A SURVEY TO DETERMINE THE FEASIBILITY OF PURCHASING HEALTH CARE INSURANCE FOR MEDICAID RECIPIENTS

by

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A research paper submitted in partial fulfillment
of the requirements for the degree

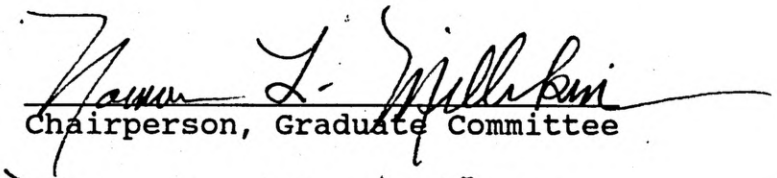
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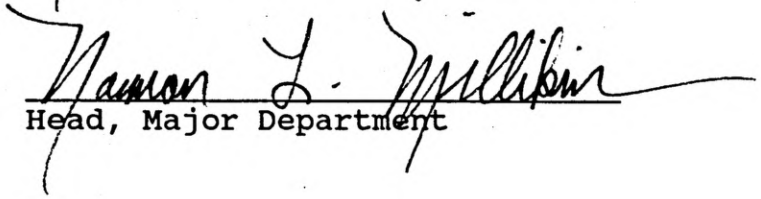
in

Business Education

Approved:



Chairperson, Graduate Committee



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MONTANA STATE UNIVERSITY
Bozeman, Montana

September 1993

ACKNOWLEDGEMENTS

The researcher would like to express his thanks to Dorothy and Nathan Sherard for providing a lifetime of support, and not allowing him to quit anything that he started.

To Phyllis, the most wonderful partner in life anyone could ever have. Thank you for the years of encouragement, never ending faith, confidence and love, and for giving me the confidence to do more than ever dreamed possible.

Special thanks to Doctors Norm Millikin, Jim Lee, Karen Vinton, and Nancy Dodd for the hours of assistance throughout this learning experience.

And to a very special little boy, Robert Oral "Robby" Sherard Junior, may this study contribute to better world for you.

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ABSTRACT

The purpose of this study was to determine the feasibility of purchasing health care insurance for Medicaid recipients in Wyoming.

Surveys were mailed to 218 employers throughout Wyoming, with 142 responding. Of the 142, 96 offered some form of group health insurance to their employees.

The names of insurance carriers were taken from the 96 responses with insurance and a second survey was sent to the carriers. The number of responses was next to nil, with only 1 carrier expressing any interest in developing a program that would benefit all Medicaid recipients.

From the data collected, and literature that was reviewed, the researcher determined that providing the portion of the eligible recipients [employees] group health program was not feasible. Instead, the researcher recommends that a task force be established to develop a comprehensive group health insurance program that would cover all eligible Medicaid recipients, small businesses, and family owned farms and ranches.

CHAPTER I

INTRODUCTION

> "The fastest-growing spending program in the U.S., Medicaid will dispense $158 billion in federal and state funds this year to provide health care to 27.3 million Americans." (Castro, 1991: 37)

"Shut it down." (Castro, 1991: 37) Medicaid cannot be shutdown. As costly and cumbersome as this program is to run, people are dependent on it for the financing of the health care they need. The number of people eligible for Medicaid has grown from 9,904 in June, 1982 (Annual Report, 1991: 4), to 27,981 as of April, 1991. (1993 - 1994 Biennium Budget Request, 1991: 302) This growth represents an increase of 65% in less than ten years. If the current trend holds true, Wyoming will have 46,168 people eligible for Medicaid by the year 2001.

With an increased client population, the Medicaid program that cost $112.9 million in Fiscal Year (FY) 89 and FY 90, and will cost an estimated $227 million for FY 93 and FY 94, will soar in cost to almost $500 million. Federal participation has not been reduced at the present time, however with budget cuts and reduced spending states may be forced to absorb more of the costs for services. Regardless of whether federal participation remains the same, increases, or decreases all states should proactively explore different methods for meeting federally and state mandated requirements that will

allow for a more cost effective means of delivering health care services.

The Omnibus Budget Reconciliation Act of 1990 (Public Law101-508), more commonly referred to as OBRA 90, is a starting point. OBRA 90 requires each state to determine the feasibility of paying premiums, co-insurance and deductibles for recipients, and (if necessary) for enrollment of non-recipients who can be covered through a group health plan offered by the employer of a recipient or the sponsor of a recipient.

Need for the Study

Under the provisions of OBRA 90, the State must determine the feasibility of paying the premiums for clients who have access to group health plans through their employers or the employers of immediate family or other sponsors. This study will fulfill those requirements, as well as expand the federal parameters and explore the possibility of acquiring health insurance for all recipients regardless of their ability to participate in other group programs.

Problem Statement

The major purpose of this study was to determine the

feasibility of purchasing health care insurance for Medicaid recipients in Wyoming.

Questions to be Answered

1. How many businesses, of the surveyed population, offer some form of health insurance for their employees?
2. Would the State recognize any cost savings, within the Medicaid program, by paying insurance premiums, deductibles, and co-insurance for recipients who are employed and have access to health care insurance?
3. Would the State recognize any cost savings, within the Medicaid program, by paying insurance premiums, deductibles, and co-insurance for all recipients regardless of employment and accessibility to health care insurance?

