered and facilitate the signing of the Physician Case Manager (PCM) contract.

    One-on-one marketing has been determined to be the most effective in achieving a high rate of PCM enrollment.

(3) Once the PCM is enrolled in the Plan, his/her name is placed in the GSHP Physician Case Manager Directory. This allows eligibles to select that PCM from among the others in the Directory.

(4) In order to maximize the number of members which can be enrolled in the Plan from the eligible community, the Plan provides training for PCM staff in marketing to the PCM's patients.

A significant percentage of a PCM's patients enroll in the Plan voluntarily, most often selecting that physician as their PCM. In some cases, this panel conversion rate may be as high as 50%. The process is purely voluntary and non-coercive. It is carefully monitored by the GSHP field staff as well as monitored to assure that PCMs do not enroll the healthiest patient, thereby having an adverse selection of participants. Eligibles enrolling in the Plan tend to be more ill, on average, than the eligibles remaining in the fee-for-service system. Inspite of this, the Plan is able to achieve and maintain a substantial amount of savings.

The method is rapid and efficient in enrolling Medicaid eligibles as Plan members. The alternatives are far more costly and less efficient. They include mass advertising and promotion among Medicaid eligibles and door-to-door marketing.

(5) This approach would be supplemented by parallel marketing to new physician provider groups.

(6) In addition, marketing and enrollment would be augmented by the assistance of community organizations.

This voluntary marketing and enrollment approach allows for rapid Plan expansion with minimal staffing and costs. In addition, it draws physicians and physician staff into a cooperative relationship with the Plan. It nurtures the confidence of providers and members in case management and rebuilds confidence in the Medicaid program. As a result, networks of motivated providers are developed.

Just as important is extension of the Plan's good reputation to all eligibles through informal community networks without the coercive enrollment of all eligibles and with a large scale opportunity to experience the benefits of physician case managed care.

By phasing in the program, maximum experience is gained for the operation and costs versus savings of a full-scale program. Also, it is possible to carry out an ongoing assessment of the issues and needs for feedback on further successful development of the program during the five-year expansion period. The approach provides for a smooth, orderly, non-disruptive and relatively risk-free transition from fee-for-service to capitated, prepaid case management and also provides flexibility for changes if needed.

RESOURCE NEEDS FOR MEDICAID EXPANSION

To expand the GSHP for the voluntary enrollment of physician case managers and Medicaid eligibles, an initial allocation of new resources is essential for the promotion, marketing and operation of the Plan on a larger scale. Initially, in the first year, this would require the addition of at least the 28 positions which have been previously identified for this purpose. Also collateral resources, such as cars for marketing and enrollment staff and promotional materials would be required. The additional positions could be allocated from existing vacant positions in the Division of Medical Assistance and Health Services with fiscal resources being provided by the use of a Revolving Fund. This should not require the allocation of new or additional monies in excess of the current appropriation for the Medicaid program, but the existing vacancies would have to be reclassified to appropriate job titles.

Thereafter, the identification of additional resources would depend in great part upon the experience gained during the first year of the expanded program, with the possibility of allocating additional resources and positions from Division vacancies or from the Medicaid program as needs are identified. However, it is not possible to provide the numbers with any preciseness at this time, but as the voluntary enrollment increased, resources would also have to be increased. Resource allocation requires the support of many levels of State government, including the Governor's Office as the prime motivator.

REVOLVING FUND

The establishment and operation of a Revolving Fund, as authorized in the Fiscal Year 1991 Appropriations Act, is essential for the operation of the GSHP. The Fund is needed to capture unexpended federal financial participation and to be a depository where savings in the form of unexpended funds are maintained. The Revolving Fund is also needed as a source for capitation payments, benefits and services provided and administrative expenditures. It is the essence of the financial management of the Plan. The details of fully establishing and using the Fund need to be worked out with various State agencies since the full support of the Revolving Fund concept is needed for the Plan to be successful. It should be established to allow the program to move forward.

PLAN SAVINGS

Although it is possible to project savings to the State under a five-year GSHP voluntary expansion to 125,000 members, 25% of Medicaid eligibles, based upon the current small scale operation of the Plan, it would be preferable to not project actual savings with any preciseness at this time pending the operational experience gained during the expansion period. However, it is safe to assume that the cost of operating the Medicaid program for the members enrolled in the GSHP should be much less than under the Medicaid fee-for-service program. If the current over-all savings rate

of approximately 30% for administration and service benefits continues at that rate, the cumulative savings to the State over the five-year period could approach $130 million, with around $65 million in federal financial participation being retained in a Revolving Fund, assuming the targeted enrollment level is reached and there is no change in HCFA requirements or policy. However, actual experience data under the expanded program should be obtained to confirm projected savings.

NON-MEDICAID ENROLLMENT AND BUY-IN

Another use of the GSHP would be to develop a program for the enrollment of non-Medicaid individuals. Under current federal HMO regulations, the GSHP is required to enroll 25% or more of its members from the non-Medicaid/Medicare population. Although the Plan presently has a HCFA waiver from this requirement, which must be renewed annually, the Plan represents a potential primary source for the enrollment of non-Medicaid persons and small employer groups, in addition to groups such as those on General Assistance, through a Medicaid buy-in arrangement.

Within the appropriate allocation of State resources, the GSHP could begin plans for the orderly development of a buy-in program for the commercial market. However, this type of program is totally new to State Government and would require a significant amount of planning and programming prior to implementation, including new supporting resources. State enabling legislation would be required, as well as approvals from HCFA, the State Department of Health and the State Department of Insurance. Other administrative issues need to be addressed, such as possible Medicaid fiscal agent contract amendments.

In addition, implementation of the program should be consistent with State policy on health care coverage for the uninsured and the underinsured. Planned premiums with possible copayments and deductibles need to be developed according to actuarial methods and in accordance with financial considerations and social policy objectives. The buy-in may require some degree of subsidization of rates from as yet unidentified sources.

Any premiums developed would have to take into account the initial health needs of an uninsured population without regular access to care, since they have unmet health needs. Subsequent costs would range from those in the Medicaid population and of the commercial population of comparable demographic and socioeconomic profile. Actually, the break-even levels are higher.

It is recognized that a separate set of resources for the marketing, enrollment and administration of the Plan would have to be established for this program over and above the resources allocated to the GSHP for the Medicaid population. Again, the movement of the Plan into the commercial market would require the support and approval of appropriate sections of State government and the federal government.

The commercial enrollment plan would contain the following key elements to assure its efficiency and effectiveness:

- The GSHP will be included in a list of participating HMOs offering membership to the uninsured, whether they are employed or unemployed. This will allow employers and individuals to select the Plan at the time they are required or have the opportunity to choose a managed care provider.

- Since many GSHP PCM sites are in areas where there is a Medicaid eligible population, the panel conversion process will be utilized to identify the patients and offer the Plan to them. This is done in the same way that Medicaid eligibles are identified and offered the enrollment opportunity.

- For identified employers who are delaying the enrollment decision, GSHP marketing staff will approach the employers and offer the Plan to them in a manner similar to the approach to physicians. The marketing will be different to employers, identifying the advantages of the Plan.

