

*Effective Coverage Expansions for Uninsured Kids and Their Working Parents:
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Hindsight and Foresight: Lessons for Getting It RItE

Speakers:

- Peter Quattromani, Office of Rhode Island Governor Lincoln Almond
- Christine Ferguson, Director, RI Department of Human Services
- Sid Goldman, Greylawn Foods, RItECare Business Advisory Panel
- Sandra Ferretti, UnitedHealthcare of New England

(Additional information about the speakers appears at the end of this section.)

Transcript:

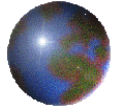
MS. HENNEBERRY: Now, to narrow our focus a little bit, we're going to shift and concentrate on one state. One of the pleasures of working with a state like Rhode Island is all of the experience they've had. They've been in this game for a long time. We've learned lots of lessons from them, and they're very generous in not only sharing their successes but some of the challenges that they have faced and how they're trying to overcome them. So we appreciate the fact that they're willing to talk about what's worked and perhaps some of the things that haven't worked. I'm going to turn this over, then, to the moderator for the Rhode Island panel, Peter Quattromani, who is the Health Policy Advisor to Governor Almond, and I'll let him introduce his colleagues.

MR. QUATTROMANI: Thank you. It's my pleasure to be here this morning to moderate on this panel that we've decided to call "Hindsight and Foresight: Lessons for Getting It RItE."

Our discussion this morning is going to focus on RItECare, which is the state's Medicaid managed care / SCHIP plan, as well as RItEShare, which is a premium assistance plan that we have unveiled over the last couple of months.

I'm going to begin by giving a little bit of a backdrop on some of the changes that occurred in the health insurance industry in Rhode Island over the last couple of years, which led Governor Almond to convene a Health Care Work Group to take a look at the issue, and I'll follow that brief presentation up with an introduction of my colleagues who will then give you some insight into the Rhode Island experience thus far.

Jumping right in, 1999 and 2000 saw significant changes in Rhode Island's health insurance market. Double digit increases were experienced by both small and large firms. As a result, low-wage workers were being priced out of the employer-sponsored market, because they were being forced to deal with the increased payments and, in some cases, deal with an increased percentage of the premium itself.



1999 and 2000 Saw Significant Changes in Rhode Island's Health Insurance Market

- Double digit increases in health insurance premium rates for small and large employer groups were seen for both 1999 and 2000 renewals.
- Employers were experiencing significant rate increases, especially small firms.
- Low-wage workers were being priced out of the employer sponsored health insurance market due to sharp increases in employee premium share requirements,
- Significant Health Plan and hospital losses occurred in 1999 and 2000.
- Two of the five operating Health Plans in Rhode Island left the Rhode Island market in January 2000, reducing competitive options.
- From November 1998 to January 2000, RItCare experienced a sharper increase in enrollment than predicted, from 75,000 to 100,000, straining the state budget.

At the same time, we had significant health plan and hospital losses. As a preface to this, I should have said earlier I'm not going to get into some of the reasons why these things may or may not have occurred. I'll let my colleagues handle those difficult questions later on.

In addition to those losses, or as a result of some of those losses, two of the five operating health plans in the state went out of business in January of 2000. Those two plans were Harvard Pilgrim Healthcare and Tufts, while the three remaining plans are UnitedHealthcare, Blue Cross/Blue Shield and Neighborhood Healthplan, which is not in the commercial market, but instead serves the slight majority of the RItCare enrollees.

With this marketplace as a backdrop, we saw some expansion in RItCare. From November '98 to January 2000, we had an increase in enrollment from 75 to 100,000 individuals. While some of this growth was expected and planned for, the magnitude of it was not, which resulted in some strain on the state budget.

As a strain on the state budget is often a catalyst for change, the governor decided to convene a health care workgroup. And we really wanted to reach out and come up with a comprehensive solution, so we got together with the House and Senate and developed a

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bipartisan, deliberative response to the challenges in the health care arena, and particularly the health insurance industry.

The goal that was established was, and I will read this: "All Rhode Islanders have quality health care in the most affordable, economical way. Health insurance will be the primary mechanism through which care is paid for by individuals and employers as well as by the state, using state and federal dollars. Such care will lead to maintained or improved health status of Rhode Islanders."

With this goal in mind, we found that it would be necessary to improve and support the employer-based health insurance market, especially low-wage workers and small employers who most at risk of uninsurance.

So as you can see, there were some really significant things going on that impacted not only government and the Medicaid program, but the business community and the health insurance community as well. For that reason, we have put together the panel that we have today, who represent each of those groups.

I will introduce them in the order in which they will present. First, to my far left is Christine Ferguson. She is the Director of the Department of Human Services and has been a key advisor to Governor Almond since he took office in 1995. Prior to her current role, she served under the late Senator John Chafee and was a principal architect of the Republican alternative to the Clinton health care reform bill.

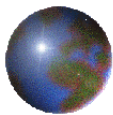
It's also my pleasure to introduce Sidney Goldman. Mr. Goldman is the President of Greylawn Foods, which is a Rhode Island-based warehouse distribution network for refrigerated foods serving the New England area. Greylawn has 46 employees who receive individual and family coverage through UnitedHealthcare. Mr. Goldman participates in the RItShare Business Advisory Committee, which has been instrumental in helping us as we continue to plan and roll out this process.

And last, but not least, Sandra Ferretti, who is the Manager of Medicaid Programs for UnitedHealthcare. United currently serves nearly 40 percent of all RItCare enrollees. Prior to her role as a manager of the Medicaid Programs, she oversaw the Quality Improvement Health Promotions and Credentialing Area for United.

And so with that, we'll turn things over to Christy.

MS. FERGUSON: What I thought I'd do is just a very brief overview and history of this program. This is a Medicaid managed care / SCHIP combined program.

We began it in 1994. The first slide shows the progression. This was very incremental reform. We went through a number of legislative and administrative expansions in coverage, mostly until 1997 all related to children.



