HRSA STATE PLANNING GRANT

INTERIM REPORT TO THE SECRETARY OF US DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBMITTED BY:
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US VIRGIN ISLANDS

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EXECUTIVE SUMMARY

Background

A major challenge for the government of the US Virgin Islands (USVI) has been in assuring access to an array of public and private health insurance plans for its citizens. Within the USVI, access to health insurance has always been dependent upon a number of demographic factors: family income level, employment status, and the eligibility criteria for public medical assistance. Other factors determining the likelihood of being insured are related to the political jurisdiction being a group of islands – St. Thomas, St. Croix, St. John and Water Island, as the major occupied islands – located thousands of miles away from the U.S. mainland.

With grant assistance from the U.S. Department of Health and Human Services Health Resource and Services Administration, the USVI developed a process to collect and analyze data to provide the basis for policy officials to consider multiple options that, if implemented, would have a high probability of decreasing the number of uninsured residents in the territory. The Bureau of Economic Research in the Office of the Governor served as the lead agency to provide coordination with all of the necessary partners required in a project of this complexity.

Researchers from the Eastern Caribbean Center (ECC) at the University of the Virgin Islands and the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota provided support in the development, fielding and interpretation of a statistically valid computer-assisted telephone household survey regarding insurance issues in the territory. Based on their expertise in understanding the dynamics of public and private insurance markets in the Caribbean and the United States, the local firm of Lewis Consulting, LLC, and the H. Calero Consulting Group of Puerto Rico were engaged as technical consultants to develop coverage expansion options for the territory. To gather consumer and employer participation in the process, a number of focus groups were held on the three main islands.

To further insure the broadest consideration of the data and potential options, the Governor appointed a 32-person State Planning Grant Advisory Committee. The Committee members have diverse ethnic, educational, professional backgrounds and are believed to represent a fair cross-section of the community from the private, public and non-profit sectors.

Project Highlights

Prior to the initiation of grant-supported activities in September 2002, the uninsured rate in the territory was estimated to be in the range of 32% to 38%, which would be 2.6 times higher than the national rate of 14%.

A random digit dial household survey concluded in December 2002 established that the uninsured rate was 24.1%. Sources of health insurance for those who have coverage are 51% through employer sponsored programs; 20.6% are covered through public programs; and 4% are covered through individual insurance plans.

More than one-half of the uninsured are employed and are male. The majority of the uninsured are between the ages of 18 to 24 years. More than 40% have less than a high school education. Within the uninsured population, 41% are married and 40% are single. Family income is less than 100% of the Federal Poverty Level for 16.8% of the uninsured; and below 200% for 21.3% of the uninsured. More than 56% of the uninsured work for firms who have fewer than 10 employees.

The cost of insurance premiums is the main reason that persons who have employer sponsored insurance do not take it. It is also the main reason that employers do not offer coverage.

Only 64.5% of the uninsured have a regular source of care compared to 87% of the insured population. For survey respondents with a regular source of care, 8% of the uninsured primarily use the emergency room for services in comparison to only 1.4% of those who have private insurance. Physician offices are used as the primary source of care for 62% of the uninsured and by 76% of persons with private insurance. Community health centers are the regular source of care for one-third of respondents with public insurance, but only one-quarter of those who are uninsured.

Community Input

Focus group meetings with employers and community members were the major means of seeking community input into the data gathering and planning process. Employers on all three islands were stratified according to number of employees and to the type of industry classification. Representatives of the identified businesses were invited to one of seven sessions held throughout the territory. Meetings were also held with church groups, services organizations, insurance agents, government agencies, and the university among others, seeking their input into the process. Findings from these meetings were incorporated into the development of plans to expand coverage.

The Advisory Committee adopted a sub-committee structure to facilitate smaller group consideration of ways to increase community input, review how health-related data could be collected and analyzed, consider how administrative costs could be reduced among health care providers, and present viable options for deliberation by the government.

Although the chairman of the Legislature's Health Committee is a member of the Advisory Committee, a meeting to brief the full Senate still remains to be scheduled after the summer recess concludes.

A review paper of the major issues in providing health insurance and the range of solutions that have been identified for other state government's was prepared by the project staff for review by the Governor's financial advisors.

Expansion Options

After consideration of the data by the Advisory Committee, the priority approach to increase access to insurance in the territory is to initially focus on the uninsured who are employed. Concomitantly with this priority would be the identification of mechanisms to expand the ability of community health centers to become primary health care providers for uninsured families who are above 100% of the Federal Poverty Level.

Three options were developed to address these two priorities that appear to be the most viable for expanding coverage in the territory. These options are summarized as follows:

Option 1: Expand health insurance access to small employers in the territory by implementation of group purchasing arrangements through either a buy-in process to the government's employee's health insurance plan or some public/private partnership.

Option 2: Expand coverage to individuals in the territory who are uninsured dependents of insured workers, or who are self-employed, or who are employed part-time, or who do not qualify for Medical Assistance benefits through implementation of insurance offerings sponsored by the 330-community health centers.

Option 3: Expand coverage to everyone in the territory through a coordinated public/private universal insurance program which combines all current sources of insurance coverage with the requirement that all businesses must "pay or play".

Any option that is eventually selected must satisfy a three-pronged criteria: 1) be economically/financially viable to all stakeholders; 2) politically acceptable to the major constituencies in the territory; and 3) socially acceptable to the broadest segments of the community including both consumers and providers of health care services, especially if behavioral changes must be adopted by the population.

The next step in the process requires further detailed premium analysis to develop estimates for the premiums, cost-sharing and deductibles levels for individuals, employers and the government under each of the identified scenarios. In addition, logistical procedures for the administrative, legislative and funding requirements and timing of each option still must be developed.

Recommended Federal actions to support the territory's efforts to provide expanded coverage still remain to be developed.