- For identified individuals who have not yet selected or enrolled in a Plan, marketing teams will approach them through employers, individually by telephone, and in work site or home visits.

REPORT AFTER FIVE YEARS

At the end of the five-year expansion plan, the Department of Human Services should prepare a report on the GSHP to the Chief of the Governor's Office of Management and Planning concerning physician participation, member enrollment, over-all costs and savings, and administrative and operational issues. The report should also make recommendations on the future status of the Plan and for Medicaid managed care initiatives in general, including whether it is feasible to transition Medicaid from a fee-for-service to a mandatory managed care program. The report should also provide a full assessment on the enrollment and participation of non-Medicaid persons in the GSHP as a part of its expansion.

CONCLUSION

The expansion of the GSHP for the next five years is an ambitious project and represents a major new public policy initiative. However, to meet the goals of the program and to accomplish the expansion successfully requires flexibility and the cooperative participation and support of many government agencies including, but not limited to, the Office of the Governor, the Office of Management and Budget, the Office of

Telecommunications and Information Systems, the Department of Personnel, and the Department of Human Services, to provide the resources and support needed.

HARNESSING THE HEALTHCARE INDUSTRY

FOR THE MEDICAID RECIPIENT

AND THE WORKING UNINSURED

A Working Document
October 29, 1990

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HARNESSING THE HEALTH CARE INDUSTRY FOR THE

MEDICAID RECIPIENT AND THE WORKING UNINSURED

Statement of the Problem

There is mounting concern in the State of New Jersey that the existing health care and health insurance systems are not meeting the needs of all of its citizens. Areas of concern include:

- the cost of the Uncompensated Care Trust Fund, which now stands at more than $700 million and rising;
- the burden on the health insurance system which is mandated to pay the fund costs through a users tax on the hospitals bills, estimated to exceed 20%;
- inadequate and poorly designed health insurance coverage for the uninsured and underinsured;
- the rise in health care expenditures, particularly for Medicaid recipients due to excess use of hospital Emergency Rooms;
- the lack of incentives in the present payment system for physicians to accept Medicaid patients;
- the rapid growth in utilization of outpatient services;
- the overly complex hospital payment system which has become increasingly cumbersome and less prospective.

In order to address these diverse but interwoven issues, the State of New Jersey must develop innovative, multifaceted approaches. Contracting for health care service is likely to be among those approaches selected. Contracting for care should focus in three areas:

- benefit design with prevention in mind;
- participation of the beneficiary where appropriate in the payment system; and
- measurement and evaluation.

Demonstration Projects for Medicaid Recipients, the Working Uninsured and Underinsured

In order to reduce the burden on the Uncompensated Care Trust Fund, there are three categories of health care consumers whose medical care requires particular scrutiny and management. These are the uninsured, the underinsured, and Medicaid recipients.

GOALS

Regardless of the new programs selected by the State of New Jersey for its citizens, the following goals are likely to be adopted:

1. to enhance the level of wellness of New Jersey citizens particularly those who are uninsured or underinsured;

2. to provide preventive services and continuity in the delivery of healthcare;

3. to provide incentives to patients to more appropriately use primary care services and reduce unnecessary institutional usage;

4. to reduce costs and unnecessary utilization of health care services;

5. to reduce demand on the Uncompensated Care Trust Fund;

6. to better manage and control health care costs;

7. to reduce the burden on N.J. health insurance, companies and hospitals to fund the Uncompensated Care Trust Fund;

8. to create a financing mechanism that distributes the cost of the Fund fairly.

A Contracted Care Initiative

The State of New Jersey should introduce a program comparable to Denver's Share Cost Option for Private Employers (SCOPE). UHSNJ, US Life, and their network of hospitals and physicians can serve as the program's Exclusive Provider Network (EPN) as well as the third party administrator. The plan would be targeted to small businesses that are not offering health insurance.

The SCOPE Program is designed as an indemnity plan with premiums to be shared between employer and employee of approximately $5 to $125 per month. For non-primary and preventive services, there is a high deductible. The employee pays the first $1500, the employer pays the remainder up to $5,000 and the Insurance program beyond the $5000 limit.

The incentives built into this program would encourage wellness and preventive care through full coverage or small copayment for well-baby care, physician office visits for evaluation, examination and prescriptions. High deductibility and copayments for hospital care, psychiatric disorders, alcoholism and drug addition would help to make the premiums affordable and would discourage unnecessary use of expensive services, while encouraging use of preventive and primary services.

NOTE: Some companies should be eligible for subsidies from the State based upon demonstration of special need or financial hardship.

A sample Request For Proposal is presented in Appendix A.

Project for the Uninsured - Medicaid Eligible

The insurance product to be made available to the medicaid eligible patient would be identical to that offered in the SCOPE initiative with one exception: the deductibles and co-payments would be made from a designated and state controlled medicaid fund used for these purposes.

Demonstration Projects and Scope of the RFPs

The medicaid and working uninsured health insurance expansion programs should be three-year demonstration projects. During this time, the State can test the market's reception of a variety of insurance products (e.g., traditional indemnity, hospital-only indemnity, HMO, preferred provider organizations and point of service programs).

It is expected that each project would facilitate the insuring of approximately:

- Ten to twenty thousand or more previously uninsured people statewide to be enrolled over a two year period; or
- A targeted medicaid population in a specific geographic locale.

Waivers may be required from the Secretary of HHS to pursue these contracted care initiatives. The specific waivers that can be used are cited here. The uses, application, and procedures required are presented in the Appendices.

The waivers required are necessary in order to allow the demonstration projects to limit covered services, restrict activities of eligible providers and create an opportunity to require copayments from Medicaid eligibles for covered services.

Evaluation

In both initiatives an evaluation component would be required that would assess the impact on:

- Morbidity
- Mortality
- Patient Compliance with Preventative Measurers
- Costs to the System
- Costs to the Taxpayer

The Reporting Requirements should be:

- Monthly eligibility list, including names of all employees and dependents.
- List of new groups (firms), with firm name and and number of covered employees and dependents.
- Total number of groups.
- Total number of employee and dependent applicants.
- Number of applicants who do not pass health screen and reasons why.
- Number of employee/dependant dis-enrollments
- Itemization of hospital cases.
- Claims experience including incurred but not reported (IBNR).

The State should specify the form in which this information should be reported as part of the Memorandum of Understanding to be signed with successful bidders.

REGULATORY ISSUES

Mandated Benefits - the insurance laws of New Jersey require health insurance organizations to provide coverage of certain benefits, commonly known as mandated benefits. The bidder should assume that this program will be exempted from the requirement of mandated benefits. A complete description of covered services under the program should be provided by each bidder. Possible waivers required are presented in Appendix B.

Medicaid Waivers - There are three particular requirements that could require waivers for a contracted care program for Medicaid eligible persons:

- -Section 1902 A-"Freedom to choose my institution agency, community pharmacy, or person qualified;

- -Section 1902 A(1)-Statewide Coverage Requirement; and

- -Section 1902 A(10)-The Comparability Requirement same services for all.

Waivers have been granted in these areas by the Secretary for Freedom of Choice and Demonstration Projects in other states. New Jersey will need to request the Secretary to provide these waivers for this initiative. A complete discussion of this issue is included in Appendix C. Appendix D discusses Federal Waivers Required.