Rite Care Expansion

8/94	Original Rite Care Waiver	1. Uninsured Pregnant/Postpartum women 185-250% FPL 2. Children under age 6 to 250% FPL 3. Uninsured Pregnant Postpartum women 250-350% FPL
5/96	Six & Seven Year Olds	4. Children ages 6 and 7 250% FPL
5/97	Welfare Reform: FIP and 8 to 18 Year Olds	<ul style="list-style-type: none"> • Children ages 8 and 18 250% FPL • Parent eligible for FIP cash assistance, previously ineligible for AFDC (no AFDC deprivation factor)
1/97	Home-Based Child Care	7. Home-Based Day Care Providers and dependents allowed to enroll in Rite Care
6/98	Extended MA lengthened to 18 months	8. Extended MA families (in effect parents. Since children would be eligible otherwise)
11/98	Low Income Parents	9. Parents of MA-eligible children, up to 185% FPL
1/99	Center Based Child Care Providers	10. Center Based Child Care Providers (subsidized coverage)
10/99	Alien Children	11. All children up to 250% FPL, without regard to alienage
10/99	18 year olds	12. Children age 18 covered to 19 th birthday
11/00	Foster Children	13. Foster children enrollment in Rite Care begins

In 1997, the legislature passed an increase in Medicaid eligibility. In other words, not putting people into the waiver, just basic 1931 Medicaid eligibility. And most of the people who came in in that expansion, whether or not they had employer-based coverage, came in between 15,000 and \$18,000 a year or 110 to 133 percent of poverty.

So when we talk about our adult expansion, we are talking about very low income families. When you look at and talk about crowd-out in terms of upper income levels, our experience was the bulk were in lower income levels.

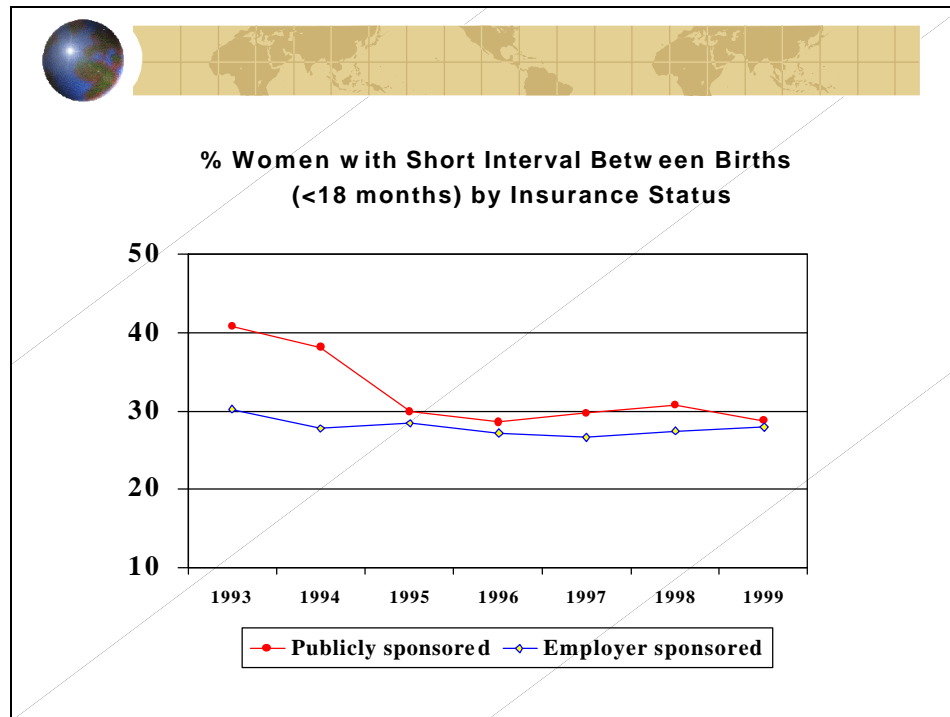
We also had some really significant health care outcomes, health status outcomes. And I'm just going to do two of them. The first one ... What we did was to compare, for publicly sponsored and employer-sponsored—people who got their insurance through their employer—the wait between births, which is an indicator of both maternal and child health. And you can see that with the inception of coverage through the publicly sponsored program—almost within the first 12 months—the gap between the two from a health status perspective closed almost entirely.