SECTION 1. SUMMARY: UNINSURED INDIVIDUALS AND FAMILIES

Introduction

The ***2003 Virgin Islands Health Care Insurance and Access Survey*** (HCIAS) concluded in December 2002 was the first comprehensive study of this type ever conducted in the territory to determine the level of insurance coverage and ascertain a broad range of characteristics of the uninsured population. This was necessary since, the U.S. Virgin Islands does not participate in other national insurance surveys, such as the Medical Expenditure Panel Survey (MEPS) or the Current Population Survey (CPS), used by other the states for comparative purposes. The only prior results on insurance coverage in the territory is the limited data available from the Virgin Islands Behavioral Risk Factor Surveillance System Survey (VIBRFSS) conducted by the local Department of Health, and the Virgin Islands Consumer Expenditure Survey (VICES), conducted by the Eastern Caribbean Center, University of the Virgin Islands.

Until the household survey was completed, the VIBRFSS has provided the only continuous trend information for estimates of uninsurance rates among individuals in the territory. The VIBRFSS reported percentage of "having no health insurance" ranged from 37.0% in 1991 to 28.3% in 2001. The lowest VIBRFSS population estimate was 29.0% uninsured, reported in 1994. All of these results were based on an analysis of only one of two insurance-related questions taken from a computed-assisted telephone survey of the health habits of 1,500 U.S. Virgin Islands residents age 18 years and older.

Findings from the 1997 VI Consumer Expenditure Survey also conducted by the Eastern Caribbean Center among adult respondents indicated that 65% (17,723) of 27,229 households had health insurance for one or more persons in the dwelling; 35% of the households had no health insurance. In the households that had health insurance, 96.4% of the coverage was through a private carrier. Assuming that the uninsured rate in the territory at worst case was 35% in 2002; this would be would be more than 2.6 times the national average of 14%.

According to the 2000 VI Census 108,612 persons were enumerated in the US Virgin Islands: 53,234 (49%) persons on St. Croix; 51,181 (47%) persons on St. Thomas; and 4,197 (4%) persons on St. John. Nearly 1 in 3 residents are under the age of 18. Females are 52% of the population. By race, the population is predominately Black or African American (78.3%); ethnically, the population is 14% Hispanic, of any race. More than 32% of the population has incomes below 100% of the Federal Poverty Level.

Researchers from the Eastern Caribbean Center (ECC) at the University of the Virgin Islands and the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota provided support in the development, fielding and interpretation of the household survey to collect definitive data regarding health insurance coverage in the territory. The selected sampling design and the methodology of data collection were determined to best be done by a random digit dial (RDD) telephone survey from a random sample of households throughout the Virgin Islands.

An appropriate sample size was determined to be 1,600 completed interviews with an additional 150 interviews planned to allow for the demands of cross-tabulations as well as to keep the margin of error relatively low. The margin of error for the overall sample is 3.5 percent. It was also decided to divide the data into two strata, comprising St Croix in one stratum and St Thomas/St John in the other. Stratifying the sample by zip code, or more typically by the census sub-district on each island would require larger (and more expensive) sample sizes.

The actual survey completed interviews with over 2,000 people from the territory according to a strict definition of residency, of which 239 were Hispanic (11.5% of the survey respondents.) The survey design over sampled children, who have historically higher rates of uninsurance, and also over sampled Hispanics, another population who tend to be of primary concern for under utilization of health services in the territory.

The Coordinated State Coverage Survey (CSCS) instrument was provided by SHADAC for estimation of health insurance coverage at the state level was selected in order to have comparability of results with other HRSA grant participants. The tool was modified to account for differences unique to the territory and was also developed in both English and Spanish versions. The Spanish version instrument was also modified to take into account St. Croix resident Hispanics whose origin is mainly from Puerto Rico and Hispanics on St. Thomas who originate primarily from the Dominican Republic.

Seventeen experienced interviewers were hired by ECC and trained to work with the CATI—Computer Assisted Telephone Interview—CSCS survey instrument. Procedures for use of random number generation, survey coding, call backs, call completion and quality assurance of the work were developed. A pilot testing period of the instrument and interview procedures was conducted before the survey began.

Although the survey was conducted in both English and Spanish, only 27 completed interviews were actually conducted in Spanish due to the vast number of bilingual speakers who preferred to answer the survey in English. One person was randomly selected in each household to complete the telephone survey. If the selected person was a child, an adult was asked to respond on behalf of the child.

Between October 24th and December 7th, interviewers called 9,003 different Virgin Island telephone numbers, resulting in 1,766 ***completed interviews*** and 8 ***partially completed*** interviews. The ***total number of calls*** made during the period was 23,919. There were 433 ***soft refusals*** and 369 ***hard refusals***. A summary of the survey process is included in the Appendix IIA.

1.1 What is overall level of uninsurance in the territory?

From the 2003 Virgin Islands Health Care Insurance and Access Survey (HCIAS) results, the best predictors of insurance status in the Virgin Islands are related to age, level of education, family income and employment status. According to the HCIAS, more than half (51.2%) of the people in the U.S. Virgin Islands are covered by health insurance

through an employer. This level of employer coverage is 18% below the U.S. average reported figure of 62.5%. Four percent purchased private individual insurance and public programs cover 20.6% of the population.

The uninsurance rate for the Virgin Islands using the point-in-time estimate is 24.1%. This estimate is 7% higher than the rate for the entire U.S., according to the 1999 Medical Expenditure Panel Survey (MEPS). It is nearly 10% higher than the Current Population Survey (CPS) which estimates the U.S. uninsurance rate at 14.6% in 2001.

1.2 What are the characteristics of the uninsured?

Income: More than half of the uninsured had family incomes that were below 100% of the Federal Poverty level (FPL). The majority of the uninsured (58%) were at or below 300% of FPL. Persons at or above 400% of FPL were significantly less likely to be uninsured.

Age: Results indicated that 50.4% of the uninsured were between 18 to 24 years of age. Children age 0 to 5 years of age accounted for 22.5% of the uninsured. Those over 65 years of age were less likely to be uninsured mainly due to Medicare participation

Gender: Males were the majority of the uninsured population.