Definition of Terms

Coinsurance (percentage participation) - A principle under which the company insures only part of the potential loss, the policy owners themselves paying the other part. For instance, in a Major Medical policy, the company may agree to pay 75 percent of the insured's expenses, the insured to pay the other 25 percent. (Longman Group, 1989: 166)

Contributory Plan - A group insurance plan issued to an employer under which both the employer and employees contribute to the cost of the plan. Seventy-five percent of the eligible employees must be insured. (Longman Group, 1989: 167)

Deductible - An amount of expense or loss to be paid by the insured before the policy starts paying the benefits. (Longman Group, 1989: 167)

Eligibility Date - The date on which an individual member of a specified group becomes eligible to apply for insurance under the group (life or health) plan. (Longman Group, 1989: 167)

Eligibility Period - A specified length of time, frequently 31 days, following the eligibility date during which an individual of a particular group will remain eligible to apply for insurance under a group life or health insurance policy without evidence of insurability. (Longman Group, 1989: 167)

Family Policy - A health insurance policy covering eligible members of one family. (Longman Group, 1989: 168)

Group Insurance - A policy protecting a group of persons, usually employees of a firm. (Longman Group, 1989: 168)

Health Insurance - Insurance against loss through sickness or accidental bodily injury. Also called accident and sickness, sickness and accident or disability insurance. (Longman Group, 1989: 168)

Individual Insurance - Policies that provide protection to the policy owner. (As distinct from group and blanket insurance.) Sometimes called "personal insurance." (Longman Group, 1989: 168)

Inpatient - A person who is admitted to a hospital as a resident (i.e., as a bed patient). (Longman Group, 1989: 168)

Insured - The individual covered by the contract of insurance. (Longman Group, 1989: 169)

Major Medical Expense Insurance - policies designed to help offset the heavy medical expenses resulting from catastrophic or prolonged illness or injuries. Generally, they provide

benefit payments of 75 percent to 80 percent of all types of medical expenses above a certain amount first paid by the insured, and up to the maximum limit of liability and within the time period provided by the policy. (Longman Group, 1989: 169)

Medicaid - Provides medical care for the needy under joint federal-state participation (Kerr-Mills Act). (Longman Group, 1989: 167) Title XIX of the Social Security Act.

Outpatient - One who receives care at a clinic or hospital without being confined to that institution as a resident. (Longman Group, 1989: 170)

Policy - That instrument, including all endorsements and attached papers, that constitutes the entire contract of insurance. (Longman Group, 1989: 170)

Preexisting Condition - An injury occurring, sickness contracted, or physical condition that existed prior to the issuance of a health policy. (Longman Group, 1989: 170)

Premium - The periodic payment required to keep a policy in force. (Longman Group, 1989: 170)

SUMMARY

Medicaid, despite the good intentions of federal lawmakers, has become a costly, and inefficient white elephant. Any mechanism that allows financial relief must be explored to determine whether or not there will truly be a cost savings, or if it is nothing more than a placebo designed to pacify the taxpayers and program administrators.

This study was to determine if the provisions of OBRA 90 is feasible or if the costs are too much for businesses to absorb.

CHAPTER II

REVIEW OF RELATED LITERATURE

This chapter is devoted to the review of literature concerning health care funding mechanisms. Because of the fluidity and uncertainty of where America's health care programs are headed, each state must be prepared to develop its own action plan for providing services to its citizens, as well as for methods for financially resourcing these programs.

The researcher has divided this chapter into two sections. The first will deal with health care costs, and the second will be concerned with the roles of public and private sectors in providing health care.

Public Health Care Costs

For fiscal year [FY] 1990, Medicaid constituted 12 percent of total expenditures (from all sources), second only to 23 percent for elementary and secondary education. Moreover, total state Medicaid spending is growing, at an average annual rate of 10 percent (per fiscal year) between 1984 and 1989 compared with around 8 percent for education (per calendar year). The state share of Medicaid outlays also grew by 10 percent a year. (GAO. 1991: 29)

A combination of factors including economic downturns, high rates of medical inflation, and disproportionate growth in numbers of aged and disabled recipients all contributed to

in numbers of aged and disabled recipients all contributed to the rapid growth in Medicaid expenditures between 1984 and 1989. (GAO. 1991: 31)

Measuring Medicaid expenditures during a fiscal year is a simple accounting function. Expenditures [in Wyoming] during [state] FY 1990 were $57.2 million and $55.7 during [state] FY 1989. The difference was $1.5 million and the growth rate 2.7%. (Wyoming Department of Health. 1991:10)

Adjusted [Wyoming] Medicaid expenditures grew by $28.9 million from last fiscal year [FY 1990]. The adjustment is necessary to account for $4.2 million in case services incurred in FY 1990, but paid in [state] FY 1991 due to a shortfall in funding. (Wyoming Department of Health. 1992:8)

Three factors account for the increased cost per case. Medical inflation continues to out-pace inflation for other goods and services, and is a contributing factor. Secondly, federal mandates increase the cost of care. Examples are requirements for increased staffing levels and nurse aide training in nursing homes, and expanded services for children to age twenty-one. (Virtually any medically necessary service, even those not covered by the Medicaid State Plan must be sponsored by Medicaid including transplants.) Finally, we appear to be sponsoring care for more catastrophic cases now than in the past. Currently, we are aggressively managing the case of forty-three (43) clients who have incurred costs of $3.4 million to date.(Wyoming Department of Health. 1992:9)

Private Health Care Costs

Americans spend $23,000 a second on medical care, more than $2 billion a day, $733 billion a year. That is nearly twice what they spent seven years ago, including annual increases of 10% during the past two years. For the Federal Government, medical costs have become the fastest growing major item, increasing at more than 8% annually when inflation is only about 5%. (Castro. 1991:34)

