

Improving Access to Health Care

A Policy White Paper Outlining Short-Term, Practical Strategies for Improving Health Care Access for Residents of Washington State

Prepared by:

Lance Heineccius
Health Services Consulting

March 6, 2000

CONTENTS

Introduction and Purpose	1
Strategy 1 – Initiative to Expand the Basic Health Plan	2
Strategy 2 – Universal Maternity Insurance	3
Strategy 3 – Guaranteed Children's Coverage	4
Strategy 4 – Universal Prescription Drug Stoploss	5
Strategy 5 – Leverage Federal Funds	6
Strategy 6 – Create a Package of Pilots	7
Implementation Options	8
Appendix A – Detailed Discussion of Recommended Strategies	
Appendix B – Summary of Other Potential Ideas	
Appendix C – Acknowledgements	

Introduction and Purpose

This white paper was prepared for the Economic Opportunity Institute (EOI) to explore practical and short-term approaches to expanding health care access in Washington state. There are a number of serious problems with health insurance which combine to leave an increasing number of people without coverage for needed health services. EOI convened a health policy brainstorming session on October 11, 1999 to discuss practical and incremental approaches to expanding health care access in Washington state in the near future (please see Appendix C for a list of participants). More than two dozen potential ideas for short-term improvements were identified and discussed at the meeting, and the ideas have subsequently been analyzed to form the basis for this paper. The EOI believes that all ideas identified at the brainstorming session were creative and useful, but given available resources it is necessary to prioritize those that EOI can pursue at this time. The underlying philosophy of the paper is that it is preferable to successfully pursue a smaller number of concrete strategies than to attempt to address an unmanageably large number of policy initiatives.

The purpose of this white paper is to present a description of practical, incremental ideas that can then lead to public or private actions to expand health care coverage. The paper does not include recommendations for comprehensive, long-range reform of the current health care system, in Washington or nationally. While many policy experts believe that comprehensive, fundamental reform is likely to be the only way the related problems of rising costs and dwindling access to care can be successfully addressed in the long term, EOI (and many experts) recognize that the timing may not be right to initiate comprehensive reform. Rather, the goal of this white paper is to identify, and then pursue, a manageable number of short-term activities that can lead to concrete, if incremental, improvements in health care access. As a result, this paper focuses on short-term, partial "fixes" to the current crisis that can at least help more people get access to care in the near future.

This paper is organized into three parts. The first part – the main body of the report – summarizes six recommended, high priority strategies that health policy experts identified as having the most potential to lead to improvement in the short-term. The criteria used to make the selection of these strategies included expanding access to health care services, being achievable or "winnable" politically, being sustainable over time, and other factors including being simple to explain, implement, and administer. The final section of the first part outlines potential mechanisms by which the priority strategies can be implemented.

The second major part of the paper – Appendix A – presents a detailed examination of the six recommended strategies, including a discussion of the major open issues to be resolved for each strategy and a listing of the major advantages and challenges for each strategy. The third major part of the paper – Appendix B – presents a brief synopsis of the other ideas identified by the brain-storming group as potential approaches to improving access to care. Even though these other ideas were not selected by the EOI as options to pursue at present, they do represent a wide array of other strategies that could be adopted to improve access or help finance health insurance. These ideas are included to encourage other organizations to consider their viability. Improving access to needed health services is a key policy objective of EOI, and the following pages outline six high priority strategies for achieving this goal.

Strategy 1: An Initiative to Expand the Basic Health Plan

The number of uninsured persons in Washington state has remained fairly constant over the past decade at around half a million people, despite the presence of the Basic Health Plan (BHP). The BHP was implemented to offer managed care coverage to persons below roughly 60 percent of the median income (200 percent of the Federal Poverty Level, or FPL) using an income-based sliding scale for premiums. Currently, the BHP covers approximately 130,000 persons. While enrollment up to 200,000 is authorized by current statute, the BHP has never been adequately funded to achieve this level of enrollment. This strategy would create an initiative to the people to increase tobacco taxes and use the revenue to expand enrollment in the BHP and extend eligibility for BHP coverage to persons below 80 percent of the median income (275% of the FPL). This idea has been developed previously by the Economic Opportunity Institute. The initiative would require an additional tax on cigarettes of 50 cents per pack, with all revenues applied to expanding enrollment in the BHP. Expected tax revenues would be about \$230 million per biennium, estimated to cover the costs of adding about 70,000 persons to the BHP and reducing the number of uninsured in Washington state to under ten percent.

Three operational and policy issues need to be resolved in pursuing an initiative to expand the Basic Health Plan, as discussed in detail in Appendix A and summarized below:

- The timing may help or hinder passage of the BHP expansion initiative.
- It may be difficult to get enough signatures to qualify the initiative for the 2000 ballot.
- The measure may be too modest in scope. It does nothing to correct the many problems underlying the current managed care health system.

The **main advantages** identified for a BHP expansion initiative at this time are as follows:

- Straight-forward expansion of basic health insurance coverage to a larger number of people through an existing state program. Initial polling results are quite supportive.
- Would give improved financial access to care for an estimated 70,000 additional persons.
- Initiative language is close to final draft. Support infrastructure for funding and to gather the required signatures can be catalyzed in a short period of time.
- Broad-based support among many public interest and health-related organizations.

The **main challenges** to expanding BHP enrollment via this type of initiative are:

- Does little to shore up the ongoing viability of the BHP, where health plan losses have caused discontinued plan participation and higher premiums for those plans that remain.
- Does not address the underlying problems in the health insurance market, which has eliminated the unsubsidized BHP program and restricted enrollment in individual plans.
- The tobacco industry would spend a considerable amount of money attempting to defeat this initiative. This may be a campaign advantage if it becomes widely advertised.

Strategy 2: Universal Maternity Coverage

This strategy would create separate universal insurance coverage for maternity for pregnant women in Washington. The insurance will cover pre-natal, delivery, and post-partum care for mother and newborn. Universal coverage can be achieved in two ways: 1) as a total replacement product for all current maternity coverage; or 2) as a separate coverage option for those not covered by other insurance. There are strengths and weaknesses of either approach, as discussed in Appendix A. In either case, the goal of the program would be to achieve universal coverage for maternity care through a state-authorized and partly subsidized program, administered either by the state or by existing insurance carrier(s).

Eight operational and policy issues will need to be resolved in fully developing the universal maternity coverage strategy, as discussed in Appendix A and summarized as follows:

- Term of enrollment (encourage women to enroll as soon as they become pregnant).
- Is this "universal maternity coverage" mandated for individuals, or voluntary?
- How does this coverage relate to health plan pre-existing condition exclusion limits
- Whether family planning services should be included in this program.
- Whether the program would include coverage of fertility treatments.
- Concerns that in a monopsony situation, payments may not cover actual provider costs.
- Retaining existing funding commitments for maternity from current insurance programs.
- Will this program lead to in-migration of non-residents to have their babies here?

The **main advantages** identified for a universal maternity insurance program are as follows:

- Has the potential to affect a large number of women, if the new individual and small group insurance pre-existing condition exclusion of nine months is applied to pregnancy.
- Does not require radical or rapid change to current insurance. Can supplement existing maternity coverage in other plans, using First Steps to cover the uninsured.
- Simple to explain and initially implement; may be simple to administer if done as a supplement for the individual and small group insurance markets only.
- May be politically attractive ("winnable") with the electorate and the Legislature, but polling is needed to verify this. Care for pregnant women has traditionally had popular support, and the initiative could use the First Steps program as a model.
- Can be combined with the third strategy (see next page) to cover mothers and children.

The **main challenges** for successfully implementing this type of program are as follows:

- Not sustainable over time unless maternity benefits for group insurance are continued.
- Self-funded employers and other purchasers may discontinue maternity coverage over time, thus shifting the costs of maternity to employees, the State, or both.
- May be redundant, since most pregnancies are already covered by current insurance.

Strategy 3: Guaranteed Children's Coverage

Virtually all children in Washington are either covered by insurance or eligible for coverage through public programs. Some parents, however, hesitate to seek needed primary care or preventive services for their children due to concerns about the out-of-pocket cost or lack of knowledge that their children are covered. This strategy would change the mind-set of parents and health care providers by guaranteeing that all health care for children in Washington will be covered. This will ensure that all children can get access to care and preventive services, with a new children's program administrative mechanism handling the billing and also guaranteeing reimbursement for any services where the insurance coverage is uncertain. This idea is already in development by the University of Washington Health Policy Analysis Program, with funding from the Washington Health Foundation.

This approach is possible at reasonable expense because it is estimated that nearly all children in Washington through age 18 are covered or will be eligible for coverage (through Medicaid or the Children's Health Insurance Program). The administrative mechanism will function like a third party payer for all medical bills that are not clearly covered by some other insurance. This is not a universal insurance concept: it is not replacing existing coverage, just providing a wrap-around function that guarantees all children are covered.