HEALTH PLAN FEATURES

The product must favor preventive and wellness programs, must discourage unnecessary utilization and (when appropriate) must encourage the use of less expensive alternative delivery systems (i.e., a community health center rather than a hospital emergency room).

Required Features

- The product must offer hospitalization benefits with appropriate deductibles and co-payments designed to discourage unnecessary utilization;

- The product must include preventive and wellness program incentives:

- The product must offer favorable preventive care benefits;

- The product must offer maternity and well-baby benefits as a standard policy feature;

- The product must provide incentives for use of less costly alternative delivery systems;

- The product must adequately protect insured against episodes of catastrophic illness;

- The product must have a "Contracted Care" feature (pre-certification, pre-admission, utilization review programs);

- The products must be sold as a "stand-alone" product, without requiring the related purchase of non-health benefits, such as life or disability insurance;

- The product must not have a deductible greater than $______ per single policy holder or subscriber, or $______ per family, in light of income restrictions common to many small business employees.

Requirements in the Bidders' Proposals:

- The insurance product must have a pre-admission certification requirement for all inpatient admissions and pre-certification requirement for certain over-utilized and/or costly outpatient procedures identified in the RFP.

- A description of the provider network and method of payment of providers (capitation, fee-for-service, per case) must be submitted. The existence and nature of any current contractual arrangements with providers should be disclosed.

- The product must contain a quality assurance/ utilization review program with a summary reporting mechanism available to external evaluators.

RATES

Required Feature

- The State should expect that premium rates for products offered through this program to reflect both the reduced administrative cost to the insurer due to the States promotional efforts, and the insurer's significantly reduced liability for medical expenses due to reduced covered services.

Desired Feature

- Rates should be guaranteed for at least 12 months.

ADMINISTRATION

Required Feature

- All routine administrative functions (eligibility determination, enrollment, billing/collection, benefits administration) will be handled by the insurer or its designee.

TARGET MARKET

Insurance plans should be offered either statewide or in specific geographic areas agreed to by the State and insurers. Any small business not currently insured will be eligible to purchase insurance under the program.

PROMOTION

The State should launch promotional campaigns in conjunction with several trade associations, labor unions, and other interested groups (e.g. HEAL etc.). The promotional campaign should include production and distribution of a descriptive brochure; establishment of a dedicated telephone line for interested small businesses; and public service announcements. Bidders must provide additional promotion and market support. A detailed marketing and advertising agenda for the program must be provided by the bidder.

APPLICANTS

The following entities should be considered eligible to respond to this RFP:

a) Health Insurance Companies - Insurers authorized to write health insurance as defined by N.J.S.A. 17B:17.4.

b) Health Maintenance Organizations - Any health maintenance organization which has a certificate issued under N.J.S.A. 26:2J-4.

c) Health Service Corporations - Corporations authorized to write health insurance as defined by N.J.S.A. 17:48E-4.

d) Hospital Service Corporations - Corporations authorized to write hospital-only health insurance as defined by N.J.S.A. 17:48-3.

e) Other entities that can meet the requirements of this RFP such as those organizations that have a relationship or affiliation with provider networks and insurers or HMOs and point of service programs.

OUTCOMES

The State should contract for the performance of an extensive evaluation of the effectiveness of these programs in providing health insurance to medicaid recipients previously uninsured persons in New Jersey and the impact of the program in reducing net costs charged to the Uncompensated Care Trust Fund. Insurers would be expected to provide data quarterly and to actively cooperate with the evaluation by providing their insights and experiential information.

The specific data elements and reporting format should be negotiated as part of the discussions between the State Contractor and successful bidders.

Questions To Be Addressed

In an effort to shape future legislative and other efforts to serve the uninsured population; the State should attempt to answer the following:

- What are the major characteristics of the small businesses that offer the reduced-premium health insurance products, and the demographic characteristics of the employees who purchase them?

- After the previously uninsured are enrolled in an insurance plan, what is their utilization rate of medical care service, in particular emergency room and hospital care?

- What is the impact on the Uncompensated Care Trust Fund?

- What is the impact of offering a subsidy for employee and dependent coverage?

- What do the results of this program indicate about benefits, rates and subsidies for the entire uninsured population?

APPENDIX A:

Sample Request For Proposal

Working Uninsured Health Insurance Expansion Program

REQUEST FOR PROPOSALS

Introduction

PROGRAM OVERVIEW:

The Working Uninsured Health Insurance Expansion Program is a demonstration project designed to expand employer-sponsored health insurance coverage by making it more available and affordable to small businesses which previously did not offer health insurance or discontinued such insurance because of costly premiums. Currently, a substantial number of people who pay little or none of their hospital bills and have their hospital bills paid through the Uncompensated Care Trust Fund are the working uninsured. Expanding the availability and affordability of health coverage to the working uninsured will enable this group of people to have an insurance mechanism that will not only pay all or part of their hospital bills, but will also give them access to providers other than the hospital for medical care.

The Administrators of the Uncompensated Care Trust Fund ("UCTF"), in conjunction with the Departments of Health and Insurance, are seeking relationships with selected insurers and HMOs, or organizations that include provider networks and payor affiliations, to develop and market reduced-premium policies for employees of small businesses. The UCTF is particularly interest in an applicant that can offer multiple health insurance products which promote preventive and wellness programs and alternative delivery systems, and which offer innovative risk and underwriting arrangements. Specifically, the UCTF is seeking products which remove barriers common to the insurability of small groups.

The UCTF is considering seeking legislation which will allow an additional feature to this program: a direct premium subsidy for employee and dependent coverage. This option will be available to employees insured through the working uninsured health insurance expansion program who also meet specific income eligibility criteria.

The UCTF encourages all interested insurers, health maintenance organizations and organizations that have provider networks and payor affiliation to respond to this Request for Proposals (RFPs).

SCOPE OF THE RFP

The working uninsured health insurance expansion program will be a three-year demonstration project. During this time, the UCTF will test the market's reception of a variety of insurance products (e.g., traditional indemnity, hospital-only indemnity, HMO, preferred provider organizations).

It is expected that the program will facilitate the insuring of approximately ____________ or more previously uninsured people statewide to be enrolled over a two-year period. (Particular products may be offered on a statewide or specific area basis; however, the UCTF will give preference to products which are offered statewide, with the exception of HMOs.)

The UCTF seeks to establish a marketable, innovative program which removes many of the barriers to insurability which currently face small employers. Participating insurers will be those who best serve the intent and purpose of the program. If none of the product proposals which meet the requirements outlined in this RFP reflect a reduction of the market premium which corresponds to the insurer's limited risk and reduced marketing costs, the UCTF has the right to select no vendors. Therefore, the specific standards and preferences noted in this document are to be used as guidelines only for the UCTF's review and selection.