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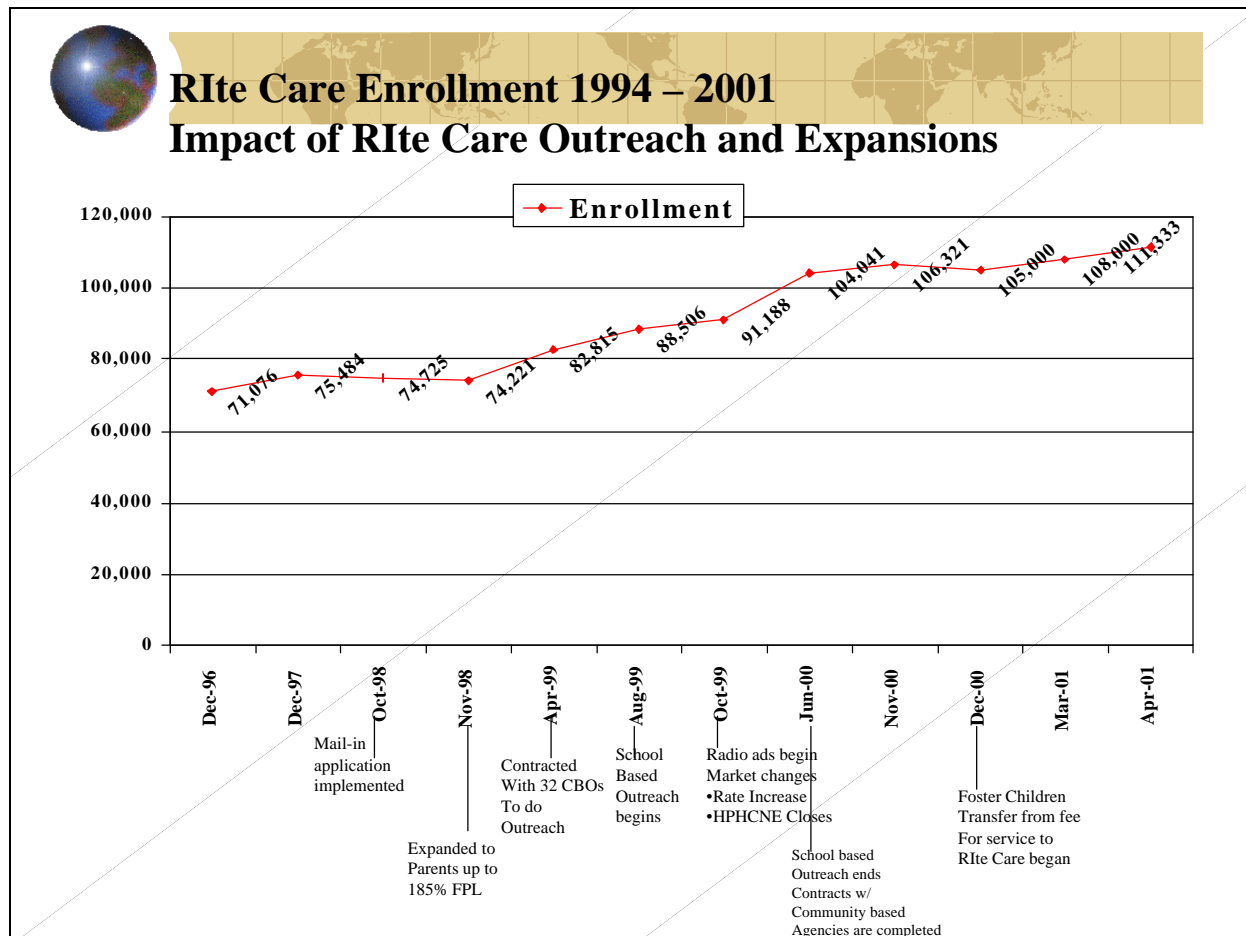
We have a chart that we're going to announce—we haven't announced it yet—that looks almost exactly the same for deaths of infants between a month and 12 months old, almost exactly the same. So we're not only seeing coverage. We're also seeing better outcomes, much better outcomes.

And we're seeing access, people accessing care the same way, whether they're middle, low, or poor families. We also saw our rate of uninsurance go from a high of 12.9 percent to 6.9 percent, making us number one in the country for health insurance coverage.

As Peter described, in 1999 and 2000, there was a convergence of a number of things. What happened for us last year is happening for everybody else this year—that is, enrollments were up, which we had anticipated, and in the work group that Peter talked about, that was one of the things we were looking at.

Rhode Island has a population of about a million people. 200,000 people fell into the income limits that were set by the legislature. So for adults and kids, about 200,000 people total could have become eligible at any time for RItCare. There were no crowd-out provisions that were significant. We had some affordability, but no waiting periods.

In addition to that, however, in late spring, we found that our estimates on the elderly and disabled portion of the Medicaid program—which is, in fact, almost 32 percent of the total population, but roughly 70 percent of the total cost of the program—that pharmaceutical expenses and other acute care expenses were skyrocketing, which everybody else is experiencing.



Now, we really experienced this growth then. So right at the time that the legislature was trying to come to closure on the budget, not only did we have the plan for increase in enrollment that we had to deal with, but we also had this huge bump in expenditures for the rest of the Medicaid program.

So everybody flipped out. They did. So what the initial reaction was, we have to do something, and the simplest thing to do is to cut eligibility. But nobody wanted to cut eligibility, really, so what they said was, okay, because this is the only part of the program you can really control, that medical expenditures, while we could manage them over time, really couldn't be immediate. You couldn't get any immediate gratification from it.

So what we did instead was to look at how to reduce eligibility without cutting it. And what we decided to do was to apply for a waiver to impose waiting periods, and also to, because at the time we thought there was a lot of crowd-out going on, to begin a premium assistance program.

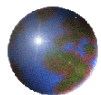
So, what happened with it? This is what happened with enrollment. And, again, we're a million-people population, so 100,000 is ten percent of our population, 111,000 is almost

12 percent. What we did was really great outreach. I mean we were the queens and kings of outreach in Rhode Island. We probably did better than anybody else in the country in terms of letting people know and getting people in.

We also got rid of face-to-face visits. We imposed mail-in applications. We did school-based outreach. We did radio ads. We were just awesome. And what happened was that, while we were doing that for kids, everything was fine, because, number one, they're cheap, and number two, we weren't having huge influxes. It was steady growth.

But when you add the adults in, where there is a lot of uninsurance and there are a lot of people who can't take up their employer-based coverage, and there are a lot of people who would prefer to go on a public program than pay anything, you had a much different scenario occur.

We believed that initially crowd-out was the big issue, and that's why we implemented a premium assistance program, put people back on their employer-based coverage, and also to impose waiting periods and everything else. But we also stopped outreach. The day we stopped outreach the caseload [growth rate] plummeted. We thought, oh, this is just an anomaly. Two months went by. Oh, this is just an anomaly. In the meantime, we have applied for a waiver to do all these really terrible—depending on how you look at it—eligibility restrictions, and we're not getting the waiver, we're not getting the waiver, we're not getting the waiver—for very good reasons from their perspective, from our perspective not so good.