Six operational and policy issues will need to be resolved in developing the guaranteed children's coverage strategy, as discussed in Appendix A and summarized as follows:

- Retaining existing funding levels from current insurance programs and self-pay parents.
- How the program would be funded, given the current financial and political environment.
- Concerns over in-migration from other states of families with chronically ill children.
- Should the program bill the parents of the few uninsurable children?
- Provider cooperation is needed to prevent this from becoming replacement coverage.
- Which services are covered, given the serious potential for unnecessary over-utilization.

The **main advantages** for a guaranteed children's coverage program are as follows:

- Expected to be politically attractive ("winnable") with the electorate, and probably the Legislature. Care for children has broad popular support.
- Does not require radical or rapid change to current insurance. Can add as "wrap-around" to existing children's coverage in other plans.
- Can be combined with the prior strategy into one effort to cover all mothers and children.

The **main challenges** for successfully implementing this type of program are as follows:

- Affects a small number of people; nearly all children now have coverage (or eligibility).
- Will not be sustainable over time **unless** current funding level of children's coverage by insurers, businesses and self-pay parents is continued.
- The small percentage of parents with truly uninsurable children will need to be billed for their care, to prevent financial incentives to discontinue available coverage for children.

Strategy 4: Universal Prescription Drug Stoploss

The high cost of prescription drugs has become a barrier to many persons who either lack insurance coverage for prescription drugs or have limits on how much their insurance will cover (for example, annual dollar limits). If these persons have serious illnesses, or chronic conditions, prescription drug costs can quickly create extreme financial hardships. This strategy would create a statewide, universal prescription drug stoploss insurance program to protect individuals against the out-of-pocket costs of prescription drugs, once a pre-defined level of expense has been met. "Stoploss" is an insurance term for having reinsurance to "stop the loss" once a target level of expenses is met. This reinsurance program would be state-authorized and financed, and administered by (or in conjunction with) existing insurance carrier(s). Individuals whose personal out-of-pocket expenses for prescription drugs exceeded the pre-defined threshold in a given year would submit documentation of these expenses for reimbursement, potentially with direct billing once the threshold is met.

Eight operational and policy issues will need to be resolved in developing the prescription drug stoploss coverage strategy, as discussed in Appendix A and summarized as follows:

- Retaining existing funding commitments from insurance programs and individuals.
- Concern that private coverage and Medicare supplemental drug policies will erode.
- Determining how the program would be funded in the current political environment.
- Establishing the stoploss limit may be more a political than a technical challenge.
- Cash flow considerations for low income persons will need to be addressed.
- Concerns over in-migration of chronically ill persons with high prescription drug costs.
- Defining which prescription drugs are covered by the program.
- The program might bring purchasing leverage to bear on pharmaceutical manufacturers.

The **main advantages** for a universal prescription drug stoploss program are as follows:

- Affects most people with chronic conditions, and virtually all Medicare enrollees.
- Likely to be politically attractive ("winnable") with the electorate, if not the Legislature.
- Does not require radical or rapid change to current insurance. Can add as "wrap-around."
- Simple to explain and implement; may be simple to administer (**if not means-tested**).

The **main challenges** for successfully implementing this type of program are as follows:

- Not sustainable over time unless current funding of prescription drug coverage by insurers, businesses and seniors is somehow retained. Could become very costly.
- Adverse selection concerns: in-migration of the chronically ill from other states.
- The "pay and then get reimbursed" approach is an access barrier for low income persons.
- Costs of the program difficult to predict, making tax funding a risky option to approve.

Strategy 5: Leverage Federal Funds

State-only programs (such as the BHP) are not eligible for federal matching funds that are available for federally-qualified programs such as Medicaid and the Children's Health Initiative. The number of persons who can be covered by these state-only programs are limited by the available state funding. Shifting state-only programs into federally-qualified programs would increase the amount of funding available and therefore increase coverage. This strategy would leverage available federal dollars by combining Basic Health Plan (BHP) with the Medicaid program. This could also apply in structuring the Children's Health Insurance Program (CHIP) to ensure maximum receipt of federal funds, which may in turn help cover program costs for Strategy 3. Other leveraging may be possible for covering more pregnant women under Medicaid (see Strategy 2). While this strategy is primarily a funding vehicle that can pump more money into the current system, it would allow an increased number of persons to be covered at minimal additional increase in state-level spending.

Three major operational and policy issues will need to be resolved in implementing this leveraging strategy, as discussed in Appendix A and summarized as follows:

- The type of change will involve extensive waivers of standard Medicaid requirements.
- The degree to which the BHP and other programs can retain their separate identities.
- Moving the BHP into Medicaid (and/or placing the CHIP program there) may increase the reluctance of some consumers to participate, due to perception that Medicaid is "public assistance" and/or concerns over government intrusion into their private lives.

The **main advantages** for a consolidation which leverages federal funds are as follows:

- The number of people with expanded access through the BHP could potentially double.
- Costs to implement would be minimal compared to benefits, and on-going program administration costs may actually be reduced somewhat as programs are combined.
- May have political attractiveness ("winnable") in a public initiative, if not the Legislature.
- Simple to explain, but may be difficult to implement given historical program separation.
- May help BHP survive by rolling population into a larger risk pool that health plans cannot abandon quite so easily.

The **main challenges** for successfully implementing this type of program are as follows:

- Political opposition in Legislature, due to concerns that DSHS is too big to work well.
- Difficulty obtaining Medicaid waivers around financial participation for beneficiaries.
- Will create administrative turf battles within state agencies (pitting HCA against DSHS).
- BHP stakeholder groups may resist being absorbed into larger DSHS and losing separate program identity; similar concerns about being placed in a "public assistance" program.

Strategy 6: Create a "Package of Pilots"

Many health policy experts believe that the American health care "non-system" is in serious trouble, with rising costs and increasing numbers of uninsured. Most expect these problems to become worse in the coming decade. However, there is virtually no consensus among the experts, let alone among public policy makers or the public at large, on how to solve these problems in a practical, meaningful manner. There are few models of success to show the way, and research and experimentation are needed to help decide what ought to be done. This strategy would create a "package of pilots" to explore -- on a small scale -- potential solutions to increasing access to health services in various parts of the state. These pilots can obtain local, state, federal, foundation, and other funding to both advance our understanding of these complex issues and give people access to health care (at least in the short-term).

There are two major issues to be resolved in EOI developing a strategy of preparing and supporting a package of improved access pilot projects, summarized as follows:

- Prepare an inventory of available funding sources and identify interested pilot participants (communities/researchers) across the state, to see if enough interest exists.
- Determining what EOI participation adds to the current pilot/demonstration environment.

The **main advantages** for assembling a package of pilot projects are as follows:

- Does not require radical or rapid change to the entire current system, but instead allows testing new ideas on a small-area demonstration basis.
- Benefits persons not now covered, by giving them increased access to health services.
- Concept simple to explain and implement, requires minimal administrative overhead.
- Gives a disciplined evaluation structure to the testing of new ideas, rather than the piecemeal, often ignored, approach to evaluating new ideas currently.

The **main challenges** for successfully implementing this type of program are as follows:

- Does not immediately lead to increased access to care for anyone, just prepares pilots.
- Specific projects cannot be sustained over time based on demonstration funding alone.
- Research is not appealing to the electorate, although a specific pilot might be popular.

Implementation Options

Once the final set of priority strategies are confirmed, the EOI will consider the best way(s) of transforming the strategies into concrete action. There appear to be four or five broad mechanisms by which these strategies can be implemented. Each is summarized below:

- **Community-based efforts** – Rather than seeking statewide implementation, these efforts are grassroots programs designed to mobilize local communities and local government to take action and more responsibility for increasing access to care in specific regions or counties. One example of a community-based program focused on improving access (and on improving the health of communities) is the CHOICE program in Southwest Washington. Local media can also be very helpful here.
- **Industry-based voluntary efforts** – These efforts rely on leadership from the industry (mainly health plans, hospitals, and physicians) to confront the problems in a voluntary, collaborative manner. Competitive pressures within and across industry segments often make these efforts difficult to accomplish, although some states have been successful in dealing with specific access issues, including salvaging the individual insurance market and expanding access to lower income people.
- **Public-private initiatives** – These efforts include programs developed jointly by state agency (and potentially federal agency) and private sector cooperation. An example in the quality arena is the quality improvement effort currently being led by Dr. Whitten of the Health Care Authority. These efforts often have unacceptably long germination periods, however, due to the need to coordinate many stakeholders.
- **Political efforts (legislative)** – These efforts are characterized by developing proposed legislation, requiring sponsorship of key legislators and at least the potential for bi-partisan support to be successful. The current legislative environment in Washington makes this mechanism uncertain, as does the passage of Initiative 695.
- **Political efforts (public initiative)** – These efforts often goad legislative action even when they never make it to the ballot (for example, the 1992 single payer initiative in Washington). Programs requiring expanded funding (e.g., Strategies 1 through 4), may need a public initiative to overcome current 601 spending constraints.

None of these approaches is a panacea in dealing with the complex and expensive issues of health care. A combination of approaches may be needed to be successful, and innovative, out-of-the-box thinking will be needed to move beyond the current stalemate in public policy. In all cases, both for the high-priority strategies and the other ideas summarized in Appendix B, the EOI reserves the right to address these approaches in whatever manner appears most appropriate, given the EOI's resources and mission.