The average health plan in the United States cost $3,600 per employee in 1991, up from $1,650 in 1984, according to a study by A. Foster Higgins & Co., Inc. And businesses with few employees are likely to pay even more. (Moeller. 1992:3)

Roles of Public and Private Sector

Perhaps most fundamental, our governments have abdicated a steering role in health care. Policy is made largely by the private sector - insurance companies, hospitals, HMOs, and the medical profession. Government simply reacts. (Gaebler. 1992: 313)

When Americans elected Bill Clinton as president, they elected a leader who is committed to 'comprehensive ' health care reform. (Salisbury. 1992:68)

Most State and/ or local governments have traditionally funded health care for various low-income populations not eligible for Medicaid, and several states are developing

innovative public and public/ private sector programs for the uninsured. (Butler. 1990:67)

The newest and broadest attempt to improve access and contain costs is taking place in Oregon. The state is asking the U.S. government to approve changes in Medicaid rules to provide a limited list of medical services to all people below the poverty level, regardless of their current Medicaid status. A companion law in Oregon's comprehensive health plan requires all employers to provide health insurance for full-time employees and obliges insurance companies to renew these policies without excluding individuals considered too risky. (Reingold. 1991:37)

Hawaii has a history of ensuring health care for its people. In the days when many people worked on the sugar cane plantations, the sugar companies provided health care for all employees. However, like other parts of the United States, many employees were uninsured until the mid-1970s. (Lewin. 1992:17)

Today, approximately 98 percent of the state's population is covered by health insurance. Approximately 82 percent are covered by either Hawaii Medical Service Association (HMSA), which is the local Mutual Benefit Blue Cross/ Blue Shield organization, or by Kaiser Permanente. An additional 16 percent are estimated to be covered by other insurers in the state. (Lewin. 1992:17)

This trend of providing health care to employees continued with the landmark passage of the Prepaid Health Care Act (PPHCA) in 1974. This was the first and only act in the United States to mandate an employers benefit program. Almost simultaneously to the enactment of Hawaii's PPHCA, was the passage of the Employee Retirement Income Security Act of 1974 (ERISA). ERISA, which was enacted in response to pension fraud and mismanagement, set out a comprehensive scheme to regulate employee benefits programs, and specified that states cannot mandate employers to provide health benefits or insurance. In order to enact PPHCA, Hawaii was granted an exemption to ERISA. (Lewin. 1992:17)

Employers will find size to be the major factor in determining how they might be affected by the likely reforms. Employers with fewer than 1,000 employees would be affected initially by incremental aspects of the package such as insurance reform (community rating, no pre-existing exclusions, etc.) and ultimately would be required to provide health protection options to an employee through a HIPC. (Salisbury. 1992:75)

Wyoming and eight other states have passed comprehensive reforms in the small group health insurance market this year [1992], according to the HIAA [Health Insurance Association of America], which represents nearly all the nation's leading insurers. (Moeller. 1992:3)

The Cowboy State's law says insurers cannot exclude small groups or their employees from coverage because of past claims. It also limits rate increases and variations between group's rates. (Moeller. 1992:3)

All employers would be in the business of health insurance, but for those who choose to have someone else worry about negotiations and administration, the HIPC would provide a simplified option. (Salisbury. 1992:75)

Summary

There is no doubt that the cost of health care (in the United States) has sky rocketed to a point where many Americans cannot afford any type of care for themselves or their families. The Clinton administration has some proposed solutions. However, the reality in Wyoming is that most of our businesses are small - many are family ventures.

Legislation has been enacted that ensures that all small groups can be covered by some form of health insurance. And safeguards have been established that prevent gross inequities between policies. What the legislation fails to address is how these health policies will be paid for.

Small businesses cannot always afford to provide coverage, of any type. There is also concern about Wyomingites who are engaged in farming or ranching, as well as those who are not employed, and the homeless population.

From the literature review, the researcher has concluded that:

1. All levels of government must work with the private sector to develop a master plan to ensure all Americans have some type of health coverage.

2. The Clinton administration must solicit input from the less populated states to determine whether or not the HIPC concept is viable for small businesses.

3. Each state must be allowed the flexibility to chart its own course. As residents of the state they work for or in, the governor, cabinet health officer, Medicaid director, and other key public and private sector people know the needs of the citizens, and the parameters that confine their abilities to meet those needs. The federal government certainly should not give each state a blank check. However, the latitude should be afforded the states that allow public/ private sector coalitions to form and develop policies and procedures that make maximum use of federal, state, local, and private funds.

CHAPTER III

PROCEDURES

The purpose of this study was two-fold: 1) To determine the cost-effectiveness of purchasing health insurance for Wyoming Medicaid recipients through employers (for those who are employed and meet the employer's eligibility criteria); and 2) To determine the cost-effectiveness of purchasing health insurance for Wyoming Medicaid recipients through a separate group policy administered by the State or a contracted insurance carrier. The first stated purpose of this study was necessary to fulfill Federal requirements mandated within the Omnibus Budget Reconciliation Act (OBRA) of 1990. The second stated purpose of this study was necessary to determine the feasibility of attempting a larger, more global approach to financing health care for qualified [Wyoming] residents. The conclusions reached and recommendations made from a survey of employers and insurance carriers will be presented to the Administrator, Division of Health Care Financing, Wyoming Department of Health, for use in determining long range methods for meeting the financial obligations of federally directed medical services.

This chapter will describe:

1. The sources of data.
2. The construction of the survey instrument.

3. The administration of the survey instrument.
4. The analysis of data.

Sources of Data

The employer population for the first portion of this study - determining the feasibility of providing employed Wyoming medicaid recipients with health insurance - was made up of Wyoming based businesses listed on the State Wage Information Collection Agencies (SWICA) report as having Medicaid recipients in their employee pool.