In Hindsight: Rite Care Enrollment Growth

- Was crowd-out a major contributor?
- On July 1, 2000, we ended incentive based outreach contracts with 32 community agencies
- We submitted waivers for waiting periods, cost-sharing and a premium assistance program not approved
- Enrollment growth plummeted anyway
- Enrollment growth was probably due to a combination of events occurring simultaneously, and not primarily due to crowd-out

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But all of a sudden, it's nine months later, and the enrollment [growth] never went back up. So, was crowd-out the major contributor? I don't know. Was it crowd-out? Was it outreach? I think it probably was a combination of those two things. The reality is that our enrollment is still way, way down, compared to what we were experiencing in the previous couple years, and we still have not implemented any cut.

So, in other words, if all we had done was stop outreach, we would have had no caseload problem this year, none. So we are in the midst of, however, implementing this very complicated and, I believe, very important program called Premium Assistance Program, which we should have done when we expanded to adults, because here's the bottom line.

This is our worst, worst case scenario—95 percent of our businesses are under 100 in Rhode Island—so this is our worst, worst case scenario. 120 employees. Over the past two years, about 40 people, 40 of their folks, have gone over to our managed care program, even though they were paying the employer share for those people two years ago. They haven't been for two years. We're coming back in and saying, you know, what we're going to do is make it possible for these people to continue to pick up employer-based coverage.

Everybody says fine until the accountant looks at the bottom line. And here's the bottom line. It's going to cost them about \$250,000 a year in addition to what they're paying, and the reason is because they basically had \$250,000 a year windfall for two years. They didn't have to pay it. They were paying it before. They didn't have to pay it for two years. We're not going to ask them to recoup the money, but going forward, they haven't budgeted in \$250,000. This is a small business. That's a lot of money.

So it's a big problem to implement something incrementally, miss a very important concept, and then try to implement that concept later. The good news is that that's our worst, worst case scenario. So it's not happening all over the place, but it is certainly affecting the rate at which businesses are coming in.

So our lessons learned? Our lessons learned are that expanding coverage really can both improve health status and the health of the population, that low and middle income families use health care the same way. They access health care. They make the same kinds of decisions. There is no a dramatic difference. And that health status, as I said, will improve.

We learned—just to file away—you can only do this well if you also have the ability to take back risk, which is why I think a lot of small group purchasing entities can't make this happen, because you can't negotiate with an insurance company if they're the ones that are taking 100 percent of the risk because they're always going to price it higher than what you think the risk might be. You can only experiment with new benefits or different benefit structures if you can take back risk and do some sort of stop loss.

The administration-budget kind of things that we learned, kids are not a problem with fast enrollments. It's when you get to the adults that the problems begin. Never implement an increase in expansion under the regular Medicaid program if you can do it with a waiver.

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[Laughter.]

MS. FERGUSON: And don't do it unless you have a premium assistance program, because the fact of the matter is, you have to have a relationship with a private market. Otherwise, even if it's just ten percent of the population going from one to the other, which is not a big deal, you're always going to have somebody who stands up in front of the legislature and says, this bum next door decided to go on to the public program instead of paying his \$100 to— instead of staying in the employer-based program, and that's not fair.

So if it's only one person, it's a problem. So put a premium assistance program in place, have the state subsidize the employee's share, if you're worried about low-income families, and have a joint program, do the wraparounds. It's not hard. Technically it's difficult, but conceptually it's not hard to put this together. You've got to have people who can technically make it work, but the reality is that it's not a hard thing to do, and you can do it, and you should.

You have to have good data. If you don't have good data, you can't show anything. You can't show what your insurance was. You can't show whether your health status improved. You can't show anything except that you spent a lot of money, and that's not a good thing unless you have something to show for it. So you really have to have good data. You have to be able to analyze utilization trends and everything else.

You have to be able to negotiate effectively with your health plans. And you're going to be constantly adjusting your program. So the legislature might think, well, we fixed this last year. Guess what. We're going to fix it again this year, and guess what, we're going to fix it again the year after that. And when I'm dead, they'll still be fixing this, because it's always going to change. The economic conditions always change. What's happening with health plans changes. Technology changes, and you just have to get used to the fact that it's not going to be the same year after year.

Your staff has to get used to it. Everybody has to get used to it. It's going to change. HCFA doesn't have to be the enemy. Sometimes they have good reasons for what they do. And you should really try to understand their rationale and work around it. Timing is everything. If you start an administrative change like elimination of face-to-face visits or application simplification, you might think it's done, but it doesn't get done for two or three years after that, because that's the way the bureaucracy works and the systems changes work.

So you may be implementing an expansion in programs and be tired of talking about the simplification efforts that you did, but guess what, they're happening at the same time. That's going to affect your caseloads and your budgets. An assumption is not a guarantee. So you make the best assumptions you can, but everybody has to understand that there is not a guarantee that this is what's going to happen next year.

So in hindsight, what I would say is, last year was miserable. I never want to go through it again. But we will. We will go through it again because the programs are changing. The employer community and the health plan community in Rhode Island have been really terrific to

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work with. We've really tried to work some of these problems out, but they keep on cropping up. And I think that the fact that we've gone from 12.9 percent to 6.9 percent uninsured in the state tells me that, even if a little bit of crowd-out was going on, it's addressable, number one, without doing anything draconian, and, number two, that might not be as important as the fact that we have fewer children in the neonatal intensive care unit in Providence. We have fewer kids with lead poisoning going into kindergarten, and we have fewer kids with developmental disabilities who haven't been dealt with, screened or seen prior to going into kindergarten.

So if you look at the system-wide issues, what's happened to the education budget, what's happening to the health care budgets, what's happening in the hospitals, the reality is that now everybody knows what they're getting paid for. They may not like it, but at least they know. And we have a better possibility of having children leave high school graduated and the appropriate levels because both them and their parents are covered. So thank you very much and we'll answer questions at the end.

MR. GOLDMAN: Good morning. I'm probably one of the only individuals in the room that doesn't come from the health care field, I believe. However, just to give you a very quick background, several years ago, the state of Rhode Island in 1990 went into a problem with workmen's comp. We were looking at 155 percent increase in insurance rates.