Improving access to needed health services is an important policy objective of the EOI. The high priority strategies presented in the preceding pages outline several ways this objective can be achieved in the near future in a practical, straight-forward approach.

APPENDIX A

DETAILED EVALUATIONS OF THE SIX HIGH-PRIORITY RECOMMENDED STRATEGIES

The following pages present a more in-depth examination of the six strategies identified as high priority for possible EOI activity in the short-term. Each strategy is defined in terms of the current problem it addresses and the proposed solution. The key open issues are discussed in greater depth, and a matrix summarizing the major advantages and challenges is also presented. These sections do not contain a significant amount of new information, but they do examine the underlying factors that went into the thinking about each strategy.

The six high priority strategies presented in this appendix are as follows:

- Strategy 1: Initiative to Expand the Basic Health Plan
- Strategy 2: Universal Maternity Coverage
- Strategy 3: Guaranteed Children's Coverage (Kids Get Care)
- Strategy 4: Universal Prescription Drug Stoploss
- Strategy 5: Leverage Federal Funds
- Strategy 6: Create a "Package of Pilots"

Strategy 1: Initiative to Expand the Basic Health Plan

The Problem: The number of uninsured in Washington state has remained fairly constant over the past decade at around half a million people, roughly eleven to twelve percent of the state population. The Basic Health Plan (BHP) was initially implemented as a small-scale demonstration project in 1988, limited to 25,000 people. It was expanded in 1993 to be statewide and serve persons below 200 percent of the Federal Poverty Level (FPL) – roughly 60 percent of the median income – using an income-based sliding scale for premiums. Currently, the BHP covers approximately 130,000 persons. While enrollment up to 200,000 is authorized by current statute, the BHP has never been adequately funded by the Legislature to achieve this level of enrollment. As a state-only program it does not receive federal matching funds, so total enrollment is based on how many people can be covered with existing funding from the Health Services Account and from enrollee premiums.

The Solution: Create an initiative to the people to increase tobacco taxes and use the revenue to expand enrollment in the BHP to cover all persons below 80 percent of the median income (roughly 275% of the FPL). This idea has been developed previously by the Economic Opportunity Institute. The initiative would require an additional tax on cigarettes of 50 cents per pack, with revenues applied to expanding enrollment in the BHP. Expected tax revenues would be about \$230 million per biennium, estimated to cover the costs of adding about 70,000 persons to the BHP and reducing the number of uninsured to under ten percent of the Washington state population. Over two-thirds of Washington voters indicated they would support such an initiative, in a poll conducted in late 1998. The basic idea has considerable merit and would also have positive public health impacts, but the current political environment may not be ripe for spending the limited resources of EOI to pursue it given the number of people who would benefit. This idea was not discussed at the meeting, but submitted subsequently and favorably received by many reviewers of the draft report.

In and of itself, increasing the cost of cigarettes is an effective and comprehensive public health measure, especially in driving down the level of teen smoking.

Key Open Issues: There are three operational and policy issues to be resolved in fully developing and pursuing an initiative to expand the Basic Health Plan, as follows:

- The measure may be **too modest in scope**. Expanding BHP enrollment clearly benefits the 70,000 new enrollees, but it does nothing to correct the many problems underlying the current managed care health system. Double-digit premium increases by health plans could eat up these new tobacco tax revenues within four years. Additionally, having an initiative on this issue may diffuse the attention of the public, if its passage left the public with the belief that they had solved the health care access problem (at least for now).
- The **timing of the initiative** must be carefully examined. The current year is a presidential election, generating higher voter turn-out. There may also be competing issues on the ballot (tax reduction initiatives, a single-payer initiative, etc.). These factors may help or hinder passage of the BHP expansion initiative, and should be explored.
- It may be a challenge to gear up to get **enough signatures to qualify** the initiative for the 2000 ballot. A great deal of preparatory work has already been done, but the decision to file the initiative and begin collecting signatures for 2000 will need to be made very soon.

Strategy 1: Initiative to Expand the Basic Health Plan

Major Strengths/Advantages	Major Weaknesses/Disadvantages
<ul style="list-style-type: none"> • straight-forward expansion of basic health insurance coverage, to a larger number of people through an existing state program • would give improved financial access to care for an estimated 70,000 additional persons • simple to explain and understand • initiative language and support infrastructure to gather the signatures is basically ready to go • broad-based support among many public interest and health-related organizations • likely to be popular with the public, especially in comparison to the expected state-level single payer initiative, which is quite complex and requires a total overhaul of the current system • likely to improve the public's overall health by discouraging smoking, especially teen smoking, due to higher taxes on cigarettes • will re-start the dialogue about the State's role in ensuring access to health services for all • can challenge the current assumption that the public is anti-tax, anti-government programs • public sentiment among voters is strongly anti-tobacco, increasing likelihood of passage 	<ul style="list-style-type: none"> • does nothing to shore-up the shrinking viability of the BHP, where health plan losses have led to discontinued plan participation in rural areas and higher overall premiums for remaining plans • simply giving health plans more money to cover more people is a short-term solution at best • does not address the underlying problems in the individual health insurance market, which has eliminated the unsubsidized BHP program and restricted enrollment in individual health plans • success as an initiative to the people is now less certain, given I-695. Voters may now be less concerned about expanding access for low income persons through a State program • the tobacco industry would spend a considerable amount attempting to defeat this initiative (this may be a plus for the pro-initiative campaign ads) • no leveraging of state dollars (see Strategy 5) • may be too modest in scope for a public initiative process, if its passage diffuses public attention on the problems of the health care system • gathering enough signatures in time to qualify for the 2000 general election may be a challenge

Strategy 2: Universal Maternity Coverage

The Problem: The individual and small group health insurance markets in Washington are very fragile. No major insurers are currently offering individual policies to new subscribers, although recent legislation is expected to change this situation. The regulations ensuring that sick people have access to coverage have collided with voluntary participation, producing an unstable market. To help restore individual insurance, recent legislation has increased the pre-existing condition exclusion up to nine months for both the individual and small group insurance markets. As a result, maternity will become a pre-existing condition for uninsured women. Further, maternity is not a mandated benefit for individual and group insurance policies in Washington, but is required by state and federal law for employer groups of more than 8 and 15 employees, respectively. Offering maternity coverage on a voluntary basis leads to favorable selection bias for insurance products that do offer maternity coverage.

The Solution: Create separate universal insurance coverage for maternity. This insurance will cover pre-natal, delivery, and post-partum care for mother and newborn. Universal coverage can be achieved in two ways: 1) as a total replacement product for all current maternity coverage; or 2) as a separate coverage option for specific markets only. There are strengths and weaknesses of either approach, as discussed below. In either case, the goal would be to achieve universal coverage for maternity care through a state-authorized and partly subsidized program, administered either by the state or by existing insurance carrier(s). This strategy can be combined with the childrens' coverage strategy into a single program.

- **Total replacement product:** In this approach, the only maternity coverage available would be through the universal, state-authorized program. Medicaid, BHP, and all other group insurance risk pools would be combined for a single maternity pool. The major challenge in this approach will be to preserve existing funding sources for maternity insurance, especially from self-funded employers which, due to federal laws, cannot be regulated by the state in terms of the benefits covered in their health plans. Maternity will continue to be a health insurance benefit for most group coverage, either with a pre-defined, community-based premium payment to the "baby authority" from all insurers or, alternatively, with direct premium payment by purchasers. Individuals would also pay the community rate (with a sliding rate subsidization, as needed), payable in installments in advance of delivery. Some reviewers were very negative on this universal option.
- **Individual and small group insurance market supplemental product:** In this approach, the program would offer maternity coverage for the uninsured and women with small group or individual insurance that is not covering their pregnancy. It is critical to continue maternity coverage for all group policies. Unless group coverage is continued, this approach would quickly evolve into a seriously under-funded and unintended total replacement product. Self-funded employers could elect to offer maternity coverage but, over time, it is reasonable to expect they would cut their costs by encouraging their employees (and dependents) to use the state-subsidized program. Whether these employers would then also help the women pay for that separate coverage is uncertain (but, given ERISA, they could not be required to do so). A sliding scale premium schedule would be developed to require financial participation in the community-based premium from individuals based on their income (or other financial means test).

