

HB

369

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

May 10, 1998

Honorable Tim Kelly, Chairman
Senate Rules Committee
State Capitol Room 101
Juneau, AK 99801-1182

Dear Senator Kelly,

The Department of Health and Social Services respectfully requests that Committee Substitute for House Bill 369 (FIN) Amended "An Act relating to Medicaid coverage for certain eligible children and pregnant women; relating to primary care case management and managed care services as optional services under the Medicaid program; relating to premiums and cost-sharing contributions under the Medicaid program; and providing for an effective date" be scheduled in the Senate Rules Committee for placement on the Senate calendar.

This bill was introduced by the House Rules Committee at the request of the Governor. You have been provided four new fiscal notes dated May 7, 1998 to reflect the amended version of the bill.

This bill will expand the availability of health coverage for eligible children and pregnant women in accordance with the recently passed federal child health care initiative.

Your favorable consideration of this request will be most appreciated.

Sincerely,



Elmer A. Lindstrom
Special Assistant to the Commissioner

cc: Bob Labbe, Director, Medical Assistance
Pat Pourchot, Office of the Governor

Medicaid Expansion Legislation

CSHB 369 (FIN)am – An act relating to Medicaid coverage for certain eligible children and pregnant women; managed care as optional Medicaid services; cost sharing.

Medicaid Expansion for Children

- ❑ HB 369 will provide Medicaid coverage for thousands of uninsured Alaska children in families with income at or below 200% of the Federal Poverty Level (\$33,340 annual income for a family of three; \$16.03 hourly wage).
- ❑ Covering these children under Medicaid is a bargain at \$504 in per child, per year.
- ❑ Alaska's Medicaid expansion would be covered mostly with federal funds. Through the recently expanded Children's Health Insurance Program (CHIP), the federal government will cover about 72 percent of the cost for non-Native children. The federal Medicaid match is 100 percent for services provided at Indian Health Service facilities. Next year, for instance, the federal government would pay about \$6.7 million of the expansion's \$8.8 million cost.
- ❑ Unless we have a plan in place this year, Alaska stands to lose \$5.6 million in federal CHIP funds that have already accrued to the state.
- ❑ Medicaid services for children are comprehensive, focusing on prevention and screening aimed at early detection of health problems. Comparable private insurance costs more.
- ❑ Children will be granted extended eligibility, which will improve access to services and reduce paperwork.
- ❑ Children without health insurance are six times more likely to go without needed medical care and five times more likely to use the emergency room as a regular source of medical care.
- ❑ Health coverage helps families become more self-sufficient, and will support families in transition from welfare to work.

HB 369 – Medicaid Expansion

- ❑ Discussions with the Robert Wood Johnson Foundation and health insurance industry officials indicate that there is very little chance of substitution of Medicaid for private insurance for families at or below 200% of the Federal Poverty Level (\$33,340 for a family of three; \$16.03 hourly rate).

Medicaid Expansion for Pregnant Women

HB 369 would also expand Medicaid coverage to approximately 800 pregnant women in Alaska.

- ❑ Alaska's Medicaid coverage of pregnant women is at the federally mandated level of 133% of the Federal Poverty Level – the lowest level allowed under federal law.
- ❑ Thirty-five states – including Mississippi – have expanded pregnant woman Medicaid coverage above the federally mandated level.
- ❑ Medicaid coverage for pregnant women will assure that children receive a healthy start through early prenatal care as well as detection and treatment of conditions that might harm the child.
- ❑ Medicaid coverage for pregnant women would last through pregnancy and two months postpartum. It also assures automatic eligibility for the child through his or her first birthday.
- ❑ Many of the costs associated with poor pregnancy outcomes are preventable.
- ❑ There is a direct correlation between the lack of prenatal care and low birthweight babies.
- ❑ Babies born too small require increased medical attention and have significantly higher mortality rates.
- ❑ Discussions with the Robert Wood Johnson Foundation and health insurance industry officials indicate that there is very little chance of substitution of Medicaid for private insurance for families at or below 200% of the Federal Poverty Level (\$33,340 for a family of three; \$16.03 hourly rate).