Family Composition: The majority of the uninsured are single (40.4%) which is significantly higher than the proportion (30.5%) of single persons in the Virgin Islands. Separated individuals, as well as unmarried living with a partner have a higher uninsurance rate than their married, divorced or widowed counterparts.

Health Status: In the survey, 22.3% of the uninsured had health status that they rated "fair" to "poor".

Employment Status: The survey showed that 40.2% of the uninsured were employed by someone else; 20% were self employed. More than 30% were not employed. Retirees and students were each just over 3% of the uninsured. Slightly more than 78% of the uninsured who were employed held permanent jobs. Seasonal workers only accounted for 3.6% of the uninsured. By size of firm, 56.5% of the uninsured who were employed worked for firms that had fewer than 10 employees.

Availability of private/public coverage: The survey found that 30% of the population has potential access to either private or public health insurance coverage. Within the uninsured population, 14.3% are eligible for employer sponsored coverage, while 16.9% are potentially eligible for public programs, if their income was less than or equal to 100% FPL. Almost 70% of the uninsured are not eligible for either private or public program coverage.

Race/Ethnicity: The most significant racial and ethnic groups in the territory are White, African American/Black and Hispanics of either race. Slightly more than 1 in 5 African American Blacks were uninsured, while almost 1 in 3 Hispanics were uninsured.

Immigration Status: This issue was deliberately not addressed in the study in order to secure adequate participation in the survey. Immigration status is a sensitive issue in the territory due to the long-standing presence of many individuals who are undocumented.

Geographic Location: Although slightly more persons were uninsured on the island of St. Thomas, the uninsured rates among the islands of residence was statistically insignificant.

Duration of Uninsurance: The survey found that approximately 21% of the population of the Virgin Islands residents was uninsured for the entire year. This estimate is 9% higher than the equivalent measurement for the entire U.S. population. The proportion of people from the U.S. Virgin Islands that were uninsured for part of the year was only 6.9%. This figure is low compared to those who are uninsured all year. This could be a reflection of the job market in the U.S. Virgin Islands where people are contracted to work for whole years with or without health insurance. Throughout this report, unless otherwise indicated, the analyses refer to the "point in time" uninsured.

Education: Slightly more than 39% of the uninsured had less than a high school education. Only 12% of the uninsured were college graduates.

1.3 Summarizing the information provided above, what population groupings were important for the territory in developing targeted coverage expansion options?

The survey identified several population groupings that are important in the development of coverage expansion options because of their disproportionately high rates of uninsurance. This suggests that health insurance coverage options will have to be tailored to particular groups of people. Important groupings include:

- 18-24 year olds
- Individuals below 300% of the Federal Poverty Line (FPL); especially those with annual incomes below 100% FPL, or $8,500 for a family of four.
- Unemployed or unpaid individuals and self-employed and temporary workers
- Employees of firms with 10 or fewer employees

1.4 What is affordable coverage? How much are the uninsured willing to pay?

The quantitative survey did not establish this component of information. Data that were gathered from meetings with community groups tended to use as a benchmark what persons who worked for the local government paid for insurance. At the time of the

study, government employees paid $33.98 per pay period (26 pay period per year) for individual medical and dental coverage, while the government paid $69.23. The employee share of the $103.21 total premium was 33%.

VI government employees pay $77.11 (41%) bi-weekly for family medical/dental coverage, while the government contributes $112.17 (59%).

On an annual basis, government employees pay $883.48 per year for individual coverage and $2,004.86 per year for family medical and dental coverage.

Work still remains to be done in subsequent focus groups to establish premium payment tolerances for persons who are now uninsured.

1.5 Why do uninsured individuals and families not participate in public programs for which they are eligible?

The public programs that are available in the territory include: public health clinics, 330-community health centers and the Medical Assistance Program (Medicaid). The Department of Human Services has a prescription drug coverage program for persons over age 65 years who meet certain income criteria. Approximately 17% of the uninsured have potential access to health care coverage through a public program. The household survey also asked respondents whether they had ever asked for or been given information about one of the U.S. Virgin Islands' public health care programs such as Medicaid. Almost two-thirds of the survey population had not heard of any of the public health insurance programs.

1.6 Why do uninsured individuals disenroll from public programs?

There is no active mechanism to "enroll" people in a public program in the territory. People usually self-identify themselves to be assessed for coverage in the Medical Assistance Program. No statistics are maintained of why individuals voluntarily drop MAP coverage. At the re-certification periods, changes in family income usually lead to being dropped from the rolls, but no data is maintained on this rate.

1.7 Why do uninsured individuals and families not participate in employer sponsored coverage for which they are eligible?

The most common, single response given for not participating in employer sponsored coverage was that it was too expensive (27%). Other responses included:

- Didn't need or want insurance
- Rarely sick
- Too much hassle/paperwork
- Own plan is cheaper
- Benefits don't meet needs
- The child is covered under a school plan

? An expectation to be covered at a later date or were in the process of changing jobs so no point in signing up now.

1.8 Do workers want their employers to play a role in providing insurance or would some other method be preferable?

Information gathered during public discussions of insurance issues indicated a strong desire to have employers provide health insurance coverage, but sharing the costs was identified as the major disincentive to participation.

1.9 How likely are individuals to be influenced by availability of subsidies or tax credits or other incentives?

Not determined. A significant portion of the population does not pay taxes; therefore tax credits would not be helpful for that group unless fully refundable. In focus groups of employers, tax credits did not seem to be the motivating factor to generate willingness to participate in a government insurance program.

1.10 What other barriers besides affordability prevent the purchase of health insurance?

Other perceived barriers to accepting or seeking health insurance coverage include:

? A perceived complexity of the insurance process seems to overwhelm some employers and individuals.

? Believe that insurance agents do not adequately understand how to match needs to products that are available.

? Language barriers – most agents are English-speaking; many of the small businesses are owned by Hispanics.

? Other cultural barriers such as the unavailability of Muslim women physicians may prevent men from seeking family coverage for female dependents in the household.