Forty insurance carriers named on the employer responses were sent a second survey to determine the availability and interest in providing coverage to all Medicaid clients. Forty survey instruments were mailed out, and six returned. Of the instruments returned only one insurance group was interested in supporting health insurance for all recipients. The researcher had been cautioned by members of the State Insurance Commission that there would be resistance as Medicaid recipients are a high risk group.

Construction of the Survey Instrument

Two survey instruments (Appendix A) were developed for this project. Questions for both surveys were developed by the researcher in consultation with the former Deputy

Administrator, Utilization Management Unit (Bonnie Masters, RN) and members of the Wyoming Insurance Commission.

Both instruments were forwarded to Dr. Norm Millikin, of Montana State University, for review, comments, and approval.

Administration of the Survey Instrument

The employer survey was mailed to 218 businesses on February 14, 1992, whose names appeared on the SWICA report as employing a Medicaid client. Table 1, below, shows the disposition of surveys after mailing.

Table 1. Disposition of Employer Surveys

Survey Activity	Number	Percentage
Mailed	218	100%
Returned - Bad Address	12	6%
No Response	62	28%
Returned - Have Insurance Plan	96	44%
Returned - Have No Insurance Plan	46	21%
Total Responding To Survey	142	65%

The researcher requested all surveys be returned by February 28, 1992. There was no need for any follow-up activities as all materials were returned on or before the suspense date.

A second survey instrument was mailed to insurance carriers listed on the employer responses on August 21, 1992. Table 2 reflects the results of this endeavor. Phone calls were made to the carriers who did not return the survey instrument by the September 11, 1992 deadline. The common theme among all non-responders was the dislike of even thinking about providing coverage to such a high risk population.

Table 2. Disposition of Insurance Carrier Surveys

Survey Activity	Number	Percentage
Mailed	40	100%
No Response	34	85%
Responded - Would Not Provide Coverage	1	2%
Responded - Would Provide Coverage	5	13%

Analysis of Data

The information collected from the employer survey was used to develop tables of comparison from which the researcher could then draw appropriate conclusions and recommendations. The researcher used Word Perfect 5.1 to organize the raw data into useful information.

CHAPTER IV
FINDINGS

This chapter was designed to present, analyze, and interpret the data received from the surveys sent to employers and health insurance carriers, respectively. To maintain order, and assist the reader in understanding the material, the results of each survey will be presented separately.

Surveys Returned

As stated in Chapter III, 142 surveys were returned with information concerning the availability of health insurance for employees through their employers. Table 3 shows the breakdown of businesses with and without employee group health programs.

Table 3. Availability of Group Health Programs

Firms With Group Health	96	68% (NOTE 1)
Firms Without Group Health	46	32% (NOTE 1)

NOTE 1: These percentages are based on the 142 surveys returned with responses.

DEMOGRAPHIC PROFILE

Small businesses are the economic mainstay of Wyoming. This point was evident from the demographic profiles of the respondents who offer their employees group health insurance. Table 4 reflects the cities/ towns where respondents are located, number of full- and part-time employees, and which employee group has the ability to participate in the group health plan. Those firms with large numbers of employees were seasonal type ventures that actually fluctuated throughout the year.

Table 4. Demographic Profile

	Number of Employees		Insurance Available	
City/Town	Full-Time	Part-Time	Full-Time	Part-Time
Casper	9	0	Yes	No
Casper	29	20	Yes	No
Casper	20	750	Yes	Yes
Casper	288	41	Yes	Yes
Casper	680	337	Yes	Yes
Casper	6	18	Yes	No
Casper	222	20	Yes	Yes
Casper	1,600	315	Yes	No
Casper	6	16	Yes	Yes
Casper	9	0	Yes	No
Casper	450	330	Yes	Yes
Casper	50	0	Yes	No
Casper	72	7	Yes	No
Casper	7	0	Yes	No
Casper	30	0	Yes	No
Casper	210	5	Yes	No
Casper	6	55	Yes	Yes
Casper	31	10	Yes	No
Casper	12	0	Yes	No
Casper	7	0	Yes	No
Cheyenne	6	10	Yes	No
Cheyenne	371	95	Yes	Yes

Table 4. Demographic Profile (Continued)

	Number of Employees		Insurance Available	
City/ Town	Full-Time	Part-Time	Full-Time	Part-Time
Cheyenne	304	7	Yes	No
Cheyenne	8	50	Yes	No
Cheyenne	1,567	208	Yes	Yes
Cheyenne	5	1	Yes	No
Cheyenne	80	0	Yes	No
Cheyenne	437	157	Yes	No
Cheyenne	371	162	Yes	Yes
Cheyenne	85	15	Yes	No
Cheyenne	102	1	Yes	Yes
Cheyenne	15	25	Yes	No
Cheyenne	369	115	Yes	Yes
Cheyenne	497	48	Yes	Yes
Cheyenne	188	5	Yes	No
Cheyenne	2,000	200	Yes	Yes
Cheyenne	163	20	Yes	No
Cheyenne	73	8	Yes	No
Cheyenne	13	1	Yes	No
Cheyenne	5	1	Yes	No
Cheyenne	175	25	Yes	No
Cody	14	1	Yes	No
Cody	253	28	Yes	Yes
Cody	90	7	Yes	No
Cody	100	200	Yes	No
Douglas	93	17	Yes	No
Encampment	52	2	Yes	No
Ethete	140	50	Yes	No
Evanston	238	10	Yes	No

Table 4. Demographic Profile (Continued)