HB 369 – Medicaid Expansion

- ❑ Pregnant women cannot easily access private insurance since this is considered a pre-existing condition under most policies. Therefore, this expansion of Medicaid would not compete with private insurers.
- ❑ Some House members said they were concerned the provision covering pregnant women would lead to more state-funded abortions for low-income women under the General Relief Medical program. Before passing HB 369, the House added the following intent language: “It is the intent of the legislature that funds expended for expansion of coverage for pregnant women under this Act will not be used for funding abortions except as required under the Hyde amendment.”

Other Provisions of CSHB 369(FIN):

Section 4 – Primary Care Case Management (PCCM)

- ❑ This section of the bill would allow the state to take advantage of managed care as a state option.
- ❑ In 1996, the Legislature adopted HB 393, requiring the department to develop a managed care system for Medicaid clients, and authorizing application for a managed care waiver.
- ❑ The Balanced Budget Act of 1997, authorized states to do primary care case management and contracts with managed care entities as a state option instead of applying for a waiver, as most states have already successfully implemented managed care.
- ❑ Under PCCM, Medicaid clients choose a primary care provider as their “medical home and receive all basic health services from that provider. The client receives better coordinated care and there are potential cost savings through prevention, early detection of health problems and reduced emergency room use.
- ❑ Waivers are administratively complex and gaining federal approval takes a lot of time.

Sections 5-6 - Cost Sharing

- ❑ These sections would allow the department to establish cost-sharing requirements for those children with incomes above 150% of the Federal Poverty Level.

- ❑ Current federal rules do not allow cost sharing for children at this time, but these sections would allow the state to implement cost sharing if federal rules are changed.

TONY KNOWLES, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 455-3030
FAX: (907) 465-3068

May 7, 1998

Honorable Con Bunde
House of Representatives
Alaska State Legislature
State Capitol
Juneau, Alaska 99801-1182

Dear Representative Bunde:

I want to take this opportunity to thank you for your support for restoring Medicaid coverage for pregnant women in House Bill 369. I would also like to briefly comment on the legislative intent attached to the bill.

I believe the intent correctly states the provisions of federal law relating to funding for abortions under the Medicaid program, i.e., the procedure can ONLY be paid for with Medicaid funds under the very limited circumstances provided for under the federal Hyde amendment.

I want to assure you that the Department of Health and Social Services will fully comply with the federal law and the legislative intent.

Again, thank you for your support for this important legislation.

Sincerely,



Karen Perdue
Commissioner

May 6, 1998

3571

HB 369

Absent: James, Therriault

And so, CSHB 369(FIN) am passed the House.

Representative Porter moved the effective date clause.

The question being: "Shall the effective date clause be adopted?" The roll was taken with the following result:

CSHB 369(FIN) am
Third Reading
Effective Date**YEAS: 30 NAYS: 6 EXCUSED: 2 ABSENT: 2**

Yeas: Austerman, Berkowitz, Brice, Bunde, Cowdery, Croft, Davies, Davis, Elton, Foster, Green, Grussendorf, Hanley, Hodgins, Hudson, Ivan, Joule, Kelly, Kemplen, Kott, Kubina, Martin, Masek, Moses, Mulder, Nicholia, Phillips, Porter, Rokeberg, Williams

Nays: Dyson, Kohring, Ogan, Ryan, Sanders, Vezey

Excused: Barnes, Kookesh

Absent: James, Therriault

And so, the effective date clause was adopted.

Representative Porter moved and asked unanimous consent that the following Letter of Intent for CSHB 369(FIN) am be adopted:

"It is the intent of the legislature that funds expended for expansion of coverage for pregnant women under this Act will not be used for funding abortions except as required under the Hyde amendment."

The question being: "Shall the Letter of Intent for CSHB 369(FIN) am be adopted?" The roll was taken with the following result:

May 6, 1998

3572

HB 369CSHB 369(FIN) am
Third Reading
Letter of Intent**YEAS: 36 NAYS: 0 EXCUSED: 2 ABSENT: 2**

Yeas: Austerman, Berkowitz, Brice, Bunde, Cowdery, Croft, Davies, Davis, Dyson, Elton, Foster, Green, Grussendorf, Hanley, Hodgins, Hudson, Ivan, Joule, Kelly, Kemplen, Kohring, Kott, Kubina, Martin, Masek, Moses, Mulder, Nicholia, Ogan, Phillips, Porter, Rokeberg, Ryan, Sanders, Vezey, Williams

Excused: Barnes, Kookesh

Absent: James, Therriault

And so, the House Letter of Intent was adopted.

