District of Columbia State Planning Grant for the Uninsured

Interim Report

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HRSA STATE PLANNING GRANT FOR THE DISTRICT OF COLUMBIA FINAL FIRST-YEAR REPORT TO THE SECRETARY: OVERVIEW

This grantee year-end report reflects the District's experience to date in examining the uninsured population under its State Planning Grant (SPG) and in developing proposals to expand health insurance coverage to District residents. This report covers activities through August 2004, addressing those issues from the HRSA template (HRSA 2004) that are pertinent to this period. It largely follows the outline of the template, with modifications as appropriate to project activities. References and endnotes appear at the close of the report.

EXECUTIVE SUMMARY

Background. Providing access to comprehensive health insurance coverage for all citizens is important not only to population well-being but also to the attractiveness of the District of Columbia as a place to live and do business. Mayor Anthony Williams has shown a strong commitment to improving such access, through Medicaid, SCHIP, and a pioneering local managed care program (the Alliance) for otherwise uninsured low-income residents (Williams 2004).

Under its 2003 State Planning Grant (SPG), the District of Columbia Department of Health (DOH) and The Urban Institute (UI) are studying dimensions of the problems of the uninsured and options for expanding insurance coverage. Available data show that the District's uninsurance rate is lower than average for a state (SHADAC 2004, KFF 2003) and substantially lower than comparable central urban areas. As elsewhere, however, an unacceptably large share of residents remain uncovered, even among workers, particularly those with relatively low wages or in small firms.

In the past, reform efforts have faltered for lack of broad support among all stakeholders, in the District as elsewhere (Alberga 2004). In its first phases, the current SPG project has concentrated on achieving the "buy-in" to the project among affected constituencies that will be key to long-run success. The project team has also worked to build connections to administrators at various decision-making and policy levels throughout the District Government, as well as its legislative body.

Project activities to date. In its first year, the project has focused on its infrastructure, from data acquisition to web page construction, and on the intra-governmental and community relations that will be important for making any policy proposals politically feasible (DOH 2004). The most important activity to date has been constituting its community Advisory Panel. After much discussion, 25 individuals were selected to represent a wide range of competing and complementary interests. They include representatives from District government agencies with responsibility for health programs and budgeting, health care safety net organizations, mainstream provider groups, the insurance industry, the business community, union workers, minority and underserved communities, and the research community. District agency representatives include top-ranking individuals in the government—most serving personally rather than through aides—including the Medicaid Director, Insurance Commissioner, and Deputy Director of the Health Care Safety Net Administration. Chosen as Chair is a university professor and former health commissioner in several states who has long advised the Mayor on

health issues. The Panel's role is to help DOH weigh evidence and probe advocacy postures, in response to information and research results presented by the project team and collaborating state agencies.

Building a productive Panel has taken much planning and coordination. Even before the first meeting, project staff and consultants individually contacted each Panel member and met with many of them personally to hear some of their concerns and help them understand the importance of their input. The Panel has met twice, in May and August 2004, and is forming its first two working groups, one on the local insurance market and the other on the costs of uncompensated care. This effort has gone well beyond the outreach originally proposed and has already borne fruit—SPG output was used by the Mayor in addressing Cover the Uninsured Week in May (Williams 2004), the project team has met repeatedly with city leaders about a planned HIFA waiver, and a special meeting of the SPG Advisory Panel was held for the District's main HIFA consultant to present the administration's proposal in process and to discuss further SPG input as the waiver process proceeds.

The composition of the District's Panel closely resembles that of most of those previously created under other states' SPGs. The Panel's involvement, however, differs from most others in that many presentations during the meetings actively involve Panel members, supported by the SPG team. The rationale for this approach is both to draw upon Panel members' expertise and to involve them more closely in the interactive communication process of the project—and ultimately in its output. Panel meetings have also been carefully phased, so as to finish discussing the extent and nature of uninsurance and the costs it imposes before discussing the range of possible policy interventions and selecting a few to focus final analyses and discussion. The research is being timed to contribute to each Panel session in turn, ultimately feeding into the final report to HRSA but more importantly into the local political process. The research and Advisory Panel schedule outline is presented in Appendix III.

Quantitative analyses of existing survey data on the uninsured and costs of their care have begun. These analyses are intended to document how many people fall into various subgroups of the uninsured. One data source is a 2003 District-specific survey done by the Kaiser Family Foundation, the DC Health Care Access Survey, from which the project has acquired previously unanalyzed data. In addition, SPG staff members have prepared a short survey questionnaire to be administered to 175 union representatives through a Panel member who represents the local AFL-CIO. This survey will identify the range of health insurance options offered to unionized employees, how the employees view the benefits offered and the associated cost, and what influences their decision to take insurance coverage that is offered. Another Panel member is finishing up a household survey of Latino residents and expects to make the results of this survey as well as the results of a focus group on Latina women's health issues available to the project shortly. Project staff members have undertaken quantitative analysis on the costs of uninsurance using MEPS and CPS data with results also expected shortly.