Key Open Issues: There are a number of other operational and policy issues to be resolved in fully developing the universal maternity coverage strategy, as follows:

- **Term of enrollment** should probably be the duration of pregnancy plus at least a few months for post-partum and well-newborn care. Financial or other incentives may be needed to encourage women to enroll as soon as (or even before) they become pregnant.
- **Is this "universal maternity coverage" mandated for individuals?** The challenge here is how to enforce enrollment, and what the "penalties" might be. Given that this coverage is dedicated exclusively to maternity, the obvious penalty is that women not covered will be financially responsible for the costs of their own pre-natal, delivery, and post-partum care. With a large enough risk pool and the purchasing power of the "baby authority," it is very unlikely that any uninsured woman's costs would be significantly **less** than the pre-payment premium, while the potential for having much higher costs in the event of a problem pregnancy is quite real. It would appear that no mandate is needed for most responsible people, while the political struggle over an individual mandate that would be applied only to women hardly seems worth the battle.
- The **expansion of the pre-existing condition exclusion limit** to nine months essentially eliminates coverage of maternity costs for women who are uninsured at the beginning of their pregnancy. Having a separate insurance program for maternity would avoid the lack of financial access to care for these women, but possibly deter them from getting other insurance coverage. The impacts of this strategy on overall insurance issues are complex.
- Another open issue is how **family planning services** will be included in this program, if at all. A comprehensive maternity program would logically include a wide range of covered family planning and reproductive services to prevent unwanted pregnancies, but this significantly increases the political challenges in creating this type of program. Care is needed in addressing this issue or it could de-rail momentum for solving this problem. One strategy might be to consider incrementally building the benefit package of services.
- **A similar concern exists for coverage of fertility treatments.** Again, a comprehensive maternity program would logically include fertility services to help enable pregnancies, but this probably increases the potential for political challenges for this type of program.
- Concerns have also been raised that in a **monopsony situation**, payments may not cover actual provider costs. This issue is a concern in the total replacement product approach.
- There is concern about **coverage erosion** in any type of universal carve-out. Those currently offering maternity coverage will, over time, have a strong financial incentive to discontinue this coverage in their current policy and, more importantly, discontinue funding that coverage. It can be a required benefit for those purchasing group coverage, but individuals and self-funded employers cannot be included in the mandate. For individuals, this may raise adverse selection concerns, while self-funded employers cannot have their health benefits regulated by the state due to federal ERISA law.
- Will this program lead to **in-migration of non-residents** to have their babies here? Probably not, given Medicaid maternity programs elsewhere. There might be some influx of middle income mothers from states where there is a problem getting maternity

coverage, but the sliding scale premiums should help resolve this. As with any "universal coverage" program, the optimal approach is for a federal program, avoiding the internal migration incentives among residents of different states.

Strategy 2: Universal Maternity Insurance	
Major Strengths/Advantages	Major Weaknesses/Disadvantages
<ul style="list-style-type: none"> • expected to be politically attractive ("winnable") with the electorate, and possibly the Legislature. Care for pregnant women has popular support • has the potential to affect a large number of women as time goes on, as uninsured women will be unable to purchase maternity coverage • costs may be minimal, but only if current group coverage for maternity is maintained. Costs may actually be somewhat offset by the consolidated purchasing power of the new program and resulting administrative standardization • does not require radical or rapid change to current insurance. Can add as supplement to existing maternity coverage in other plans • will result in a healthier population, especially to the extent the program gets more women into early pre-natal care than currently occurs • a better value for the current dollars spent, in terms of administrative simplification, as long as the current funding streams are maintained • simple to explain and initially implement; may be simple to administer if done as a supplement for the individual and small group markets only 	<ul style="list-style-type: none"> • may not be viable at state level, given Medicaid and ERISA constraints; it may be more effective to do this nationally, e.g., as Medicare Part D? • funding sources are unknown; amount uncertain. • will not be sustainable over time unless current maternity benefit for group insurance is continued • strong disincentive for individuals to purchase this coverage unless it lowers their current premium • self-funded employers may discontinue maternity coverage over time, shifting the costs of maternity to employees (maybe with some cash?) • in a total replacement product approach, there is a strong potential for monopsony payments that do not cover actual provider costs (over time) • political difficulties (and possibly costs) will increase if family planning or fertility services are added to the services covered by the program • adverse selection in terms of in-migration of pregnant women from other states seems minimal, given Medicaid coverage elsewhere • has the potential to introduce unanticipated consequences into the financing of maternity services due to lack of prior experience • Washington is already a leader in maternity coverage (First Steps). Is more really needed?

Strategy 3: Guaranteed Children's Coverage (Kids Get Care)

The Problem: Virtually all children in Washington are either covered by insurance or eligible for coverage through public programs, but some parents hesitate to seek needed primary care or preventive services for their children due to concerns about the out-of-pocket cost and/or a lack of connection to the health care system. One in five Washington children in low income families were uninsured for at least part of 1998, although many of them would have been eligible for Medicaid coverage had they applied. One estimate is that 98 percent of all children in Washington are either insured or eligible for health insurance.

The Solution: Change the mind-set of parents and health care providers by guaranteeing that all health care for children in Washington will be covered. The strategy is to create a "kids get care" mentality for service delivery, and defer the financial coverage complexities to a newly created administrative mechanism. This will ensure that all children can get access to care when needed, and to preventive services, with the administrative mechanism handling the billing and also guaranteeing reimbursement for any services where the insurance coverage is uncertain. This idea is already in development by the UW Health Policy Analysis Program, with funding from the Washington Health Foundation.

This approach is possible at an affordable cost because it is estimated that nearly all children in Washington through age 18 are covered or will be eligible for coverage (through Medicaid or the Children's Health Insurance Program - CHIP). The administrative mechanism will function like a third party payer for all medical bills that are not clearly covered by some other insurance. The provider will send the bill to the administrative mechanism, which will promptly pay the claim, then bill the appropriate insurance company or establish the child's eligibility for public programs. In the event there is not way to insure the child, the administrative mechanism will pay for the care itself. Note, this is not a universal insurance concept in that it is not replacing existing coverage, just providing a supplemental function that guarantees providers that all children are covered. This strategy can be combined with the universal maternity insurance strategy to cover mothers and children in a single program.

Key Open Issues: There are a number of operational and policy issues to be resolved in fully developing the guaranteed children's coverage strategy, as follows:

- One key issue is how to **retain existing funding commitments** from current insurance programs and self-pay parents once it is known that there is a public program that will pay for children's care as the payer of last resort. Purchasers and insurers will have a clear financial incentive to reduce their costs by discontinuing or limiting children's coverage in their plans, knowing that children can still get care. This will also create a dilemma for employees who are required to pay for dependent coverage; many may elect to discontinue this coverage. Similarly, many self-pay parents may decide to stop paying for the care at time of service if this type of program is available to them. Without some form of "pay or play" requirement for self-funded parents, businesses and insurers (impossible to enforce for self-funded employers due to ERISA), there will be serious erosion of the current funding stream for children's coverage, and program cost increases.

- Determining **program costs** may be a challenge. While the current costs of the program will be fairly low and straight-forward to calculate actuarially, the issue presented above makes it likely that, over time, some of the private sector and self-pay children's health expenses will migrate into the program as private insurance coverage and self-payment erodes. If these concerns can be addressed, the program should not be very expensive.
- A third, and related, issue is **how the program would be funded**. As a statewide program, the most equitable form of funding would be in the form of a legislative allotment, although this might be a difficult approach for the Legislature to approve in the current financial and political environment. Tax funding for a children's insurance program might be more acceptable through a public initiative process, although the concern raised in the above issues might make it difficult to predict precisely what the program costs would be over time.
- **The definition of "guaranteed"** will also require careful consideration. This will involve political debates over who qualifies as a Washington "resident," as well as addressing concerns over in-migration of families with chronically ill children who face financial ruin from their health costs. The potential for adverse selection from out-of-state will definitely exist, since residents of other states would not have similar protection. However, most seriously ill children, especially those in low income families, are already covered by federally-funded public programs (similar to the Children with Special Health Needs program in Washington state). As a result, the in-migration concerns may not be as serious for this program.
- **Collection of copayments** at time of service would be required for parents with no other insurance, but this could be set at a nominal level. The providers would be asked to collect the copayment if possible, but otherwise to send the full bill to the administrative mechanism. Collection of the copayment should not be a barrier to access.
- **Should the administrative mechanism bill the parents of the few children not covered by any type of insurance?** After initial analysis, the answer seems to be a definite yes. Although this adds a back-end burden on the parent and may defeat the message of "kids get care," it seems likely that a billing will be required to prevent self-pay parents from simply taking advantage of "free" care. This may also serve as an incentive for employees to continue paying for dependent insurance coverage through their employer's plan. The administrative mechanism may want to provide an option for low income families to qualify for reduced payment levels, but for the majority of Washingtonians there needs to be an understanding that they are ultimately responsible for paying for children's care either through insurance or out of their own pocket.
- **Provider cooperation will be required** to prevent this strategy from becoming the path of least resistance for overworked provider billing offices. Given insurance complexity, particularly with referral authorization becoming the norm, the provider billing office will have a strong incentive to just send the claim off to the administrative mechanism and let it handle all the insurance hassles. This program is designed as a safety net for the few, not as replacement coverage. This type of program is not sustainable unless providers make a sincere, good faith effort to determine the proper eligibility and bill the insurer.

- A final issue relates to **which services are covered** by the program. The clear intent of the program is that "kids get care," but in a guaranteed reimbursement world the potential for unnecessary over-utilization is quite real. Rather than developing a cumbersome and expensive medical necessity review process, it is recommended that the minimum fee schedule for covered services be set quite low (for example, a \$25 conversion factor applied to a Resource Based Relative Value Scale). This will minimize provider financial incentives to game the system on an incremental basis. Finally, exclusion of experimental treatments in clinical trials will need to be addressed explicitly to avoid shifting these potentially extremely high costs to the program.