Representative Mulder gave notice of reconsideration of his vote on CSHB 369(FIN) am.

HB 375

The following was read the second time:

HOUSE BILL NO. 375

"An Act relating to children in need of aid matters and proceedings; relating to murder of children, criminally negligent homicide, kidnapping, criminal nonsupport, the crime of indecent exposure, and the crime of endangering the welfare of a child; relating to registration of certain sex offenders; relating to sentencing for certain crimes involving child victims; relating to the state medical examiner and reviews of child fatalities; relating to teacher certification and convictions of crimes involving child victims; relating to access, confidentiality, and release of certain information concerning the care of children, child abuse and neglect, and child fatalities; authorizing the Department of Health and Social Services to enter into an interstate compact concerning adoption and medical assistance for certain children with special needs; authorizing the establishment of a multidisciplinary child protection team to review reports of child abuse or neglect;

8325 Security Boulevard
Baltimore, MD 21207

December 28, 1993

RECEIVED
DEC 16 1993
OFFICE OF THE DIRECTOR

Dear State Medicaid Director:

The purpose of this letter is to notify you about a recent Congressionally enacted revision to the "Hyde Amendment" which affects the Medicaid program and to tell you how this revision in the law is to be implemented.

Effective October 1, 1993, as part of P.L. 103-112, the Health and Human Services Appropriation bill, Congress passed a revision of the Hyde Amendment pertaining to Federal funding of abortions under the Medicaid program. As enacted, the provision states:

None of the funds appropriated under this Act shall be expended for any abortion except when it is made known to the Federal entity or official to which funds are appropriated under this Act that such procedure is necessary to save the life of the mother or that the pregnancy is the result of an act of rape or incest.

Thus, Federal funding (FFP) is now available for abortions performed to save the life of the mother or to terminate pregnancies resulting from rape or incest when the claim for such an abortion is paid by the State on or after October 1, 1993. Please note that it is the date that the State pays the claim and not the date of the service which determines the availability of FFP.

In order to implement this provision of the law, we are requesting that beginning with the first Quarterly Expenditure Report (HCFA-64) for fiscal year (FY) 1994 in January, States submit to the Health Care Financing Administration (HCFA) regional office (RO) a form certifying the number of abortions for which FFP is being claimed. The form should outline the number of abortions performed to save the life of the mother, the number performed for a pregnancy resulting from an act of rape, and the number performed for a pregnancy resulting from an act of incest. This certification should be submitted to the RO on a quarterly basis with the completed HCFA-64.

Current regulations at 42 CFR 441.203 and 441.206 require that before FFP can be made available, the State must obtain a signed physician's certification that, based on the professional judgment of the physician, the abortion was necessary because "the life of the mother would be endangered if the fetus were carried to term." Because the language of the current Hyde Amendment differs somewhat from its predecessors, the State must change the wording of the physician's certification to comport with the current statutory language. With regard to this portion of the Hyde Amendment, the new legislative language, "to save the life of the mother", has essentially the same meaning as the previous legislation.

As with all other mandatory medical services for which Federal funding is available, States are required to cover abortions that are medically necessary. By definition, abortions that are necessary to save the life of the mother are medically necessary. In addition, Congress this year added abortions for pregnancies resulting from rape and incest to the category of medically necessary abortions for which funding is provided. Based on the language of this year's Hyde Amendment and on the history of Congressional debate about the circumstances of victims of rape and incest, we believe that this change in the text of the Hyde Amendment signifies Congressional intent that abortions of pregnancies resulting from rape or incest are medically necessary in light of both medical and psychological health factors. Therefore, abortions resulting from rape or incest should be considered to fall within the scope of services that are medically necessary.

The definition of rape and incest should be determined in accordance with each State's own law. States may impose reasonable reporting or documentation requirements on recipients or providers, as may be necessary to assure themselves that an abortion was for the purpose of terminating a pregnancy caused by an act of rape or incest. States may not impose reporting or documentation requirements that deny or impede coverage for abortions where pregnancies result from rape or incest. To insure that reporting requirements do not prevent or impede coverage for covered abortions, any such reporting requirement must be waived and the procedure considered to be reimbursable if the treating physician certifies that in his or her professional opinion, the patient was unable, for physical or psychological reasons, to comply with the requirement.