APPLICANTS

The following entities will be considered eligible to respond to this RFP:

a. Health Insurance Companies - Insurers authorized to write health insurance as defined by N.J.S.A. 17B:17.4.;

b. Health Maintenance Organizations - Any health maintenance organization which has a certificate issued under N.J.S.A. 26:2J-4.

c. Health Service Corporations - Corporations authorized to write health insurance as defined by N.J.S.A. 17:48E-4.

d. Hospital Service Corporations - Corporations authorized to write hospital-only health insurance as defined by N.J.S.A. 17:48-3.

e. Other entities that can meet the requirements of this RFP such as those organizations that have a relationship or affiliation with provider networks and insurers or HMOs.

REGULATORY ISSUES

Mandated Benefits - The insurance laws of New Jersey require health insurance organizations to provide coverage of certain benefits, commonly known as mandated benefits. The bidder should assume that this program will be exempted from the requirement of mandated benefits. A complete description of covered services under the program should be provided by each bidder.

HEALTH PLAN FEATURES

The UCTF is seeking insurance products with certain standard features, as outlined below, that have discounted premiums because insurers are not bound by mandated benefit requirements and because of cost containment features in the product. The product must favor preventive and wellness programs, must discourage unnecessary utilization and (when appropriate) must encourage the use of less expensive alternative delivery systems (i.e., a community health center rather than a hospital emergency room).

TARGET MARKET

Insurance plans will be offered either statewide or in specific geographic areas agreed to by the UCTF and insurers. Any small business not currently insured will be eligible to purchase insurance under the program.

PRODUCT FEATURES

Required Features:

- The product must not have a deductible greater than $______ per single policy holder or subscriber, or $______ per family, in light of income restrictions common to many small business employees;

- The product must offer hospitalization benefits with appropriate deductibles and copayments designed to discourage unnecessary utilization;

- The product must offer maternity and well-baby benefits as a standard policy feature;

- The product must be sold as a "stand-alone" product without requiring the related purchase of non-health benefits, such as life or disability insurance;

- The product must offer favorable preventive care benefits;

- The product must have a managed care feature (pre-certification, pre-admission, utilization review programs);

- The product must adequately protect insureds against episodes of catastrophic illness;

- The product must include preventive and wellness program incentives;

- The product must provide incentives for use of less costly alternative delivery systems.

MANAGED CARE

Required Feature:

- The product must have a pre-admission certification requirement for all inpatient admissions and pre-certification requirement for certain overutilized and/or costly outpatient procedures.

- A description of the provider network and methods of payment of providers (capitation, fee-for-service, per case) must be submitted. The existence and nature of any current contractual arrangements with providers should be discussed.

-The product must contain a quality assurance/ utilization review program.

RATES

Required Feature:

-The UCTF expects that premium rates for products offered through this program will reflect both the reduced administrative cost to the insurer due to the UCTF's promotional efforts, and the insurer's significantly reduced liability for medical expenses due to reduced covered services.

Desired Feature:

-Rates should be guaranteed for at least 12 months.

PROMOTION

The UCTF will launch a promotional campaign in conjunction with several trade associations. The promotional campaign will include production and distribution of a descriptive brochure; establishment of a dedicated telephone line for interest small businesses; and public service announcement. Bidders must provide additional promotion and market support. A detailed marketing and advertising agenda for the program must be provided by the bidder.

ADMINISTRATION

Required Feature:

-All routine administrative functions (eligibility determination, enrollment, billing/collection, benefits administration) will be handled by the insurer or its designee.

DATA COLLECTION AND EVALUATION

Collection of data for both ongoing contract management and evaluation purposes is critical to this program. Therefore, the UCTF will expect insurers to provide information in the following two areas:

<u>Monthly Data Reporting</u>:

The UCTF will require reports on a minimum of six items monthly for the full contract period:

- -Monthly eligibility list, including names of all employees and dependents.
- -List of new groups (firms), with firm name and number of covered employees and dependents.
- -Total number of groups.
- -Total number of employee and dependent applicants.
- -Number of applicants who do not pass health screen and reasons why.
- -Number of employee/dependent disenrollments.
- -Itemization of hospital cases.
- -Claims experience including incurred but not reported (IBNR).

The UCTF will specify the form in which this information should be reported as part of the Memorandum of Understanding to be signed with successful bidders.

QUARTERLY EVALUATION DATA

The UCTF intends to perform an extensive evaluation of the effectiveness of this program in providing health insurance to previously uninsured persons in New Jersey and the impact of the program on reducing net costs charged to the UCTF. Insurers will be expected to provide data quarterly and to actively cooperate with the evaluation by providing their insights and experiential information.

The specific data elements and reporting format will be negotiated as part of the M.O.U. between the UCTF and successful applicants.

With the data collected, the UCTF will try to answer the following questions, in an effort to shape future legislative and other efforts to serve the uninsured population:

-What are the major characteristics of the small businesses that offer the reduced-premium health insurance products, and the demographic characteristics of the employees who purchase them?

-After the previously uninsured are enrolled in an insurance plan, what is their utilization rate of medical care service, in particular hospital care?

-What is the impact of the UCTF?

-What is the impact of offering a subsidy for employee and dependent coverage?

-What do the results of this program indicate about benefits, rates and subsidies for the entire uninsured population?

PROPOSAL PROCESS AND TIMETABLE

Submission of Proposals:

-<u>Letter of Intent</u>:

Any interested applicant should submit a Letter of Intent to the UCTF (at the address in Section 4.1.2, below) by ___________, 1990, signifying the applicant's intention to respond to this RFP. This will facilitate the UCTF's ability to follow-up with interested bidders to forward any clarifying correspondence.

-<u>Submission</u>:

Each interested applicant should submit and original and 6 copies of its proposal application with a cover letter to:

The application must be received no later than 4:00 p.m. on ________________, 1990. Applications received after this time and date will not be considered.

-<u>Inquiries</u>:

Prospective applicants may address questions in writing to the person and address list above, or by telephone to the same person at __________ no later than ________________, 1990. Inquiries will be consolidated and written responses will be made available to all prospective applicants upon request.

Timetable:

-RFP Issues: ________________, 1990.

-Letter of Intent Due: ________________, 1990.

-Written Inquiries Due: ________________, 1990.

-Applications Due: ________________, 1990

-Expected Date for Announcement of Selection: ________________, 1991.

-Anticipated Effective Date of M.O.U. ________________, 1991.

New Jersey State Library

APPENDIX B:

Mandated Benefits: Possible Waiver Options that may be considered

A discussion by Counsel

MEMORANDUM

TO: Michael J. Kalison, Esq.
Ann Bitton Gavzy, Esq.

FROM: Kathryn A. Hockenjos, Esq.

RE: U.S. Life Indemnity Health Insurance for the Working Uninsured

DATE: October 26, 1990

I. Introduction and Overview.

This memorandum reviews various provisions of New Jersey's Insurance Code to determine the type of legislation that would be required before U.S. Life would be permitted to offer a basic type of a group insurance product to employers who now do not provide any health insurance to their employees. The product that U.S. Life proposes to offer would be a "no frills" or "plain vanilla" type of policy providing group coverage for catastrophic and preventive care through the UHSNJ's network of physicians and hospitals. (The proposed insurance product offered by U.S. Life will be referred to hereinafter as the "Basic Policy").