Qualitative research takes several forms under the SPG. Substantial literature review has been done, including work done at UI and elsewhere. Several focus groups have been planned to address individuals', workers', and business owners' circumstances and preferences about coverage, including willingness to pay. In addition, case studies are underway on the District's budget spending on services for the uninsured and on the local insurance market.

Project challenges. Budgeting and contracting issues delayed the start of the project. The project has also weathered unexpected organizational changes, which have slowed initially scheduled activities but enabled the project team to build strong bridges to key District actors. In late September 2003, the second highest official in the District, the City Administrator, left office. His successor quickly began recalibrating the administration's posture on safety-net support (Timberg 2003a & b). The current City Administrator's senior policy advisor now serves on the SPG Panel. In March 2004, DC Agenda, an important private non-profit project partner, abruptly announced that it was ceasing operations, which necessitated shifting to UI all meeting-support functions and focus-group operations (DC Agenda 2004). After some months of uncertainty, in April 2004, the DOH Director who had supported the SPG proposal resigned, and an Interim Director was appointed (Goldstein 2004). He and the new City Administrator both attended the first Panel meeting to emphasize the importance of this project. In July 2004, the DOH Principal Investigator announced that he would retire in August, and his replacement began attending SPG functions in early August. A new Acting DOH Director is to start work on September 7, 2004 (Adler 2004).

The future. By carefully laying the groundwork for the Panel through outreach meetings, the current project has been able to establish the Panel as an important forum for insurance policy. Both for the main SPG and for the continuation tasks whose proposal for funding is pending, ongoing and planned research will feed into both Panel deliberations and the broader SPG project the Panel advises. The results of these tasks will be incorporated into the project's recommendations to the Director of DOH and the District's report to HRSA on grant activities.

SECTION 1. SUMMARY OF FINDINGS: UNINSURED INDIVIDUALS AND FAMILIES

The rate of uninsurance in the District of Columbia is slightly below the national average and similar to Maryland and Virginia (See Table 1). By category, the District's rate of employer-sponsored insurance rate is almost three percentage points below the national average, and even further below its neighbors. This shortfall is offset by the District's unusually large Medicaid program, covering well above the national average share of the population and almost triple the percentages in Maryland and Virginia. Overall, District insurance coverage is better than in most comparable central urban areas, which typically have higher rates of uninsurance than do states.

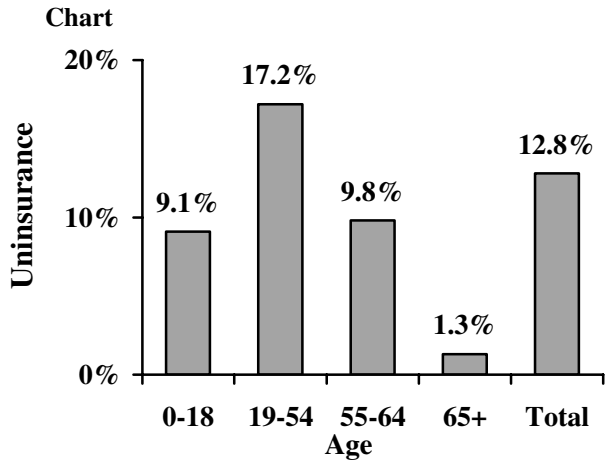
Table 1: Health Insurance Coverage, 2001-2002

	DC	MD	VA	US
Uninsured	12.8%	12.8%	12.2%	14.9%
Employer	53.6%	65.2%	60.9%	56.3%
Medicaid and State	17.4%	6.1%	6.6%	11.2%
Medicare and Other Fed'l (VA/Champus)	10.9%	11.7%	15.9%	12.9%
Private Non-Group	5.3%	4.2%	4.4%	4.8%
Total	100.0%	100.0%	100.0%	100.0%

Source: Urban Institute 2004. Tabulations of the March 2002-2003 Current Population Survey.

The large federal and District governments, of course, offer generous insurance, but so do about two thirds of private-sector employers—the second-highest rate in the country after Hawaii (Ormond et al. 1999). Nevertheless, about one in seven District residents remain uncovered, according to these coverage data from the Current Population Survey (CPS).[i]

The uninsured fall into roughly three groups: (1) those with access to employer-sponsored insurance (ESI) or public insurance who choose not to enroll; (2) those without access to ESI or public insurance who find private nongroup coverage unaffordable or not worth the cost; and (3) those who have affordable coverage potentially available, but lack information or have poor knowledge of these options.



Source: *Health Insurance Coverage in America: 2002 Data Update.* Prepared for KFF. December 2003; Urban Institute, 2004. Tabulations of the March 2002-03 CPS.

Of those insured, most have good coverage—given high labor force participation in the District, large public-sector employment, many incomes above national averages, and the large Medicaid program. The rate of uninsurance varies markedly by age, as seen in the chart. Children under age 19 whose family incomes are at or below 200 percent of the federal poverty level (FPL) are covered by the District's S-CHIP program, DC Healthy Families. Over the past six years, DC Healthy Families has made a transition from utilizing a public relations campaign for the purpose of increasing enrollment to a true social marketing model that employs baseline research through

surveys and focus groups. According to their July 2004, Medical Assistance Administration Report, 4, 382 children are currently enrolled. Adults without children, age 50-64, with incomes at or below 50 percent of the FPL receive coverage through the District's Medicaid program. Adults 65 years and older are eligible for Medicare.

