

Improving Health Insurance Coverage in the District of Columbia

Report of
the Health Care Coverage Advisory Panel
to the D.C. Department of Health
under Its State Planning Grant

May 1, 2006



The D.C. Health Care Coverage Advisory Panel

State Planning Grant/D.C. Department of Health

GOVERNMENT OF THE DISTRICT OF COLUMBIA



State Planning Grant
Health Care Coverage Advisory Panel

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The Health Care Coverage Advisory Panel is proud to submit our report, *Improving Health Insurance Coverage in the District of Columbia* to the D.C. Department of Health. The Panel first convened in May of 2004 to begin a serious dialogue on the problems of uninsurance facing our city. To ensure valuable discussion, it was critical that the panel be a diverse representation of residents. Amongst us were public health professionals, business associations, insurance companies, and representatives for the uninsured. We gave generously of our time because we share the vision of improving health and access to care in the District of Columbia. So after numerous debates, long hours, and a thorough review of all the relevant data, we provide policy recommendations that get us to our vision. As the Chair, I am proud of the progress we have made.

Early on the Panel established guidelines that support the notion that health insurance coverage is the most effective means to improving health outcomes for vulnerable populations in the District. Although, coverage for all residents is the preferable policy, our current recommendations offer a more immediately feasible approach to expanding health care coverage. We have focused on developing sound and affordable policy options that should achieve a reasonable impact for the expected cost. The recommendations, when implemented, will further the District in its efforts to improve access to healthcare for its residents. In particular, these recommendations strive to enhance what the District currently does by increasing enrollment of currently eligible residents into already established public insurance programs and by increasing the number of residents who qualify for eligibility.

The Panel looks forward to building on the work accomplished so far and to the further promotion of these recommendations as sound health policy.

Sincerely,

A handwritten signature in black ink, appearing to read "Bailus Walker, Jr.".

Bailus Walker, Jr., Ph.D., MPH

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Executive Summary

While the uninsurance rate in the District is lower than the national average, there remains an unacceptably high number of residents who are not covered. Among residents under age 65, on average about 74,000 people did not have coverage at some time during the year. Within this population, about 15,000 have family incomes above 200 percent of the federal poverty level, disqualifying them for public insurance programs such as Medicaid and the Alliance. Among families that do qualify for these programs, some have been successfully enrolled, but a large number have not. Families that qualify for public coverage but are not currently enrolled make up a large portion of the uninsured in the District.

The purpose of health insurance is to improve access to health services to improve health status. Death rates and morbidity are demonstrably lower among the insured. Insured people are also more efficient and effective consumers of health services, in that they are more likely to have a regular source of care and to seek help when first needed rather than showing up at a hospital with more advanced problems. Regular care, especially for chronic conditions, can also help prevent or postpone longer-term worsening of health. Healthy residents are more productive workers and students, and contribute to the economic well-being of the community.

To help assess ways to improve coverage, the Department of Health convened the Health Care Coverage Advisory Panel under the District's State Planning Grant (SPG). The Panel represents residents of the District as well as associations, private-sector groups, and public agencies. Over the course of 10 full meetings and additional meetings of working groups, Panel members weighed evidence on who is uninsured and why, what other jurisdictions have done to expand coverage, and what is the full range of options for increasing coverage in the District of Columbia. Based on this information, it developed eight recommendations for expanding health insurance in the District.

The Panel adopted three key criteria for options worthy of recommendation. Members agreed that any intervention recommended should achieve a reasonable impact for the expected cost, be politically feasible, and encourage the maintenance of private support for existing and expanded insurance coverage. Change needs to be perceived as making the District a better place to live, work, and do business. The Panel also took as a guiding principle that providing or ensuring health insurance coverage was the most effective means to improve health outcomes for vulnerable populations; investment in improving the delivery system was identified as a second priority. Panel members share the vision of coverage for all residents but recognize this as a long-term goal. The recommendations proposed here offer more immediately feasible approaches that do not require the kinds of mandates for coverage and federal action that would be needed to achieve 100 percent coverage. They represent the consensus of the Panel.

Recommendations 1, 2, and 3 address ways for the District to do better what it is already doing to enroll eligible residents in applicable programs and to help employers find appropriate health insurance plans. Recommendation 4 addresses improving the public coverage available to residents below the poverty line.

Recommendations 5 and 6 both target the working poor who do not currently qualify for publicly sponsored coverage programs, the former through public programs and the latter through development of private coverage options. The Panel recommends that the public

program be implemented but notes that the private option needs additional study before it can be recommended for implementation.

Recommendations 7 and 8 address issues that will be critical to the implementation of all of the recommendations. One deals with personnel and the other with evaluation and monitoring.

Specifically, the DC Health Care Coverage Advisory Panel recommends

1. that the Department of Human Services, Income Maintenance Administration, develop a unified system for enrollment into publicly financed health programs working in conjunction with the Department of Health, Medical Assistance Administration, and the Health Care Safety Net Administration;
2. that the District establish an information clearinghouse on health insurance products;
3. that the District improve outreach and enrollment for the Alliance and Medicaid in order to enroll eligible residents who are not yet enrolled;
4. that the District improve the public coverage available to nondisabled adults with family incomes below 100 percent of FPL through a public program that has benefits and access comparable to Medicaid;
5. that the District develop a mechanism to allow uninsured residents with family incomes between 200 and 400 percent of FPL to buy into Medicaid or the Alliance;
6. that the Department of Health provide analytic support to the further development of the Healthy D.C. proposal, a public reinsurance program for small business health insurance plans under consideration by the Council;
7. that the Mayor ensure that implementing agencies have adequate staff with appropriate training and other necessary resources, dedicated to supporting implementation of these recommendations; and
8. that the District make tracking and assessment of new coverage initiatives part of their design and implementation.

Each of these recommendations is described more fully in the body of this report identifying the target group, where appropriate, and the supporting rationale. Following some recommendations is a list of outstanding questions needing further investigation. These generally relate to implementation and so were beyond the scope of the Panel to address. These are left to the Department of Health and other policymakers to address in the final design of the recommended programs.

Each of the proposed programs comes with a cost, the size of which will be determined by its final specifications. Any could be implemented with a budgetary limit. The Panel did not identify funding for the recommendations. The Panel recognizes that the District will always have competing uses for any available funding and that, even within the funds available to fund health, there will be competition among alternative ways to promote access to services and improved health outcomes. Members feel strongly that expenditures on expanding health coverage for District residents is one of the most effective investments the District can make toward improving health outcomes and health status. However, decisions about funding must be made as part of the overall budget process and in collaboration with affected stakeholders.

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Vision for the District of Columbia

The vital goal of this project has been to maintain and expand access to health insurance in the District. Panel members have weighed evidence on who is uninsured and why, on what other jurisdictions have done to expand coverage, and on the full range of options for increasing coverage worthy of consideration for the District of Columbia. Members have given generously of their time because they shared the vision of improving health insurance and access to care in the District of Columbia.