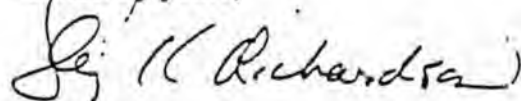
States which have State Plan language more restrictive than that provided for under the revised Hyde Amendment may qualify for Federal funding for the first quarter of FY 94 if they submit approvable State Plan language changes by December 31, 1993.

By March 31, 1994, all States must ensure that their State Plans do not contain language that precludes FFP for abortions that are performed to save the life of the mother or to terminate pregnancies resulting from rape or incest.

As you know, it is necessary for States to adhere to all conditions for Federal Medicaid funding. As part of its ongoing State assessment and audit programs, HCFA may include reviews of abortion claims, if necessary, to assure compliance with these conditions.

Please call my office if you have any questions about this matter.

Sincerely yours,



*Sally K. Richardson
Director
Medicaid Bureau*

cc: All Regional Administrators

CHILD HEALTH INSURANCE PROGRAM (CHIP)

- **WHO IS ELIGIBLE:** children under age 19, ineligible for Medicaid, not covered by health insurance, whose family income does not exceed 200% of the federal poverty level, not an inmate in a public institution, or dependent of a family member with benefits from public agency employment. Children with a pre-existing condition cannot be excluded; Alaskan Native children must be included. Any child applicant eligible for Medicaid must be enrolled in Medicaid.
- **BENEFITS:** State option: provide health insurance, expand Medicaid, or a combination of both.
- *Health Insurance* coverage must be equivalent to one of the following plans: the standard Blue Cross PPO plan for federal employees, the state employee plan, or an HMO plan; or a different benefit package that includes basic services that has an aggregate actuarial equivalent to one of the latter specified plans.
- *Medicaid Coverage* includes: the state has income and asset rules no more restrictive than those in place on June 1, 1997, a state can choose to expand coverage immediately for children born after October 1, 1983, and a state can allow 12 month continuous eligibility of children.
- **FUNDING:** \$24 billion has been appropriated for 5 years of the program; Alaska's allotment for Federal Fiscal Year 1998 is \$5,664,899. Enhanced Federal Medical Assistance Percentage (FMAP) expenditures can be used for health insurance, outreach activities, and administration. The FMAP for Alaska is 71.86%.
- Funds will remain available for three years as long as a state has an approved CHIP state plan in place; the Secretary will give unspent funds to other states who have spent their allotment. A plan must be approved by September 30, 1998 in order to retain the FFY 98 allotment; states are to submit plans by June 1, 1998 in order to allow sufficient time for approval.
- Administration of the plan is limited to 10% of expenditures, and include outreach, data collection, performance measurement and the required annual assessment.
- **CHIP STATE PLAN:** include a description of children with health coverage, state efforts to provide health coverage, how the plan will coordinate with efforts to increase coverage of children with health insurance, methods of delivery, utilization control, eligibility criteria, outreach activities, and methods of assuring appropriate care and access.
- **COST SHARING:** for families below 150% of the FPL, enrollment fee, premium or similar charge must be related to income, and deductible and cost sharing cannot exceed a "nominal" amount. For families with higher income, cost sharing can be imposed on a sliding scale fee but may not exceed 5% of the family's annual income. If child health services are provided through Medicaid, cost sharing is not allowed because of Medicaid rules.

WHY MEDICAID

Leverage more federal funds because Alaska Native children served by IHS are reimbursed at 100% federal. Of the 6,000 children to cover, about 1,100 are Native.

Medicaid Benefit package is a good one for children because it includes well child services and immunizations. Comparable private insurance package costs more.

Medicaid administrative structure in place. Can use existing payment system, and network of Medicaid providers.

CHILD HEALTH CARE PROGRAM:
Why Choose Medicaid
Instead of Private Health Insurance Plans ?

Under the State Child Health Insurance Program (SCHIP) federal law, states have the option to use their allotment to cover uninsured children through Medicaid, a health insurance purchase program, or a combination of both.

- If a state chooses the Medicaid option, Medicaid rules apply and a state must offer the Medicaid benefit package. If a state chooses to purchase health insurance it must offer a benefit package actuarially-equivalent to either the state's employee health plan, the federal employee health plan, or the largest HMO in the state¹.

For any state, the best option is dependent on many factors and the decision should be based on the following criteria:

- minimizing state general fund cost;
- maximizing the number of children covered;
- the cost of administrating the program; and
- the benefit package most appropriate for children.