The SPG is addressing a number of gaps in the data on the uninsured in the District including the number and characteristics of the uninsured in each of several subgroups. The recent survey of District residents by the Kaiser Family Foundation (KFF 2003), the DC Health Care Access Survey, has provided a rich source of data that is currently being analyzed by project staff. This survey includes data not only on insurance status but also on source of insurance coverage for the insured and, for the uninsured, why the person is uninsured. In addition, it is the only survey to collect data on the District's state-run health program, the DC Healthcare Alliance. (This innovative program, known as "the Alliance," is described in more detail below.) The small sample size (about 1500) will limit some analyses. Analysis of these data has begun and is expected to be completed for presentation to the Advisory Panel at the October meeting. Analysis of the most recent CPS data for the District and comparisons with neighboring states has begun and will also be completed for presentation in October. (The research and Advisory Panel schedule outline is presented in Appendix III.) Focus groups with uninsured and publicly insured residents scheduled for early fall 2004 will investigate the reasons behind the insurance choices of these groups to help illuminate the "story" behind the picture painted by the data. These focus groups will be conducted separately in English and in Spanish. The focus group protocols have been developed using information from other states that have done focus groups in their SPG research.

Of particular interest for some possible reforms is the number and coverage rates of District residents working in low-wage jobs or small firms and of residents who cycle on and off of private insurance, Medicaid, and/or the Alliance. In addition to the lack of quantitative data on these populations, there is very little known about what determines the choices they make about health insurance including the role of price, benefit packages, and eligibility and enrollment processes. Analysis of the Kaiser data will provide some information on these groups. Focus groups will be conducted in late fall 2004 with employees of small businesses to investigate responses to offer rates, benefit packages, and costs of insurance. Again, the protocols for these focus groups have been shaped by the experience of other SPG grantees.

1.2 KEY HEALTH ISSUES RELATED TO UNINSURANCE

The characteristics of the District's uninsured population reflect differences in income, race, and health status. According to the 2003 Kaiser Family Foundation DC Health Care Access Survey (KFF 2003) and the District of Columbia State Center for Health Statistics,

- About one-third (32%) of Latino residents age 18-64 are uninsured, three times the rate for African-Americans (10%) and eight times the rate for whites (4%).
- About one in five residents (20%) are poor, and an additional 16% are near poor (incomes between 100-200% of the FPL). About 14% of poor residents and 16% of near poor residents age 18-64 are uninsured, three times the rate for higher-income residents (5%).

- The infant mortality rate was nearly twice the national average in 2002 (11.5 vs. 7 per 1,000 live births); the AIDS case rate was 10 times the national average in 2000 (152.9 vs. 15 per 100,000 individuals).

The elevated local rates of births particularly to African American women keep the District's infant mortality rate well above the national average. The District in 2000 compared unfavorably to the US as a whole in the number of women receiving prenatal care in the first trimester, with one main exception – Whites in the District were slightly more likely than all Whites in the US to enter care in the first trimester (90.1 percent vs. 85.0 percent). For heart disease, the leading cause of death both for women and men, a disproportionate number of deaths occurred among African Americans (25.6 percent on average) in comparison to their share of the total population (approximately 60 percent). The highest mortality rate was for African Americans (346 per 100,000), followed by Whites (202.2), Asian (32.9), and Hispanics (24.5). These concerns further accentuate the disparities in health status and access to care for individuals without health insurance.

The District is divided into eight wards. As the following tables show, there are important differences across the wards in both demographics and health status indicators. Low incomes, high uninsurance, and poor health outcomes tend to go together. According to figures compiled by the DC Primary Care Association in its 2003 Update of the Primary Care Safety Net: Health Care Services for the Medically Vulnerable in the District of Columbia some of these indicators are represented in the following table.

Ward	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**DC**
Poverty rate	22.0%	18.7%	7.4%	12.0%	20.0%	21.1%	24.9%	36.0%	20.2%[1]
Infant mortality rate, 2001 (per 1,000 live births)	5.4	8.4	1.1	10.3	13.5	8.5	12.1	23.1	10.6
Death rate: heart disease, 2001 (per 100,000 population)	178.7	183.5	251.4	382.4	372.7	229.2	338.5	208.0	265.2
Death rate: diabetes, 2001 (per 100,000 population)	21.2	22.9	20.1	50.4	36.1	51.9	47.9	37.4	35.1

[1] US Census, 2000 figures, DC Office of Planning/State Data Center

Death rate: HIV/AIDS, 2001 (per 100,000 population)	40.0	30.2	2.5	33.6	57.1	41.2	37.3	45.5	35.0

Unfortunately, there are no data available on insurance coverage by ward, and such data would be prohibitively expensive to collect. However, unemployment figures are strong indicators of residents' ability to obtain adequate health care. The overall unemployment rate for the District in 2000 was 11 percent. Unemployment also points to stress, poor nutrition, poor living conditions, and other factors that may affect the health and well being of city residents. As shown in the following table, there were significant differences in the unemployment rate among wards.