The Health Care Coverage Advisory Panel, under the District's State Planning Grant (SPG), represents residents of the District. Member organizations include associations, private-sector groups, and public agencies. Unlike many prior panels, the Advisory Panel includes a broad cross-section of entities including not only health care providers and advocates but also private business representatives and people concerned with economic development. It has held 10 full meetings approximately quarterly beginning in May 2004, along with a similar number of sub-panel meetings.

Nationwide, there have been efforts to assess the uninsured population and seek feasible policy options to address their needs. In the District of Columbia, there is an identified gap in health insurance coverage, with deleterious impacts on the uninsured, their employers, their families, and their communities. Among residents under the age of 65, about 74,000, or 15 percent, lacked coverage at some time between 2001 and 2003 according to recent federal census data. Perhaps a third of these had coverage under the District's innovative D.C. Healthcare Alliance, which is not tabulated by the census survey. By some comparisons, the District is doing relatively well; its employers have commendably high rates of offering coverage, though most workers in D.C. are nonresidents. The District, to its credit, already operates a substantial Medicaid program, including D.C. Healthy Families, and the Alliance covers childless adults and others ineligible for Medicaid for those with family incomes up to 200 percent of the federal poverty level (FPL). Still, tens of thousands of people with family incomes under 200 percent of FPL lack coverage, people seemingly eligible for public programs but not enrolled. Also uninsured are about fifteen thousand people who have family incomes of 200 to 400 percent of FPL, incomes too high to qualify for today's publicly sponsored programs. Small businesses are especially hard pressed because of the ever-increasing cost of health insurance, even though most continue to offer their employees coverage, usually with a substantial employer contribution to premium.

Although the District has made significant efforts to reduce the rate of the uninsured, there is more to be done. The facts support that it is desirable for communities to have as much of their population insured as possible. Death rates and morbidity are demonstrably lower among the insured. Insured people are also more efficient and effective consumers of health services because they are more likely to have a regular source of care and to seek help when first needed, rather than show up at a hospital with more advanced problems. Regular care (including dental care) especially for chronic conditions can also help avoid

or postpone longer-term worsening of health. Healthy residents are more productive workers and students, and contribute to the economic well-being of the community. Total health care spending can be expected to increase when people are insured because they get more of the care they need, but the return to investment in health is seen in improved quality of life and greater productivity in the workplace, for adults, or in school, for children. Insurance also reduces the burden on hospitals and other safety net providers to provide uncompensated care to those who lack coverage. The SPG conducted a survey of small businesses that showed that most small employers feel that offering health coverage is the “right thing to do.” So does this Panel. More can and should be done to help District residents get the insurance coverage they need to be productive community members.

It has been very useful for both business and government to be represented capably on this Panel, exchanging information about the constraints each faces and ideas about how to work jointly to reduce barriers to coverage. Early on, the Panel adopted three key criteria for options worthy of recommendation. Members agreed that any intervention undertaken should

- achieve a reasonable impact for the expected cost,
- be politically feasible, and
- encourage the maintenance of private support for existing and expanded insurance coverage.

Change needs to be perceived as making the District a better place to live, work, and do business. Panel members share the vision of coverage for all residents, but recognize this as a long-term goal. Today’s recommendations offer more immediately feasible approaches, ones that do not require the kinds of mandates for coverage and federal action that would be needed to achieve 100 percent coverage of District residents. The federal government exercises enormous influence in the District’s insurance markets, given the size of the federal employees’ health benefits program, Medicare, and Medicaid, as well as federal jurisdiction over employment-based benefit plans under ERISA (the Employee Retirement Income Security Act of 1974). Many see lack of insurance as a national problem, and cross-state issues also loom especially large in D.C. because the neighboring state lines are so close. Businesses, workers, and residents can easily change jurisdictions with little disruption to their business and personal lives. It is noteworthy that interstate and even international business locational decisions can be affected by the availability and cost of coverage, and the Panel expresses the hope that the federal legislative and executive branches will soon again address the problems of uninsurance that go beyond any single jurisdiction.

Guiding Principles and Priority for Implementation

With the foregoing vision and under the constraints noted, the Panel has agreed upon the following set of principles for expansion along with eight recommendations for its convener, the Department of Health.

Guiding Principles

The D.C. Health Care Coverage Advisory Panel promulgated several key principles for District investment in improving health outcomes. These principles are summarized here; full text is provided in the appendix.

- The highest priority must be providing or ensuring health care coverage.
- As a second priority, the delivery system available to vulnerable populations needs to be strengthened.
- Any investments in improving access to care should be made in a manner that promotes a coordinated system of primary, preventive, and continuing care for chronic conditions on an ambulatory basis with provision for judicious use of inpatient services.
- The District needs a sustainable structure for financing access to necessary care with the flexibility to adjust to expected demographic trends.
- The most effective way to improve health outcomes and reduce unnecessary costs is to invest in appropriate levels of preventive services, primary care, specialty care, and management of chronic conditions. Numerous studies suggest that provision of coverage for individuals rather than subsidies to institutions promotes choice in health care, encourages quality improvement, and ultimately leads to greater improvement in health outcomes.

These final recommendations represent the consensus of the Panel. This preamble sets forth the Panel's vision for the District. Subsequent sections offer concrete policy recommendations on insurance policy and identify a set of next steps for implementation and ongoing monitoring.

Priority Order for Implementation of Recommendations

In setting priorities for implementation, the Panel considered the target group for coverage, feasibility of the proposal, additional work required on the details of each recommendation, and cost.

The first two recommendations are near-term, low-cost options (*combined intake of enrollees into public coverage and information clearinghouse on private coverage*) that can and should be quickly implemented. The next three all constitute ways to increase the number of publicly insured residents in the District but will require additional analysis and work before implementation (*improved public enrollment of those already eligible, Medicaid or equivalent benefits for nondisabled adults under 100 percent of FPL, and buy-in to public coverage phased in for individuals with income between 200 and 400 percent of FPL*). These three recommendations are listed in the order of priority established through Panel deliberations.

The next recommendation (*analysis and development of Healthy D.C. proposal providing private coverage for individuals with income between 200 and 400 percent of the FPL*) is a recommendation for further study rather than for implementation since the Panel felt that there were significant unresolved issues in the proposal that precluded a recommendation of implementation at this time. The Panel believes that individuals with incomes in the 200

to 400 percent of FPL range are an important target group for expansion of coverage options. Both Healthy D.C. and a public program buy-in target this group, but through different mechanisms, the former with eligibility rising over time from 300 to 400 percent of FPL. If the available funds and administrative capacity are insufficient to support both initiatives for this group, the Panel recommends that priority be given to the public program buy-in.

The final two recommendations (*adequate resources for implementation and monitoring of operations over time*) relate to the implementation and operations of any recommended action and need to be effected at the same time as any other action taken.

Recommendations

Recommendation 1. Unified System for Public Eligibility Determinations and Enrollment

We recommend that Department of Human Services, Income Maintenance Administration, in conjunction with the Department of Health, Medical Assistance Administration, and the Health Care Alliance, be given responsibility to develop a unified system for enrollment into publicly financed health programs.

