

DRAFT

I. General Concept

Use same basic *hawk-I* plan of insurance for those a) covered under SCHIP, b) not covered under Medicaid or SCHIP but subsidized by the state and c) not covered under Medicaid or SCHIP.

Those at lowest poverty levels would pay no premium and have no (or very low) co-pays, deductibles or coinsurance. As incomes rise, insureds share more of the cost through increased premiums paid by insureds and increased co-pays, deductibles and coinsurance.

We need to look at Medicaid to see if it could also be the same basic SCHIP plan or if there are reasons why it has to be different.

Many children that would be eligible for state subsidized coverage are currently covered by commercial insurance, often employer based. That is an efficient way to cover children and we don't want to do anything that would cause a mass exodus from commercial plans into Medicaid or *hawk-I*. Two approaches to controlling this have evolved:

- a) Apply government subsidies only to *hawk-I* plans (not other private plans) and require a waiting period (perhaps 6 months) between the time a child drops out of a private plan of insurance before they are eligible to participate in a government subsidized plan. In the near term this is a less expensive approach because it greatly limits those eligible for a subsidy, but could result in a 6-month period being uninsured for those who leave a private plan.
- b) Provide the same government subsidy (based on income) regardless of whether a child is insured in *hawk-I* or a private plan. In the near term this would result in significantly increasing the state subsidy, however, the costs should begin to become more comparable over the long term. Additionally, it is more equitable and eliminates any periods of forced uninsurability.

We need to decide which approach to recommend.

II. Cost of Coverage

The current *hawk-I* cost of \$190 to \$200 per child per month is quite high. And with rapidly escalating health care costs, *hawk-I* costs will continue to increase faster than people's ability to pay. We need to work hard to reduce the cost of *hawk-I*.

The possibilities to be considered are:

- A) Reduce the benefits covered. The Benefits Review Subgroup has not been able to identify any services which could be considered as “in appropriate” or “unnecessary” at this time.
- B) Increase deductibles, co-pays and co-insurance. We need to be careful about increasing this cost sharing for the lowest income families but should consider some cost sharing. Maybe start at \$5 co-pays for doctor and hospital admissions; \$3 co-pay for generic prescriptions and \$25 co-pay for non-emergency visits to emergency room (after first visit, and assuming we make sure there are other good options.) These would then grade upwards as the family’s household income increases.
- C) Drive care to least expensive but acceptable options. Example would be generic drugs (already included in program) and not using Emergency Room for non-emergency care. We should ask the insurance carriers to recommend possibilities for this.
- D) Decrease anti-selection by covering all children. This would have limited impact unless and until we move to an enforceable mandate. The Lewin report has estimated a 25% reduction in per member costs if all children are covered. We need to work with insurers on this.
- E) Reduce administrative costs. Need to look at insurance carrier costs, but I expect there is little or no room for help there. The state costs for enrolling and administering the program seem incredibly high (___ per covered child per year.) We need to look at ways to lower this cost including potentially merging with Medicaid enrollment/administration.
- F) Reduce reimbursement amounts to providers. One option would be to reimburse providers at Medicaid levels. We are opposed to using Medicaid reimbursement levels because it puts an unfair squeeze on providers, would cause cost shifting to other payers, and may limit the number of providers willing to provide services to *hawk-I* insureds. We should, however, consider a state mandate reimbursing at the lowest rate that a provider makes available to a non-governmental payer.

III. There should be no waiting periods, no pre-existing exclusions and no annual or lifetime caps on benefits. The current *hawk-I* program has no waiting periods, no exclusion for pre-existing conditions, and no overall annual benefit limit. It only has a lifetime benefit maximum of \$1 million. The cost to remove the \$1 million lifetime maximum benefit has been estimated to be a 2% increase in premiums.