COST/NUMBER OF CHILDREN COVERED

Using Alaska's SCHIP allotment to extend Medicaid coverage will stretch the State's general funds further and cover many more children.

- Between 25 and 40 percent of the SCHIP eligible children will be Alaskan Native and by law must be included in any SCHIP plan. Under a Medicaid expansion for SCHIP, services provided to Alaskan Native children by IHS or tribal providers will be paid with 100 percent federal funds *outside of the state's SCHIP allotment*. Under an insurance purchase plan, costs for Alaskan Native children will come out of the state allotment at a 72 percent federal match. A Medicaid SCHIP expansion takes advantage of the special funding for Alaskan Natives.
- Based on preliminary information fathered by the Division of Medical Assistance², comparable private health plans appear more costly than the average cost for a Medicaid child. The Division compared the per-child cost for a Medicaid expansion, estimated at \$1,908, to what the Medicaid benefit package would cost in the current private market. These preliminary estimates suggest that the comparable (Medicaid) package in the current private market would cost at least \$400 more per year per child.
- The Governor's Smart Start proposal to invest \$4 million in general funds will cover 6,000 uninsured children and 800 pregnant women. Under a separate insurance program, only an estimated 3,300 to 4,000 children (and no pregnant women) could be covered with that general fund investment.

¹The HMO option is not currently applicable in Alaska since there are no HMOs licensed to sell health plans.

² The Division of Medical Assistance continues to seek information from insurers on private insurance options but to date, has not received any information suggesting that less costly options exist in Alaska's private insurance market.

The Cost and Ease of Administering the Program

Extending Medicaid, as compared to creating a child health insurance program, minimizes new administrative and cost management.

- Implementation of a new child health insurance program would require duplication of many administrative components which already exist in the Medicaid Program. A further consideration is that start-up costs cannot be funded with SCHIP funds as administrative costs are limited to 10 percent of *actual* expenditures on children.
- As a condition of receipt of federal funds, each child who applies for SCHIP must be screened by the state for Medicaid eligibility. Therefore, eligibility determination in a child health insurance program is still linked to the Medicaid Program.
- Most health care providers are already enrolled and familiar with the Medicaid program.
- Extending Medicaid to additional children can be readily implemented³.

An appropriate Benefit Package for Children

- Medicaid provides an appropriate benefit package for children including preventive services such as well-child exams and immunizations which are not covered by most insurance plans.
- The preventive health services offered under Medicaid make this approach a better fit in addressing issues like Alaska's declining child immunization levels.
- The benefit package for either Medicaid or an insurance purchase option is stipulated in federal law, therefore, reducing services in the benefit package as an approach to lowering premiums is largely precluded.

CONCLUSION

Given the data available to the Alaska Department of Health and Social Services at this time, expanding Medicaid to uninsured low-income children represents the best financial and least burdensome approach to providing health coverage. The department is continuing to seek additional information by meeting with private insurers and health care providers and securing the analysis and consultation of national experts.

Summary
Meeting Between Knowles Administration Representatives
and Health Insurers
Regarding the Children's Health Insurance Program

February 13, 1998
Anchorage

State/HCFR Participants: *Commissioner Karen Perdue, Jeff Bush, Alison Elgee, Bob Labbe, Marianne Burke, Nancy Cornwell.*

Industry Participants: *Mike Wiggins, NYLCare; Jeffrey Davis, Blue Cross/Blue Shield of Alaska, Cleo O'Rourke, (Great West) One Health Plan of Washington, Inc.; Patrick Carmody, Mutual of Omaha.*

State Children's Health Insurance Program (S-CHIP): Legal Guidelines and Requirements. *Elizabeth Trias, CHIP Coordinator, Region 10, Health Care Financing Administration explained the federal requirements and options available to the State of Alaska. Bob Labbe, Director, Alaska Division of Medical Assistance briefly reviewed the State's cost under a Medicaid CHIP program.*

Trends in Employer-Financed Health Coverage. *Nancy Cornwell, Alaska Division of Medical Assistance, briefly reviewed some national data which show a significant decline in employer-financed dependent coverage, particularly for low-income workers. Each of the insurers present explained their companies have experienced a significant decline in the financial contributions made by employers for dependent coverage.*

General Conclusions. *The following general conclusions were made related to the families expected to be covered under the Governor's Smart Start (Medicaid) coverage expansion.*

