

HRSA VIRGIN ISLANDS STATE PLANNING GRANT
INTERIM REPORT TO THE SECRETARY
June 30, 2004

Background

Goals: The Virgin Islands HRSA State Planning Grant Project (SPG) began with the premise that potentially 35% to 38% of the population did not have health insurance. The previous lack of coordination between the various health planning and regulatory agencies compounded by insufficient micro-level data hampered the government's ability to adequately understand and plan future health insurance expansion programs. The USVI had historically not participated in national insurance surveys, such as the Medical Expenditure Panel Survey (MEPS) or the Current Population Survey (CPS), so those data sources for comparative purposes were unavailable. The initial goal of the VI State Planning Grants Project (VI-SPG) therefore, was to collect statistically valid data to establish an estimate of the number of uninsured residents. The second goal of the project was to use the defined characteristics of the uninsured population to accurately inform policy decisions regarding the government's expansion efforts.

Objectives: Data collection and analysis activities proposed for the grant were to accomplish four major objectives in order to better inform policy officials about which approaches to expand insurance coverage in the territory might be financially, economically and politically feasible. The first objective was to develop a quantitative and qualitative understanding of the level of health insurance access and coverage disparities in the territory. The second objective was to develop an understanding about the characteristics of the private sector and determine what types of incentives are necessary to motivate them to provide health insurance to their employees. The third objective was to improve our understanding of how the differences in eligibility for public programs affect access and delivery of health services. The fourth objective was to increase our knowledge about the relationship between access to health insurance and economic development in the territory.

The result of accomplishing these objectives would be to structure the development of consensus on options that could be adopted by the government to expand insurance coverage. The long term goal of insurance expansion would be to reduce government expenditures for uncompensated care.

Progress on Objective 1: The project has accomplished the objective of developing quantitative micro-specific data relevant to the Virgin Islands describing the characteristics of the uninsured which can be used to inform policy makers in designing expansion options. Through support from the HRSA grant, services were contracted with the Eastern Caribbean Center at the University of the Virgin Islands and SHADAC (State Health Access Data Assistance Center) at the University of Minnesota, School of Public Health to conduct a statistically valid household survey to determine the demographics, source of coverage and health status of the residents. A modified version of the

Coordinated State Coverage Survey (CSCS) instrument developed by SHADAC was chosen as the survey tool to provide comparability with other HRSA state planning grant projects.

The 2003 Virgin Islands Health Care Insurance and Access Survey (VIHCS) was a random digit dial computer assisted telephone survey conducted in English and Spanish between October 2002 and January 2003. A total of 2,073 interviews were conducted for an overall response rate of 65.7%. The cooperation rate was 83.4%.

Other pertinent characteristics of the uninsured population determined in the survey are described below.

By age: more than one-half of the uninsured are between 18-24 years of age; children under age 5 account for 22.5% of the uninsured; more than one-third are between the ages of 25 to 54 years of age.

By education: persons with less than a high school education represent 39% of the uninsured; those with post graduate training only account for 3% of the uninsured.

By income: more than one-half of the uninsured have family income less than 100% of the US Federal Poverty Level (FPL); 29% have income between 101 to 200% of FPL; 13% percent of the uninsured have family incomes above 400% FPL

By employment: the majority of the working uninsured is permanently employed and has only one job, and work more than 40 hours per week.

By island: St. Thomas has a larger percentage of uninsured residents most likely related to the greater number of tourist-related small businesses on the island; St. Croix has almost twice as many residents with Medical Assistance coverage than the other islands.

By eligibility: 14.3% of the uninsured are presumptively eligible for employer coverage but do not take up insurance, primarily due to cost. 16.9% are potentially eligible for public coverage, but do not take-up coverage for several reasons: e.g., do not know how to or choose not to access the bureaucracy to apply; do not trust public programs.

By source of care: 87% of both privately and publicly insured have a regular source of care compared to 65% of the uninsured. Physicians Offices are the predominant regular source of care, regardless of insurance status. Community Health programs are the next frequent source. Few people use the emergency room (8%, if uninsured; 4% if public; 1% if privately insured).