This memorandum assumes that U.S. Life is not a hospital service corporation or a medical service corporation.[1] This memorandum does not review or analyze any provisions concerning individual or group life insurance, individual health insurance or dental coverage. Moreover, it does not discuss required capital and surplus, the required deposit with the Department of

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[1] The reasons for this assumption are set forth on Appendix A.

Insurance, reserves, investments, reports, examinations, or rules concerning agents or brokers as I was unaware of any circumstances which would prevent or make it more difficult for U.S. Life to comply with these statutory requirements.

The following sections of this memorandum discuss various statutes which mandate specific types of coverage that need to be repealed or amended before the proposed Basic Policy can be issued in New Jersey.[2]

The requisite legislation needed to allow the issuance of the Basic Policy can take one of two forms. The first, and probably the easiest, is to amend the statutory provisions which mandate coverage so that the Basic Policy is exempt from each statute's requirements. The second form of legislation is to enact a new section in the group health insurance statutes containing only those laws which are applicable to the Basic Policy. This second alternative may be more difficult to implement as it requires a new set of statutes and it would

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[2] It should be noted that an employee of the Department of Insurance advised that the "minimum standards" set forth in N.J.A.C. 11:4-16.1 et seq. were applicable to group health insurance policies. After careful review, it appears that these standards are applicable only to individual health insurance policies. This conclusion is based on the fact that N.J.A.C. 11:4-16.2 specifically states it is applicable to "individual health insurance policies" and the authority section of the regulation does not cite to any group health insurance statute. I intend to pursue this matter further with the Department and will advise you accordingly. I was also advised that there were no statutes, regulations or internal rules of the Department concerning freedom of choice issues.

duplicate many of the statutory provisions already applicable to group health insurance.[3]

II. Mandated Coverages.

A. Dependents.

1. Statutory Provision.

N.J.S.A. 17B:27-30 discusses dependent coverage. It permits such insurance benefits to be provided to family members or dependents ("dependents"). If dependent care is offered in connection with "hospital, nursing, medical or surgical services", the policy, subject to payment of the appropriate premium, must continue for at least 180 days after the death of the person in the insured group, subject to policy provisions as to termination of coverage with respect to dependents for reasons other than death.

2. Legislative Alternatives.

Provided U.S. Life intends to offer coverage to dependents, it is likely that the continuation of coverage under such circumstances would be provided for in the Basic Policy. One amendment might be to revise this section to shorten the period for which dependent coverage would be provided for in the Basic Policy, e.g., from 180 days to 90 days.

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[3] As an overview, Appendix B sets forth an overview of the revisions that such legislation could include.

3. Statutory Provision.

N.J.S.A. 17B:27-30 also provides that if dependent coverage is provided on an expense incurred basis, or if the policy provides coverage to the insured on an experse incurred basis but not to a dependent, the policy must provide that the benefits applicable for children "shall be payable with respect to a newly-born child of that insured from moment of birth." Coverage for such newly-born children must include coverage "of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities." There are various notification or application provisions set forth in this statute and if an additional premium is required, it must be sent to the insurance company within 31 days from date of birth.

4. Legislative Alternatives.

An amendment to this statute with respect to the Basic Policy would be to limit the types of birth defects or abnormalities that the Basic Policy would cover for a newly-born child. In addition, the period of coverage before payment of a premium is required could be shortened, e.g., coverage is provided for only 15 days after the birth of the child.

5. Statutory Provision.

The last paragraph of N.J.S.A. 17B:27-30 provides that if a policy terminates dependent coverage at a specified age, the coverage cannot be terminated with respect to an unmarried child covered by the policy prior to the attainment of age 19, who is

"incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapable prior to attainment of age 19 and who is chiefly dependent upon such employee or member for support and maintenance . . ."

6. Legislative Alternatives.

For the Basic Policy, this requirement could be deleted or amended to provide for payment of a separate premium for coverage of a mentally retarded or physically handicapped child after he or she reaches the age of 19.[4]

B. Alcoholism.

1. Statutory and Regulatory Provisions.

N.J.S.A. 17B:27-46.1 states that a group policy which provides hospital or medical expenses benefits must provide benefits for "expenses incurred in connection with the treatment of alcoholism when such treatment is prescribed by a doctor of medicine." Benefits for alcoholism treatment must be provided to the same extent as any other covered sickness. The statute then provides that such benefits must include treatment for inpatient or outpatient care in a licensed hospital, treatment at a

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[4] You should be aware that N.J.S.A. 17B:24-12 provides that if a policy insures against more than one hazard or peril, the insurance against any specific hazard or peril cannot be separately cancelable unless the policy specifies a separate premium for such insurance. Therefore, by permitting optional coverages with separate premiums, you may be creating an administration nightmare as various coverages can be cancelled at different times. This comment is applicable to all of the other recommendations in this memorandum where a separate premium is suggested.

licensed detoxification facility or confinement at a state approved residential treatment facility. These benefits are detailed more fully in N.J.A.C. 11:4-15.1 *et seq*.

2. Legislative Alternatives.

This statute and corresponding regulations should be repealed with respect to the Basic Policy. As an alternative, the statute could be amended to make this an optional type of coverage for which the employer would pay a separate premium and/or the policy could have a separate deductible for this type of benefit.

C. Reconstructive Breast Surgery.

1. Statutory Provision.

N.J.S.A. 17B:27-46.1a requires that if a group health insurance policy provides hospital or medical expense benefits it must provide benefits for reconstructive breast surgery, including, but not limited to, the costs of prostheses. In addition, if the coverage includes outpatient x-ray or radiation therapy, it must cover the costs of outpatient chemotherapy following surgical procedures in connection with the treatment of breast cancer.

2. Legislative Alternatives.

This requirement should be deleted from the statute with respect to the Basic Policy. Another option is that it could be amended to permit the employer or group policyholder to

purchase this as an optional type of coverage for which it would pay a separate premium and/or a separate deductible.

D. Maternity Benefits.

1. Statutory Provision.

N.J.S.A. 17B:27-46.1b requires that any group health insurance policy providing hospital or medical expense benefits must offer coverage for maternity care "without regard to marital status to subscribers or other persons covered thereunder for expenses incurred in pregnancy and childbirth." These benefits are to be provided to the same extent as the hospitalization benefit is provided for any other covered illness. If a fixed amount is specified for surgery, the fixed amount for a pregnancy-related surgical procedure shall be commensurate with the fixed amount payable for a surgical procedure of comparable difficulty and severity.

2. Legislative Alternatives.

If maternity benefits are to be covered under the Basic Policy, this statutory provision does not have to be amended. If such coverage is not contemplated, this statute with respect to the Basic Policy should be repealed. Another alternative is to charge the employer a separate premium for such coverage and/or have a separate deductible.

E. Treatment for Hemophilia.

1. Statutory Provision.

N.J.S.A. 17B:27-46.1c states that any group health insurance policy providing hospital expense benefits in connection with the treatment of routine bleeding episodes associated with hemophilia must also provide benefits for expenses incurred "in connection with the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia when the home treatment program is under the supervision of a State approved hemophilia treatment center."