At that time, I was very fortunate to get together with a number of small businessmen, and we formed a self-insurance group that, not only did we not have the 155 percent, we were able to reduce rates by 60 percent in our state. The reason I mention this, this led to this group of business people then looking at health care, saying if we can do this in workmen's comp, we can do it in health care.

Well, we thought we did. We came somewhat around where we found that by putting into interventions within our group of employees, we actually reduced costs. It brings to me my topic of is health care a right or a benefit for the employees?

All individuals—this group of businessmen that I belong to believes that all individuals/families should have access to affordable health insurance. What we're being faced with today is making sure that our employees have affordable health care. The problem that we're being faced with, as Christy so well pointed out, we faced double-digit increases last year. When you start to see that your employees, even if they're making, let's say between 30 and \$40,000 a year, are now still contributing 15 to 20 percent of their gross income for health care—it's a very large amount.

The other factor that's coming into play this year with a number of people is they're looking at energy costs, and they're really not sure where it's going to impact them. I'm sure every one of us has gone to the gas pump, fueled your car and said, what's the tradeoff here?

We as the business community feel that the employers can no longer really afford health care. We're into the small employer, as I mentioned to the gentleman who spoke prior, you're

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involved with COBRA, you're involved with HIPPA, the Family Medical Leave Act. The small employer can't handle this.

This is why it's so important that we band together, do something for our employees. In the absence of that, that's why I got involved with the RiteShare program. The RiteShare in Rhode Island, the business community feels will work. It's been two years that I've sat in meetings. I've spent this last year, every couple of weeks, in meetings, and understanding.

And one of the other issues that was brought up by a young lady in the back, one of the other speakers—you have two people working together, one person is paying for health care, one person is not paying for health care. And yet getting the same benefit or possibly an even richer program than what the employer is offering. This presents problems.

This is why, in answer to your question, this is why I'm here, I'm looking for the fact that, hopefully, the state of Rhode Island being a very small state and a beautiful state to do a study on could actually bring about a health care situation whereby the state is in control. They're the largest purchaser of health care in the state of Rhode Island.

One third of our state budget goes to human services. I'm ahead of myself. Excuse me. One of the problems that we're faced with, however, especially in my case with some of my employees, and this was also mentioned. You're getting into the family level to discuss what earning capacities are, what people are able to do, where they're going.

Someone who has contributed to health care and employers that have provided health care to their members, it's very difficult for them to go to an assistance program. You got a very proud workforce. The overall situation is, though, they're now saying, I can no longer afford health care. In my own company, what I'm seeing is, I'll take the employer-sponsored health care, I'm dropping the family coverage. That is when we'll start to get into trouble. That's the problem.

The group of individuals that I belong to feel firmly for our employees. We want to make sure that we have the most, the best, but also the most affordable health care for our employees, and we're hoping that the RiteShare program that we're bringing into Rhode Island will still keep the level that we've been able to attain to this point at that level.

Thank you very much.

MS. FERRETTI: Good morning. I'm Sandy Ferretti. I'm from UnitedHealthcare, and probably, with Kathlyn, one of the few health plan representatives at this conference. I wanted to first give you a quick highlight about UnitedHealthcare and put UnitedHealthcare in its context outside of Rhode Island.

We serve 8.4 million members in over 40 health plans across the country, so many of you from other states are probably familiar with the name UnitedHealthcare. As it relates to the Medicaid and SCHIP programs, we serve about 630,000 members across 14 states and including the District of Columbia.

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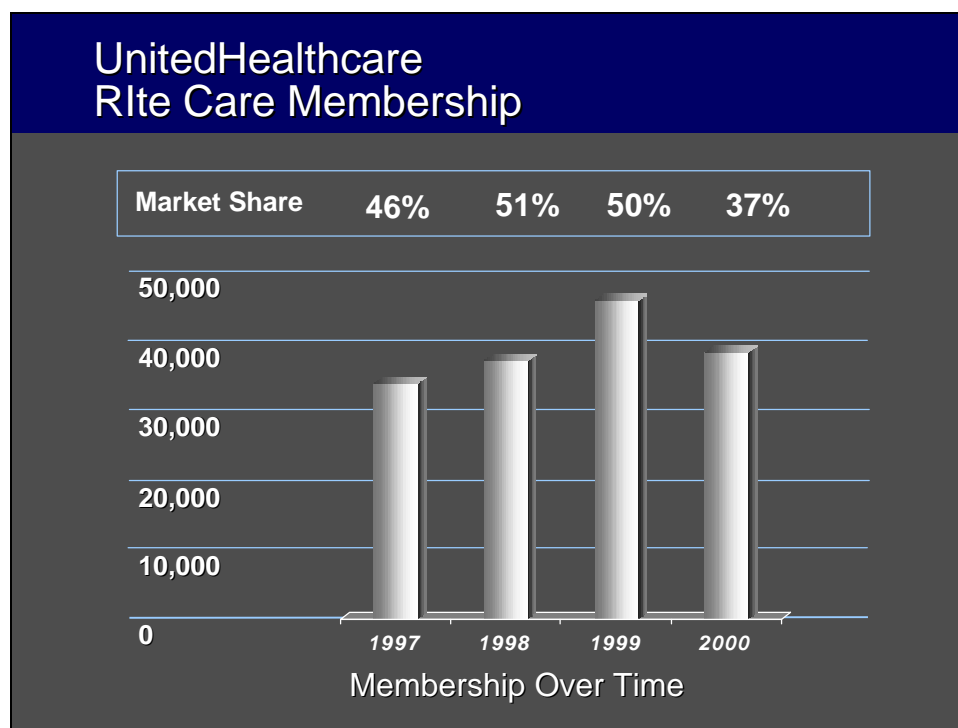
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To turn towards UnitedHealthcare of New England, we've been a participant in the RiteCare program since its inception. I've personally been with UnitedHealthcare about five years, and I have seen enormous amounts of change, both internal to the company and in our health care market in Rhode Island, as I think you've heard talked about.