Discussion

The District should provide coordinated eligibility and enrollment determinations for Medicaid and the Alliance, the two largest publicly financed health coverage programs for low-income residents. Such a system minimizes the administrative burden both for the District and for applicants and should allow economies of scale in processing applications. Improving the accuracy of assignment into Medicaid over the Alliance, where appropriate, should increase the federal contribution to health coverage in the District. Finally, this initiative builds on existing efforts of the Medical Assistance Administration (MAA) and the Income Maintenance Administration (IMA) to improve enrollment processes.

This recommendation was developed in February 2005 and was largely accepted by administrative policymakers soon thereafter, although at the time of this report, not all of the necessary agreements for implementation were in place. IMA currently expects to begin enrollment under a “combined eligibility and enrollment” system in June 2006.

The Panel notes that the implementation of a unified system of enrollment as called for in this recommendation would not bear fruit without adequate personnel and other resources. Therefore, the Panel emphasizes that implementation of this recommendation will require concurrent implementation of recommendation 7, below.

Recommendation 2. Information Clearinghouse on Private Coverage

We recommend that the District establish an Information Clearinghouse on Health Insurance Products available to the public.

It is recommended that the District (1) assure adequacy of funding for the clearinghouse for both start up and ongoing operations within the budget of the Department of Insurance, Securities, and Banking (DISB); (2) fund an annual insurer survey of policies actually sold within the District, including information about the structure of the coverage (e.g., HMO, PPO, POS, indemnity; typical cost sharing provisions), the size of groups currently insured, the volume of sales to these groups, and company contact information for prospective clients/enrollees; and (3) work with the appropriate government and private entities to promote use of the clearinghouse among local employers and residents.

Discussion

Many small D.C. business owners and residents who are not eligible for workplace or publicly financed health care coverage are not aware of private insurance options that may be available to them. Research conducted under the SPG showed that more than half of small businesses in the District had difficulty finding helpful information on the range of coverage options for their workers. Focus group participants also suggested that information barriers exist. DISB is the logical institutional home for the clearinghouse because it relates to private insurance rather than public health programs, and improved information about market functioning could help inform DISB's regulatory decisions.

According to a national survey of small employers conducted by the Employee Benefits Research Institute about five years ago, better information about health insurance options could slightly increase the offering of employee health benefits by small employers. If workers within the insurance clearinghouse and public-program-intake offices were cross-trained to appropriately refer cases to one another, information about all types of options could be improved simultaneously.

The Clearinghouse should be more than a compendium of products and services. It should include information to help employers and consumers address problems they might encounter in trying to get health insurance. Sites in some states provide both consumer complaint resolution information and guidance to help address some of the challenges and obstacles that consumers face. The final design of the Clearinghouse should take into account the coordination of insurance information and consumer complaint assistance for District residents and employers.

Currently, the District government maintains a web site with information about public health insurance programs (e.g., Medicaid, Medicare, SCHIP, the Alliance) and a list of

private insurance companies that are licensed to sell health insurance products, but who may or may not actually do so, in the District.¹ This site emphasizes public options, however, and provides very little information about private coverage.

Several states, including Maryland and Virginia, provide web-based consumer guides. Maryland's addresses small business.² The state also gives residents counseling and assistance in identifying health coverage options and in negotiating complaints and appeals processes, among other functions.³ Other states, including Virginia, limit hands-on assistance to subgroups of consumers, such as Medicaid or managed care enrollees, state employees, or consumers of special services such as mental health care. Virginia Department of Health also has an informative web site,⁴ created by a private nonprofit firm, that lists insurers offering plans to small businesses and individuals in the various regions of the state. It includes information on typical premiums (before underwriting), extent of cost sharing, and provider networks.

A clearinghouse could be run as solely a public entity, or it could be a public-private partnership combining public needs and funding with private expertise and operations. Each alternative has advantages and weaknesses. One of many tasks for the recently authorized Department of Health's Ombudsman is providing information about coverage options to District residents. This office could provide a locus for clearinghouse activities. However, the core ombudsman function is responding to complaints about denied insurance claims. It is not apparent that either funding or institutional support will be sufficient to operate a useful clearinghouse. Furthermore, neither businesses nor health insurers are used to seeking information from or reporting it to the Department of Health.

The DISB also has a claim to be the right public entity to run a clearinghouse. In contrast to the Ombudsman, it is an established operation with ongoing responsibilities for the conduct of insurance business in the District. It also collects information from licensed insurers annually, mainly as part of analyzing their financial security. This function could be expanded to include the collection and publication of information about health insurance products offered in the District. DISB, however, also has many competing responsibilities, and its institutional commitment to and resources for providing client services to D.C.'s large number of small businesses is uncertain.

Basing the clearinghouse in a private sector organization—such as the D.C. Chamber of Commerce—has the advantage of locating the responsibility for informing small businesses within an institution that already serves this function in other matters. Such a group benefits from greater confidence among local business owners. The clearinghouse could be a higher institutional priority within an organization whose mission is congruent with the activity. On the other hand, it may be more difficult to obtain funding for an activity that is conducted outside government. On balance, a public-private approach seems best.

1. <http://hc.rrc.dc.gov/hc/cwp/view,a,1221,Q,454849,hcNav,|.asp>

2. <http://mhcc.maryland.gov/smallgroup/index.htm>

3. Fish-Parcham, Health Assistance Partnership, Families USA, January 2005

4. See <http://www.insuremorevirginians.org/smallbusinessguide>, which refers to <http://gunston.doit.gmu.edu/chpre/smallbusinessguide/>

Actions required to support this recommendations would include; (1) funding an annual insurer survey of policies actually sold within D.C. and the volume of sales to individuals, small groups, and large groups, (2) appropriation of funds for the Clearinghouse function (a) for start up and (b) for ongoing operations; and, (3) locating the clearinghouse responsibility within the DISB and possibly contract with a private business association or affiliated entity to perform certain clearinghouse functions.

Start-up spending is likely to run in the range of \$150,000 to \$300,000, depending on the effort put in to create or revise descriptions of options, to render them in Spanish and possibly other languages, and to develop new information on the insurance market and offerings within it. Annual costs would probably be in the lower end of this range and might be found within the current DISB budget. Costs would also depend on operational parameters. For example, the focus might be limited to small employers, or policies sold to very few clients might not be covered. Similarly, the extent of call-in help could vary enormously.

Remaining questions

The Panel notes the following open questions whose answers may affect the final design or implementation of this option:

- Is this activity sufficiently like other public programs to be effectively run from within government or should many tasks be contracted out?
- How can this effort best relate to existing agents and brokers who also inform prospective purchasers and actively provide advice and assistance in buying a policy?
- How will employers and residents be made aware of the clearinghouse and get access to it?
- How often will information in the clearinghouse be updated?
- Would this function, if assigned to DISB, require an increase in the assessment on insurers and HMOs?

Recommendation 3. Improved Outreach and Enrollment for Medicaid and Alliance

We recommend that the District improve outreach and enrollment for the Alliance and Medicaid in order to enroll residents who are eligible but not yet enrolled in these programs.

It is recommended that the District (1) take advantage of the new combined eligibility and enrollment process at IMA to simplify the process and thereby encourage applications; and (2) undertake targeted outreach efforts within identified communities with currently low enrollment rates (particularly Latinos, workers in small businesses, and men) using known and trusted community organizations.