Unemployment	**Ward**							
Years	**Ward 1**	**Ward 2**	**Ward 3**	**Ward 4**	**Ward 5**	**Ward 6**	**Ward 7**	**Ward 8**
1980	7.7	4.1	3.0	5.5	7.1	7.6	28.6	10
1990	7.0	4.8	2.4	6.2	9.2	8.2	8.1	13
2000	7.5	8.2	9.6	6.6	15.0	9.6	14	22

Note: Figures are in percentages

Source: DC Office on Planning/State Data Center

SECTION 2. SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE

Literature search findings show that, although federal and District government offer generous plans, and private sector employers in the District are more likely to offer coverage than are their counterparts nationwide, fewer District residents are covered by employer-sponsored insurance than elsewhere. Data comparing the District to the neighboring states of Maryland and Virginia in 2000 show that a much higher proportion of private sector establishments offer coverage in the District, 74.2 percent compared to 62.0 percent in Maryland and 62.3 percent in Virginia, and almost 95 percent of private sector employees in the District work for an establishment that offers insurance (Lillie-Blanton 2004). To a large extent, this difference reflects the fact that the characteristics of private sector establishments in the District are more conducive to offering insurance. Even so, one recent estimate suggested that over 9 thousand District firms did not offer health coverage to workers (ESRI 2000). An estimated 33 percent of employed residents are among the uninsured in the District. Further complicating the picture is the fact that most

jobs in the District are held by non-District residents; according to the 2000 US Census, 71.6 percent of District jobs were held by residents of the suburbs, up from 67.6 percent in 1990 (Irwin 2004).

Ongoing research—insurance market case study and focus groups of both employees and small business owner—is investigating these questions further. This research is expected to be completed for presentation at the winter meeting of the Advisory Panel.

SECTION 3. SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE

3.1 INSURANCE

Other variations are seen in the region's insurance market. The District's Department of Insurance, Securities, and Banking tracks health insurance coverage sold in the District of Columbia. This market includes many non-District residents receiving coverage from a District workplace and is dominated by the Federal Employees Health Benefits Plan (FEHBP). FEHBP premiums for calendar year 2002 totaled $1,767 million; for all other accident and health coverage the total was $1,557 million (including self-funded plans). The same two insurers top the list for both FEHBP and other coverage—Kaiser Foundation Health Plan of the Mid Atlantic and Group Hospitalization and Medical Services Insurance (GHMSI, which is the Blues plans). Of the 311 other carriers providing coverage in 2002, only 20 sold as much as $10 million in coverage either to federal employees or to others.

3.2 HEALTH CARE SERVICES

According to the DC Primary Care Association, the District had the highest physician to population rate of any state (DCPCA 2003). However, providers are not evenly distributed across all wards of the city. Fifty-two percent of the total population lives in federally designated primary care Health Professional Shortage Areas. As described above, many residents receive care from Medicaid, Medicare and the Alliance. The Alliance is a locally funded health benefits program that provides basic coverage for uninsured residents with incomes up to 200 percent of the FPL. Since it is not insurance, but rather an insurance-like program, its enrollees are still considered as uninsured. Approximately 4 percent of the population receives benefits/coverage through the Alliance, leaving 9 percent wholly uncovered (Lillie-Blanton 2004).

The Alliance was begun in 2001 to provide new access to care for low-income residents to offset the closing of inpatient services at the city's former public hospital, DC General. The Alliance has contracted with primary care providers across the City to better match the residential location of its beneficiaries with a nearby provider. Alliance enrollees are then referred, as needed, to hospitals and medical specialists citywide.

A substantial health care safety net serves the uninsured. Hospitals provide major amounts of unsponsored care—some $150 million in 2002 or over 6 percent of total hospital care—but with levels varying markedly by location, from under 1.4 percent to over 13 percent of total care (DCHA 2003). Free or reduced-fee services are also provided by several clinics—independent nonprofits, hospital-affiliated clinics, and school-based (DCPCA 2003, Rubin 2002). Fourteen independent clinics with 43 sites belong to the Non-Profit Clinic Consortium (NPCC); 14 sites

are affiliated with a major hospital; four are school-based sites; two are senior wellness centers; and four mental health sites provide primary medical care.

The uninsured are much more likely to have no usual source of care or to get their care in a hospital emergency department. According to the DC Health Care Access Survey, 60 percent of the non-elderly total population report receiving their regular source of medical care at a doctor's office or HMO, 27 percent report receiving care from an outpatient department or clinic, 7 percent receive care from an emergency room, and 2 percent report having no regular source of care. In sharp contrast, among the uninsured, 28 percent receive their regular source of medical care at a doctor's office or HMO, 32 percent receive their care through a hospital outpatient department or clinic, 21 percent receive care at the emergency room, and 15 percent have no regular source of care (KFF 2003).