2. Legislative Alternatives.

This type of mandated coverage may not be an issue if the Basic Policy does not provide hospital expense benefits in connection with the treatment of hemophilia. If it does, this requirement for coverage for such products and equipment should be repealed with respect to the Basic Policy. Another alternative is to amend this statutory provision allowing the Basic Policy to cover only a certain percentage of the costs of such equipment, e.g., 45% of the costs. A third alternative is to make this type of coverage optional which would be purchased by an employer by paying a separate premium and/or having a separate deductible.

F. Preexisting Condition.

1. Statutory Provision.

N.J.S.A. 17B:27-46.1d provides that no group health insurance policy shall contain a provision denying benefits for a preexisting condition to any person becoming a member of that group "if: (1) during the period immediately preceding the person's becoming a member of the group the person was enrolled as a member under another group policy issued by the insurer; and (2) the insurer paid benefits for the condition under the group policy in which the person was previously insured."

2. Legislative Alternatives.

This provision eliminates the common preexisting condition exclusion when the new member was insured before by the same insurance company and the insurance company made payments for such condition. An amendment should be enacted with respect to the Basic Policy repealing this provision.

G. Surgical Opinions.

1. Statutory Provision.

N.J.S.A. 17B:27-46.2 through 17B:27-46.9 concerns second and third surgical opinions. If a group insurance policy is issued which provides coverage for surgical operations while as an inpatient at a hospital, the insurer must "make available and if requested by the group policyholder, provide a second surgical opinion program for elective surgical procedures, which would require inpatient admission to a hospital. . ." An

elective surgical procedure is any "nonemergency surgical procedure . . . scheduled at the convenience of the patient or the surgeon without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions." N.J.S.A. 17B:27-46.2(a). Payment for the second surgical opinion services of an eligible physician and for essential laboratory and x-ray services incidental thereto is covered under the group insurance policy. N.J.S.A. 17B:27-46.4. If the second surgical opinion does not confirm the first opinion, coverage is also provided for a third surgical opinion. An insurer may provide reduced benefits for the surgeon's charges if the elective surgery is performed without obtaining a second or third opinion confirming that the elective surgery was advisable. N.J.S.A. 17B:27-46.6. A second surgical opinion program may exclude benefits for any surgical procedures not covered by the group insurance policy and surgical procedures in the following categories: cosmetic surgery, dental surgery and podiatric surgery. N.J.S.A. 17B:27-46.7.

2. Legislative Alternatives.

With respect to the Basic Policy, under the above definition of "elective surgery", the surgical opinion requirement may not be covered. Moreover, the statute provides that the second surgical opinion program is available when requested by the group policyholder. In the event elective surgery is covered under the Basic Policy, an amendment to this should provide that if the group policyholder under the Basic

Policy requests this surgical opinion program, that his, her or its premium be increased accordingly to pay for such benefits.

H. Home Health Care.

1. Statutory and Regulatory Provisions.

N.J.S.A. 17B:27-51.4 provides that any group insurance policy which provides coverage for inpatient hospital care or skilled nursing facility care, must also provide coverage for home health care. Home health care is defined as those "nursing and other home health care services rendered to a person in his place of residence, under the following conditions:

> (1) on a part-time and intermittent basis, except when full-time or 24-hour services are needed on a short-term basis;
>
> (2) if continuing hospitalization could otherwise have been required if home health care were not provided;
>
> (3) pursuant to a physician's order and under a plan of care established by the responsible physician in collaboration with a home health care provider, which plan shall be periodically reviewed and approved by said physician. All care plans shall be established within 14 days following the commencement of home health care."

"Home health care services" means any of the following services necessary for achievement of the care plan set forth for the patient:

> (1) nursing care;
>
> (2) physical therapy;
>
> (3) occupational therapy;

(4) medical social work;

(5) nutrition services;

(6) speech therapy;

(7) home health aide services;

(8) medical appliances and equipment, drugs and medications, laboratory services and special meals, to the extent such items and services would have been covered under the policy if the covered person had been in a hospital;

(9) any diagnostic or therapeutic service, including surgical services, performed in a hospital outpatient department, a doctor's office or any other licensed health care facility, provided such service would have been covered under the policy if performed as inpatient hospital services.

N.J.S.A. 17B:27-51.5 specifically provides that coverage for home health care must not have a separate deductible or coinsurance provision. These benefits are detailed more fully in N.J.A.C. 11:4-14.1 et seq.

2. Legislative Alternatives.

These statutory and regulatory provisions should be repealed with respect to the Basic Policy. Another alternative to the statute is to limit the types of services provided by home health care. A third option is to make home health care an optional coverage for which the group policyholder would have a separate deductible and/or premium.

Appendix A

N.J.S.A. 17:48E-1 defines a hospital service corporation as a corporation "established pursuant to the provisions of this act, which is organized without capital stock and not for profit, for the purpose of (1) establishing, maintaining and operating a non-profit health service plan and (2) supplying services in connection with (a) the providing of health care or (b) conducting the business of insurance as provided for this by this act." A hospital service plan is then defined as a "plan under which contracts are issued providing complete or partial prepayment or postpayment of health care services and supplies eligible under the contracts for a given period to persons covered under the contracts where arrangements are made for payment for such health care services and supplies directly to the provider thereof or to a covered person under these contracts." A medical service corporation and medical service plan are similar to a hospital service corporation or hospital service plan but for the fact they provide medical services rather than hospital services.

The distinction between hospital service corporations or medical services corporations and "ordinary" health and accident insurers was explained by the New Jersey Supreme Court in Group Health Ins. of N.J. v. Howell, 40 N.J. 436 (1963). The court stated,

> The basic distinction between medical service corporations and ordinary health and accident insurers is that the former undertake to provide prepaid medical services through participating physicians, thus relieving subscribers of any further financial burden, while the latter only undertake to indemnify an insured for medical expenses up to, but not beyond, the schedule of rates contained in the policy. The ordinary health and accident insurer makes no attempt to provide medical services as such. The primary purpose of a medical service corporation, however, is an undertaking to provide physicians who will render services to subscribers on a prepaid basis. Hence, if there are no physicians participating in the medical service corporation's plan, not only will the subscribers be deprived of the protection which they might reasonably have expected would be provided, but the corporation will, in effect, be doing business solely as a health and accident indemnity insurer without having qualified as such and rendering itself subject to the more stringent financial requirements of the General Insurance Laws, N.J.S.A. 17:17-1 et seq. [Citations omitted].

Because U.S. Life is a for profit health insurer and the Basic Policy is intended to be an indemnity product, I have concluded that it is not a health service corporation or medical service

corporation. The mandated coverages for a health insurer or a hospital service corporation or medical service corporation are similar to those of an ordinary health insurer. Arguably, as U.S. Life introduces a managed care element to the Basic Policy, such as preferred or exclusive providers, the characterization of U.S. Life in that role becomes less clear.

Appendix B

1. Dependent Coverage (N.J.S.A. 17B:27-30)

   A. Continuation of Coverage After Death of Insured.

   * Amend statute to shorten period of coverage.

   B. Newly-Born Child

   * Amend statute to limit types of birth defects or abnormalities covered.

   * Amend statute to shorten period of coverage before payment of premium required.

   C. No Termination Of Coverage At Age 19 For Mentally-Retarded Or Physically Handicapped Unmarried Child

   * Amend statute to repeal this requirement with respect to Basic Policy.