Discussion

An estimated 22,000 of D.C.'s nonelderly uninsured are eligible for existing publicly financed coverage programs, primarily the Alliance, but also Medicaid. Truly effective outreach is needed to bring actual coverage more closely into line with eligibility. Expanding enrollment into Medicaid for categorically eligible enrollees brings additional federal funds into the District's health care system, while some federal waivers and the Alliance provide coverage for residents not eligible for conventional Medicaid. Increased coverage through existing programs will reduce uncompensated care at hospitals and primary care providers, allowing scarce funding for the uninsured to be targeted at populations in the District ineligible for coverage.

An estimated two-thirds (roughly 50,000 residents) of D.C.'s nonelderly uninsured are in households with incomes less than 200 percent of the federal poverty level and thus are eligible for either the Alliance or Medicaid. The Alliance reports that it now covers more than half of these (about 28,000). The remaining 22,000 residents are eligible but not enrolled in publicly sponsored coverage programs. Three groups—Latinos, workers, and men—are disproportionately represented among the uninsured and so are priority groups for outreach efforts.

Assuming outreach and enrollment efforts are successful in reaching at least half of the eligible but not enrolled population, an additional 11,000 low-income residents would have coverage and the uncompensated care burden of health providers that now serve these residents would be commensurately lower.

We estimate that an increase in enrollment in these two programs would require an additional \$10–33 million in District funding annually with the exact amount depending on the distribution of enrollees between the two programs. For residents who are eligible, enrollment in Medicaid is preferable to enrollment in the Alliance because 70 percent of Medicaid's cost is covered by federal financial participation. If we assume that each new enrollee would cost on average \$3,000 in services, then 11,000 new Medicaid enrollees would cost the District about \$9.9 million per year. If all enrolled in the Alliance under the same service cost assumption, the cost would be \$33 million per year. These costs do not

include administrative costs at IMA, MAA, or the Alliance, nor do they include the cost of the outreach programs to achieve this enrollment.

It is suggested that the District undertake outreach efforts within identified communities with currently low enrollment rates. We recognize that current mass media efforts to reach eligible populations are laudable but insufficient and that the scheduled improvements in enrollment practices are helpful but also likely to fail to reach and enroll most of the uninsured. Recent research has suggested that the most effective outreach uses organizations that have developed trust within the communities they serve. Therefore, in addition to the DHS/IMA operational changes to improve enrollment processes for eligible residents, targeted outreach efforts should be undertaken for the identified priority population groups using known and trusted community organizations. Outreach programs should be designed to use existing communication networks that employ multiple communication channels, including electronic messaging and word-of-mouth, to optimize dissemination of the hours, locations, and details of enrollment services throughout the community. Particular emphasis should be placed on outreach efforts to low-income members of the following groups:

Latinos. Research suggests that the Latino community is particularly skeptical of official communications and hesitant to interact with government organizations. Specific outreach programs should be designed for organizations that have the trust of this community to use for their constituents. In addition, as the outreach programs are rolled out, IMA workers should be aware of and prepared for the likely increase in applications from these groups. Consideration should be given to out-stationing eligibility workers during designated enrollment periods or to establishing formal links between the community organizations and IMA. In order to reduce attrition of enrollees, efforts should be made to maintain consistency of staff working in the community sites, as personal connection has been shown to be the single most important factor in retention rates for any program, and to develop a system for providing reminders of the date the next action is required on the part of the enrollee.

Workers in small businesses. Workplace-based strategies should target both employees and employers. Consideration should be given to combining the information about insurance options for small businesses (a separate Panel recommendation) with information about public program eligibility. In addition, outreach materials at clinics should be designed with workers in mind since workers often look to clinics rather than employers for health and coverage information.

Men. Men are disproportionately represented among the uninsured. Research has suggested that the entire family benefits when all are enrolled together. The outreach efforts for both Latinos and workers should be designed specifically to encourage enrollment by men.

Remaining questions

The Panel notes the following open questions whose answers may affect the final design or implementation of this option:

- How much of available resources will be consumed by covering these people, who constitute a large majority of the uninsured?
- What share of current nonenrollees are categorically eligible for Medicaid and hence will attract federal matching funds?
- To what extent is it true, as theory suggests, that current nonenrollees are healthier and hence less costly to serve than existing enrollees?
- To what extent will the new enrollees be placed in managed care versus fee-for-service coverage?
- Should new enrollees be enrolled in managed care plans or provided with fee-for-service coverage?
- What are the relative advantages and disadvantages of each approach, and do these depend on the characteristics of the new enrollees (such as age, family status, health status)?

Recommendation 4. Improved Coverage for Low-Income Non-Disabled Adults

We recommend that nondisabled adults with family incomes under 100 percent of FPL be given access to coverage in a public program that has benefits and access comparable to Medicaid.

Such coverage could be accomplished by expanding Medicaid to include this group under a waiver program, which might allow the District to receive federal financial participation for coverage of this group. Alternatively, it could be accomplished by making benefits and reimbursement under the Alliance, for which this group is already eligible, comparable to that found in the Medicaid program. The Panel recommends that *at least* 50 percent of the new Medicaid DSH funds under the recent federal technical correction be directed to enrolling this group.

Discussion

Individuals in this income category often have among the greatest health care needs of the nondisabled population and the least ability to pay for the needed services, and so the Panel recognizes them as a priority target population. Use of the new monies embodied in the technical correction for coverage of this group is consistent with the Panel's principles of supporting insurance coverage and ambulatory care in order to avoid unnecessary hospitalizations and improve health. Although District hospitals have previously received a proportion of any new federal DSH funds made available under technical corrections, the Panel recommends that *at least half* of the new federal funds received each year under this technical correction go to coverage expansion. Increased coverage will reduce the need for uncompensated care at hospitals.

An estimated 21,000 of D.C.'s uninsured are adults without dependent children who have incomes below the federal poverty level. Extending coverage to this population using Medicaid, rather than the Alliance, is desirable because Medicaid has traditionally been better able to assure access to care for this needy population. (New changes to the Alliance may alter the balance.) Again, the shift to Medicaid might also reduce the financial burden on the District since there could be federal matching funds for some members of this population, depending on how eligibility is structured.

This recommendation could result in an expansion in coverage to about 5,000 D.C. residents even if the waiver enrollment is capped at roughly one-quarter of uninsured childless adults. The expansion would improve access to care for these residents and eliminate the cost shifting that now occurs by hospitals and other providers to finance their care.

This proposal could build on an existing Medicaid waiver although the preparation of additional or amended waiver requests to CMS can be a costly and lengthy process. After extensive debate, the D.C. Council gave the Department of Health approval to request a federal waiver to expand Medicaid to childless adults ages 19–27 and 50–64 with incomes below FPL, on a phased-in basis. In 2002, the Centers for Medicare and Medicaid Services

(CMS) granted D.C. approval for a Medicaid waiver to serve these populations through 2008. Only the near-elderly category has been implemented, and enrollment has been limited. D.C.'s experience with the waiver has shown that low-income adults of this age have substantial medical needs and poor connections to primary care services. As of January 2005, some 719 individuals were enrolled in the waiver. The District has now suspended intake in the waiver because costs exceeded the funds allocated. The high costs were due in part to beneficiaries' frequent use of hospital emergency departments as a primary source of care. To better manage care and control costs, the District now has enrolled beneficiaries in Medicaid managed care plans that serve low-income families.