	Number of Employees		Insurance Available	
City/ Town	Full-Time	Part-Time	Full-Time	Part-Time
Freedom	51	1	Yes	No
Gilette	175	250	Yes	No
Gilette	25	80	Yes	No
Gilette	280	10	Yes	Yes
Gilette	51	0	Yes	No
Gilette	155	205	Yes	No
Gilette	5	20	Yes	No
Green River	69	80	Yes	No
Greybull	1	0	Yes	No
Greybull	70	20	Yes	No
Jackson	25	50	Yes	No
Laramie	13	2	Yes	No
Laramie	14	4	Yes	No
Laramie	17	10	Yes	No
Lingle	6	1	Yes	No
Lovell	18	17	Yes	No
Lusk	50	15	Yes	No
Mills	24	30	Yes	No
Mills	15	4	Yes	No
Mills	180	5	Yes	No
Mountainview	118	25	Yes	No
Mountainview	10	0	Yes	No
Newcastle	63	8	Yes	No
Powell	3	65	Yes	No
Rawlins	14	21	Yes	No
Riverton	80	13	Yes	No

Table 4. Demographic Profile (Continued)

	Number of Employees		Insurance Available	
City/ Town	Full-Time	Part-Time	Full-Time	Part-Time
Riverton	390	35	Yes	No
Riverton	143	0	Yes	No
Riverton	44	0	Yes	No
Riverton	20	0	Yes	No
Rock Springs	9	1	Yes	No
Rock Springs	180	60	Yes	No
Rock Springs	150	112	Yes	Yes
Rock Springs	5	1	Yes	No
Rock Springs	2	4	Yes	No
Rock Springs	20	0	Yes	No
Rozet	5	2	Yes	No
Saint Stephens	97	1	Yes	No
Sheridan	37	0	Yes	Yes
Sheridan	55	25	Yes	No
Sheridan	82	30	Yes	No
Sundance	215	0	Yes	No
Thermopolis	100	0	Yes	No
Thermopolis	6	2	Yes	No
Torrington	135	15	Yes	No
Worland	6	1	Yes	No
Worland	114	51	Yes	No

REQUIRED MEDICAID SERVICES

Table 5 lists the services that are required by the Wyoming Medicaid program, the cities responding to the survey and the number of businesses whose group health program covers the specific service.

Table 5. Available Services

	SERVICES									
CITY/ RESPONSES	HOSPITAL	PHYSICIAN	OUT PATIENT	DENTAL	PRESCRIPTIONS	VISION	HOME HEALTH	NURSING HOME	LAB & XRAY	AMBULANCE
Casper/ 20	20	19	19	8	16	3	9	2	18	16
Cheyenne/ 21	21	18	21	17	20	4	11	7	20	16
Cody/ 4	4	4	4	2	3	1	1	1	3	3
Douglas/ 1	1	1	1	1	1	0	1	0	1	1
Encampment/ 1	1	1	0	1	1	0	0	0	1	1
Ethete/ 1	1	1	1	1	1	1	1	1	1	1
Evanston/ 1	1	1	1	1	1	0	1	1	1	1
Freedom/ 1	1	1	1	0	1	0	1	0	1	1
Gilette/ 6	6	6	6	2	4	0	4	3	6	6
Green River/ 1	1	1	1	1	1	0	0	0	1	1
Greybull/ 3	2	2	2	0	1	0	1	0	2	1
Jackson/ 1	1	1	1	0	1	0	0	0	1	1
Laramie/ 3	3	3	3	2	3	0	3	0	3	3
Lingle/ 1	1	1	1	0	1	0	1	0	1	0
Lovell/ 1	1	1	1	1	1	0	0	0	1	1

Table 5. Available Services (Continued)

	SERVICES									
CITY/ RESPONSES	HOSPITAL	PHYSICIAN	OUT PATIENT	DENTAL	PRESCRIPTIONS	VISION	HOME HEALTH	NURSING HOME	LAB & XRAY	AMBULANCE
Lusk/ 1	1	1	1	1	1	0	0	0	1	1
Mills/ 3	3	3	3	2	3	1	2	2	3	3
Mountain-view/ 2	2	1	2	0	1	0	1	1	2	2
Newcastle/ 1	1	1	1	1	1	0	1	1	1	1
Powell/ 1	1	1	1	1	1	1	0	0	1	1
Rawlins/ 1	1	1	1	1	1	0	1	0	1	1
Riverton/ 5	5	5	5	3	4	1	4	2	4	5
Rock Springs/ 6	6	6	5	5	5	2	4	1	6	5
Rozet/ 1	1	0	1	1	0	0	0	1	1	1
Saint Stephens/ 1	1	1	3	0	3	0	1	0	3	1
Sheridan/ 3	3	3	1	1	1	0	0	0	1	1
Sundance/ 1	1	1	1	1	1	0	0	0	1	0
Thermop-olis/ 2	2	2	2	1	1	0	1	1	2	1
Torrington/ 1	1	1	1	0	1	0	0	0	1	1
Worland/ 2	2	2	2	1	2	0	1	1	2	2

Nursing home and vision services are extremely limited with only fourteen (14) and twenty-five (25), respectively, of all surveyed employers offering these services through their insurance programs. While the limited availability of vision services (14%) is concerning, the significant lack of nursing home coverage (75%) is alarming. Coverage for home health care is offered by half (50%) of the employers surveyed.

From this analysis the researcher has determined that all policies must be uniform. The addition of some services may prove to be cost prohibitive for some of the businesses surveyed. Therefore, to achieve uniformity at a competitive rate some type of group would need to be formed by businesses and a bid process established to acquire a policy that meets both health needs, as well as monetary constraints.