? Perceived hassles since many physicians in the territory require cash payments upfront even if the person has insurance.

? Although the subject of immigration status was avoided in the survey, it is well established that there are many illegal immigrants who work in temporary or seasonal jobs who do not have insurance and would not seek it out if offered.

? Distrust of government and the system to maintain confidentiality of information was another reason given for not registering for a public program.

? A bad stigma associated with accepting “public handouts”.

? Time in the job –some individuals were not been employed long enough to receive coverage.

? Belief in the use of natural remedies and not "Western" medicine was another reason for not accepting health insurance when available.

1.11 How are the uninsured getting their medical needs met?

Uninsured individuals and public program enrollees are less likely to see a particular health care professional (78% and 81% respectively) than their privately insured counterparts (93%). A doctor's office is where most people seek medical care, particularly those with private health insurance. Public program enrollees, as well as the uninsured, are likely to use a public health or community clinic. A higher proportion of the uninsured are more likely to use an emergency room than people with either private or public coverage.

1.12 What are the features of an adequate, barebones benefit package?

No minimum benefit has been agreed upon in the territory. From discussions with members of the Advisory Committee and some community group members, it is anticipated that minimum coverage would be constituted by 1) some preventive health care visit coverage 2) prenatal coverage 3) mental health care coverage 4) catastrophic coverage, and 5) hospital coverage.

1.13 How should the uninsured be defined? How many of those defined as "insured" are underinsured?

This has not been established. Insurance plans that have high deductibles or low caps or high ratios of co-insurance may effectively make a person underinsured, though no percentage of the level of such coverage in the territory was established. The standard plan for comparison locally is the government's employee coverage plan which has a $50 per year individual deductible, 20% co-insurance within the network, and generous preventive care coverage.

The 18,360 persons who met the criteria to be eligible for the government's Medical Assistance Program (Medicaid) in 2002 are effectively underinsured. In the Virgin Islands, 32% (34,755 people) of the population in 2000 lived at or below the federal poverty level which is triple that of the U.S. mainland. Since Medicaid in all of the territories is a caped program with a mandated 50% local match, stringent criteria are applied in order to "stretch out" the limited funding rendering less than half the potential participants eligible for services. Local guidelines limit participation to individuals with an income level of $5,500 plus $1,000 for each additional dependent family member (Family of 4 with household income equal to $8,500). Restricted from the program are person's age 22-64 who are not disabled and who have no dependent children.

On average, the territory spent $436 per eligible recipient compared to a national average of $3,862 per recipient in 2002. Coverage is restricted to the most basic of services under MAP guidelines which includes low reimbursement rates to providers, and elimination of optional services —prosthetic devices, dentures, durable equipment, institutionalized mental health services; limits on prescription drugs over $200 and restriction of the number of nursing home beds in the territory.

SECTION 2. EMPLOYER-BASED COVERAGE

In the Virgin Islands, the private sector provides approximately 30,000 jobs, with the majority in the retail trade and service industries, where low wages are common. Most of the jobs in the retail trade sector are related to the tourism industry. The local government is the largest single employer accounting for approximately 12,000 jobs. Data from the local Department of Labor, Bureau of Labor Statistics (BLS) in 2003 indicate that there are 3,026 private sector employers who report wages paid every quarter.

Stratification by size of firm in BLS database indicates that 44 percent of the firms employed less than 5 employees; 15% employed 5 to 9 individuals. Fewer than 3% of firms employed more than 100 persons; 21% reported no employees. In a market where nearly 80 percent of the firms employ less than 10 persons has important implications in the design of meaningful policy options that provide affordable premium pricing to expand health insurance coverage.

Due to irresolvable statistical issues in defining the appropriate "universe" of employers from which to sample, qualitative data regarding employers were based on that gathered from focus groups conducted on each island. Quantitative data regarding employer coverage were garnered from the household survey respondents who were employed.

During March 2003, six (6) focus groups were held with employers: three on St. Thomas; two on St. Croix, and one on St. John. The 50 employers who attended ranged from several self-employed individuals to the Territory's largest private workforce of over 1,000. Public sector employers were deliberately excluded since the Planning Grant had other mechanisms in place to gather information from them.

Of the 50 participants in the employer focus groups:

- All 27 of the large employers (more than 10 employees) offer health insurance to at least some portion of their workforce
- 11 of the 23 small employers (fewer than 10 employees) do not offer insurance to any employees

2.1.1 What are the characteristics of firms that do not offer coverage, as compared to firms that do?

Employer size: Whether an employer offers coverage depends upon the size of the firm. Among employers with fewer than ten employees, 25% of firms offer coverage. In larger companies with 50+ employees, 89% of employers offered coverage.

Industry sector: Firms in the agriculture, retail, and the business and personal services sectors were less likely to offer insurance to their employees than firms in other sectors.

Employee income brackets: Employee income is directly related to the offer of employer sponsored health insurance. Working people earning below the poverty level were only offered health insurance by 32% of firms. People earning more than 300% of FPL were nearly three times more likely to be offered health insurance by their employers.

Percentage of part-time and seasonal workers: Part-time (54.4%) and temporary (28.5%) workers were less likely to be offered health insurance than permanent full time workers (80%).

Geographic location: Person employed on St. Thomas were more likely to be offered health insurance (82%) than workers living on St. Croix (72.8%) and St. John (72.1%).

Cost of policies: Data from the VI Office of Banking and Insurance indicate that the range of insurance premiums is $2,700 to $4,500 for single group coverage. The range for family group coverage is $10,200 to $12,600 per year. While there are no data available on the relative breakdown of premium payments between employer and employees in the private sector, a 50% minimum is required by law to be paid by employers.

Level of contribution: People covered under public programs (52.4%) or individual coverage (58%) are less likely to have deductibles, compared to those with employer sponsored coverage (83.6%).

Persons covered by employer sponsored insurance or public programs are more likely to have prescription drug coverage than those with individual coverage. Dental coverage is primarily provided as part of employer sponsored plans. Dental coverage is only purchased by 1.9% of the uninsured.