As of January 2004, 10 states and the District of Columbia covered some childless adults using a Medicaid waiver.⁵ The experience of Minnesota and Washington (two states with available data) indicates that average per capita costs vary for working adults from roughly \$200 to \$300 per beneficiary per month to over \$500 per beneficiary per month when covering very low income adults.

Assuming that each new waiver enrollee would cost a yearly average of about \$3,600 (\$300 x 12 months), then 5,000 new Medicaid beneficiaries would cost an estimated \$18 million (\$5.4 million in local match, \$12.6 million in federal funds). Public funds will need to be identified to cover the District's share. The District also will need to ensure that extending coverage will not exceed projected federal spending without the waiver since waivers must be "budget neutral." The current 50-64 waiver is financed using funds from a technical correction to the disproportionate share hospital (DSH) payment allocated to the District. Perhaps a similar approach can be proposed using some of the projected \$20 million in new District DSH funds included in the 2005 Congressional conference agreement for FY 2006 spending. Using such funding for coverage is important.

Remaining questions

The Panel notes the following open questions whose answers may affect the final design or implementation of this option:

- What proportion of the uninsured are in this category?
- Is the proposed DSH allotment sufficient to fund coverage for all of them?
- What evidence is there on the adequacy of access to needed specialty care for those now under the Alliance?

5. S. Dorn et al. 2004. "Medicaid and Other Public Programs for Low-Income Childless Adults: An Overview of Coverage in Eight States." Kaiser Family Foundation, WashingtonD.C. [[City?]]

Recommendation 5. Buy-In Mechanism for Public Coverage

We recommend that the District develop a mechanism to allow eligible uninsured residents with family incomes between 200 and 400 percent of the FPL to buy into Medicaid or the Alliance, paying premiums based on a sliding scale.

Development of the initiative will include elaboration of the premium structure and a plan for phasing eligibility over time, taking into account likely selection effects, and development of procedures and policies regarding premium collection.

Discussion

Individuals with family incomes under 200 percent of the FPL are already eligible for coverage under either Medicaid or the Alliance. Individuals with family incomes greater than 400 percent of FPL are presumed to have sufficient resources to purchase coverage on their own, and the vast majority already has coverage. The Panel believes that giving individuals with incomes above the current eligibility cutoff the option to participate in publicly financed programs will contribute to continuity of coverage, and that offering a coverage package at a price that is in keeping with the individual's available resources fosters individual responsibility for the purchase of health care coverage. The goals of continuity of coverage and individual responsibility both require that funding for such an initiative be sustainable over the long term so that the option is reliably available. Individuals in focus groups held under the auspices of the SPG indicated their willingness to contribute toward the cost of coverage if the coverage is reasonably comprehensive and the price within their means.

The Panel recognizes that the design of the premium structure and the mechanisms for collecting premiums will be both difficult to accomplish and critical to the success of this initiative. It also recognizes that a large majority of residents in this income range already have private support for coverage, usually through an employer, which should not be discouraged; the extent of shifting from existing private coverage into the buy-in is uncertain and partly dependent upon final decisions of design and implementation. Therefore, the Panel recommends that final design and implementation learn from the experience of other states in similar efforts. It also recommends phasing in the higher-income limits in increments as eligibility for assistance rises to 400 percent of FPL so that mid-course corrections can be made based on experience.

Implementation of this recommendation would make public coverage available to D.C. residents in households with incomes between 200 and 300 percent of FPL who do not have other health insurance, private or public (e.g., Medicare or employer coverage through District Government). Individuals who were offered, during the most recent open enrollment period, employer-provided health insurance coverage for which the employer would pay at least 50 percent of the premium cost and declined such coverage would not be eligible. Persons who initially did not have access to such coverage through an

employer, enrolled in the buy-in program, and were later offered such employer-provided coverage would not be eligible for the buy-in program as of the end of the first open enrollment period when such coverage was available. Individuals in a family household who were offered single but not family coverage would, however, be eligible for dependent coverage through the buy-in.

Enrollment in the Medicaid/Alliance buy-in option would be handled by the Income Maintenance Administration (IMA), which (as of June 1, 2006) is responsible for eligibility determination and enrollment for the Medicaid and Alliance programs. IMA would verify D.C. residency, income, age, parental status, and, if necessary, other Medicaid eligibility criteria per standard procedures. Persons falling into one of the Medicaid categorical eligibility groups (generally children, parents, aged, and blind or disabled people, with the exception of nonqualified alien adults) would be given the option to buy into Medicaid; all others would be given the option to buy into the Alliance.

IMA or its designee would collect premiums upon enrollment and at designated intervals (e.g., either annually or semi-annually) thereafter. Premiums for the Medicaid and Alliance buy-ins would be set by MAA and the Health Care Safety Net Administration (HCSNA), respectively, using a sliding scale based on income and taking into account the estimated average annual cost of Medicaid or Alliance coverage. MAA and the HCSNA would consult with IMA regarding the sliding scale. The sliding scale premiums would be the same regardless of health status or health history—that is, there would be no medical underwriting in the program. In the event of a change in income, the new premium would be collected at the next premium due date—changes in the premium would not be retroactive.

IMA would send notices to enrollees in the program regarding upcoming premium payments and termination notices (e.g., enrollment will be terminated within 30 days) to enrollees who failed to make scheduled premium payments. Enrollees who failed to make their premium payments within a grace period after receipt of the termination notice would be dropped from the program.

IMA would transfer the premiums collected to MAA and HCSNA via intra-District agreement(s); IMA might be permitted to retain a percentage of the premiums collected to fund the additional administrative costs associated with the buy-in program.

The benefit package would be the standard Medicaid benefit package (for a beneficiary in that categorical eligibility group) or Alliance benefit package. Participants in the buy-in program would be treated exactly the same as Medicaid and Alliance members not in the buy-in program. For example, parents and children buying into Medicaid, and anyone buying into the Alliance, would be enrolled in managed care. There would be no pre-existing condition exclusions in the program.

For individuals otherwise eligible for the Medicaid/Alliance buy-in who also qualify for COBRA continuation coverage, IMA (or MAA and HCSNA) would offer to subsidize the purchase of COBRA coverage. Individuals who qualify for COBRA coverage would not

be eligible for the Medicaid/Alliance buy-in. The subsidy for purchase of COBRA coverage would be limited to the average cost of the comparable Medicaid (single or family) or Alliance coverage, less the applicable sliding scale premium. The premium payments for COBRA coverage could be made through a vendor to limit the administrative burden for IMA (or MAA and HCSNA). The COBRA subsidy could be made available to persons in households with incomes below 200 percent of FPL as well, but such persons would remain eligible for Medicaid or Alliance coverage even if they declined the COBRA subsidy (and for wraparound Medicaid coverage if they opted for the COBRA subsidy).