SECTION 4. OPTIONS AND PROGRESS IN EXPANDING COVERAGE

As noted above, the District has a relatively low rate of uninsurance. One option to be considered is maintaining the status quo. Research is currently underway to document the cost of doing nothing, i.e., the costs of uninsurance. Two research projects currently underway will provide estimates of the cost of uninsurance. The first uses data from the Medical Expenditure Panel Survey (MEPS) and the CPS to estimate the costs to the individual and to providers of caring for the uninsured. The second will document current District government expenditures on services for the uninsured. The results of this research will be presented to the Panel at its meeting in early spring 2005.

The MEPS/CPS analysis is nearing completion. It will duplicate for the District's population estimates made for the US by Urban Institute researchers (Hadley and Holahan 2003) on how much money is currently expended on the uninsured and who are making those expenditures. It will then estimate how much it would cost to cover the District's uninsured population under public insurance and, alternatively, under private insurance.

Documentation of current District expenditures on service for the uninsured has begun by identifying agencies and programs within the District budget that provide such services. The next step will be to meet with collaborating agencies to estimate how much of their budget is spent on services for the uninsured that would be covered by various insurance proposals. These monies are theoretically moveable and could be used to pay for the expansion of insurance coverage that would make them unnecessary.

A growing body of research has documented many costs of uninsurance, going well beyond the most visible costs of public support for the medical-care provider safety net. Uninsurance reduces access to care. Moreover, the uninsured are often asked to pay high charges for care, and they do not benefit from the discounts given to Medicaid, Medicare, and private insurance plans. The high cost exacerbates problems of access to care. Reduced access to care is related to reduced health status and life changes, notably including ability to work, save, pay taxes, and contribute to community development.

Urban Institute researchers are among the leaders in documenting the extent of uninsurance, problems of the safety net, and the harm to health of low insurance coverage (e.g., Holahan &

Spillman 2002, Hadley 2003). The prestigious Institute of Medicine has now recognized the interrelated problems of uninsurance and lower health status (e.g., IOM 2002, 2003a, b). Quantitative estimates of the effect of having health insurance on the uninsured's health suggest that mortality could be cut at least 4 percent or 5 percent, possibly as much as 20 percent to 25 percent; improving health status from fair or poor to very good or excellent would increase both work effort and annual earnings by approximately 15 percent to 20 percent (Hadley 2003). While the SPG team recognizes these costs and will present them to the Panel when it considers the cost of the status quo, further research on this topic is beyond the scope of this grant.

After consideration of the costs of doing nothing, the team and the Panel will move on to consider various proposals for expansion of insurance. The research function at this stage of the project will become more interactive, with the Panel requesting research that addresses questions that arise in the consideration of specific expansion options. A literature review on initiatives in other states of potential interest to the District will be presented to the Panel. A compilation of prior District efforts and the degree of success each achieved and why is nearing completion and will be presented to the Panel at the late spring meeting.

The Advisory Panel has been asked to consider two proposals that pre-date the SPG. These two proposals—one concerning private insurance, the other public insurance—will be considered in the context of the range of options that the Panel chooses to address. However, because these proposals are already sketched out and have constituencies supporting them, the Panel has decided to include them in their choice set.

The first option that will likely be considered as the SPG progresses is expansions to Medicaid. Indeed, DOH's Medical Assistance Administration (MAA) has already briefed the Mayor on the desirability of using a Health Insurance Flexibility and Accountability (HIFA) Medicaid expansion waiver to shift some coverage of low-income District residents from the Alliance to Medicaid. Plans to submit such a waiver to CMS are under way. MAA, its HIFA consultant, and the City Administrator's Senior Policy Advisor for health discussed those plans at a meeting of the SPG Advisory Panel in August 2004, and indicated that Panel input will be important for decisions leading up to final implementation of the waiver, starting in autumn 2004.

A second option is a proposal from the Insurance Commissioner that is intended to "level the playing field" by making health insurance available to all on equal terms, regardless of employment status (DISR 2003). The Equal Access Act relies on two key mechanisms to achieve full access to coverage. First, it would establish the District of Columbia Health Benefits Program (Program), to be operated by the Program Board. The Program would offer a menu of insurance options to all who live or work in the District, in the same way that the Federal Employees Health Benefits Plan (FEHBP) offers options to federal workers. Employment groups, including District government, would be expected to use this mechanism, but community-based, non-workplace groups and individuals would be eligible as well. Coverage is to meet all state regulatory requirements, and premiums are to be based on adjusted community rates. Second, the Act would also establish a Risk Transfer Pool to reinsure participating insurers against the costs of a very high-cost enrollee. Participating health plans would continue to administer health insurance benefits for all their own enrollees, but plans would be able to choose in advance to cede the high-end risk of any enrollee to the Pool.

Research to support these proposals will include, for the HIFA initiative, a review of the experience of other states in this area to be presented to the Panel. Contingent on the receipt of continuation grant funding, focus groups with likely beneficiaries of the HIFA program will examine the desirability and acceptability of various components of the program. For the Equal Access Act proposal, research will be undertaken as needed to examine the implications of various aspects of the proposal, including costs and feasibility, with more work to be done if the SPG receives additional funding from its June 2003 proposal for limited continuation funds. This research and other research on options identified by the Panel will be completed for presentation to the Panel at its meeting in late spring 2005.