   * Amend statute to permit a separate premium and/or deductible for continuation of coverage.

2. Alcoholism Treatment (N.J.S.A. 17B:27-46.1 and N.J.A.C. 11:4-15.1 et seq.)

   * Amend statute and regulations to repeal this requirement with respect to the Basic Policy.

   * Amend statute and regulations to permit a separate premium and/or deductible for such coverage.

3. Reconstructive Breast Surgery (N.J.S.A. 17B:27-46.1a)

   * Amend statute to repeal this requirement with respect to the Basic Policy.

   * Amend statute to permit a separate premium and/or deductible for such coverage.

4. Maternity Benefits (N.J.S.A. 17B:27-46.1b)

* Amend statute to repeal this requirement with respect to the Basic Policy.

* Amend statute to permit a separate premium and/or deductible for such coverage.

5. Treatment for Hemophilia (N.J.S.A. 17B:27-46.1c)

* Amend statute to repeal this requirement with respect to the Basic Policy.

* Amend statute to provide coverage for only a small percentage of the costs of such equipment and products.

* Amend statute to permit a separate premium and/or deductible for such coverage.

6. Preexisting Condition (N.J.S.A. 17B:27-46.1d)

* Amend statute to repeal this requirement with respect to the Basic Policy.

7. Surgical Opinions (N.J.S.A. 17B:27-46.2 to 17B:27-46.9)

* Amend statute to repeal this requirement with respect to the Basic Policy.

* Amend statute so that if a basic insurance group policyholder requests the surgical opinion program, that the group policyholder's premium be increased to pay for the benefit.

8. Home Health Care (N.J.S.A. 17B:27-51.4 and N.J.A.C. 11:4-14.1 et. seq.)

* Amend statute and regulations to repeal this requirement with respect to the Basic Policy.

* Amend statute and regulations to permit a separate premium and/or deductible for such coverage.

APPENDIX C:

State Waiver Requirements in Contracted Care Services for Medicaid Eligibles

A discussion by Counsel

M E M O R A N D U M

TO: Thomas E. Terrill, Ph.D.

FROM: Ann Bitton Gavzy, Esq.

DATED: October 26, 1990

RE: Managed Care Program for Medicaid Recipients: State Legislative and Regulatory Issues

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The focus of this memorandum is to describe those statutory and regulatory provisions under New Jersey law that might be implicated as a result of the proposed managed care program for Medicaid recipients. For purposes of this memorandum, I have assumed that the managed care program contemplates the following: (i) limitations on the scope of covered services; (ii) restrictions on eligible providers of services; and (iii) co-payments by Medicaid recipients.

1. MANDATED SERVICES

N.J.S.A. 30:4D-6 outlines basic medical care and services to be provided to Medicaid recipients. Such services include in-patient hospital services, out-patient hospital services, laboratory and x-ray services, skilled nursing or intermediate care facility services, early periodic screening and diagnosis services, and physician services. Additionally, this section lists those services that the Medical Assistance Program may provide to Medicaid recipients. The nature of these discretionary services include the type of services that the proposed managed care program might exclude such as physical therapy and related services, optometric services, podiatric services, chiropractic services, psychological services, in-patient psychiatric services, and in-patient or out-patient drug abuse services. Although these services are designated as discretionary, there are two qualifications in the statute. One such qualification relates to those services required under federal law. The other qualification relates to subsection (g) of N.J.S.A. 30:4D-6 which requires certain services to be provided to "medically needy individuals." For example, dependent children are required to be provided with the following services: medical care not provided by physicians but by other licensed practitioners, home health care, clinic, dental, physical therapy, prescribed drugs, devices and eyeglasses, optometric, psychological, diagnostic, screening, preventative and rehabilitative, transportation, and any other medical care or other type of remedial care recognized under state law and approved by the commissioner.

To the extent the managed care program intends to narrow the scope of health care services provided to Medicaid recipients or medically needy individuals (as defined under law), appropriate revisions to the above statute and corresponding regulations will be required. Additionally, the desire to limit the scope of benefits available raises a practical issue. Assuming Medicaid recipients will not be required to participate in the managed care program, what incentives do Medicaid recipients have to participate if they receive fewer benefits and are subject to a co-pay?

2. CO-PAYMENTS

N.J.S.A. 30:4D-6(d) provides "no payment or other form of cost-sharing shall be imposed on any individual eligible for medical assistance, except as mandated by federal law as a condition of federal financial participation." To the extent the managed care program proposes to control utilization by some co-payment from the Medicaid recipient, this statutory provision must be amended.

3. RESTRICTIONS ON PROVIDER SELECTION

N.J.A.C. 10:49-1.20 provides the following: "The concept of freedom of choice applies to both provider and recipient. An eligible person is free to choose providers of service who meet program standards and elect to participate." If the managed care program intends to establish preferred providers or exclusive providers, this regulation must be modified.

4. DEMONSTRATION PROJECTS

N.J.A.C. 49-8.1 et seq. outlines the parameters for demonstration projects relating to the Medicaid program. As expected, this section references the requirements under federal law as a prerequisite for a demonstration project in this state. Additionally, N.J.A.C. 10:49-8.4, a copy of which is attached, outlines the criteria for demonstration projects. In reviewing whether or not the managed care program meets the criteria imposed under state regulation, the criteria should be read in conjunction with the requirements and procedure outlined in Jim Laskey's memorandum relating to federal waivers required to implement the managed care program.

5. EXISTING UTILIZATION CONTROLS

Although not directly applicable to the proposed managed care program, I thought you might be interested to know that there are certain "managed care" controls in the existing Medicaid program. For instance, N.J.S.A. 30:4D-6(c) provides as follows: "No provider whose claim for payment pursuant to this Act has been denied because the services, goods or supplies were determined to be medically unnecessary shall seek reimbursement from the recipient, his family, his representative or others on

behalf for such services, goods and supplies provided pursuant to this Act." Additionally, N.J.A.C. 10:49-1.5 provides for the following exclusions from New Jersey Medicaid coverage: (i) any service, admission or item which is not medically required for diagnosis or treatment; and (ii) any admission service or item requiring prior authorization, where authorization has not been attained or has been denied.

cc: Michael J. Kalison, Esq.

APPENDIX D:

Federal Waivers Required for Implementing a Managed Care Program for Medicaid Recipients

A discussion by Counsel

MEMORANDUM

TO : Michael Kalison, Esq.
Ann Bitton Gavzy, Esq.

FROM : James H. Laskey, Esq.

RE : Federal Waivers Required for Implementing a Managed Care Program for Medicaid Recipients

DATE : October 26, 1990

The purpose of this memorandum is to describe (1) the waivers that may be needed in order to pursue a managed care program for Medicaid recipients, and (2) the procedures for obtaining such waivers. For purposes of this memorandum, I have assumed that the managed care program contemplates limitations on covered services, restrictions on eligible providers and copayments from Medicaid eligibles for covered services.