Strategy 3: Guaranteed Children's Coverage	
Major Strengths/Advantages	Major Weaknesses/Disadvantages
<ul style="list-style-type: none"> • expected to be politically attractive ("winnable") with the electorate, and probably the Legislature. Care for children has broad popular support • costs will be minimal, but only as long as all other current children's coverage is maintained • does not require radical or rapid change to current insurance. Can add as a supplement to existing children's coverage in other plans • will result in a healthier population to the extent that children now needing care or preventive services go without due to parent cost concerns • probably better value for the dollars spent, in terms of administrative simplification, as long as the current funding streams are maintained • simple to explain and initially implement; may be simple to administer if providers do not see this as the path of least resistance for insurer billing • has the potential to change the mindset for most parents and providers from how to pay for the children's medical care to one of appropriate care • this idea is already in development by the UW Health Policy Analysis Program, with funding from the Washington Health Foundation • may be a good candidate for local community demonstrations or pilot projects 	<ul style="list-style-type: none"> • will <u>not</u> affect a large number of people, as nearly all children now have coverage (or eligibility) • will not be sustainable over time unless current funding level of children's coverage by insurers, businesses and self-pay parents is continued • gives employers a financial incentive to drop dependent coverage, unless there is an offsetting new tax incentive to retain dependent coverage • adverse selection in terms of in-migration of the chronically ill children from others states is a concern, but may not materialize due to current Medicaid benefits for seriously ill children • to prevent financial incentives for over-use, the payment for truly uninsured patients will need to be set quite low. The alternative is cumbersome medical necessity review, which is quite costly • providers must agree not use this program as the path of least resistance for billing insurance, or the administrative burden will crush the program • the small percentage of parents with children without any other coverage will need to be billed directly to prevent perverse financial incentives to discontinue available coverage for their children • administrative functions could be cumbersome and expensive to set-up and operate

Strategy 4: Universal Prescription Drug Stoploss

The Problem: The high cost of prescription drugs has become a barrier to many persons who either lack insurance coverage for prescription drugs or have limits on how much their insurance will cover (for example, annual dollar limits). If these persons have a serious illness, or a chronic condition, prescription drug costs can quickly become an extreme financial hardship. With the rapidly escalating price of prescription drugs and the expectation of many new, high-priced drugs being introduced in the coming decade, this problem is expected to become worse.

The Strategy: Create a statewide, universal prescription drug stoploss insurance coverage that will protect individuals against the out-of-pocket costs of prescription drugs, once a pre-defined level of expense has been met. "Stoploss" is an insurance term for having reinsurance to "stop the loss" once a target level of expenses are met. This reinsurance program would be state-authorized and financed, and administered by (or in conjunction with) existing insurance carrier(s). Individuals whose personal out-of-pocket expenses for prescription drugs exceeded the pre-defined threshold in a given year could submit documentation of these expenses for reimbursement from the program.

Key Open Issues: There are a number of operational and policy issues to be resolved in fully developing the universal prescription drug stoploss strategy, as follows:

- One key issue is how to **retain existing funding commitments** from current insurance programs once there is a program that ensures everyone is covered for high-cost prescription drug expenses. This may especially become a challenge for prescription drug costs, which are currently the fastest growing component of most health plans' costs. Purchasers and insurers will have a clear financial incentive to reduce their costs by discontinuing or limiting prescription drug coverage in their plans, knowing that individuals will be protected by the universal stoploss program. Since the program is designed to be stoploss (coverage only after a certain expense limit is reached), it seems likely that most purchasers/insurers will design their packages to cover drug costs only up to that threshold. Some Medicare beneficiaries may also decide to drop their individually purchased prescription drug supplemental coverage if a stoploss program is available to them. Without some form of "pay or play" requirement for Medicare beneficiaries, businesses and insurers (impossible to enforce for self-funded employers due to ERISA), there will be serious erosion of the current funding stream for prescription drug coverage. This will result in rapidly escalating program costs.
- Determining **program costs** will be a challenge. While current costs of a reinsurance program will be fairly straight-forward to calculate actuarially once the appropriate stoploss level is established, the issue presented above makes it likely that, over time, virtually all high cost prescription drug expenses will roll into the program as private insurance coverage and participation in Medicare supplemental drug policies erodes.
- A third, and related, issue is **how the program would be funded**. As a universal, statewide program, the most equitable form of funding would be in the form of a

dedicated tax, although this might be a difficult approach for the Legislature to approve in the current financial and political environment. Tax funding might be more acceptable through a public initiative process, although the concern raised in the above issues would make it difficult to predict precisely what the program costs would be over time.

- **Establishing the stoploss limit** may be more a political than a technical challenge. To be most equitable, the individual's stoploss level should be income (or means) dependent. For example, a \$1,500 personal annual out-of-pocket stoploss level might be reasonable for a middle income family but would be an extreme financial burden for low income persons (even with the pre-funding mechanism described below). However, introducing means testing and a sliding scale for the threshold will make the concept much more complex and difficult to sell politically. There is also the danger that whatever threshold is set will become the maximum coverage level for private insurance policies.
- **Cash flow considerations** for low income persons will need to be addressed. Since there are no prescription drug limits for Medicaid, the size of this potential problem is reduced. There are still many low (or no) income persons not covered by Medicaid, however, and without some form of pre-funding obtaining costly prescription drugs would still be a challenge for low income persons with serious or chronic illnesses. If there is a means testing approach to set the personal stoploss threshold (see above), this could also allow some form of pre-authorization to assist in the initial purchase of prescription drugs for eligible persons. An (expensive) alternative might be make interest expense on the initial outlay a covered cost while the person is awaiting reimbursement.
- **The definition of "universal"** will also require careful consideration. This will involve political debates over who qualifies as a Washington "resident," as well as addressing concerns over in-migration of chronically ill persons who face financial ruin from their prescription drug costs. This may be especially true of retired seniors who have greater mobility. These latter concerns may be able to be addressed by requiring new residents to contribute a "back premium" to help fund the program (although the legality of this approach may be questionable). In any event, the potential for adverse selection will exist even in this "universal" program, since residents of other states would not have similar protection. For Washington residents, the program would be universal.
- Another issue relates to **which prescription drugs are covered** by the program. There are several concerns here. First, there are efficacy issues – especially given the growth of drug manufacturer advertising and the knowledge of prescribing physicians that the costs would now be covered. Some type of multiple-tier drug benefit structure might be needed, in which some drug costs would not be counted in reaching the threshold (e.g., Viagra?) and some would still require co-payment even after the threshold was reached (e.g., Claratin?). Second, the technical issues of how formularies relate to this program would need to be resolved, and there might be a need for a single formulary for prescription drugs after the threshold was reached. Third, coverage (or, more accurately, exclusion) of experimental drugs in clinical trials would need to be addressed explicitly to avoid shifting these potentially extremely high costs to the program.

- Finally, a well-designed program might be able to bring some **purchasing leverage** to bear on pharmaceutical manufacturers. How this issue might play out is uncertain, but (for example) drug manufacturers might agree to help pay for some of the costs of the program in return for retaining an open formulary once the stoploss threshold level is reached. They might also be helpful in encouraging continuation of other funding sources. This would be especially true if this strategy were pursued in lieu of forming a prescription drug buying group, as is being experimented with in several other states. The pharmaceutical industry will need to be brought on board early in the process, or else their lobbying efforts will be directed at killing the program or defeating the initiative.

Strategy 4: Universal Prescription Drug Stoploss	
Major Strengths/Advantages	Major Weaknesses/Disadvantages
<ul style="list-style-type: none"> • will affect a large number of people with chronic conditions, and virtually all Medicare enrollees • expected to be politically attractive ("winnable") with the electorate, if not the Legislature • does not require radical or rapid change to current insurance. Can add as a supplement • will result in a healthier population to the extent that persons now needing drugs but unable to purchase them go without medications • probably better value for the dollars spent as long as the current funding streams are maintained • simple to explain and implement; may be simple to administer, but only if sliding stoploss thresholds and means testing are not adopted 	<ul style="list-style-type: none"> • this program could become very costly, depending on where the threshold is set • costs of the program will be difficult to predict, making tax funding a risky option to approve, but any other funding source appears unlikely • may not be sustainable over time unless current funding of prescription drug coverage by insurers, businesses and seniors is somehow retained • adverse selection in terms of in-migration of the chronically ill from other states is a concern, especially more mobile seniors with Medicare • defining the stoploss threshold based on personal means will add both administrative complexity and increase political opposition • defining what is covered (before and after the threshold level) will be technically and politically challenging. Issues include drug efficacy, drug formularies, and experimental drugs in testing • the "pay and then get reimbursed" approach may create access barriers for low income or unemployed persons • would probably require a "pay or play" funding requirement for insured employers, to keep them from dropping prescription drug coverage. This could not be applied to self-funded employers, due to their ERISA protection under federal law.