Remaining questions

The Panel notes the following open questions whose answers may affect the final design or implementation of this option:

- What, if any, federal requirements apply, including any budget neutrality conditions?
- What levels of premium could be expected? How would premiums relate to family income and to expected costs?
- How much enrollment would be attracted with different levels of subsidy?
- How can new public support for coverage best protect against the tendency of people to reduce private support for coverage in response?
- How will the details of the programs affect implementation? Implementation would offer the challenge of collecting premiums from individuals, which is not now done. Medicaid implementation would be harder than for the Alliance, as it would require a federal waiver, a potentially time-consuming effort with no guarantee of success. Impacts on coverage and cost are highly dependent on final design, which may in turn be heavily influenced by available resources.
- How might any stigma attached to publicly financed coverage programs affect enrollment?

Recommendation 6. Analytic Support for “Healthy D.C.” Private Coverage Proposal

We recommend that the Department of Health provide analytic support to the further development of the Healthy D.C. proposal under consideration this year by the Council.

Support will be directed at addressing questions about rate setting, stop loss threshold, take-up rates, applicability of the New York experience to D.C., market considerations, agent-broker roles, and other similar issues to help determine the advisability of implementing the program in the District. Healthy D.C. seeks to make managed care coverage available to uninsured working residents with family incomes between 200 and 400 percent of the FPL. A contracted private vendor (or vendors), which might include Medicaid managed care plans, is to offer guaranteed coverage at modified community rates, with its costs subsidized by public reinsurance (stop loss) that reimburses plans for 90 percent of covered annual claims between \$5,000 and \$75,000 per enrollee. The amount of annual subsidy is to be set by public allocation; no amounts or funding source are yet identified. The Panel recommends that further development pay particular attention to the issues of feasibility, sustainability, and barriers to implementation.

Discussion

The Healthy D.C. proposal, modeled on Healthy NY, would build on the current health insurance market and would address incrementally one gap in that market. Success requires that private insurers participate; participation, however, is not mandated, unlike in New York. Some increase in the extent of private coverage purchased can be expected in response to reduced premiums for enrollees and reduced high-end risk for insurers. The design is modifiable over time. D.C.’s administrative costs are expected to be low, as mechanisms are private, and the D.C. obligation per year can be fixed in advance by budget allocation, with pro rata reduction in reimbursement to plans, if necessary. New York’s experience with a similar initiative shows it is feasible to implement. Based on New York’s experience and level of subsidy, take-up is estimated at 2,000 to 4,000 of the District’s uninsured.

The Healthy D.C. Act of 2005 is designed to motivate uninsured small employers and individuals to buy coverage by offering attractive benefits at a price subsidized by the stop loss funds. Because the reinsured insurers bear lower costs in high-cost cases, they are expected to reduce premiums, as in New York. Lower premiums should put the cost of insurance within reach of more small employers, and employers’ required 50 percent share of premiums makes “take up” of coverage more attractive to eligible employees. Similarly, where employers do not offer coverage, eligible employees may buy at the same subsidized rate (but without employer contribution).

The Act establishes guidelines for qualifying health care services contracts, and it requires that by January 1, 2007, the District enter into one or more such contracts to be made

available to qualifying employers and individuals. It would allow contracts with HMOs, corporations, and “other entities.”

It specifies community-rated premiums and rate tiers for individuals, two-adult families, and at least one other family tier. It also requires that qualifying employers and individuals be charged the same premium rates per enrollee.

The Act also establishes stop loss funds for individuals and for small employer plans separately. The stop loss funds substantially reduce the risk of unexpectedly very high losses for participating plans, which plausibly encourages them to participate.⁶ The public stop loss reduces plans’ incentives to “cherry-pick” enrollees at high underwriting expense, and plausibly smoothes out the variability of plans’ benefits costs over time. Reinsurance spreads the risk associated with high cost enrollees to those who finance the reinsurance. The bill does not specify a financing mechanism. If general revenues are used, the stop loss funds will act as public reinsurance, redistributing insurers’ costs of high-risk individuals to all taxpayers, and allowing insurers to reduce premiums commensurately. If funds are raised to support the program via assessments on insurers including participating HMOs, there will be less redistribution of costs away from participants.

These stop loss funds are to be administered by the Mayor and will reimburse claims for members under “qualifying health care services contracts” at the rate of 90 percent for claims totaling between \$5,000 and \$75,000 per person per calendar year. Reimbursements from this fund appear to be limited to an appropriated amount, with carryover of unpaid claims or unexpended funds allowed from year to year. (It is unclear whether the small employer stop loss fund will pay claims for noneligible employees if an employer chooses to cover them, although it seems likely that only eligible employees’ claims are to be included. The stop loss provision refers to claims “for any *member*” rather than any “qualified” employee or individual.)

The Act would limit total eligible enrollment under the qualifying health care services contracts to the “total funds available for distribution ... [divided by] the estimated per member annual cost of total claims reimbursement” from the stop loss funds. Preference in enrollment may be given to firms “whose eligible members have the lowest average wages.”

The Act requires that employers pay at least 50 percent of the premium and offer coverage to all employees meeting the income guidelines. (It is not clear whether the employer can or must offer coverage to all employees regardless of their income and, if so, on what terms, especially with regard to whether stop loss applies.)

The Act specifies that participating HMOs will report data as necessary for the Mayor to oversee and evaluate the operations of the program.

No funding source is specified in the Act.

The Act allows the Mayor to modify the program based on experience to address adverse selection and/or crowd-out, and to revise income guidelines as needed.

6. Exactly how much impact the stop loss funds will have depends upon whether the funds cover claims from *all* of an eligible employers’ employees offered coverage or, as seems more likely, only those from *eligible employees*.

Healthy NY is the most visible example of this model of coverage expansion. The NY program has a similar focus on small employers and specifies that at least 30 percent of the employees must earn less than \$32,000 annually, with this income limit adjusted annually. Rather than requiring that there had been no offer, the program requires that the employer not have contributed more than \$50 per month to coverage in the prior year. Like the proposed Healthy D.C., it requires that employers pay at least 50 percent of the premium, but further specifies that at least half of the firm's employees participate, which is designed to reduce adverse selection. Sole proprietors and individuals working in an uninsured firm may also buy coverage; they must meet the program's income requirements.

Healthy NY contracts only with HMOs and has attracted participation by 21 of them. Premiums are community-rated, the same for individuals and firms, as proposed for D.C.

Enrollment as of December 2004 was about 76,000, the majority of whom were individuals.⁷

Reinsurance pays 90 percent of claims between \$5,000 and \$75,000, as proposed for D.C. For the first two years of operation, this rate corridor was \$30,000 to \$100,000. When the corridor was lowered, plans responded by reducing premiums by about 17 percent. The lower rate corridor resulted in much greater demand on the fund and a larger subsidy to the program by the state.⁸

New York's insurance market is different from that of the District. The individual market in New York is highly regulated and has only a few companies selling. In the small group market, premiums are based on modified community rating. Under the less extensive insurance regulation of D.C., adverse selection is likely to be a greater threat in the proposed Healthy D.C. since healthy individuals will have lower-priced options outside of the program than do similar individuals in New York.