2.1.2 What influences the employer's decision about whether or not to offer coverage? What are the primary reasons employers give for electing not to provide coverage?

The primary factor influencing the decision to provide or not provide health insurance to their employees is premium cost.

2.1.3 How do employers make decisions about the health insurance they will offer to their employees? What factors go into their decisions regarding premium contributions, benefit packages, and other features of the coverage?

There are two factors which affect employer the decisions about benefits, premium cost sharing and other features of the coverage. The first is, as identified above, cost of the premium and the impact on the profit margin of the firm. By statute, employers must pay for at least 50% of the premium costs for employees. In the focus groups, most employers paid at least 80% of the cost. The second consideration in decision making is the restrictions imposed by the limited number of insurance carriers in the Virgin Islands,

especially for small businesses. The focus group employers said they often switched carriers to obtain lower premiums. Several employers said they switched carriers to get better services (faster claim processing and fewer rejections) even though it might have cost more. Restriction were also placed on providing family coverage, employees usually paid for this coverage themselves.

2.4 What would be the likely response of employers to an (continued) economic downturn or increase in premium costs?

Faced with increasing premiums, employers in the focus groups have adopted or intend to adopt the following strategies. These are listed in order of frequency.

- Increase the Deductible

  This is the most common solution, but employers expressed concern that it was a severe hardship on employees so they tried to look for alternatives. A couple of employers mentioned that while they had increased the deductible, they have instituted a "self-insurance" plan for the difference between the old deductible and the new deductible (called a "corridor deductible"), so that the impact will not be felt by the employees.

- Change Carriers

  Although there are few carriers in the Virgin Islands, especially for small businesses, the employers said they switched carriers to obtain lower premiums. Several employers said they switched carriers to get better services (faster claim processing and fewer rejections) even though it might have cost more.

- Increase the Co-Pay

  The first choice for a co-pay increase was prescription drugs.

- Reduce or Change the Coverage

  Options for reducing coverage included

  - Limiting the coverage area network to providers in the VI and Puerto Rico

  - Eliminating certain options (pregnancy, vision or dental)

- Increase the Employee Share of the Premium

  Employers were reluctant to shift the burden to employees, because they feared employees would opt out of the plan.

? Eliminate Health Insurance Entirely

Although no employer said this had happened to date and this was a last resort, several said it would be considered.

2.5 What employer and employee groups are most susceptible to crowd-out?

This question was not addressed in the household survey and only indirectly in the focus groups. Most respondents did not have an understanding of the term. The only statement that can be made at this time is if the government were to offer a lower cost buy-in to its employee program for small businesses, then small business employers would most likely drop private coverage that is currently offered.

2.6 How likely are employers who do not offer coverage to be influenced by:

Expansion/development of purchasing alliances?: There was overwhelming consensus in the focus groups (88%) that the solution to health insurance should be in the hands of the private sector. Specifics of this option varied among the focus groups, but basically, the private sector would pool its coverage and select a single plan administrator. The plan administrator could be a group such as the Chamber of Commerce or an association of industries. Inclusion of the Virgin Islands Government (VIG) within the purchasing alliance was endorsed by the majority of supporters of this approach. However, VIG would not direct the alliance, but merely be a participant or indirect sponsor.

Individual or employer subsidies?: 20% of the members of the focus groups favored this approach. Although there was some discussion of universal coverage, the majority recommended that this be limited to people who were employed, either under a certain annual income or on a sliding scale. A few people mentioned that this should also be available to people with disabilities to supplement the Medical Assistance Program and Medicare. It was mentioned several times that they did not want this to be another welfare program with the potential of becoming a run-away entitlement.

Additional tax incentives?: Although 46% of the participants of the focus groups thought this was a viable option, they endorsed it without much enthusiasm. The main reason expressed was that businesses aren't making any profit to tax.

2.7 What other alternative coverage might be available to motivate employers not now providing or contributing to coverage?

Fewer employers (18%) endorsed the concept of a private industry buy-in to the VI Government's employee insurance program. If this option were to be pursued, the employers preferred that the government insurance program be privatized. They expressed concern about the ability to sustain such a complex program. A similar concern was expressed when the idea of buying-in to Puerto Rico's plan was discussed. The general consensus was that the role of government should be minimal and that privatization should occur wherever possible.

SECTION 3. SUMMARY OF FINDINGS: HEALTH CARE MARKET PLACE

3.1 How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions?

Variability Based on Pre-existing Conditions: There were reports made during the focus groups that there is variability in private insurance for those with pre-existing conditions, based on employer size. Both small groups and individuals are medically underwritten which has resulting in dramatic increases in premiums for firms/individuals who develop serious conditions in the year preceding premium renewal.

Instability in the Market: The Virgin Islands Office of Banking and Insurance (OBI) is responsible for regulating insurance carriers in the territory. Since the five destructive hurricanes that hit the territory in the period 1989 through 1996 exposed significant weaknesses in the property coverage market. OBI has focused almost exclusively on that sector. Many firms who wrote both property/casualty and health insurance coverage left the market. Until recently, the regulatory procedures for rate review and rate increases were contentious causing additional firms to also leave the market. Of the 100+ carriers licensed to provide insurance in the territory, only four firms have any significant health insurance presence. In addition, limitations regarding staffing and resources available to OBI to perform regulatory oversight have lessened its impact in oversight beyond financial stability of the insurance carriers.

3.2 What is the variation in benefits among non-group, small group, large group and self-insured plans?

There appears to be significant differences in accessibility and affordability of insurance options in the Virgin Islands based on income levels of individuals and gross profitability of the employers. Information on the insurance market was gathered through telephone interviews with several insurers and agents and a review of data maintained within various government agencies.