PREMIUM COSTS

Table 6 is a comparison of premium costs of single versus family coverage. The rates reflected are an average of all reported prices (by city). In addition to the location, the reader should also remember that policy cost is also driven by the services covered.

Table 6. Monthly Premium Costs

	PREMIUM COST PER MONTH			PREMIUM COST PER MONTH	
CITY	SINGLE	FAMILY	CITY	SINGLE	FAMILY
CASPER	111.81	254.08	LUSK	145.16	386.64
CHEYENNE	114.02	245.91	MILLS	134.20	326.90
CODY	152.58	308.57	MOUNTAIN-VIEW	100.23	314.14
DOUGLAS	120.00	258.00	NEWCASTLE	124.56	330.44
ENCAMPMENT	107.12	207.42	POWELL	NA	368.00
ETHETE	193.60	375.87	RAWLINS	156.15	330.42
EVANSTON	134.79	381.53	RIVERTON	123.31	335.04
FREEDOM	191.00	191.00	ROCK SPRINGS	143.47	244.08
GILETTE	117.51	275.72	ROZET	52.00	60.00
GREEN RIVER	180.85	483.79	SAINT STEPHENS	137.86	390.33
GREYBULL	68.22	463.42	SHERIDAN	96.75	275.82
JACKSON	186.12	413.38	SUNDANCE	150.00	350.00
LARAMIE	124.30	334.82	THERMOP-OLIS	101.23	280.64
LINGLE	NA	200.00	TORRING-TON	150.07	293.95
LOVELL	169.55	422.36	WORLAND	139.35	322.98

NOTE: NA means that single coverage was not available or there were no employees requiring a single policy.

STAFFING

Under the provisions of OBRA 90, Medicaid would be required to pay the employee's (Medicaid recipient's) portion of the premium, as well as any co-pay and deductibles. The breakdown of premiums at Table 6 suggests that developing and maintaining a method for making and tracking payments to insurance carriers may be costly in terms of man-hours: to develop a data base; track payments to insurance carriers; ensure accuracy of payments to insurance carriers; ensure accuracy of claims from insurance carriers or health care providers; monitoring of each policy in effect for rate or services changes; and effective and termination dates/ times.

In addition to the Medicaid staff's responsibilities, The Department of Family Services (DFS) intake workers would also be responsible for collecting insurance information from eligible recipients or their sponsors, verifying the information with the employer, reporting the information to Medicaid, and maintaining the information on the eligibility data base.

The additional man-hour requirements placed on both staffs would amount to approximately one (1) full-time equivalent per agency or two (2) more people. Salaries, based on the present State Pay Schedule, and benefits would be approximately $50,835.00. The costs incurred for additional programming requirements on the State's mainframe, and changes

to the Medicaid Management Information System (MMIS) have not been factored, however, based on the researcher's experience these requirements could easily $500,000.00 - not including any on-going charges. These additional monetary requirements must also be considered before developing any conclusions or recommendations. Like the hidden charges an automobile dealer includes in the price for a new car, these charges are not readily apparent, but they help determine whether the OBRA 90 requirement is a luxury sedan or a potential lemon.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The purpose of this study was to determine the feasibility of purchasing health care insurance for Medicaid recipients. As the researcher progressed with the study the state of health care coverage began to take on a new direction as the Bush Administration was replaced by the Clinton Administration, and so too were the philosophies and edicts that drove the financial arm of health care.

Summary of Literature

Health care is an industry that costs Americans billions of dollars each year for their own coverage, as well as the coverage for Americans who are eligible for programs like Medicaid. (Researcher's note: There are still numerous Americans who are unaccounted for, the majority of whom probably have no coverage and no way of acquiring any health insurance.) The cost of care has increased at a rate 3% higher than inflation.

Recognizing that health care costs have created a crisis situation, the Clinton administration has undertaken the task of developing a system, or at least overhauling the present system, that will allow Americans access to some form of

health care coverage.

The key ingredient to the proposed changes are American businesses. As group or independent purchasers, the private sector will assume more responsibility for providing, or at least making available, health care insurance for employees.

Findings

1. Of the 218 surveys mailed to employees, 142 (65%) with usable data.
2. All returned surveys contained the name and other pertinent data of the contact person for the firm.
3. Ninety-six (96) of the 142 (68%) respondents had some form of group health insurance available for their employees.
4. Forty (40) surveys were mailed to insurance carriers with only six (6), or 13%, responding. One (1) carrier hand delivered their survey responses and expressed an interest in developing a private/ public program to meet the needs of Wyoming citizens.
5. The services covered by each policy varied greatly. The following is a breakdown of how many of the 96 policies included the specified service: Hospitalization = 96; Physician = 84; Out Patient = 87; Dental = 53; Prescriptions = 76; Vision = 14; Home Health = 46; Nursing Home = 25; Lab and X-ray = 85; and Ambulance = 74.

6. The cost of monthly premiums for single coverage ranged from $68.22 to $193.60. Monthly premiums for family coverage varied from $60.00 to $483.79.

Conclusions

1. Implementing and managing OBRA 90 provisions for funding a Medicaid recipient's share of an employee health plan would be costly - not only in terms of money, but in time and personnel requirements.
2. Extending insurance coverage to all eligible recipients - employed or not - may prove to be less cumbersome, however, there is an established protocol that would have to be followed:
   a. A Request for Proposals (RFP) would have to be developed and approved by HCFA, and the Department of Administration and Information, Purchasing Division. The RFP would have to specify the types of services to be covered, whether or not certain pre-existing conditions can/ will be grounds for non-enrollment of recipients, and other conditions that will allow Medicaid to fulfill its mission (in as cost effective manner as possible), and still allow prospective carriers to make a profit. Once approved, the RFP would have to be mailed to insurance carriers for review and development of bids.

b. Bids would have to be received by a specified date, reviewed, and the winning bid selected. Upon selection, the winning carrier would be notified, and dates established to develop and sign the contract.

c. The role of the corporation that operates the Medicaid Management Information System (MMIS) would have to be reviewed and included in all facets of planning for a and b above.