These families are poor or very low income. They live on tight budgets, and health care coverage is not their highest priority unless they have a child with high health care needs, for example, a chronically ill or disabled child. It is reasonable to assume that given the demands on their budgets for food, housing, clothing, child care, and other basic needs, that their ability to pay their portion of a health premium in an employer-supported benefit program is very limited (assuming their employer makes a plan available to them at all). With the understanding that most employers are increasingly requiring their employees to contribute a portion of their premium and other cost-sharing, particularly for dependents, it is reasonable to assume that these poor and low-income employees are MOST likely to participate in an employer-sponsored program for

their dependents when they a child with have high health care needs. In contrast, parents with healthy children are less likely to make the budget sacrifices on an ongoing basis if their child has no few health care needs.

If these poor and low-income families do not have access to an employer-sponsored benefit plan, and they are purchasing an individual plan for their child in Alaska's insurance market, they have a limited number of insurers to choose from. By far the largest, Blue Cross of Washington and Alaska, offers their Traditional Program (under 30, non-smoker) for the annual premium (\$1,560) and (\$200) deductible cost to a family for the for one child is \$1,760. Again, given the tight budgets that these families exist on, it is reasonable to assume that most families at these income levels do not purchase individual policies for their children unless they are high health care needs.

Families at these income levels often have few assets so they are less concerned than higher income families about losing their assets as a result of a catastrophic health problem and the accompanying medical bills.

For families in these income levels, a parent may decide to take a particular job solely because the employer covers most or all of the cost for dependent coverage. If the employee's motivation is access to employer-financed dependent coverage, it should be anticipated that the parent's decision to stay with the employer will be driven by their child's health care problems and that they are prepared to wait through the pre-existing exclusion period in order to get their child's health care bills covered.

For the reasons stated above, the insurers who attended this meeting agreed that the poor and low-income Alaskan children who are expected to be eligible under the Governor's coverage expansion are not attractive as potential subscribers.

Future Meeting. Marianne Burke, Director, Division of Insurance, reminded the group that these insurers would be in Alaska in late summer for unrelated meetings and that would be a good opportunity to reconvene the participants of this meeting.

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

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FAX: (907) 465-2204

MEMORANDUM

DATE: February 23, 1998

TO: Karen Perdue, Commissioner
Department of Health and Social Services

FROM: *BL* Bob Labbe, Director
Division of Medical Assistance

SUBJECT: Crowd-out

Attached is a memorandum from Deborah Chollet of the Alpha Center in which she provides an assessment of issues related to "crowd-out." She defines crowd-out as the "reduction in private effort to purchase private health insurance because of eligibility for public program coverage." I've summarized the key points:

- Only a few studies of crowd-out have been done and the results are inclusive.
- Estimates of crowd-out are greater when the program enrolls higher income adults than when it enrolls only children.
- Few people who would qualify for public insurance have access to affordable private coverage.
- States that have already expanded public coverage to low and middle income children (below 200%FPL) have not found crowd-out to be a problem. They believe:
 - Lower income workers typically have either steady but low wage jobs, or are periodically unemployed due to lay off or seasonal work; and that
 - These workers generally do not have ongoing access to employer based coverage.
- To prevent crowd-out some states have limited eligibility for public health insurance to those who don't have insurance.

Conclusion

Ms. Chollet's assessment supports our conclusion that crowd-out will not be a significant issue when we expand Medicaid coverage as the Governor has proposed in Smart Start.

Attachment



MEMORANDUM

TO: Bob Labbe, Director
Division of Medical Assistance
Department of Health and Social Services, State of Alaska

FROM: Deborah Chollet, Ph.D.
Vice President

SUBJECT: Issue of crowd-out

DATE: February 10, 1998

RECEIVED
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DIV. OF MEDICAL ASSISTANCE
OFFICE OF THE DIRECTOR

This memorandum responds to your request for a summary of the issue of crowd-out in public insurance programs. It addresses four aspects of the issue:

- What is crowd-out?
- How big is the problem of crowd-out?
- State program features to deter crowd-out; and
- State programs to buy employer-based coverage as one way potentially to mitigate crowd-out.

As you are aware, in states that are considering extending public health insurance eligibility to children and adults with income above poverty, concern about the potential for crowd-out has grown. Most recently, this concern underlies the federal requirement that states explicitly propose how children's health insurance programs will deter crowd-out in order to qualify for federal funds under Title XXI.