Although data are still being confirmed, it is estimated that over $200 million is written in the private sector for group insurance and the significantly smaller volume of individual insurance. The central government's employee insurance coverage program adds an additional $72 million in coverage. Depending upon the size of the firm, the industry sector of the firm and the hours of employment determines the availability and extensiveness of the insurance benefits. Full-time workers in the government and in firms with 10 or more employees have the greatest likelihood for individual and family coverage with the most extensive benefits. Workers in smaller firms have either no coverage or more limited and expensive coverage. While coverage may be more than adequate for a number of these workers, limitations in the range of services and providers available often results in individuals going off-island for treatment. Although the supporting data sources are not confirmed as of yet, testimony from several physician group representatives estimates that $100 in direct health care costs is paid off-island. A

significant portion of these off-island payments are financed by government sponsored premiums.

The Medical Assistance Program (MAP) in 2002 will provide $6.2 million in federal Medicaid coverage which is matched by the local government. Services provided in the Department of Health at its various clinics and in the 330-community health centers is also primarily through federal grants estimated to be valued at close to $26 million. Low income residents with health service options financed wholly or in part by the local government have the least amount of coverage product. To qualify for coverage through MAP, family income of four cannot exceed $8,500. [This is equivalent to a dollar value of $18,400 in the 48 contiguous states in 2003 at 100% of FPL for a family of four.] Adults with incomes above this level may not be able afford health insurance in the territory

Due to the ceiling imposed on the S-CHIP program for the territories, the funds are used to cover services already rendered to children in the previous fiscal year. No active recruitment is carried out for either MAP or S-CHIP.

Medicare premium volume for 9,000+ individuals with Part A and Part B coverage is still being determined. The financial intermediary for the program is based in Puerto Rico. While Medicare coverage is considered a high benefit, many providers in the territory do not accept assignment necessitating off-island travel for services

3.3 How prevalent are self-insured firms in the territory? What impact does that have in the marketplace?

At least four large firms (more than 100 employees) in the territory self-insure coverage for their workers. No data are maintained about these firms and the experience of the workers in the management of their health care needs. One of considerations of the central government in the near-term is the conversion of its fully insured plan providing coverage to 33,000 employees, retirees and dependents to a self-insured program. A preliminary description of the advantages and disadvantages of self-insurance was outlined in the option review paper prepared by the project staff attached in the Appendix.

Based on discussions with several Advisory Committee members and key leaders in the insurance industry, the impact of self-insured firms at this time on the local insurance marketplace is considered negligible.

3.4 What impact does the Virgin Islands as a purchaser of health care (e.g. for Medicaid, SCHIP and government employees)?

The local government as a purchaser of health care services has a substantial impact on the marketplace. The government is the largest employer in the territory offering a health insurance benefit package that will cost $72 million this year for 33,000 beneficiaries. The Medicaid program pays for an additional 18,000 beneficiaries whose expenditures

impact all of the local providers. Any changes that are made in the structure of the government programs will have substantial economic impact on the local market.

3.5 What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?

The continuing increase in group and individual health insurance premium costs will affect both private and government employers. In 1993, the Virgin Islands government spent $30.9 million in health insurance premiums to cover 24,000 employees, dependents and retirees. Today, a decade later, premium costs for approximately 33,000 employees, dependents and retirees is over $70 million, which is an increase of 240 percent in the 10-year period. The number of covered lives only increased 38 percent in the same time span. Private employers in the focus groups are reporting premium increases averaging 10 to 12 percent per year for the past several years. The response to this continued trend is to increase employee cost-sharing, decrease benefits, or to simply drop coverage, as smaller-sized firms are doing.

An analysis of which regulatory changes would have to be made in the Virgin Islands to provide for universal coverage is not complete at this time.

3.6 How would universal coverage affect the financial status of health plans and providers?

This component of the analysis is not complete at this time.

3.7 How did the planning process take safety net providers into account?

All of the safety net providers in the territory are members of the State Planning Grant Advisory Committee.

3.8 How would utilization change with universal coverage?

All though we have no supporting data for this question, the expectation is that utilization would increase for persons who are currently without coverage.

3.9 Was the experience of other States taken into account with regard to expansion of public coverage, developing public/private partnerships, developing incentives for employers to offer coverage, and determining regulatory changes?

Other State programs were reviewed and an overview paper was prepared to summarize these efforts. Given the substantial difference in the structure of the Medicaid program in the territory to the other 50 states, a more depth analysis was made of the Puerto Rican experience in expanding health insurance to low income persons. A report was prepared discussing at length the effect on population health status (significant positive for 1

million people) and government finances (question of sustainability of the $1 billion costs) subsequent to privatizing the Medicaid program. The report is contained in the Appendix.

SECTION 4. OPTIOS FOR EXPANDING COVERAGE

4.1 Which coverage expansion options were selected by the Virgin Islands?

Not complete. Expansion options that are based on SCHIP, Medicaid Section 115, and Medicaid Section 1931, however, are not applicable in the Virgin Islands.

4.2 What is the target eligibility group(s) under the expansion?

Although the expansion options have not been finalized, target groups by priority include uninsured persons who are working and dependents of insured workers who currently have no coverage.

4.3 How will the program be administered?

Not yet determined.

4.4 How will outreach and enrollment be conducted?

Not yet determined.

4.5 What will the enrollee (and/or employer) premium-sharing requirements be?

Not yet determined.

4.6 What will the benefits structure be (including co-payments and cost-sharing)?

Not yet determined.

4.7 What is the projected cost of the coverage expansion? How was this estimate reached? (Include the estimated public and private costs of providing coverage.)

Not yet determined.

4.8 How will the program be financed?

Not yet determined.

4.9 What strategies to contain costs will be used?

Not yet determined.

4.10 How will services be delivered under the expansion?

Not yet determined.

4.11 What methods for ensuring quality will be used?

Not yet determined.

4.12 How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?

Not yet determined.

4.13 How will crow-out be avoided and monitored?

Not yet determined.

4.14 What enrollment data and other information will be collected by the program and how will data be collected and audited?

Not yet determined.

4.15 How (and how often) will the program be evaluated?

Not yet determined.