Plausibility of Design. The Health Care Safety Net Administration (HCSNA) will administer the program. Small employer and individual service contracts will be issued separately, but benefits (and premiums) are the same. This proposed benefit structure seems generous enough to appeal to uninsured firms and to individuals within them:

Services contract details: The contracts are to cover in-plan benefits only, and covered benefits are comprehensive but not all-inclusive. Covered benefits include inpatient and outpatient hospital care, physician services, preventive care services (including well-child visits and immunizations), and prescription drugs, among other benefits. (Notably, the benefits list does not include dental or vision services or behavioral health care services.) The Act specifies moderate deductibles and co-payments. However, its maximum annual coverage for prescription drugs is \$300, and limitations "may" be imposed on coverage of pre-existing conditions—both of which limit attractiveness to many chronically ill enrollees.

The Act would make it more affordable for employers to "do the right thing" by providing coverage, as respondents to the D.C. small employer survey put it. How appealing the

7. EP&P Consulting, "Report on the Healthy NY Program, 2004." Prepared for State of New York Insurance Department, December 31, 2004. <http://www.ins.state.ny.us/website2/hny/reports/hnyep2004.pdf>.

8. The Lewin Group, "Report on the Healthy NY Program, 2003." <http://www.statecoverage.net/statereports/ny24.pdf>.

price is depends upon how much the stop loss subsidy lowers premiums. The D.C. small employer survey suggested that lower premiums would increase offers of coverage.

The bill requires participating employers to offer coverage to “all employees receiving annual wages of no greater than \$35,000 or with a household income between 200 percent and 300 percent of the [FPL].” This clause appears designed to limit crowd-out and to target the coverage to employees most likely to need assistance getting it. However, this specification leaves some gaps. For example, someone with an income of \$35,001 with four or more people in his or her household would not be eligible since he or she would be below 200 percent of FPL but above \$35,000 in annual wages.

It would seem to be an open question whether employers want to offer coverage only to the subset of enrollees eligible for stop loss subsidy. (This observation assumes that stop loss applies only to eligible employees.) One factor that has limited participation in some states’ Medicaid “premium subsidy” assistance for employer-based coverage has been reluctance of employers to introduce perceived inequities in benefits across employees.

In addition, the income guidelines appear to steer all employed individuals with incomes below 200 percent of FPL to the Alliance, which is fully District funded, while Healthy D.C. is to be mainly employer and enrollee funded.

Feasibility of Implementation. HCSNA has experience dealing with health plan contractors and generally administering an insurance-like benefits program. It deals with individual enrollees under the Alliance, but not with small businesses. The bill allows the District to contract out administration of the two stop loss funds, and because they will function much like private reinsurance, it will be feasible to contract with an experienced private administrator to operate the funds.

Remaining questions

The Panel notes the following open questions whose answers may affect the final design or implementation of this option:

- What entities are plausibly expected to contract with the District and run this program?
- What range of premiums is likely, given the proposed level of reinsurance subsidy from the District? How might premiums and expected enrollment change with a different level of subsidy?
- What can the District learn about implementation and take-up from New York’s experience with a similar program, Healthy NY?
- What is the cost per additional insured person as compared to the cost of Alliance buy-in coverage?
- Would funding Healthy D.C. by adding a “pay-or-play” requirement on some or all D.C. employers have unintended consequences beyond the effect on coverage by, for example, transforming the proposal into a broader mandate that could affect decisions on where to locate and how many people to employ, or by undercutting existing or proposed health reform?
- How will the final design of Healthy D.C. take into account compliance with federal HIPAA regulations?

Recommendation 7. Adequate Resources for Effective Implementation

We recommend that the Mayor ensure that implementing agencies have adequate staff with appropriate training and other necessary resources, dedicated to supporting implementation of these recommendations.

With regard to enrollment into publicly financed health programs, for example, the Panel seeks assurances that there will be adequate numbers of personnel and that these personnel will have the necessary training, language, and cross-cultural skills and tools to communicate effectively and sensitively with the diverse population in the District. Their training also needs to include competence with the both the technology (including the telephone interpretation system) and current and new procedures for eligibility and enrollment.

Discussion

The Panel heard strong testimony that various structural problems often impede policy implementation, especially shortfalls in personnel or monies for administrative support functions. It noted that the implementation of combined-enrollment and other improvements called for in this document can only occur if adequate personnel and other resources to implement new initiatives are assured. Enrollment is labor intensive, and having adequate staff with the appropriate skill set, including facility with the new computer system, will minimize the administrative burden in the long run. The Panel is not requesting broad waivers of personnel rules or suggesting that each agency have its own official personnel section, but it is recommending measures that have proved effective in other situations—for instance, granting agencies specific time-limited authority to hire as needed or the dedication of central personnel staff to priority projects with clear accountability for progress toward meeting agency staffing objectives.

Recommendation 8. Ongoing Monitoring of Program Accomplishments and Market Conditions

The D.C. Health Care Coverage Advisory Panel recommends that the District make tracking and assessment of new coverage initiatives part of their design and implementation.

The final design of each initiative should include specific measurable goals to be accomplished within designated time periods, and should identify the entity responsible for monitoring progress. Assessment of new coverage initiatives should take into account what is happening to pre-existing coverage as well.

Discussion

Part of a good policy process is ongoing monitoring of interventions to track success, identify obstacles, and consider mid-course corrections. Panel members are aware that policy implementation does not always occur as envisaged. Good monitoring begins with program design and a clear statement of program goals. Implementation needs its own goals as well, in the form of a clear work plan with milestones to be met. Tracking of progress toward goals is needed from the start of the implementation phase—for instance, to see whether structural impediments are frustrating timely implementation and hence need corrective action as noted in recommendation 7. After a new initiative is implemented, its operations need to be monitored for actual impacts in practice.

The Panel also recognizes that general social and economic conditions change, which can change the effects of enacted reforms or the feasibility or desirability of approaches not adopted. For example, one reasonably well-specified proposal that received significant attention from the Panel was the Equal Access Act originated by DISB. It was concluded that the Act's emphasis on involvement of the District employees' health benefits plan, and making coverage accessible other than through employers were all major changes not suited to this era. If there are changes in the structure of the employer insurance marketplace or in employers' attitudes about providing coverage, this proposal might become more attractive.

Call to Action

Since the creation of the Health Care Coverage Advisory Panel in 2004, the Panel has focused on developing sound and affordable policy options for addressing the needs of the uninsured within the District of Columbia. The recommendations in this document, when implemented, will assist the District in its efforts to improve access to health care for its residents. In particular, the recommendations promote four themes: (1) enhancing what the District currently does by increasing enrollment of eligible residents into already established public insurance programs, (2) promoting the maintenance and expansion of private coverage, (3) providing the District the opportunity to expand the number of residents who are eligible for these established programs, and (4) underscoring to the District the importance of establishing the support structure needed to ensure success, through proper staffing, resources, and monitoring.