Strategy 5: Leverage Federal Funds

The Problem: State-only programs (such as the BHP) are not eligible for federal matching funds that are available for federally-qualified programs such as Medicaid and the Children's Health Initiative. The number of persons who can be covered by these state-only programs are limited by the available funding. Shifting state-only programs into federally-qualified programs would increase the amount of funding available and therefore increase coverage.

The Strategy: Leverage available federal dollars by combining Basic Health Plan (BHP) with the Medicaid program. This could also apply in structuring the Children's Health Initiative Program (CHIP) to ensure maximum receipt of federal funds, which may in turn help cover program costs for Strategy 3. Other leveraging may be possible for covering more pregnant women under Medicaid (see Strategy 2). While this strategy is primarily a funding vehicle that can pump more money into the system, it would allow an increased number of persons to be covered at minimal additional increase in state-level spending.

Key Open Issues: There are several operational and policy issues to be resolved in fully developing a strategy to leverage available federal funds, as follows:

- The change will involve **extensive waivers of standard Medicaid requirements**. This is primarily an administrative burden, but the issue is especially problematic concerning how benefit differences will be resolved and BHP cost sharing requirements (copayments and premium share) will be handled, given current Medicaid policies. These issues have historically been major stumbling points for waiver applications that have different benefits or expect program participants to contribute to the costs of their care. Also of concern is how quickly the waiver applications could be prepared, reviewed, and approved, and how favorably they will be received by the next administration (after the 2000 presidential election). These are open questions requiring more research and expert guidance prior to EOI investing major resources in pursuing this access strategy.
- The degree to which the BHP and other programs can **retain a separate identity** (both for the public and within state government) is uncertain. The Health Care Financing Administration (HCFA) requires a single state agency to administer Medicaid, although DSHS has been successful in assigning operational responsibility for different parts of the program (e.g., acute care versus long term care) to different administrations within the overall department. Whether this is desirable, or even possible, for a consolidated state purchasing program is uncertain.
- Moving the BHP into Medicaid (or placing the CHIP program there) may increase the **reluctance of some consumers** to participate, due to perception that Medicaid is "welfare" and government intrusion into their private lives. This issue was identified as a major concern in the creation of the Basic Health Plan ten years ago, but it is unknown how widespread the concern may be currently among BHP enrollees. The transition may also be able to be fairly transparent to current enrollees, if implemented efficiently and with attention to this concern. New enrollees may be reluctant to participate, however, if the program(s) are too closely tied to their perception of big government.

Strategy 5: Leverage Federal Funds

Major Strengths/Advantages	Major Weaknesses/Disadvantages
<ul style="list-style-type: none"> • given an over 50% match on federal funds for Medicaid, the number of people with expanded access through the BHP could potentially double • costs to implement would be minimal compared to benefits, and on-going program administration costs may actually be reduced somewhat • seems likely to have political attractiveness ("winnable") in public initiative, although technical complexity hard to explain in easy sound bites • should be sustainable over time, barring major changes to Medicaid program at national level • could be done fairly quickly, once legislation authorizing the change was in place • will result in a healthier population to the degree that more people are able to be covered under the BHP, children programs, and other programs • much better value for the current dollars spent, since leveraged by federal funds • simple to explain, but may be difficult to implement given historical program separation • may help BHP survive by rolling population into a larger risk pool that health plans cannot abandon quite so easily • simplifies health plan contracting process • Clinton administration is attempting to add parents of eligible children in the CHIP, which, if it occurs, could then allow melding CHIP and BHP to get some federal matching funds 	<ul style="list-style-type: none"> • many people are dubious that DSHS could handle the increased responsibilities • expected political opposition in the state Legislature, again in part due to concerns that DSHS is already too big to work well • likely to create an "entitlement" mentality for the whole consolidated program, causing difficulty with the current BHP paradigm of responsibility • difficulty obtaining Medicaid waivers around financial participation for beneficiaries (e.g., copays, premium sharing on a sliding scale) • will appear to be a radical change to current BHP enrollees, who may be more comfortable dealing with HCA than with DSHS (or at least think they will be more comfortable with HCA) • opposition expected from those consumers who consider the Medicaid program to be unwanted "public assistance" intrusion into their lives • will create administrative turf battles within state agencies (pitting HCA against DSHS) • BHP stakeholder groups may resist being absorbed into larger DSHS and losing separate program identity or independence • will take several years to achieve, thus not a short-term strategy to improve access now • combining programs might threaten BHP's Title 48 exemption from OIC regulation of health plan benefits, limiting program flexibility

Strategy 6: Create a "Package of Pilots"

The Problem: With very few exceptions, health policy experts believe that the American health care "non-system" is in serious trouble, with rising costs and increasing numbers of uninsured. Most expect these problems to become worse in the coming decade. However, there is virtually no consensus among the experts, let alone among public policy makers or the public at large, on how to solve these problems in a practical, meaningful manner. Transforming one-sixth of our economy is a huge and complex undertaking, and there are few models of success to show the way. Research and experimentation are needed to help decide what ought to be done.

The Strategy: Create a "package of pilots" that explore on a small scale (at the community level) potential solutions to increasing access to health services in various parts of the state. These pilots can obtain local, state, federal, foundation, and other funding to both advance our understanding of these complex issues and give more people access to health care (at least in the short-term). Part of this strategy will be a comprehensive review of demonstrations conducted or underway in other parts of the country, to see what has and has not worked and why. This effort can be done in conjunction with some combination of health policy researchers at the UW/WSU. The EOI, working with other interested parties, can develop a package of potential pilot designs that can then apply for and be financed by demonstration funds. This "soft money" approach is clearly not a long-range solution to increasing access, but it does appear preferable to having people remaining uninsured.

Key Open Issues: There are two key issues to be resolved in EOI deciding to fully develop a strategy of preparing and supporting a package of improved access pilot studies, as follows:

- **Cost-benefit analysis.** Simply put, is there enough chance of obtaining demonstration funding that it will be worth the initial investment of scarce EOI resources to implement this strategy? This will require several steps: 1) preparing an inventory of available funding sources; 2) identifying the types of projects or demonstrations these sources are currently (or expected to be) funding and at what levels; and 3) developing a consortium of interested pilot participants (communities and researchers) across the state.
- **Determining what EOI participation adds to the current environment.** There are already dozens of researchers and grant applicants in Washington that focus on health-related demonstration projects. Is there value in having some form of coordinating entity (either EOI or some other organization) that helps prioritize pilot projects and also helps disseminate information? Is the link between this type of effort and the mission of the EOI sufficiently strong that it makes sense for EOI to at least serve as the catalyst for initiating this package of pilots concept? Will this activity be welcomed by researchers and community organizations, or will they view EOI participation as just further competition for already limited funding?

Without further research, it is unclear which types of increased access efforts should be included in the package of pilots. All but a few of the lower-priority ideas from the brainstorming session (summarized in the appendix) are potential projects for inclusion in a

package of pilots, as are many other ideas which could be identified by a literature review. Indeed, the first three high-priority strategies may each be worthy of a pilot study prior to going statewide. Which to pursue will depend upon finding an interested pilot site and the availability of demonstration funding.

Strategy 6: Create a Package of Pilots	
Major Strengths/Advantages	Major Weaknesses/Disadvantages
<ul style="list-style-type: none"> • does not require radical or rapid change to the entire current system, but instead allows testing new ideas on a small-area demonstration basis • would benefit any persons now not covered, by giving them increased access to health services • should result in a healthier population in the pilot community, as one of the demonstration criteria • can leverage demonstration funding to get better value for the dollars spent (at least short-term) • operational costs are relatively low, probably no more than one FTE to assemble these packages • concept simple to explain and implement • brings health service researchers into a more hands-on approach to improving access to care • potentially creates a forum where participants can continue to advance ideas for improved access to care, involving a wide range of policy experts and researchers • gives a disciplined evaluation structure to the testing of new ideas, rather than the piecemeal, often ignored, approach to evaluation currently • can tie together many of the other EOI health-related efforts into a single theme of improved access to care for all Washington workers • the recent (November '99) rural health summit strongly supported the idea of local area pilots to test ideas and improve access to care 	<ul style="list-style-type: none"> • does not immediately lead to increased access to care for anyone, just prepares pilot designs • any specific project is unlikely to be sustainable over time based on demonstration funding alone • the approach is not appealing to the electorate, although a specific pilot might be quite popular in a local area – for example, a local initiative through a hospital district

APPENDIX B

SUMMARY OF OTHER IDEAS

Medium Priority Ideas

There were a number of other good ideas identified by the brainstorming group that were generally considered to be worthwhile ideas, but are somewhat lower in priority for EOI to pursue at this time. In addition, three additional ideas were suggested via e-mail following the meeting and are included here for broader consideration. Each of these other ideas is summarized briefly in the following pages.