4.16 For each expansion option selected (or currently being given strong consideration). Discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the Virgin Islands to consensus on each of these approaches?

The Insurance Options Sub-committee of the VI-SPG Committee has supported the broad outlines of the policy recommendations described below. Everyone on the sub-committee recognizes that further detailed premium analysis is required, including specific estimates for the premiums, cost-sharing and deductibles levels for individuals, employers and the government under each of the identified scenarios. The full Advisory Committee has not yet acted on these recommendations.

The basic descriptions of the three options are as follows:

Option 1: Expand health insurance access to small employers in the territory by implementation of group purchasing arrangements through either a buy-in process to the government's employee's health insurance plan or some public/private partnership.

Option 2: Expand coverage to individuals in the territory who are uninsured dependents of insured workers, or who are self-employed, or who are employed part-time, or who do not qualify for Medical Assistance benefits through implementation of insurance offerings sponsored by the 330-community health centers.

Option 3: Expand coverage to everyone in the territory through a coordinated public/private universal insurance program which combines all current sources of insurance coverage with the requirement that all businesses must "pay or play".

At the beginning of the planning process for the VI State Planning Grant (VI-SPG) project, a three-pronged test was described that would be applied to any recommended option. The test criteria defined in the grant application and affirmed by the Advisory Committee are:

A. An option must be economically/financially viable to all stakeholders - individuals, employers, employees, and to the government, although not necessarily in equal proportions, either as a direct or indirect benefit.

B. An option must be politically acceptable to the major constituencies in the territory if changes, additions, or deletions to the VI Code must be made to provide enabling legislation for enactment of the specifics.

C. An option must be socially acceptable to the broadest segments of the community including both consumers and providers of health care services, especially if behavioral changes must be implemented.

4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed), and the remaining challenges.

Not yet determined.

4.18 What policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, and constituency/provider concerns)?

Not option has been eliminated as of this time.

4.19 How will the territory address the eligible but not enrolled in existing programs? Describe efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners.

Not yet determined. The household survey did indicate that apart from cost as a major barrier to accepting coverage, a significant number of respondents were not aware of the public programs offered in the territory. Public education will be an important component of our outreach programs developing with partners in the public and private sector.

SECTION 5. CONSENSUS BUILDING STRATEGY

5.1 What was the governance structure used in the planning process and how effective was it as a decision-making structure? How were key government agencies identified and involved? How were key constituencies (e.g., providers, employers, and advocacy groups) incorporated into the governance design? How ere key government officials in the executive and legislative branches involved in the process?

The VI State Planning Grant governance structure had delegated authority directly from the Governor. The Bureau of Economic Research (BER) in the Office of the Governor was designated as the lead agency responsible for the overall direction of the grant activities. The Director of the Bureau served as the Principal Investigator. Daily operations of the project were contracted to a Project Management/Database Management firm.

A State Planning Grant Advisory Committee (SPGAC), chaired by the Principal Investigator, was formally appointed by the Governor to provide oversight to the process. The SPGAC members have diverse backgrounds and represent a cross section of the community in the private, public and non-profit sectors. Three major policy meetings were held with the SPGAC during the project. A 4th meeting is scheduled for the end of August.

The Advisory Committee adopted a sub-committee structure to facilitate smaller group consideration of ways to increase community input, review how health-related data could be collected an analyzed, how administrative costs could be reduced among health care providers, and which options would be viable for deliberation by the government.

Focus group meetings with employers and community members were the major means of seeking community input into the data gathering and planning process. Employers on all three islands were stratified according to number of employees and to the type of industry classification. Representatives of the identified businesses were invited to one of seven sessions held throughout the territory. Meetings were also held with church groups, services organizations, insurance agents, government agencies, and the university among others, seeking their input into the process. Findings from these meetings were incorporated into the development of plans to expand coverage.

Although the chairman of the Legislature's Health Committee is a member of the Advisory Committee, a meeting to brief the full Senate still remains to be scheduled after the summer recess concludes.

5.2 What methods were used to obtain input from the public and key constituencies (e.g., town hall meetings, policy forums, focus groups, or citizen surveys)?

Focus group meetings with employers and community members were the major means of seeking community input into the data gathering and planning process. Employers on all three islands were stratified according to number of employees and to the type of industry classification. Representatives of the identified businesses were invited to one of seven sessions held throughout the territory. Meetings were also held with church groups, services organizations, insurance agents, government agencies, and the university among others, seeking their input into the process. Findings from these meetings were incorporated into the development of plans to expand coverage.

5.3 What other activities were conducted to build public awareness and support (e.g., advertising, brochures, and Web site development)?

A project web site was developed to post meeting information and key documents for the public and committee members to read.

Public presentations on the topic were made at luncheon meetings of the Chamber of Commerce and the various Rotary Clubs in the territory.

Project staff participated in a radio call in show conducted solely in Spanish to discuss concerns of the Hispanic community about health care services.

Newspaper (print and on-line) briefings were provided by the Principal Investigator at significant milestones of the project.

5.4 How has this planning effort affected the policy environment? Describe the current policy environment in the territory and the likelihood that the coverage expansion proposals will be undertaken in full.

Like all other state governments, the territory is facing financial deficits. Reducing or containing the increase in the cost of public health services has become a priority for the Governor and his staff. A Pharmacy Benefits Management Program is being developed for the Medicaid program. An analysis has begun in order to identify insurance options that can be offered by the 330-community health centers to the public who meet specified income criteria. Due to the rising cost of health insurance premiums, the legislature has passed a bill to raise the contribution levels of government employees and dependents. Discussions are also in process regarding the logistics for changing the government's fully-insured plan to a self-funded plan. Most of these initiatives have begun as an outgrowth of the State Planning Grant project.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

6.1 How important was territory specific data to the decision-making process? Did more detailed information on uninsurance within the specific subgroups of the territory help identify or clarify the most appropriate coverage expansion alternatives? How important was the qualitative research in identifying stakeholder issues and facilitating program design?