When considering these recommendations for implementation, the District should take into account the following ongoing issues that logically follow the issuance of these recommendations, specifically, identification of funding and establishment of a process to address remaining tasks.

Identification of Funding Sources

All of the proposed options come with a cost, the size of which will be determined by the final specifications. All could be implemented with a budgetary limit. The District should look first at funding mechanisms used in other states to assess their applicability and advisability in the District. The most common expansions in other states have related to Medicaid and have involved general state revenues and federal Medicaid match, if available. States have also tapped other sources, such as the following:⁹

- tobacco tax increases, as in New Jersey;
- tobacco settlement fund receipts, as for Healthy New York;
- provider assessments, like Maryland's assessment on hospital net patient revenues to subsidize its high-risk pool;
- taxes on insurers, including Blues plans and HMOs, as for many states' high-risk pools;
- business assessments, such as those that were enacted but never implemented in California and those that now apply to very large employers in Maryland.
- DSH funding, which has been used extensively in states like Massachusetts and Missouri; and,
- internal administrative reallocation of funds, as in numerous states.

The Panel recognizes that the District will always have competing uses for any available funding and that, even within the funds available to fund health, there will be competition

9. Listing of funding sources used by other states does not imply Panel recommendation of such mechanisms for the District. This list is provided only to illustrate the range of funding mechanisms other states use.

among alternative ways to promote access to services and improved health outcomes. Members feel strongly that expenditures on expanding health coverage for District residents is one of the most effective investments the District can make toward improving health outcomes and health status. However, decisions about funding must be made as part of the overall budget process and in collaboration with affected stakeholders.

Process to Address Remaining Tasks

The foregoing recommendations are made at the level of general design appropriate for a body such as the Panel, with recognition that additional specifications are necessary in order to enact and implement many of the recommended initiatives. The Panel also recognizes that additional information may be helpful to the policymakers who will reach final decisions. For these reasons, the Panel recommends that additional efforts be made in the spirit of the Panel process to continue to inform District policymaking and suggests that some of the remaining SPG grant resources be used to address the issues listed with each recommendation.

This Panel advisory process has been successful in bringing a full range of expertise to bear on the issues and in creating constructive give and take between contending groups and with staff. It is important that such activity continue as more information is generated to support implementation planning for options remaining under consideration. Examples include continuing inquiry into the performance of Healthy New York and the operations of private sector pooling for coverage and investigating areas for cooperation with the three jurisdictions in the DC metropolitan area. The Panel recommends that DOH continue a version of this activity as an ongoing input to District policy. Panel members pledge to make themselves or others within their organizations occasionally available to assist in this effort.

Finally, the Panel recognizes that under the District's State Planning Grant its role is advisory to DOH. As with earlier, interim recommendations, however, it is anticipated that members will remain free to disseminate these recommendations through public channels as well as to the Department.

Appendix

Statement of Principles on Expanding Health Coverage and Safety Net Protection¹⁰

The District of Columbia Department of Health (DOH) received a grant from the U.S. Department of Health and Human Services (DHHS) to identify policy options for providing health care coverage to the uninsured population of the District of Columbia (the District). A critical element to the success of the State Planning Grant for the Uninsured is the Advisory Panel, which consists of members of the community, health care professionals, and academicians. The Panel has been established to work in collaboration with the DOH and the Urban Institute, sub-grantee, to assist in formulating a plan to move toward full access to coverage. Concurrently with this effort, the District is also in the process of making policy decisions that are aimed at improving health outcomes for the residents of the District of Columbia. Early in its deliberations, the Panel agreed that it was important to add to this discussion. The Panel concluded that there was a need to articulate some fundamental principles that should guide the District in its efforts. To this end, the Panel met on May 9, 2005. At that time, the Panel agreed to the following Guiding Principles.

GOAL

To improve health outcomes in the District

In order to achieve improved health outcomes, District residents need access to preventive services, primary and specialty care, continuous and coordinated care for chronic conditions, and judicious use of inpatient services.

POLICY OBJECTIVE

Therefore, the public policy objective is

to provide the support necessary for the low-income uninsured to get and maintain access to the full continuum of health care services.

RESEARCH FINDINGS

- The most effective way to improve health outcomes and reduce unnecessary costs is to invest in appropriate levels of preventive services, primary care, specialty care, and management for chronic conditions.
- Numerous studies suggest that provision of coverage for individuals rather than subsidies to institutions promotes choice in health care, encourages quality improvement, and ultimately leads to greater improvement in health outcomes.
- Closer proximity to a safety net hospital increases emergency room and hospital utilization, while closer proximity to community health centers decreases utilization of emergency rooms and inpatient care.

10. This statement was previously promulgated.

GUIDING PRINCIPLES

Therefore, the Department of Health's Health Coverage Advisory Panel strongly recommends that the following principles guide public investment in support of this policy objective:

- The highest priority must be providing or ensuring health care coverage.
- As a second priority, the delivery system available to vulnerable populations needs to be strengthened.
- Any investments in improving access to care should be made in a manner that promotes a system of primary, preventive, and continuing care for chronic conditions on an ambulatory basis with provision for judicious use of inpatient services. A fragmented, incremental approach to improving access to health care services is likely to be costly, inefficient, and at cross-purposes with improved health care quality and health outcomes.
- The District needs to establish and maintain a sustainable structure for financing access to necessary care with the flexibility to adjust to expected demographic trends over the life of the investment.

COROLLARY PRINCIPLES

The Advisory Panel also identified corollary principles in four areas:

Continuity of care:

- Continuity of care promotes both quality and efficiency. Therefore, public investment should be directed toward supporting coverage and access that is continuous.
- Public money should be invested based on an appropriate balance between a system of care and a particular health care institution. Any public investment in facilities should be directed at facilities that are part of a continuum of care.
- Segregation of care for poor people can readily promote discontinuities in care and undermine quality goals.

Beneficiary focus:

- Subsidizing ongoing health coverage for individuals rather than subsidizing institutions promotes choice in health care and acts as an incentive for quality improvement.
- Programs to support coverage for individuals should be designed to support family-based coverage and service delivery in order to improve their effectiveness in reducing the complexities inherent in having different family members covered by different programs.
- All providers receiving public funding or participating in public coverage programs should be required to provide a reasonable level of uncompensated care to District residents regardless of ability to pay on a sliding scale, as appropriate.

Accountability:

- Public investment in subsidies either for coverage or for providers must be tied to accountability for quality and efficiency, with appropriate reporting requirements, public audits, and feedback to strengthen provider capacity and performance.

Program design and administration:

- Wherever possible, initiatives should use incentives rather than mandates to achieve their objectives thus avoiding unintended consequences that may undermine the achievement of coverage goals.
- Representatives of the economic development community should be included in any discussion of the design and administration of public investment in coverage and access.
- Good program design requires addressing issues of the health care labor force and how to attract sufficient provider participation.
- Before implementation of any initiative, the District should establish baseline indicators of health access and outcomes and measure achievements with respect to this baseline.

N.B. The DC Primary Care Association, which participates on the Panel, has posted these principles at

http://www.dcpca.org/index.php?option=com_content&task=view&id=81&Itemid=79.