

Rhode Island's Uninsured Basic Reform Landscape

November 30, 2007



Today

- OHIC report and recent CPS data
- Trends in RI's uninsured
 - What?
 - Why? (Employer-based coverage erosion)
 - Who?
- Policy considerations



OHIC report and recent CPS data

OHIC Uninsured Report

- 2005 CPS and 2004 RI Health Insurance Survey (RI-HIS) data
- Combines national, broad CPS with local RI-HIS
- Next OHIC report will incorporate latest CPS data



OHIC report's key points

- Trend
The long-term future of employer-sponsored coverage is not good even with year to year fluctuations
- Eligibility
Tighter eligibility rules by large employers is the main contributor to RI's rising uninsured
- Low-income
The uninsured are overwhelmingly low-income and working



Trends in RI's uninsured

- Uninsured Rlers under age 65 increased from 6.9% to 13.3% from 2000 to 2005 (119,157 total)
- RI's uninsured rate is slightly higher than neighbors' and New England's, but much lower than national
- Rlers covered by employer-based insurance dropped from 77.7% to 67.6% from 2000 to 2005



Eligibility: employer-based coverage erosion

Why are employees not enrolled in employer coverage?

- **Offer** - employers do not offer
- **Eligibility** - offered, but employee is not eligible, e.g.:
 - the number of hours per week one must work to be eligible
 - the number of months an employee must work before eligibility
- **Take-up** - employer offers, employee is eligible, but employee declines coverage



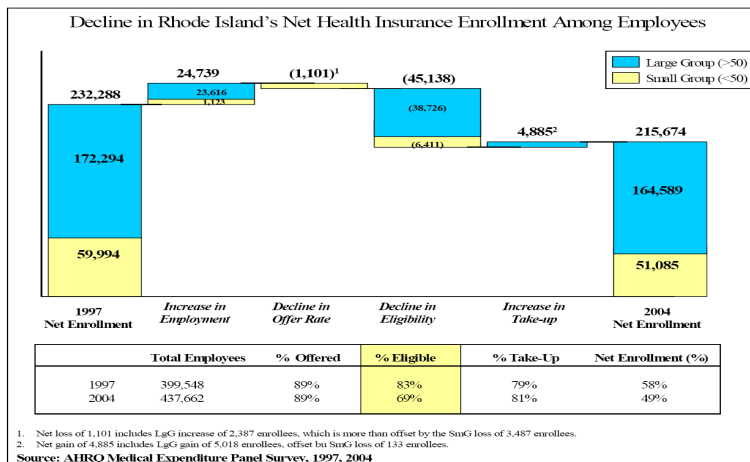
Eligibility: employer-based coverage erosion

- **Offer and take-up rates** were steady between 1997 and 2004:
 - **Offer** rates overall remained about 88%
 - The offer rate for small employers declined from 70% to 66%
 - **Take-up** rates actually increased from 78.8% to 80%.
- **Eligibility** rates have declined from 83.4% to 68.9% between 1997 to 2004
 - RI employee eligibility lagged behind MA and the nation in 2004:



Eligibility: employer-based coverage erosion

Declining eligibility: a key driver



Eligibility: Employer-based coverage erosion

- Some of the employees who are no longer eligible for health insurance may still have access to insurance through other sources (e.g. family member).
- Much of the decline in eligibility could be due to a transition in business mix in Rhode Island, away from manufacturing and toward service industries that rely more on part-time workers and do not typically offer health insurance.



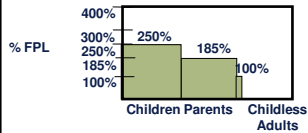
Who are RI's uninsured?

Low-income and working

- Virtually all of the *growth* (91.8%) of uninsured from 2001-2005 was from people with income below 300% FPL
- The total uninsured are disproportionately low-income:
 - 48% of Rlers make less than 300% FPL (\$51k for family of three)
 - 78% of RI's uninsured make less than 300% FPL
- 62.9% of the uninsured are working



Who are RI's Uninsured: Strategy Implications

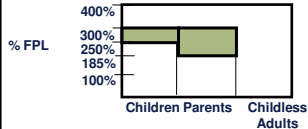


32% of the uninsured (37,871)

Low income families currently income eligible for Medicaid or RItteCare but not enrolled.



Expanded Medicaid outreach?

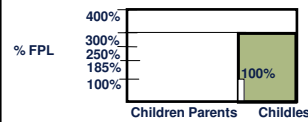


8% of the uninsured (9,090)

Children and parents, below 300% FPL - do not qualify under current RItteCare income eligibility rules.



Expanded income guidelines for RItteCare? Medicaid subsidy for private purchase?