The qualitative research in the territory conducted under the HRSA grant was very important in identifying stakeholder issues and developing expansion options. The ***2003 Virgin Islands Health Care Insurance and Access Survey*** (HCIAS) concluded in December 2002 was the first comprehensive study of this type ever conducted in the territory to determine the level of insurance coverage and ascertain a broad range of characteristics of the uninsured population, both adults and children. This was necessary since, the U.S. Virgin Islands does not participate in other national insurance surveys, such as the Medical Expenditure Panel Survey (MEPS) or the Current Population Survey (CPS), used by other the states for comparative purposes.

Until the household survey was completed, the VI Behavioral Risk Factor Surveillance Survey had provided the only continuous trend information for estimates of uninsurance rates among individuals in the territory. The uninsured estimates, however were based on an analysis of only one of two insurance-related questions taken from a computed-assisted telephone survey of the health habits of 1,500 U.S. Virgin Islands residents age 18 years and older.

6.2 Which of the data collection activities were the most effective relative to resources expended in conducting the work?

The computer-assisted telephone interview survey was the most effective use of resources in conducting the work

6.3 What (if any) data collection activities were originally proposed or contemplated that were not conducted? What were the reasons (e.g., excessive costs or methodological difficulties)?

A survey of employers was contemplated, but was not performed due to the difficulty in determining the universe of employers in the territory. The idea was also not pursued given the expense of doing follow-up with small companies (80% of the firms) on three islands.

6.4 What strategies were effective in improving data collection? How did they make a difference (e.g., increasing response rates)?

The most effective tool in increasing response rates was word of mouth that the study was underway. The local chapter of AARP also assisted by undertaking a mailing describing the survey to 17,000 members residing in the territory

6.5 What additional data collection activities are needed and why? What questions of significant policy relevance were left unans wered by the research conducted under the HRSA grant? Does the territory have plans to conduct that research?

Utilization data are still being collected from the various government agencies and providers. This has been difficult information to retrieve since 1) there is no central repository of information 2) MIS systems in each agency are not the same 3) special programs had to be written to retrieve some of the data 4) other resource limitations preventing the timely retrieval of the information.

6.6 What organizational or operational lessons were learned during the course of the grant? Has the territory proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?

Not completed.

6.7 What are the key recommendations that the territory can provide other states/territories regarding the policy planning process?

Not completed.

6.8 How did the local economic and political environment change during the course of the grant?

The financial condition of the territory worsened, as has happened in the other states.

6.9 How did your project goals change during the grant period?

No significant change.

6.10 What will be the next steps of this effort once the grant comes to a close?

Not completed.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

7.1 What coverage expansion options selected require Federal waiver authority or other changes in Federal law?

To be developed.

7.2 What coverage expansion options not selected require changes in Federal law? What specific Federal actions would be required to implement those options, and why should the Federal government make those changes?

To be developed.

7.3 What additional efforts should the Federal government provide in terms of surveys or other efforts to identify the uninsured in states/territories?

To be developed.

7.4 What additional research should be conducted (either by the federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion programs?

To be developed.

APPENDIX I: BASELINE INFORMATION

Population:

According to the 2000 VI Census 108,612 persons were enumerated in the US Virgin Islands: 53,234 (49%) persons on St. Croix; 51,181 (47%) persons on St. Thomas; and 4,197 (4%) persons on St. John. Nearly 1 in 3 residents are under the age of 18. Females are 52% of the population. By race, the population is predominately Black or African American (78.3%); ethnically, the population is 14% Hispanic, of any race

Number and percentage of uninsured (current and trend):

24.1% of the population is uninsured (26,000 people). No comparable trend information is available.

Median age of population:

Median age is 33.4 years

Percent of population living in poverty:

More than 32% of the population has incomes below 100% of the Federal Poverty Level. Table translates the percentages of the Federal Poverty Level (FPL) into dollar equivalents for the Virgin Islands and the U.S. mainland.

Table I-1: Federal Poverty Levels in the U.S. Virgin Islands, 2003

	Dollar Value U.S. Virgin Islands	Dollar Value US 48 Contiguous states 2003
100% FPL		
1 person	$5,500	$8,890
2 people	$6,500	$12,120
3 people	$7,500	$15,260
4 people	$8,500	$18,400
200% FPL		
1 person	$11,000	$17,780
2 people	$13,000	$24,240
3 people	$15,000	$30,520
4 people	$17,000	$34,000
300% FPL		
1 person	$16,500	$26,670
2 people	$19,500	$36,360
3 people	$22,500	$45,780
4 people	$25,500	$55,200

Primary Industries:

Sector	Employment Ending 2002
Private Sector	
Construction	**3,017**
Manufacturing	**2,148**
Transportation & Public Utilities	**2,446**
Wholesale & Retail	**9,788**
Finance, insurance & real estate	**1,918**
Services	**11,195**
Government	**12,617**
Federal government	**905**
Territorial government	**11,793**

Number and percent of employers offering coverage:

Not quantitatively established.

Number and percent of self-insured firms:

Of the 3,026 firms that report wages paid, only 4 firms are known to be self-insured.

Payer mix:

According to the 2003 Virgin Islands Health Care Insurance and Access Survey, more than half (51.2%) of the people in the U.S. Virgin Islands indicated that they are covered by health insurance through an employer. This level of employer coverage is 18% below the U.S. average reported figure of 62.5%. Four percent purchased private individual insurance and public programs cover 20.6% of the population.

Provider competition:

There are over 175 insurance companies registered with the VI Office of Banking and Insurance. Four (4) companies control than 95% of the health insurance market.

Insurance market reforms:

Not finalized.

Eligibility for existing coverage programs:

Medical Assistance Program (Medicaid): After other income adjustments, 100% of local Federal Poverty Level (see previous table)

Department of Health Clinics/330-Community Health Centers: Sliding fee scales based on local Federal Poverty Levels

Use of Federal waivers:

Not applicable to the capped Medicaid program in the territory.