SECTION 5. CONSENSUS BUILDING STRATEGY

AcademyHealth's assessment of the degree of success achieved in other states emphasized the importance of two main factors—political leadership and affected constituencies' willingness to compromise (Alberga 2004). Maine's progress, for example, was driven by give and take among constituencies (Riley & Kilbreth 2004); this finding underlined the need for deliberate and careful outreach in the District's SPG, even in the early stages of the project.

The District of Columbia's efforts to date on the State Planning Grant have entailed much outreach and communication with government officials and representatives from the community. While the District has a diverse population, the healthcare community works closely together in its undertakings. This collaborative spirit is reflected in the major areas where the SPG has made progress during this year. These areas are the Health Care Coverage Advisory Panel, outreach and communication, as described in more detail below, and research activities, as described in the preceding section.

HEALTH CARE COVERAGE ADVISORY PANEL

The most significant achievement thus far has been the implementation and advancement of the District's Health Care Coverage Advisory Panel. After much discussion, 25 individuals were carefully selected as Panel members. The Panel members represent a diverse group of constituencies with a wide range of competing and complementary interests. They include representatives from District government with responsibility for health programs and budgeting, health care safety net organizations, mainstream provider groups, the insurance industry, the business community, union workers, minority and underserved communities, and the research community. While many of the Panel members have worked together on health issues over the years, many others are new to the process. For example, representatives of unions, the restaurant industry, and small businesses are pleased to be at the table where issues of great concern to their constituents are under discussion.

On May 24, 2004, the first of four or five full Advisory Panel meetings was held. This meeting was primarily aimed at educating Panel members and making sure they all had the background knowledge necessary to ensure a successful Panel process. Given the diverse backgrounds of the members, their individual agendas, and their levels of knowledge of health care coverage in the District, this first meeting required much planning and coordination. With the help of two consultants, project staff individually contacted each Panel member and met with many of them

personally to hear some of their concerns and help them understand the importance of their input (See Appendix IV for a summary of their statements).

Dr. Bailus Walker of Howard University Medical School chaired the first Panel meeting. Herbert Tillery, Interim Director of the Department of Health, and Robert Bobb, City Administrator, spoke on the importance of the Panel. Substantive presentations were made by chosen Panel members on the issue areas they represent: Larry Mirel, Director of Insurance, Securities and Banking, introduced critical concepts in private insurance; Robert Maruca, Medicaid Director, provided an overview of the District's public insurance programs, including the DC Health Care Alliance; Marsha Lillie-Blanton of the Henry J. Kaiser Family Foundation presented data on insurance status and the uninsured in the District; and Wilhelmine Miller of the Institute of Medicine spoke on the safety net and cost of uninsurance.

Using Panel members as presenters was part of a careful strategy to involve Panel members in the process and to identify to other Panel members, many of whom were new to one another, their respective areas of expertise. It is planned that all Panel members will contribute in such a way at some point in the Panel process. For example, the project team is assisting a Panel member who represents unions in designing a survey for union representatives on health insurance issues. The results will be presented to the Panel. Another Panel member is expected to share the results of a forum on Latina health issues. Panel members will also contribute to recruitment of focus group participants. Drawing all Panel members actively into the process will help ensure that all viewpoints are heard and will give all an extra stake in the proposals ultimately forwarded to District government.

OUTREACH AND COMMUNICATION

Outreach and communication was not originally expected to be a major task in the project. However, given the political landscape of the District, its importance quickly became apparent. As mentioned above, prior to the first Panel meeting, project staff spoke with each Panel member personally to identify their priorities for the project and any concerns they might have about project process. Staff also met with key government officials within the Department of Health and the City Administrator's office, and City Council members with responsibility for health programs were contacted. The importance of these meetings cannot be overstated. The commitment of these key stakeholders to the SPG process and outcome will enable the project to move forward and receive recognition from the mayor and City Council members. Such high level support will give the project's recommendations credibility among other constituencies within the District.

The website for the District's State Planning Grant was launched on June 21st, 2004, with a link directly from the Department of Health's homepage (www.dchealth.dc.gov). The intent of the website is to serve as the primary information source for not only Advisory Panel members but also any other interested parties. Meeting agendas, minutes, and presentations are posted, along with additional information on project goals, background literature, and links to sites of interest. In the future, the project team intends to incorporate information submitted from our Advisory Panel members and have made provisions for accepting public comment.