But the one thing I can say that has been consistent throughout that time about UnitedHealthcare of New England has been its continued commitment to the RiteCare program and to making a managed care program for the Medicaid population work. We think it brings the best access to care for that population, among other benefits. It enables them to access the same types of care and the same level of care that commercial members receive.

We've maintained close to 50 percent of the RiteCare eligibles throughout our participation in the program, although that is down somewhat today. Today, we have about 38,000 members in the program.



If we look at our trend in membership, this slide illustrates the trend for over four years, where we've maintained about 50 percent of the market share. The notable bump in enrollment in 1999 relates to the expansion that we've been talking about this morning, and you'll notice what happened in 2000. We noticed at the end of 1999 some changes in what was happening in our commercial insurance. We're approaching the crowd-out discussion here in terms of what our personal plan experience was and what we were able to identify.

But as a result, in October of 1999, we closed to new members, and our rationale for that at that point was really two-pronged. First was the crowd-out phenomenon. We found that

persons under 185 percent of the poverty level didn't have a waiting period to enroll in RItCare after they dropped their employer-sponsored insurance. And as we looked at the year of 1999—and this is in October when we're making that decision—we had already experienced 4,200 disenrollments from commercial products across 630 different employer groups that resulted in reenrollments into UnitedHealthcare's RItCare program.

OCT '99: Closing to New Members

- Crowd-out phenomenon
 - ◆ Persons under 185% of the FPL experienced no "waiting period" to enroll in RItCare after dropping ESI
 - ◆ In 1999, 4,228 disenrollments from 630 employer groups with re-enrollments into RItCare
- RItCare reimbursement vs. Cost Trend
 - ◆ Less financially viable product

So we were seeing a shift from commercial enrollment directly into RItCare, and those were the people we were able to capture, the ones that we could identify, because certainly they could drop their commercial coverage with UnitedHealthcare and enter into one of the other plans available under RItCare. So we knew that this was an estimate and somewhat of an understatement, potentially, of what was occurring.

Clearly, in most cases when you look at the commercial marketplace and the RItCare marketplace, we would much rather have folks in employer-sponsored insurance, as RItCare reimbursement compared with the cost makes RItCare less financially viable for health plans than commercial products.

If we can look, I want to give you some further information. Tricia mentioned that this was of particular interest to this group. This slide shows some of the data that we collected to demonstrate what was happening to us from a business standpoint. All of these disenrollments occurred in the year of 1999. The 1998 data reflects when they first joined our commercial product. So, all 4,200 were really folks who disenrolled during 1999. And you can certainly see a difference. I think the key point here is that the folks that had no waiting period from dropping

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employer-sponsored insurance and going directly into the RItCare program were the most likely to make that shift and move to RItCare.

UnitedHealthCare "Crowd-out" Study				
	1998		1999	
	< 4 mo	> 4 mo	< 4 mo	> 4 mo
RItCare Members up to 185% of FPL	1,361	530	2,143	0
RItCare Members 185% - 250% of FPL	55	30	24	0
	<u>1,416</u>	<u>560</u>	<u>2,252</u>	<u>0</u>

83% of Voluntary Terminations were from <185% FPL within 4 months of Commercial disenrollment

So we felt that some sort of policy change was needed in order to stem the tide and to get better balance in the commercial market. And due to this pattern, as well as the financial viability of the RItCare program itself in terms of our business operations, we felt that we needed to close to new enrollment, and that's why you see that drop in 2000. We have steadily declined our enrollment based on the typical types of churning that you experience in a Medicaid program.

If we can move on to collaborating, what I really wanted to emphasize today is how the state has partnered, truly partnered, I believe, with health plans, and with the business community, to really create a RItShare premium assistance program that will work and will be effective. And I wanted to provide some examples of ways that they have listened to us to make the point and encourage states to work closely with health plans.

UnitedHealthcare participated heavily in all of the small group reform legislation. That wasn't something that I was personally involved with. I heard about lots of very, very long meetings. But they really had the goal of rate stabilization in the small group market as well as closing this window of opportunity to drop out of employer-sponsored coverage.

As they went to design the premium assistance program, I think Tricia and others have made very clear to the health plans and to the community that's been participating in the development of this program that they do not want to disrupt the commercial marketplace. Everything that they have done has been deliberately and carefully planned so as not to disrupt

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how the commercial market operates in Rhode Island, as well as not creating complicated systems that create more difficulties and more barriers both for employers and for health plans in actually administering their programs.

So they wanted to keep business processes similar to how the commercial insurance market works in order to help make the program successful, and I think that some of those guiding principles that they set out will really help make the program successful in the long run.

And one example of the type of things that the health plan has been able to influence is medical assistance being a qualifying event to enable someone to participate in employer sponsored insurance. Typically, in the commercial world, if you want to join in employer's plan, you get a once a year opportunity to join that employer's plan unless you have a baby or divorce or what we call "qualifying events." So we wanted to be sure that qualification for medical assistance would be a qualifying event to enable someone to enroll in our employer-sponsored coverage.

Another key example—I'll just highlight one other—is the RItCare program emphasizes a gatekeeper in a primary care model. And the commercial insurance market in Rhode Island and many other places has moved much more to an open access model. The initial thought about how to implement RItShare was that it would be with a RItCare-type of model with regard to the types of health plans that would be qualified to participate in Rite Share. We said to the state, you're not going to find very many employers that offer a health plan that has a gatekeeper product. That's not what we sell. That's not what employers want, and so you're going to have a tough time with that, and they listened to us with regard to that.