What is crowd-out?

Crowd-out is defined as a reduction in private effort to purchase private health insurance because of eligibility for public program coverage. In theory, crowd-out can result from any of four types of reduced effort:



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- (1) individuals may stop buying nongroup (individual) health insurance for themselves or their dependents, when it is available and affordable to them;
- (2) individuals may stop making required contributions to employer-sponsored insurance for themselves or their dependents, when group insurance is available and affordable to them;
- (3) employers may increase the level of employee contributions that they require, presuming that lower-wage employees have access to public coverage or subsidies; or
- (4) employers may terminate the group health insurance plan altogether or some employees' eligibility for the group plan, presuming both that lower-wage employees have access to public coverage and that higher-wage employees can buy individual private health insurance.

Most states' concerns about crowd-out focus on the potential for workers or their employers to substitute public coverage for employer-group coverage (issues 2 through 4, above). In general, policy makers are less concerned about the possibility that individuals would substitute public coverage for individual insurance because few people who would qualify for public insurance would find individual insurance affordable. In some states, as public program eligibility begins to reach middle-income families without group coverage, concern about public programs crowding out individual insurance purchase may grow.

How big is the problem of crowd-out?

The research literature measuring the magnitude of crowd-out is thin and offers conflicting estimates of how great crowd-out might be when more people are made eligible for public insurance programs. Estimates of crowd-out range from quite large (in one study, researchers estimated that as many as 50 percent of new Medicaid enrollees would otherwise have been privately insured) to zero. In considering the usefulness of this literature to public policy makers, two aspects are of particular importance:

- (1) The differences among estimates appear (in part) to be driven by the population subgroup being studied. Estimates of crowd-out are greater when



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the program enrolls adults at higher income levels than when it enrolls only children or families with lower levels of income.

- (2) The reliability of the estimates is unknown. None of the available estimates is based on actual observation of employer or individual behavior. Instead, all of the research to date compares population groups that are broadly similar (for example, women with similar annual income, age, employment and education levels) over time. None of these studies control for whether workers who enroll in public insurance programs have access to affordable employer-sponsored insurance.

Because these studies are inconclusive, public policy makers must base their decisions about whether a specific proposal would cause crowd-out on an appraisal of whether private health insurance is available, affordable and stable for most people who would become eligible for public coverage. No research to date is adequate to inform public policy makers about whether or how employers might adjust group health benefits in response to wider eligibility for public programs.

State program measures to deter crowd-out

In a recent monograph prepared for the Robert Wood Johnson Foundation's *State Initiatives in Health Care Reform* Program (attached), we reviewed sixteen states' public insurance programs, including:

- public programs for children,
- public programs that enroll adults and children, and
- Medicaid programs that have expanded eligibility under Section 1115 waivers.

In states that had expanded public health insurance not just to people in poverty but also to people with incomes as high as 200 percent of poverty or more, officials had differing views about the relative importance of crowd-out as an issue for the programs. In states that had developed programs only for low- or middle-income children or that had extended program eligibility to only the near-poor population (under 185 percent of poverty), officials were unconcerned about crowd-out. In these states, officials presume



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February 10, 1998

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that people with such low income have few or no options for finding group insurance. In families with such low income, workers typically are either (1) steadily employed, but at very low wages; or (2) periodically unemployed due to lay-offs or seasonal work opportunities. In either case, few of these workers are likely to have ongoing access to employer-based coverage.

Insurance programs that target populations up to 400 percent of poverty generally devote more attention to crowd-out than programs that cap eligibility at 200 percent of poverty or less, especially when they enroll adults as well as children. In states with programs that enroll low-income adults or that extend eligibility to middle-income populations, the potential for crowd-out is believed to be greater, and these programs are designed with various features to deter crowd-out. These features are of two major types:

- (1) *Measures designed primarily to address other program issues but which also discourage crowd-out.* These include:
 - program limits on enrollee assets and age, as well as income;
 - requiring enrollees to pay premiums; and
 - limited program benefits (for example, no coverage for hospitalizations).

These measures typically are imposed to address public funding constraints, not because the program is particularly concerned about crowd-out. However, they deter crowd-out *de facto* by targeting public programs to families and individuals who are less likely to have private insurance options.

- (2) *Measures designed explicitly to address crowd-out.* These include:
 - requirements that applicants be uninsured or underinsured;
 - requirements that applicants be without insurance for some minimum spell; and
 - requirements that applicants have no access to employer-based insurance.