A. Background

Section 1902 of the Social Security Act, 42 U.S.C. 1396a, establishes numerous requirements that must be included in state plans for medical assistance. Three particular requirements that could interfere with a managed care program for Medicaid-eligible persons are: Section 1902(a)(23), which guarantees freedom to choose "any institution, agency, community pharmacy or person qualified to perform the service or services required" (the "freedom of choice" requirement); Section 1902(a)(1), which requires that the State plan be in effect throughout the State (the "statewideness" requirement); and Section 1902(a)(10), which

provides that medical assistance be made available to all eligible individuals in equal amount, duration and scope (the "comparability" requirement).[1]

There are two commonly pursued avenues for waiver of these requirements: "freedom of choice" waivers under Section 1915(b) of the Act, and demonstration project waivers under Section 1115 of the Act.

B. Freedom of Choice Waivers

Section 1915(b) of the Act, 42 U.S.C. 1396n(b), authorizes the Secretary of HHS to waive any of the requirements of Section 1902 in four specific cases: (1) to implement a primary care case-management system, (2) to allow a locality to act as a central broker for competing health care plans, (3) to share with recipients of medical assistance cost savings resulting from use by the recipient of more cost-effective medical care, and (4) to restrict choice to providers or practitioners who meet, accept and comply with reimbursement, quality and utilization standards under the State plan. In all cases the Secretary (through HCFA)

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[1] In addition to Subsections (1), (10) and (23), the following subsections have been the subject of recent waiver applications as reported in HCFA's Medicaid Waiver Fact Sheet.

- (5) (single agency to administer)
- (7) (confidentiality of information regarding recipients)
- (13) (reimbursement rates)
- (14) (enrollment fees)
- (17) (eligibility standards)
- (30) (utilization review)

Precisely which of Section 1902(a)'s 44 requirements will need waivers for the present project remains to be determined.

must find that the waiver would be cost-effective, efficient and consistent with Medicaid program objections. For waiver categories (1) and (2), there must also be a finding that the restriction does not substantially impair access to services of adequate quality. No waiver, regardless of the category, may restrict individuals of child-bearing age in their choices to receive family planning services and supplies.

Although HCFA may waive any of the requirements of Section 1902, the most common provision for which a waiver is sought is Section 1902(a)(23), the freedom of choice provision, and as a result all waivers granted under Section 1915(b) are known as "freedom of choice" waivers.

There are currently 32 freedom of choice waivers in effect. Twenty-six of these are primary care case management waivers under Section 1915(b)(1); six of these also involve provider restriction under Section 1915(b)(4). The remaining six are strictly provider restriction waivers under Section 1915(b)(4), of which three -- in California, Illinois and Washington -- involve contracts with particular groups of hospitals.

Freedom of choice waivers may only be requested by the State. They are submitted to HCFA's Regional Office, with final approvals granted by the Associate Administrator for Program Development. Requests are acted upon within 90 days, or else deemed granted. The action may include grant, denial, or request for more information, in which case a new 90-day period begins when the information is provided. The requirements for an

application are set forth in HCFA's State Medicaid Manual. They are quite detailed, and while a complete description is beyond the scope of this memorandum, a summary of some of the key requirements is set forth on Exhibit A attached hereto. Freedom of choice waivers may extend no longer than two years. They may be renewed for additional two-year periods.

C. Demonstration Project Waivers

A second source of waiver is under Section 1115(b) of the Act, 42 U.S.C. 1315(b), which relates to demonstration projects under any public assistance program. New Jersey has obtained one such waiver, for a respite care pilot project.

One advantage of a demonstration project waiver is that it does not need to fall within the strict confines of the four specific waiver categories under Section 1915(b). However, HCFA's policy appears to be that if the proposal does fall within Section 1915(b), then it is not eligible for consideration under Section 1115(b).

Under Section 1115(b) and 45 CFR 282.13, a State can have only three demonstration projects, only one of which can be a statewide project. They can only last for two years, and participation by any individual receiving AFDC benefits must be voluntary.

It should be noted that many of the "freedom of choice" waivers granted by HCFA are in fact for various types of demonstration projects. Based upon a review of reported waivers, it appears that the "freedom of choice" waiver is the far more

common route for pursuing projects of the type now being contemplated.

Exhibit A

An application for a waiver under Section 1915(b) must include the following:

- Description of statutory provisions sought to be waived;
- Purpose of the waiver;
- Services to be provided, and how this compares to services covered under the ongoing Medicaid system;
- Types and number of participating providers, by type of service offered and by location, and how the rate of provider participation under the proposed waiver compares to the current rate of participation;
- Qualification requirements for providers and how providers are selected;
- Methods of payment (full capitation, partial capitation), and general description of how payment rates were set and determined;
- Types of reimbursement arrangements or insuring mechanisms being used such as a risk or nonrisk contract;
- Categories of eligible recipients included in the waiver;
- Nature of participation, e.g., whether voluntary or mandatory;
- Numbers of recipients by category expected to participate, or projections by category of enrollment months;
- The average distance and travel time for recipients to obtain medically necessary services, and how this compares with time and distance without the waiver;
- How enrollments and disenrollments (if applicable) are to be handled under the proposed waiver;
- Areas of the states in which the program is implemented;
- Description of marketing plans for the waiver program;
- Project administration costs and activities, including start-up and ongoing costs of administrative requirements and procedures;

- Impact on ongoing Medicaid program administration;

- Description of quality assurance mechanisms, and means of protecting recipient rights, such as grievance procedures, appeal rights, etc.;

- Copies of, or a description of, any contracts for the provision of services under the waiver which must meet the requirements of 42 CFR 434, and an explanation of how the contract relates to the range of services and reimbursement mechanisms proposed in the waiver request (a contract in excess of $100,000, which is also subject to the federal requirements in §1903(m)(2)(A) of the Act, must be prior approved by the HCFA Regional Office;

- Qualification requirements for any contractors;

- Other factors and requirements unique to the state's waiver proposal;

- Documentation on methods to ensure that there will be no restriction of emergency services;

- Procedures for monitoring costs, utilization access and quality under the waiver;

- Documentation establishing cost-effectiveness, meaning that the costs of the project may not exceed what Medicaid would have paid, in the absence of the waiver, under the State's plan for comparable services furnished to the same recipients and for related administrative costs.

In addition, an application under Section 1915(b)(4) must include the following:

- The standards providers must meet regarding reimbursement, utilization and quality, and whether and how they differ, if at all, from those in the state plan;

- Documenation to show how these standards are consistent with access, quality, and efficient and economic provision of services. Standards must be based on written policies, procedures, and criteria that conform to acceptable medical practice and professional standards;

- A description of the type and number of providers to whom recipients are to be restricted, how the providers are selected, and the selection criteria;

- A description of how the state assures that providers are selected based solely on demonstrated effectiveness and efficiency in providing services and not on any other

standard or criterion which discriminates among classes of providers;

- A description of how the state restricts recipients to obtaining services only from qualified providers or practitioners that undertake to provide the covered care or medical services needed;

- A description of how the restrictions are not applied in emergency circumstances; and

- A description of how recipients residing at a long term care facility are not subject to a restriction of freedom of choice based on this waiver authority unless the state arranges for reasonable and adequate recipient transfers.

Finally, if the projects involve capitation arrangements or contracts, the requirements of 42 CFR Part 434 apply. These include upper payment limits based on the actuarial equivalent cost under a fee-for-service program.