2. Given what the future [appears] to hold, small businesses, to include family owned farms and ranches, should be considered in the development process of the RFP mentioned in conclusion 1. Specifically, a buy-in option that would provide the aforementioned to be carried on what will be a large group health policy. Volume buying would allow for lower premium costs, and lower costs for claims processing.

3. The researcher believes that costs for health care services provided by local providers for other state agencies could also be contained by: establishing a fee schedule based on current market rates, and not paying above the schedule; using the same type of claim form, regardless of agency, and differentiating agencies by numeric code; and expanding the role of the MMIS to process all state claims. Additional research would need to be conducted to determine feasibility, as well as logistical and legal requirements.

Recommendations

First and foremost, in order for any plan to work all participants must be committed to the old U.S. Army saying, "Cooperate and graduate" (creator unknown). By that, the researcher means that any task force appointed to review and develop a health care payment process must [solely] focus on the best interests of the people of Wyoming. Ensuring our hospitals, doctors, and other providers are able to meet their fiscal obligations must also be considered by the task force as well. Litigation madness is also of concern, however, the lawmakers, federal and state, will have to address this problem through legislation.

Based on the findings from the study, the researcher makes the following recommendations:

1. Advise HCFA that the OBRA 90 plan is not cost effective for Wyoming.
2. Establish the Wyoming Health Insurance Plan (WHIP) task force to develop a plan, with objectives, goals, time lines, etc. for:
    a. Creating a RFP for the procurement of a group health policy to cover all eligible Medicaid recipients, small businesses, governmental entities, and others yet to be determined.
    b. Coordinating/ contracting through the Division of Health Care Financing (HCF) use of the MMIS for

processing claims filed through the selected carrier.

3. In concert, the Departments of Health, Family Services, Corrections, and any other agency that utilizes private sector health services, and appropriate advisory councils, establish:
   a. Fee schedules for all health services delivered by local providers to the institutions or programs controlled by any of the three departments.
   b. A mechanism that allows medical claims incurred by the state to be processed by the MMIS, thus centralizing all payment and reporting activities.
   c. An agreement with Department of Administration and Information, Computer Technology Division for programming and backup support in case an emergency situation arises.
4. Finally, all agreements involving use of the MMIS need to be coordinated through HCF, with HCF providing a single contract monitor - this is a preventative measure that, hopefully, reduce or eliminate confusion between the state and the MMIS operating firm. Regular status meetings between HCF, state agencies utilizing the MMIS, and the firm operating the MMIS should be conducted at least weekly. The term MMIS should be changed when applied to non-Medicaid programs to help prevent confusion by auditors.

Recommendations 2 through 4 go beyond the original scope of this paper. However, the researcher feels a sense of obligation to the Department of Health, and the state, to help contain costs, and develop a system and accompanying methodology that will allow all Wyomingites to access health care.

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APPENDICES

APPENDIX A
REQUEST TO PURSUE THE STUDY

TO: Ken Kamis

FROM: Bob Sherard

RE: Professional Project for Masters Degree

DATE: December 24, 1991

I have submitted a proposal for my Masters degree professional project to Dr. Norm Millikin - my academic advisor. The project I have chosen is in conjunction with OBRA 90 requirements to purchase health insurance for employed recipients when the cost is feasible.

My research and subsequent paper will expand beyond the parameters of OBRA 90 and explore the feasibility of purchasing health insurance for all recipients who would qualify under the carrier's guidelines. Since this proposal involves using State resources for development of a document for satisfying both State and personal objectives, I would like to have your approval.

ADDITIONAL INFORMATION.

Attached is a copy of the project proposal that was sent to Dr. Millikin and approved. The only change is in procedure. Initially 50 employer surveys were to be sent out. However, I am proposing mailing employer surveys out based on the SWICA reports and insurance carrier surveys out based on reports provided by the Insurance Commissioner.

In conducting the research we would use DA & I to process and mail the cover letters and surveys. Return postage would be absorbed by HCF.

There will be no personal recipient data involved, thus protecting the clients privacy and any sensitive information will not be a problem. Any information that may be required in addition to data collected from the surveys will be from journals, books, GAO reports and other public domain documents.

All drafts for Dr. Millikin will be mailed at my expense. I will also absorb the cost for binding the requisite number of reports for submission to Montana State University (MSU), however final reports submitted to you and Cheryl McVay, as well as any other requested copies will be reproduced here.

There are no copyright requirements for this publication, however, I would like for the cover page to reflect my name as the author.

Please let me know whether or not you can support this request as soon as possible.

Your assistance in this matter would be greatly appreciated.

APPENDIX B
EMPLOYERS SURVEY

February 14, 1992

Dear Employer:

The Wyoming Department of Health (WDH), Division of Health Care Financing (HCF) is conducting a two-part study to determine the cost effectiveness and feasibility of providing health care insurance for Medicaid clients and/ or their family member(s).

This portion of the study will also satisfy present federal legislation which requires HCF to: (1) gather information concerning group health care policies available to medicaid clients and/ or their family member(s), through the employer; and (2) determine if it would be more cost-effective for Medicaid to pay premiums, coinsurance, and deductibles then to continue the present practice of paying directly for services.