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Restrictions intended explicitly to deter crowd-out may seem necessary from the viewpoint of protecting the resources of public programs, but they can cause serious problems of equity and efficiency. Waiting periods, in particular, cause problems of equity because not all uninsured families with the same financial resources qualify for public coverage (some must wait), and because families that have made an effort to find and buy insurance must wait longer for public coverage than families that never tried. Problems of efficiency arise because families are forced to weather gaps in coverage to qualify for the public program. Gaps in coverage are a problem that the program ideally would solve, not require.

In addition, for all programs that require minimum spells without coverage or ineligibility for private coverage, enforcement is a problem. Verifying applicants' declarations that they are uninsured or underinsured is time-consuming and costly. Among the states that we reviewed, state-only children's programs were especially reluctant to invest resources to verify applicant declarations. Most state-only programs that include adults had found that verifying all applicant declarations was too costly to implement or to continue. In general, Medicaid expansion programs were the most likely to attempt to verify minimum spells without access to employer-based coverage. However, even these programs more often rely on partial and/or random audits to enforce restrictions than on systematic verification of applicant declarations.

With respect to their proposed Title XXI programs, two states -- California and Colorado -- have adjusted their use of waiting periods in an effort to minimize the equity and efficiency problems that they entail:

- California proposed a 3-month waiting period for any child who had been covered by an employer-sponsored plan. Children who had been covered in the nongroup (individual) market are not subject to the waiting period, nor are children of parents who lose coverage involuntarily (through job loss or termination of the group plan).
- Colorado also proposed a 3-month waiting period for children who were covered by an employer-sponsored plan, but (as in Minnesota's MinnesotaCare program) only if the employer pays at least 50 percent of the premium for dependents. As in California, the waiting period does not apply if prior coverage was nongroup, or if the parent loses coverage involuntarily.



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Like research studies that attempt to measure crowd-out from available national data, studies that have attempted to evaluate the effectiveness of restrictions to reduce crowd-out are compromised by the quality of available information. However, evaluation studies conducted in a number of states with varying programs and restrictions on eligibility all have indicated that the potential crowd-out caused by the programs is small. Most program officials and policymakers also believe that their programs reach target populations with reasonable efficiency and that crowd-out is not a serious problem.

State programs to buy employer-based coverage

We identified two states (New York and Oregon) that have programs to assist employees in purchasing employer coverage when it is available. In principle, such programs would discourage crowd-out by maximizing available employer-based coverage. However, crowd-out still can occur if employers respond to available public contributions for coverage over time by reducing employer payments for coverage (substituting public funding for employer funding). In addition, a premium subsidy program may have trouble constraining its budget if the program becomes liable for any level of premium cost that the employer does not pay.

New York's program, an older pilot program to insure adults, is exclusively an employer-premium subsidy program for workers who (1) have access to employer coverage; and (2) have family income less than 200 percent of poverty. The program limited its total cost by closing new enrollment, and at this time, no new enrollment is contemplated. Because the program was experimental and ultimately enrolled very few workers, it is unlikely that crowd-out was ever a significant problem.

Oregon's new Family Health Insurance Assistance Program (FHIAP) is designed to enroll workers and dependents who (1) have income less than 200 percent of poverty; and (2) are without insurance for 12 months. The program screens applicants for available employer coverage. FHIAP will pay the applicant's employee contribution to enroll in the employer plan if it costs less than the average cost of FHIAP coverage. FHIAP is a new program, and at this writing, has processed few if any applicants pending the design of Oregon's Title XXI program for children. FHIAP's restrictions on income for eligibility and its 12-month waiting period both suggest that crowd-out will not be a significant problem. However, FHIAP's design suggests equity problems (families that succeed in finding or buying health insurance cannot qualify as soon as families that never try). In addition, over time, FHIAP may pay employee premiums for fewer and fewer applicants if FHIAP is able to control its costs more successfully than employers do.



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I hope that this information is useful to you. Please do not hesitate to call on me or on other Alpha Center staff if we might be of further assistance to you in considering this issue.

Attachment: *Deterring Crowd-out in Public Insurance Programs: State Policies and Experience* (Alpha Center, October 1997).

cc: Nancy Barrand, Robert Wood Johnson Foundation, *State Initiatives in Health Care Reform* Program
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