I wanted to hit quickly on what I think some of the risks are, at least as we stand today with the RItShare implementation. Currently, there is little incentive for employers to participate. This is a greater administrative burden. They are paying more premiums for more folks, et cetera. The state is getting back into the business of performing benefits and claims administration, which they had truly tried to remove themselves from with the implementation of a managed care program. And I think there are some risks inherent in that. I think another risk is the potential for unexpected or unanticipated enrollment growth as people—the low-income workers who have struggled and pained to participate in their employer-sponsored insurance—now have the opportunity and the option to opt into a state-subsidized program.

One anecdotal item that I'll share with you that suggests that unexpected growth might occur is that one of the other health plans did a presentation to their customer-service folks, and in explaining what the RItShare program was, the folks all took it from the viewpoint of, "Well, are we going to participate in RItShare and when I can sign up," because they thought this was such a great opportunity.

So I think there is a lot of unmet demand out there that could impact the program. And the other risk is that the benefits in RItShare are more rich than standard commercial benefits in that you're going to have two employees sitting next to each other who experience different benefits.

But I think some of the rewards of moving forward with this type of program are that it's a cost-effective mechanism to provide insurance to the uninsured and underinsured, that we're going to be able to enroll children and families who are not otherwise captured in public assistance programs, and it continues the mainstreaming concept that we've put forward in Rhode Island for moving public assistance folks into the mainstream of medical care and how they obtain medical care.

Rewards: RItE Share Implementation

- Cost effective mechanism to provide insurance to uninsured and underinsured
- Enroll children and families not otherwise captured
- Continues the "mainstreaming" concept for public Medical Assistance

And finally, who are the "winners and losers," if you will, with the way we've set up the RItEShare program? I think the state wins clearly in the cost savings that they're able to achieve, as well as coverage for folks. Obviously, medical-assistance-eligible persons benefit. Physicians, hospitals and providers win because they get commercial reimbursements, whereas if these eligible people went on RItECare, they would receive the state or the Medicaid payments. And health plans obviously win because we get our commercial premiums instead of RItECare premiums. And I think to some degree employers can win, but I think that's a little more limited and difficult to argue and I therefore didn't put them up on the slide.

[Laughter.]

MS. FERRETTI: I'm happy to take questions as I'm sure everyone is on the panel.

MS. FERGUSON: Any questions about our words?

AUDIENCE PARTICIPANT: Any sense about what was the risk profile of the 600 businesses that moved and the risk profile of the people who moved? Were the riskier

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businesses more likely to move from private to public coverage and were the riskier employees more likely to move?

MS. FERRETTI: We weren't necessarily seeing employers dropping coverage and telling their employees, hey, you can go visit the state. This is more on an individual basis, a recognition that individual employees have the ability to do this. I think there were some other dynamics in the market with some small groups and things, but I think that, when looking at the fact that this occurred over across 630 different employer groups, that this was really occurring on a widespread basis and not employer by employer.

MS. FERGUSON: It was one or two employees in each business. Now, we have some difference of opinion about whether the data is absolute. In other words, how much of it might have happened because of churning, because of losing jobs, because of moving jobs. So we don't entirely agree that, especially based on our experience after we dropped outreach, we don't entirely agree that that level of crowd-out was really going on. We think there may have been some other things happening.

So we still have a difference of opinion about that. And we will continue to until the end of time. It will never be resolved. There will be no way of solving it. But what we do know, we do know sort of aggregate data across the state in terms of what's happened with insurance and uninsurance. We have not seen in the people who are enrolling an increased risk profile. So in other words, we're not seeing adverse selection. We're not seeing people coming in to the RItCare program because they're sicker. We're looking at utilization patterns and all of those kinds of things across the board, and that doesn't appear to be a primary issue.

AUDIENCE PARTICIPANT: Christy, how are you dealing with the wrap benefits and what portion of benefits are you finding you need to wrap and are there—in our state, \$1,000 deductible plans are very popular in our small employer community—are those just off the table for participation?

MS. FERGUSON: Yes.

AUDIENCE PARTICIPANT: And if they are, can you talk about how much wrap you've had to do on benefits?

MS. FERGUSON: We're really fortunate in Rhode Island in some ways because we have a small number of plans in the market, especially since we lost two, since Harvard Pilgrim decided to go, you know. So it's good and bad. But they offer pretty much, pretty rich—compared to other parts of the country—very rich benefits, low deductibles, basically a PPO that's really fee-for-service, but you only have to pay \$10 for—it's really indemnity, but it's a very labor-oriented state so the benefits are pretty broad.

The wrap benefits, we decided—and people have very different opinions about this. We're looking at it more from the impact on the system as a whole, as I said, the impact on education, the impact on all of these other pieces. And we view it as a way of getting Medicaid

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dollars into help with the wraparound services. So the EPSDT services and all of those kinds of things that people think of as rich in terms of actual benefits, we think there is a reason to do, and we want to do them. So we made a conscious decision to wrap all those benefits and not to ask for waivers about them or anything else. The cost of that is minuscule. When you look at it as a portion of our premium, it's less than a dollar or two dollars a month, as I recall. No?

MS. FERRETTI: That's the services that are between our in-plan RiteCare benefits—

MS. FERGUSON: And out of plan RiteCare. It's not a huge amount of money in terms of percentage of premium, and we can get that to you. The issue is, when people say rich, what they mean is copays. They don't really care about transportation and all those other things. They're talking about copays because you've got two workers side by side. One is paying ten bucks when they go to the doctor and the other one, the doctor bills us for the ten dollars. Okay. So the doctor is ticked and the person is ticked. The person that has to pay the \$10 is ticked. So that's really the issue when people talk about richer benefits, and we've been going back and forth with the business community about the fact that, well, if they're on RiteShare, then they get better benefits than the person sitting next to them, but if we didn't do anything, it would have been on RiteCare and they would have gotten better benefits.