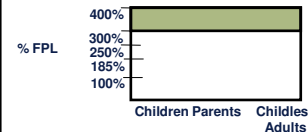


38% of the uninsured (45,577)

Childless adults, below 300% FPL. RItteCare eligibility only allows for disabled adults under 100% FPL.



A new population of Medicaid eligibles (childless adults) – add to RItte Care or private buy in?



22% of the uninsured (26,620)

Have incomes above 300% FPL, ineligible for any Medicaid enrollment.



Multiple studies have shown that voluntary programs do not affect take-up. Some form of individual and employer mandate, requiring people to purchase health insurance?

Key Take-Aways from Uninsured Report

- The vast majority of the uninsured are <300% FPL
 - Subsidies required
 - Many are already eligible for RItteCare
 - Heavily reliant on Federal Medicaid partnership
- Declines in employer-based coverage are predominantly driven by large group eligibility and small group offer rates
 - Focus for short term targeted strategies
- Caveat: Results are not exact. Data is limited and becoming outdated

Where we are: Short-term RI reform initiatives

Budget reality: focusing on initiatives that increase access but don't cost money

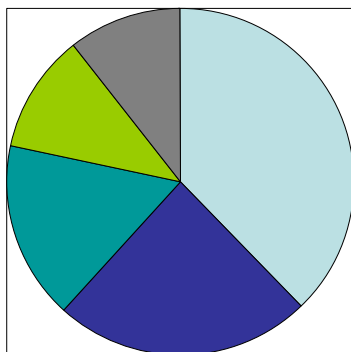
- **Protect RIte Care**
- **Facilitate more individuals purchasing directly**
 - Stabilizing direct pay market: 10-12% cheaper than small group. But at price....
 - Section 125 requirement: buying pre-tax
- **Keeping SmG employers “in the game”**
 - HealthPact
 - Market Merger Study – refining small group rating rules, distribution processes, etc.
 - “Basic Plan” for companies not currently offering.
- These initiatives do not address bulk of uninsured: low income workers in large businesses.

Current Realities for Financing

- ❖ No new public money for coverage expansion
- ❖ Employer-based coverage is slowly eroding, overall driven by costs - effecting low income workers.
- ❖ Cost crunch may be greatest on public purchasers – Medicaid, Medicare and Public employees.
- ❖ Change is incremental – the current system *sort of works* for 85% of population and 20% of economy.
- ❖ Employer-based coverage: all the inequity of private market and all the efficiency concerns of public financing.
- ❖ Multiple financing sources for medical care make it very easy to shift costs and forego long term investments (e.g. HIT, Chronic Care and Primary care).

Current Realities

- Insured by source of coverage in RI



Legend for the pie chart:

- Fully Insured
- Self Insured
- Medicaid
- Medicare
- Uninsured

State Gov't Covers (in part) for :

-175 k Medicaid
-50k state ees
-70 k schools and municipals
= 1/3 of covered lives

Key Policy Decisions

- ❖ Where we go from here depends upon the problem we are trying to solve: Access? Cost? Medical Care Quality? Public Health? Cost Trends
- ❖ Financing – how much more are we willing to pay to cover the uninsured? How much to pay for not covering them? Do we want to partner with CMS or go it alone?
- ❖ How much inequity can we stand?
 - ❖ Is it **medical care** – a personally driven commodity, like food or housing, or is it **health** – a public good like water, or roads?
- ❖ Where do we want to end up?
 - ❖ Need to understand the ideal end point – even if we never will get there – so incremental decisions can head in that direction.

End Points (Simplified) – Who pays the bill?

- ❖ **Employer:**
 - ❖ Health Insurance as employment benefit. Public picks up those left out.
 - ❖ Looks like – what we got
- ❖ **Individuals**
 - ❖ At minimum - Health insurance is catastrophic protection.
 - ❖ Looks like: auto. Riding the bus = going to public provider.
- ❖ **Public – Regulator**
 - ❖ Current system plus public regulating private utilities. Low income subsidies.
 - ❖ Looks like: National Grid.
- ❖ **Public Purchaser**
 - ❖ Public purchases from administrators on behalf of all (or almost all) beneficiaries. Sets rules, makes market.
 - ❖ Looks like: Rite Care or State employees for all.
 - ❖ (But: What differentiates Rite Care from Local municipality? Also – does this end up being truly different from a regulator?)
- ❖ **Public Payer**
 - ❖ Public pays providers for basic benefit for all. Individuals buy up with private



Evaluating the End Points (no magic wand required)

Attribute	Defn.	Employer Based	Individual Based	Public Rate Setter	Public Purchaser	Public Payer
Cost	Lower Cost of Medical Services	(what are levers? How effective?)				
Trend	Lower trend going forward					
Uninsured	Reduce/eliminate uninsured					
Quality	Improve quality of medical care					
Health	Improve Public Health					