The project team has worked to increase the visibility of the planning grant to the general public in a number of ways. During Cover the Uninsured Week, Mayor Anthony Williams spoke at the kick-off event and used information provided by project staff about the uninsured and the project (Williams 2004). Additionally, two presentation have been prepared for Department of Health officials that give an overview of healthcare in the District and that explain the goals of the State Planning Grant (see SPG web page, DOH 2004), as well as, State Agency staff served on a panel at a public forum on health insurance sponsored by a local university and Families, USA. The breadth of the Panel membership has also served to spread knowledge about the project to constituencies not usually included in the health insurance debate.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

The project team has made substantial use of the experiences of other states, both through the auspices of AcademyHealth and HRSA quarterly meetings as well as by direct contact with other state officials. We have greatly benefited from earlier SPG grantees' experience in the areas of both process and content. Our only current recommendation to other states is twofold. First, we add our encouragement to that of both AcademyHealth and HRSA to build on what other states have done. Second, we join in urging grantees to document what they do, so that other states can build on their experiences.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

Recommendations to date can only relate to SPG process. First, the DC SPG team urges that HRSA continue supporting SPG grantee states--through the quarterly meetings, as well as through support for SHADAC and AcademyHealth. These meetings and resources are very helpful. Second, we urge that the timing of SPG application deadlines be made consistent with approving grants and continuation proposals on time.

APPENDIX I: BASELINE INFORMATION

Population, US Census 2000	572,059
Uninsured, 2001-2002	
Number	72,210
Percent	13%
Trend (see following table)	
Median age of population (years), 2000[1]	34.6
Share of population living in poverty (<100% FPL), 2001-2002	23%
Primary industries: Government, government services, tourism	
Share of private sector establishments that offer health insurance to employees, 2001[2]	74%
Share of private sector establishments that offer health insurance that self-insure at least one plan, 2001[2]	31%
Insurance market reforms: minimal	
Medicaid eligibilty levels as a percent of Federal Poverty Level, 2003	
Children	200%
Pregnant women	200%
Non-Working Parents	200%
Working Parents	200%
Supplemental Security Income	74%
Aged, Blind, Disabled (OBRA '86)	100%
DC Health Care Alliance eligibilty level as a percent of Federal Poverty Level	200%
Approved Federal Waivers	
1115 Waiver for Childless Adults	
1115 Waiver for HIV/AIDS Population	
1915(b) Waiver for Medicaid Managed Care	
1915(c) Waivers for Home and Community Based Services for Mentally Retarded/Developmentally Disabled, HIV/AIDS, and Elderly and Disabled Populations	

Source: Unless otherwise noted, data are from State Health Facts Online, http://statehealthfacts.kff.org

Uninsurance Rate in the District of Columbia, 2003-1987

Year	Uninsurance Rate (%)
2003	14.3
2002	13.0
2001	12.7
2000	14.0
1999[1]	14.1
1999	15.4
1998	17.0
1997	16.1
1996	14.8
1995	17.3
1994	16.5
1993	20.7
1992	21.7
1991	25.7
1990	19.2
1989	21.0
1988	16.8
1987	15.6

Source: U.S. Census Bureau, Current Population Survey, 1988 to 2004 Annual Social and Economic Supplements. Accessed at http://www.census.gov/hhes/hlthins/historic/hihistt4.html
1. This estimate and estimates after 1999 reflect the results of follow-up verification questions and of Census 2000 based population controls.

1. U.S. Census Bureau, Census 2000 Summary File 1, accessed at http://factfinder.census.gov
2. Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2001 Medical Expenditure Panel Survey-Insurance Component

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

DOH (District of Columbia Department of Health, Washington DC). 2004. District of Columbia State Planning Grant for the Uninsured <http://www.dchealth.dc.gov/information/grants_funding/grant_program/index_spgu.shtm>.

Jack Hadley and John Holahan, The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending? Issue Update 2004, Prepared for the Kaiser Commission on Medicaid and the Uninsured, May 10, 2004 <http://www.kff.org/uninsured/upload/35965_1.pdf>.

APPENDIX III: RESEARCH AND ADVISORY PANEL MEETING SCHEDULE OUTLINE

Second Panel meeting: More on the uninsured and the barriers they face
Quantitative studies
1. Re-analysis of Kaiser data and preparation of tables on DC's uninsured
2. Preparation of tables from Current Population Survey (CPS) on uninsurance rates for DC, MD, VA, and USA (2 year moving averages over a ten-year period)
3. Preparation of tables of DC uninsurance estimates from other secondary data sources

Qualitative studies
1. Completion of the first 2-4 focus groups and presentation of preliminary findings
2. Review of past DC initiatives to address the problem of uninsured and presentation of findings

Third Panel meeting: Costs of uninsurance to business, DC, and residents
Quantitative studies
1. Completion of statistical estimates of the cost of uninsurance by payor source (using Medical Expenditures Panel Survey data and CPS data)
2. Completion of estimates of DC government expenditures on services for the uninsured.

Qualitative studies
1. Completion of the remainder of the planned focus groups and presentation of findings
2. Case study of small business decisions about insurance and presentation of findings

Fourth Panel meeting: Possible approaches to addressing uninsurance
Qualitative studies
1. Literature review of initiatives in other states that should be of interest to DC and presentation of findings.