- **Permit Self-funded BHP in Areas Where Managed Care Plans No Longer Offer Coverage.** This idea is currently before the Legislature. By statute, the BHP can only be offered through managed care plans. In some areas of the state, primarily rural areas to date, managed care plans have been unable to be financially viable and have discontinued offering the BHP. This leaves local, low income residents with no option for subsidized health coverage. The idea is for the state to self-fund health insurance in these areas, similar to the Uniform Medical Plan for public employees or traditional Medicaid. Direct contracting may still be a challenge for the BHP, but at least the program could again be offered statewide. The EOI was encouraged to support this effort, both for BHP and potentially in the future for Healthy Options as well, if managed care plans discontinue operation in local areas. The idea was not raised at the meeting, but submitted subsequently. It received considerable favorable support from reviewers.
- **Promote Discussion of Better Use of Limited Resources.** Many participants identified the lack of a "forum" in Washington to have meaningful discussions about what direction the health care system should take. Many reviewers also supported the forum idea. One suggestion was that EOI sponsor a series of community meetings around the state, similar to what was done in Oregon in the early 1990s, to obtain widespread public input on how our limited resources can best be allocated through benefits design. In the absence of a sizeable program to implement the recommendations, however, it is not clear the EOI effort would have any constituency to give it credibility. In Oregon, the results of the community forums define the coverage package for the Oregon Health Plan (Medicaid) and were intended to provide a benchmark for other health plans (although this latter application has not happened to date). In Washington, public programs have elected to use managed care plans to implement defined coverage for subsidized populations.
- **Low Cost Health Care for Low Income Residents in a Community.** This idea is similar to a pilot program considered by CHOICE in southwest Washington in 1998. The concept is that a community-based group (and/or local government) would enroll local, low income residents (e.g., the working poor not eligible for public programs or employer-sponsored coverage) in a "mixed-mode" health care access program. In this

program, the sponsor would buy catastrophic (very high deductible) health insurance for financial protection and also arrange for donated health provider time (charity care) to offer primary care and local hospitalization. These providers would be protected against serious financial obligation by the catastrophic insurance coverage. The community focus of the idea might lead to greater acceptance among a majority of local physicians and dentists than current voluntary efforts. There was a concern that some providers might discontinue other charity care except for this type of program. The consensus was that having a pilot of this concept in a local community might be worth exploring, if a suitable sponsoring organization could be identified.

- **Security Against Financial Catastrophe Due to the Costs of Health Care.** This idea was for a universal, very high deductible health insurance plan that would use the insurance model for what it was originally intended, protecting against catastrophic financial hardship in the event of a high cost illness or accident. For anyone not currently insured (or unable to obtain insurance), the program would offer very high deductible health insurance, potentially with a differential deductible based on a percent of income (e.g., three percent of annual income). The program could subsidize premium costs for low income persons, although the funding approach for this subsidy was not identified. Without external funding, it seems unlikely the higher income participants would voluntarily consider significant funding of the premiums for low income persons. A mandatory program (like mandatory auto insurance) might solve that issue, but raises other issues including political feasibility. Historically, catastrophic health insurance policies have not been popular in the individual insurance market (but might become popular if they were mandated, or the only option for individual coverage). Like other universal insurance ideas (see discussion on page Appendix-5), coordinating this coverage with existing insurance protections for those already insured could also pose a serious challenge, over time, to the continued funding of high-end costs in existing insurance plans. Carving-out high-end costs from traditional insurance into some form of state-run, universal stoploss pool might be one way to avoid the erosion of high-end coverage from traditional insurance. This idea would do nothing to help increase access to primary care, especially for low income families, due to the very high deductible level.
- **Pre-Paid Care Cards.** This idea would create a "care card" similar in concept to a pre-paid telephone card, which could then be used to cover a specified set of services. The covered services could be custom designed, for example emphasizing primary care and prevention, or health promotion services. This approach might remove some of the stigma of participating in Medicaid, if it was adopted by a wide range of insurers and self-funded plans. If there was widespread use of this card, it could also reduce administrative complexity of billing and accounts receivables for providers. Without widespread adoption, however, the card would otherwise just be another among many payment options requiring special handling by the medical office or hospital billing staff. Since the card is pre-paid, it is not clear that this concept is fundamentally different than a cash transaction except that financial sponsors could pay for the card and design its coverages, and a percentage of the pre-payment would be needed to cover the administrative costs of the system. For this reason, many reviewers were negative about this idea. The card might be one idea where the private sector could take the lead to

explore the viability of the concept and, if it became popular, public sector sponsorship programs could then consider adopting it as well. It was also unclear whether a pre-paid health care card would constitute an "insurance product" and need to be regulated as such by the Office of the Insurance Commissioner.

- **Universal Vision Exams and Hardware via the Schools.** The concept here is to provide funding to all public school districts (and possibly private schools as well) to cover the costs of an annual vision exam for all students, at least at the elementary school level. If vision problems were detected, a second-level exam could be used to make a prescription and get glasses. Funding for hardware could be handled through a collage of private insurance, public programs, and voluntary efforts (such as the Lions Club). Many school districts already offer such programs (e.g., Seattle, Lake Washington) but the program is not statewide. Making the exam program universal could reach a larger number of children statewide and, potentially, help head-off many learning problems.
- **Initiative to the Legislature 227** – This effort is titled "the patient protection and health care access act", but spends most of its detail describing how all State health purchasing activities, including Medicaid, would be combined into the Health Care Authority. Patient protection is addressed by requiring independent review of all medical necessity denials and making carriers (and individual reviewers personally) liable for any harm that occurs as a result of a medical care denial. This program would be administered under the regulatory authority of the Office of the Insurance Commissioner. Health care access is improved by giving any individual and any small business group the opportunity to purchase health insurance through the Washington Health Insurance Plan (the newly combined state purchasing program). To prevent individuals from buying coverage only when needed, there would be a 12 month participation requirement and any person or group re-joining the plan after previously dropping it would be subject to a first year 25 percent premium surcharge. The benefits package would be quite comprehensive, combining all services now covered in the Medicaid program and the public employees' benefits package. Direct provider contracting would replace use of health plans, except at the discretion of the administrator. The combined state programs would retain their individual identity but have joint purchasing requirements and, "to the greatest extent possible", joint risk-sharing. The current public employee benefits board would be replaced by a board with greater representation of labor and consumer advocates. The initiative as written also requires the legislature to "fully fund its fiscal responsibilities" for the program and establishes a separate fund, outside the state general fund and exempt from the limits of 601 and 695, to finance the program. The creation of a consolidated state purchasing pool with an individual participation option is a politically controversial and complex undertaking. To conduct a meaningful evaluation of that proposal is well beyond the scope of this project, which is focused on identifying short-term, incremental efforts to improve access to health services. The potential for adverse selection to the plan by higher risk individuals, however, is readily apparent. This idea was not discussed at the brainstorming meeting, but a request for its inclusion was submitted subsequently. Several reviewers indicated that this effort was a concern, and that EOI should not support this initiative. [This initiative may be moot given recent legislative action.]

Other Good Ideas, But Where Leadership Needs to Come from Elsewhere

The following ideas were also identified and discussed at the brainstorming session, but the consensus of the group was that the leadership for expanding the idea into an operational approach would be better coming from other parties (and in some cases, these efforts are already underway in specific parts of the state). A brief overview of each is as follows:

- **Create direct access to care in the community.** Assemble direct access to care for uninsured persons via formal community networks involving the public health districts, local hospitals, volunteer providers, local government, IHS, civic groups, etc. This is not an insurance model, although it might be linked to high deductible (stoploss) coverage for funding care outside the local community. It was mentioned that this concept may already be under consideration as a pilot in northeast Washington, with leadership from the State Department of Health. The consensus was that this was a valuable idea worth pursuing, but that the leadership was already coming from elsewhere. As a result, there would be little advantage to EOI also making a major effort in developing this idea.
- **Expanded immunization coverage.** This idea calls for a joint effort among the major health plans and the public health districts to expand immunization coverage to all children, possibly in conjunction with the public schools. A variety of options for implementing this approach were discussed, including community-based pilots in several communities. A concern was raised over liability issues if the schools were involved. Another concern was also raised, that Washington already has one of the highest pediatric immunization rates in the nation, and that EOI efforts might be better spent on more critical access problems or other systemic issues, such as dental access for children and adults. The group consensus was this idea was better pursued by public health districts.
- **Pilot a universal coverage mechanism in a specific community.** The desirability of piloting a universal coverage, single payer (or single sponsor) system in a defined community was identified by several participants. The consensus was that there were still too many unknowns about what a universal coverage system would really look like to sell it on a statewide (or, more appropriately, national) basis. However, if the right community (e.g., Spokane or possibly Grays Harbor/Pacific counties) were interested in a local initiative to conduct a pilot single payer system, participants believed that would be an excellent way to both expand local access and demonstrate the viability of the concept. Defining a uniform benefits package and creating a functioning information system to effectively manage care were identified as two critical components of such a pilot. Finding the needed funding to cover the uninsured (estimated at over \$100 million a year for a community the size of Spokane) did put a damper on the discussion. It was also not apparent that an outside, Seattle-based entity such as EOI was the appropriate champion for an idea that truly needed grass-roots, locally-based support to be acceptable.
- **Educate high school students on the protection aspects of health insurance.** This idea addresses problems in the individual insurance market, and in employer-sponsored but employee-paid health insurance, that arise when individuals decide they cannot afford to purchase insurance. It was suggested that a targeted program in high schools might make people think harder about the decision to forego coverage or only buy it when it would be

needed (e.g., maternity). The long-term nature of this effort before an impact might be seen, the questionable receptiveness of high school students to this information, and the overwhelming impact of personal financial circumstances on these decisions were all raised as concerns. This idea was rejected by several reviewers as not worth doing.