Attached is a survey that will allow HCF to collect the data necessary to determine the cost-effectiveness of providing insurance for clients and/ or their family member(s).

Please note: All information will be handled in the strictest of confidence and should be returned, in the postage paid envelope, by February 28, 1992. Neither you nor your firm will be named in any part of any drafts or the final report.

Your assistance and cooperation in this project are greatly appreciated.

Sincerely,

Robert O. Sherard, Manager
Recovery, Contracts and
Management Information Systems Programs

EMPLOYER'S HEALTH INSURANCE QUESTIONNAIRE

Name of Business:_____

Your Name:_____
FIRST MIDDLE INITIAL LAST

Business Address:_____

_____

Business Phone:_____

1. How many full time employees do you presently have? ____

2. How many part time employees does your business have? ____

3. Is health insurance offered to your full time employees?

Yes __ If yes, please go to question 5. **No** __ If no please return the survey in the postage paid envelope, and thank you for your time.

4. Do you offer medical coverage to part time employees?

Yes ___ (please go to 4a) **No** ___ (please go to 5)

a. If yes, do part time employees receive the same coverage as full time employees? **Yes** ___ (please go to 5) **No** ___ (please go to 4b).

b. What, if any, are the major differences between the two policies?

_____

_____

5. How much is the premium per month?

Single Coverage _____ Family Coverage _____

6. Please check the items that are covered by your policy.

Hospitalization _____ Physician Services _____

Outpatient Services _____ Dental _____

Prescriptions _____ Vision _____

Home Health _____ Nursing Home _____

Lab and X-ray _____ Ambulance Services _____

7. Is there a specified time period for enrollment in this policy?

Yes ___ **No** ___ If yes, what is the enrollment period? _____

_____

8. Are there any medical conditions that prevent an employee from being eligible for coverage?

Yes ___ **No** ___ If yes, what are those conditions? _____

_____

9. Do you plan to change either the coverage or the carrier?

Yes ___ **No** ___ If yes, which do you plan to change and how soon?

_____

_____

10. What is the name and address of your insurance carrier?

_____

CARRIER'S NAME

_____

CARRIER'S ADDRESS

_____

CITY STATE ZIP CODE

11. Other comments or suggestions:_____

_____

_____

_____

12. Would your firm like a copy of the results of this survey?

Yes ___ No ___

Please return this survey in the postage paid envelope. Thank you for your time and participation.

APPENDIX C
INSURANCE CARRIER SURVEY

August 21, 1992

To Whom It May Concern:

The Wyoming Department of Health (WDH), Division of Health Care Financing (HCF) is conducting a two-part study to determine the cost effectiveness and feasibility of providing health care insurance for Medicaid clients and/ or their family member(s).

This portion of the study is designed to determine: (1) what services carriers cover; (2) the current cost of these services, through group, as well as individual policies; (3) the ability of carriers to provide a unique policy, one that is tailored specifically for HCF; and (4) any potential cost savings by obtaining, **through a competitive bid process**, and enrolling eligible clients in a group health policy.

Attached is a survey instrument that will allow HCF to collect the data necessary to complete the study, and determine the feasibility of possibly providing insurance for clients and/ or their family member(s).

Please note: All information will be handled in the strictest of confidence and should be returned, in the postage paid envelope, by September 11, 1992. Neither you nor your firm will be named in any part of any drafts or the final report.

Your assistance and cooperation in this project are greatly appreciated.

Sincerely,

Robert O. Sherard, Manager
Contracts and
Management Information Systems Programs

HEALTH INSURANCE QUESTIONNAIRE (CARRIER)

1. Does your firm offer health insurance? YES___ NO___

If you answered YES to question number 1 please proceed to question number 2. If you answered NO to question number 1 you will not need to complete the survey, please return it in the postage paid envelope - Thank you.

2. What type of health plans does your firm offer?

a. Individual Plans ___ b. Group Plans ___ Both a & b ___

3. Please check the services that can be covered through your firm:

a. Inpatient Hospital ___ b. Outpatient Hospital ___

c. Skilled Nursing Facility (SNF) for individuals:

21 and Older ___ Under 21 ___

d. Physician ___ e. Laboratory and X-Ray ___

f. Home Health Services ___ g. Home Health Supplies ___

h. Preventive services for individuals $\leq$ 21 ___

i. Treatment of problems associated with the following discovered during preventive screening:

Dental ___ Vision ___ Hearing ___

j. Family Planning Services and Supplies ___

k. Nurse Midwife ___ l. Nurse Practitioner ___

m. Nurse Anesthetist ___ n. Emergency Hospital ___

o. Intermediate Nursing Facility (INF) ___

p. Mental Health: Clinic ___ Rehabilitation __

q. Optometric: Exams ___ Services ___ Eyeglasses ___

r. Prescriptions ___ s. Prosthetic Devices ___ Orthotics _

t. Therapy: Physical ___ Occupational ___ Speech ___

u. Ambulance Services: Ground ___ Air ___

4. Are there any pre-existing conditions that preclude an individual from obtaining coverage? Please list below.

_____

_____

_____

5. What are the present monthly premiums and deductibles for a group policy, family and individual?

FAMILY		INDIVIDUAL	
PREMIUM	DEDUCTIBLE	PREMIUM	DEDUCTIBLE

6. Are there any co-pay requirements, if so what are they?

_____

_____

7. Are there any restrictions on the enrollment period?

Yes__ No__ If yes, what are they?

_____

_____

_____

8. Thank you for your participation. Please return this survey in the postage paid envelope.