Additional studies (qualitative or quantitative) to be completed will be those requested by Panel members or identified by the project team as necessary for the Panel's deliberation or DOH's decision making

Fifth Panel meeting: Recommended approaches to addressing uninsurance
Studies to be completed will be those requested by Panel members or identified by the project team as necessary for the Panel's deliberation or DOH's decision making

APPENDIX IV. EMERGING ISSUES AND CONCERNS FROM THE HEALTH CARE COVERAGE ADVISORY PANEL MEMBERS, PRIVATE PROVIDERS AND CHAIRPERSON OF THE COUNCIL OF THE DISTRICT OF COLUMBIA, 2003-2004

Name/Organization	Hope/Highlighted interest re the uninsured.
DC Chamber of Commerce Cynthia Brock-Smith	For small business, the cost of providing health insurance is the biggest issue in talking about coverage.
Carefirst Blue Cross/Blue Shield Julie Hatton	We need to get a thorough understanding of the problem before we start looking at solutions. Pleased to hear about the research component, and the ability of the Panel to raise perceived gaps in information/data.
Partnership for the Prevention of Homelessness Sue Marshall	Her focus is on the poor, and homeless people's needs for health coverage. She has a particular interest in the Safety Net program.
America's Health Insurance Plans Jeffrey Tindall	He is focused on health care costs that underlie the high cost of health insurance. He hopes for a good report that would examine why costs are so high and the impact of high costs on coverage.
AFL-CIO Washington DC Metro Council Joslyn Williams	For Labor, the concern is about working people whose employers do not offer health insurance or offer insurance with poor coverage and/or with a co-pay that is unaffordable given low wages/income. This is particularly a problem for service workers including those employed in the health care industry.
Health Care Now! Sam Jordan	He sees a cascade effect from the closing of DC General -- decreased access to health care, people without insurance. Even with the Alliance many people are not fully involved with health insurance, families are not enrolled, and can't afford needed health care. He would like to see expansion and funding of the Alliance. He also has a strong interest in seeing consideration of insurance pools. He is interested in learning about other state experiences with insurance pools, particularly best practices or good approaches, since there is little evidence about the impact of using pools. He is particularly interested in insurance pools for workers in the service industry, *e.g.,* janitors, hospitality industry employees who are often seasonal. The Service Employees International Union (SEIU)'s Janitors for Justice creates a vehicle for encouraging employers to offer health insurance. He thinks a look should also be taken at seeing whether there is a role for churches and community based organizations to enroll their members/clients in insurance pools. He would like the Panel/DOH to see its work as an opportunity

Name/Organization	Hope/Highlighted interest re the uninsured.
	.to be on the cutting edge, to demonstrate new approaches for the Federal Government as it inevitably moves (his perception) towards universal coverage.
Restaurant Association of Metro Washington Lynne Breaux	Health care has a big impact on restaurants/employers (her members) because most of their employees don't have health insurance coverage. Because having healthy employees is important, the adequacy of health care coverage impacts their businesses directly and also the functionality of the city as a whole.

Name/Organization	Hope/Highlighted interest re the uninsured.
DCPCA Sharon Baskerville	DCPCA has been in the lead of a number of initiatives looking at the uninsured for the Robert Wood Johnson Foundation. RWJ has urged her to be an active member of the Panel so she feels a sense of responsibility to see it work. She hopes that there will be capacity within DOH to carry forward what the Panel does. She is looking for practical planning and applications. She believes that DCPCA has a lot to offer - expertise, experience.
Department of Health Medical Assistance Administration Robert Maruca	Comprehensive accessibility and analysis of existing health insurance data to determine population needs. Strategically plan on developing partnerships for facilitating greater access to coverage by health insurance.
Kaiser Permanente Gail M. Thompson	She would like to see the Panel examine the private sector insurance industries' capability to provide alternative solutions for the provision of reasonable and affordable health insurance coverage for District residents. She would also like to see a regional approach taken to examine interstate medical care utilization patterns and trends in order to develop solutions needed to address the uninsured.
United Planning Organization Gladys Mack	Hopes to establish mechanisms to provide health insurance for those who make a considerable amount but not enough to pay out-of-pocket (i.e. construction workers) and to emphasize small group insurance.
DCHA Robert Malson	Would like to focus on rising health care costs, which are driving up health insurance premiums. Premiums are becoming increasingly unaffordable, especially if employees lose their jobs or coverage at work. Uninsurance impacts the health delivery system as people postpone medical treatment and end up in emergency rooms and hospitals for avoidable problems. Emergency room overcrowding is evidence of the impact.
Chairperson of the Council of the District of Columbia Linda W. Cropp	Ms. Cropp hopes that the Panel addresses the persistent needs of the uninsured by continuing to build public/private partnerships.
Chairperson of the Human Services Committee of the Council of the District of Columbia Sandra C. Allen	Major concern is expanding health coverage for low-income single parents who are not eligible for other types of insurance and including benefits for covering prescription drugs and other therapeutic alternative treatment regimens.

Source: PANEL MEMBER FEEDBACK REPORT Based on telephone calls between May 7 and May 19, 2004, statements from letters of support and interviews with collaborative partners

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[ii] Figures like these generated by The Urban Institute routinely combine two years of CPS data to increase sample size and improve precision.