- **Fix the individual insurance market in Washington.** The specific idea suggested and briefly discussed at the meeting was to pool the individual market with other risk pools (such as the small group market, the high risk pool, Medicaid, the BHP, and/or public employees). Others suggested mechanisms to "reward" those who continued to purchase coverage and "punish" those who only purchased coverage when needed. Many other suggestions for solving the individual insurance crisis in Washington have also been proposed in other forums, such as avoiding sick people, requiring all insurers to offer individual policies or help fund the losses (i.e., spread risk over a much larger population in a different way). Most participants agreed that one key challenge was to achieve considerably lower premiums in order to convince a broader selection of the healthy to enroll. There are a wide variety of interest groups, state agencies, and health plans grappling with this issue already, and it did not seem to the group that having EOI enter the fray would change the dynamics of the debate. Putting attention and resources here will limit the resources available to EOI to address other ideas identified in this paper.
- **Allow the public to buy into PEBB.** A variation on the above was to allow individuals to purchase health insurance coverage through the Public Employees Benefits Board. The adverse selection problems with this approach, the likely need for separate risk pools, and the political difficulty in achieving this change in public policy were identified as strong reasons for EOI to avoid spending effort on developing this idea. Some reviewers believed this was very unlikely to ever occur, given state employee objections.
- **Internet, Web-based health solutions.** While most participants agreed that electronic information exchange and e-commerce may have tremendous potential for re-structuring the health care delivery system (and possibly the health care and health insurance financing systems as well), there was consensus that many others were clearly taking the lead in this arena. EOI attention and resources here will limit the resources available to address other ideas identified in this paper.
- **Health mobiles for local areas.** One participant suggested a return of health mobiles for increasing direct services delivery to under-served areas. The general consensus was that this idea had some merit, but that it was simply one option open for local communities and health districts to implement direct care delivery programs (see prior page, first bullet). As such, it did not seem the best use of EOI resources to push for a specific approach that might, or might not, be the most appropriate for a given community.

In addition, one participant suggested that this paper examine the strengths and weaknesses of the single payer effort being organized under the heading of **Health Care 2000**. This non-profit, statewide coalition is attempting to place an initiative on the November 2000 ballot to enact a universal health care program financed through a single, publicly accountable agency. The implementation of a statewide, universal health care trust that would replace all private and public health insurance in Washington is an exceptionally complex undertaking. To conduct a meaningful evaluation of that proposal is well beyond the scope of this project.

Four Funding Vehicles – New Methods to Fund Health Services

In addition to the ideas already presented, the brainstorming group also identified four approaches for raising additional funds to help purchase health services or health insurance, or for spreading the financing out over a longer period of time. The first two of these "funding vehicles" could potentially be used for many of the ideas previously identified. The last two appear to be more private sector financing approaches, at least to date. Each of these potential funding vehicles is described briefly as follows:

- **United Way Model.** Use a community-based, "United Way" model to channel charity donations to community-based health care access programs (e.g., primary care for the poor). This could involve direct access to care, as well as sponsorship for health insurance as in the BHP sponsorship program. This could be linked to the low cost coverage/catastrophic insurance programs discussed under the medium priority ideas earlier (see Appendix Page 18).
- **Local Government Taxes.** This funding vehicle could be used for many community-based health access solutions, similar to the family support levy passed in King County. This funding vehicle could be linked to specific services, such as immunizations, or targeted to pay for services such as 911 emergency access (as used to be done with the Medic One program in Seattle). Raising taxes may be difficult to do in rural areas, where there are very limited resources; on the other hand, it may be easier in smaller areas to generate community support and participation for funding health care services locally.
- **Health care mortgages.** Develop administrative mechanisms that allow individuals to finance high cost health care over an extended period of time, similar in concept to mortgaging a house over 30 years. This approach might work best in conjunction with federal tax reforms allowing increased individual tax credits for health care expenses. Concerns were raised over how to prevent default on the loan, particularly in situations of continued poor health, personal bankruptcy, and other complications.
- **Health Care Credit Card.** This would be a dedicated health care credit card, for which each individual (or family) is personally responsible. For low income persons with financial sponsors (e.g., BHP or Medicaid), there could be periodic settlements to prevent undue burden on the beneficiary. The health care credit card could be combined with a high deductible, catastrophic insurance plan to give personal financial protection against extremely high cost events. The major difference between this card and typical credit cards would be low interest rates to allow practical financing of medical costs over time. The low interest rates could occur either through sponsorship by a not-for-profit agency or possibly via a government sponsored program. Several companies in other states are currently offering these types of cards in conjunction with preferred provider network discounts, but the interest rates charged have not made them particularly attractive to most consumers.

Several other ideas were raised by individual reviewers of the draft report. These have not been analyzed, but are presented below to make sure all ideas generated by this project are captured and documented.

- Mandatory catastrophic health insurance, with a high deductible, combined with expanded public delivery of primary and preventive care through the schools and the public health system. This might be the ultimate answer to improving access in a no frills, low cost manner.
- A citizen's initiative to study the problem. The initiative would require the legislature to convene a broad-based study/recommendation process, resulting in some set of measurable goals by some date. For example, that all Washingtonians be both eligible for and enrolled in health coverage. It was acknowledged that this is neither direct nor incremental, "but if someone doesn't start something, no one will..."
- Press DSHS to do a better job of streamlining the Medicaid application process, and study why current eligibles do not sign up for Medicaid. The administrative hassles need to be reduced. [*EOI may want to check with the WSHA Kids.Health.2001 program at the Washington State Hospital Association to see if they have any data on why eligible people do not enroll.*]
- Lobby at the national level for Medicare coverage of prescription drugs.
- Sponsor creative public forums to get more visibility for these issues and for EOI.
- Pull together a joint meeting of the various entities working on access problems (e.g., WHF, FHCQ, HPAP, Friends of the BHP, EOI, etc.) to coordinate efforts, improve synergy, and have complementary efforts that support each others' work.
- Address the lack of choice many employees have when their employer offers only one health plan. This is an access issue too, given health plan network restrictions.
- Segment the population into three parts – seniors (already covered under Medicare), children (to be covered by a separate carve-out insurance program similar to Strategies 2 and 3 combined), and other adults (continue the current piecemeal system). Support the children's insurance (including pre-natal and childbirth) via a tax-based funding system. If this area (children) could be addressed, then time and other factors would enable the remainder of the problem to be addressed in proper order.
- Two aspects of health care are largely ignored by the recommendations and analyses: rural health care access issues and access to dental care. These should also be addressed by EOI, since in many areas uninsured adult access to dental care is the biggest issue.
- Hire a bunch of Access Coordinators all over the state in a massive effort to get all eligible people enrolled in Medicaid and BHP. This is the most practical approach to getting people enrolled in existing programs.

APPENDIX C

ACKNOWLEDGEMENTS

The Economic Opportunity Institute (EOI) convened a health policy brainstorming session on October 11, 1999 to discuss practical and incremental approaches to expanding health care access in Washington state. Participating in the brainstorming session were:

Anita Boser	Bob Crittenden	Leo Greenawalt	Marc Provence
Dennis Braddock	Aubrey Davis	Susan Johnson	Margaret Stanley
John Burbank	Cheryl Ellsworth	Pam MacEwan	Kirsten Wysen
Eileen Cody	Paul Goode	James Matthisen	

The participants attended as concerned citizens and did not participate as representatives of their respective organizations. The session was facilitated by the project consultant, Lance Heineccius, with detailed meeting notes compiled by Kristina Wilfore of EOI. Participants were also asked to submit via e-mail any ideas they had subsequent to the meeting, and several participants did follow up with additional ideas.

Once an initial set of potential ideas were identified, the group then discussed priorities for subsequent action, primarily using the following evaluation criteria in an implicit manner:

1. **Must** actually expand access to health care services
2. **Must** be feasible (meaning achievable, "winnable" politically)
3. **Must** be sustainable over time (or at least appear to be so at present)
4. Should be gradual and incremental rather than requiring radical, rapid change
5. Should be able to generate broad support (especially within the electorate)
6. Should result in a healthier population as one ultimate outcome
7. Should result in value for the dollars spent; greater value than current approaches
8. Should be simple to explain, implement, and administer

A first draft report was prepared by the project consultant and distributed for review to the brain-storming session participants and others in mid-November, 1999. Comments were received from most of the initial participants, plus the following individuals:

Ros Bond	Aaron Katz	Peter McGough	Kristen West
----------	------------	---------------	--------------

The final report was prepared in early 2000, reflecting as many of the reviewer comments and concerns as possible. A summary of the comments is available from the EOI.

The Economic Opportunity Institute gratefully acknowledges and appreciates all the efforts of the above-named volunteers in helping to make this a useful and focused report.