So ultimately what we will do is, everybody will have to pay a percentage of premium toward their cost so it will be sliding scale, percentage of premium, each individual, so you will have people in the same company potentially contributing different levels, but it will be based on income. And ultimately I'd like to get away from the wraparound copays and instead charge it up front with premium levels just because I think that that's a better way to do it.

But that's kind of where we are. The wrap has not been—I mean it's complicated for the staff to do, but it's not that complicated to conceptualize or explain.

MR. CURTIS: We need to wrap up and get over to lunch so we can get you back here in time to talk with Mark McClellan from the White House. It was a wonderful panel.

There are several people in the room that would want me to mention the following, I believe. Rhode Island is in the fortunate position of having the ability to self-administer a wrap as an extension of its Medicaid fee-for-service program capacity. In a number of state SCHIP-only plans, where they don't have any fee-for-service capacity, it's a far more difficult issue. I think you'll probably hear something about that in some later panels. Christy gets the quote of the day. I'll refer to that during the wrap-up.

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About the Speakers:

Peter Quattromani currently serves as a Policy Advisor to Rhode Island Governor Lincoln Almond on the issues of health care, welfare, early childhood, senior citizens, disabilities, mental health, and substance abuse. He has served in the Governor's Office since 1998. Prior to working in the Governor's Office, Mr. Quattromani was an associate with The Futures Health Group, a firm specializing in new business development and management consulting for organizations within the health care and human services arena. Mr. Quattromani received a Bachelor's degree from Tufts University and a Master's degree in Business Administration from the Carroll Graduate School of Management at Boston College.

Christine C. Ferguson, director of the Rhode Island Department of Human Services, has served the highest levels of state and federal government with honor and distinction, for more than two decades. As head of the agency which consists of 1/3 of the State's budget - for critical services for veterans, elderly, low-income families, children and the disabled - Ferguson has been applauded as a national leader in health care and human services policy, earning more than a few prestigious awards. As a key advisor to Governor Lincoln Almond, R-RI, she has spearheaded reform in health insurance, welfare, child care, information systems and management, and made the 'Ocean State' a model for others to follow.

Her negotiation skills led to the restructuring of the faltering Rhode Island Medicaid managed care program – Rite Care – and gained vital health care coverage for more than 100,000 citizens. They also led to the successful bipartisan effort resulting in Health Reform RI 2000. She also helped create the first, formal collaboration of New England states on the issue of Medicare/Medicaid waivers. Ferguson was able to bring Democrats and Republicans together to craft a successful welfare reform law shifting the emphasis to work supports in the form of wage subsidies, child care and health insurance for low-income families. She also helped develop the groundbreaking Starting Rite program, to improve access and affordability to quality child care and early education for our children. As an administrator and a parent, she understood the urgency of having youngsters prepared to enter school, and required outcome measurements for the support of early childhood programs. She also created a system to help at-risk 3- and 4-year-olds through formal cooperation among school, Head Start child care providers and home. Ferguson has been cited by the U.S. Association of Retarded Citizens, *Working Mother* magazine, the *National Law Journal*, the American Society for Public Administration – R.I. Chapter, and the National Association of Community Health Centers, for her excellence in service.

On the national level, Ferguson was hailed as a "profile in courage," by David S. Broder and Haynes Johnson, authors of The System, who studied efforts towards health care reform. As counsel and deputy chief-of-staff to the late U.S. Senator John H. Chafee - whom she served for 13 years - Ferguson was the principal architect of the leading Republican and later "Mainstream Coalition" alternatives to the Clinton Health Care Reform bill. She was lead staff person and facilitated sensitive negotiations among the "Mainstream Coalition," a group of 25 Democrat and

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Republican senators. She consistently earned a place in the nation's Most Influential Health Policymakers list, by Faulkner & Gray, for her sterling reputation in health care policy.

Ferguson holds a Juris Doctorate degree (American University, 1986,) a Bachelor of Arts degree (University of Michigan, 1980,) and is a graduate of The Lincoln School in Providence, RI. She is a resident of Jamestown, RI, and is married to Fred Glomb. They are the parents of eight-year-old, Gregory.

Sandra H. Ferretti. Ms. Ferretti has been involved in health care management for the past 10 years, both on the "delivery side" and "managed care side" of health care. Ms. Ferretti received her Master's Degree in Health Services Administration from the University of Michigan School of Public Health in 1991, and her Bachelor's Degree from Northwestern University in 1989. Ms. Ferretti's early career was at the Oakwood Healthcare System as an Associate Administrator responsible for Medical Staff Affairs and Quality Improvement. Oakwood is a multi-hospital integrated delivery system with six medical staffs. Upon moving to the East Coast, Ms. Ferretti joined UnitedHealthcare as a consultant, specifically to assist the New England Plan with preparations for its first NCQA site visit. In July of 1996, she joined UnitedHealthcare full time, overseeing Quality Improvement, Health Promotion, and Credentialing. In September of 2000, Ms. Ferretti became the Manager, Medicaid Programs for UnitedHealthcare.

Sidney Goldman is President of Greylawn Foods a Rhode Island-based warehouse distribution network for refrigerated foods, serving the New England region. Greylawn has 46 employees, and offers individual and family coverage to its employees through United HealthCare of New England. Greylawn is one of the first businesses to participate in RItte Share, Rhode Island's combined SCHIP/ Medicaid premium assistance program. Since October 2000, Mr. Goldman has participated on the RItte Share Business Advisory Committee, an advisory group of 19 business leaders, which has advised the state on the development of RItte Share. Mr. Goldman has extensive experience in the area of employee health insurance. He is currently the Vice President of BIRMA, which was formerly the largest self insured workman's compensation group in Rhode Island, and now operates as a safety group. Formerly, Mr. Goldman served as President of TEAMA, a group of Rhode Island businesses which worked together to jointly purchase the best health insurance product at a reasonable price for their employees. Not only did TEAMA negotiate the purchase of health insurance as a group, but it also offered programs to reduce employee risk.