Progress on Objective 2: The private sector provides approximately 30,000 jobs, with the majority in the retail trade and service industries, where low wages are common. Analysis of data from the local Department of Labor, Bureau of Labor Statistics (BLS)

estimates that of the 3,243 private sector employers who report paid wages and hours worked, 80% percent of the firms employ fewer than 10 persons. The predominance of small firms in the business sector has important implications in the design of meaningful policy options that will provide affordable premium pricing for employers and employees.

A by-product of the VI-SPG project was the development of an agreement with the Agency for Health Research and Quality (AHRQ) to conduct a special Medical Expenditure Panel Survey Insurance Component (MEPS-IC) on employers in the territory. Quantitative results are expected to be available in July or August 2004.

Qualitative knowledge about the concerns of the employers in the territory was acquired through the activity process of Focus Group meetings held on three islands. The 70 participating employers provided a broad cross section by firm size and industry type of their representation in the Virgin Islands market. A full survey of all employers was not feasible in the scope of the grant.

Major qualitative findings from the Employer Focus Group meetings include:

- 52% of focus group employers with less than 10 employees offered health insurance.
- 100% of focus group participants with 10-50 workers provided health insurance.
- Employers in small firms not offering insurance indicated that cost was the major reason.
- Other reasons for not offering insurance included language barriers, particularly for Spanish speaking firms on St. Croix dealing with English speaking agents, since on the island nearly 1/3 of population is ethnically Hispanic and has ownership of many small business firms.
- Need more coverage options for single employees with children, since family coverage which is offered is more expensive; also young workers do not take full coverage plans, even when offered; premium rates have gone up 12-30% in last year for the firms; many have considered dropping coverage if premiums continue to rise.
- Most participants favor creating purchasing alliances not managed by the government; tax subsidies were the second favored approach to help small employers purchase insurance.

Qualitative information was also gathered from a series of meetings with various community and non-profit groups, such as churches, the AARP, Rotary Clubs, Hispanic Action Groups, the University, and the Territorial Insurance Association. Findings from these meetings indicate a need for a comprehensive focused bi-lingual consumer

education program on how to use insurance and the importance of prevention and primary care.

Progress on Objective 3: Health service utilization and financial data was collected from numerous institutional sources in the territory to improve our understanding of how the differences in eligibility for private/public programs affect access and delivery of those services. The data was then entered into a computer system to enable SQL processing of complex queries. While the activity of collecting financial and utilization data was completed, the problems that were encountered in acquiring, structuring, cleaning, and organizing the data indicate further work is required to: 1) develop uniform and automatic reporting systems; 2) develop more refined and coordinated micro-level reporting; 3) implement training programs for consistent interpretation of the data by analyst in the various agencies; 4) develop more robust analysis of relational patterns across the different data sources; and, 5) consider a reorganization plan within the Executive branch to better perform health policy analysis and health policy development

Results from a basic analytical process that was completed suggests that persons using local health services are either a) sicker at the point of seeking care, b) do not use preventive early screening services as recommended, c) have little coordination of their primary care, d) do not have accurate means of coordination of their various potential sources of coverage at health facilities, and d) if insured by the local government, do not seek care outside of the territory in as significant a number as general beliefs have held. In addition, findings tentatively suggest that persons with Medicaid were least likely to have coordination of their care, even though services are restricted to government facilities.

Progress on Objective 4: The fourth objective was to increase our knowledge about the interrelationship between access to health insurance and the economic growth of the territory. Data gathering activities were conducted to determine the local government's overall contribution to funding health care in the territory. The major categories of local expenditures identified in fiscal year 2003 were: 1) subsidies to the hospitals and health centers for uncompensated care (\$33 million); 2) the local Medicaid match (\$3.4 million in direct dollars and \$3.8 million to be delayed in subsequent year appropriations); 3) premium contributions for the government worker's insurance program (\$72 million); and, 4) other departmental health delivery services (\$36 million). The preliminary total of these major expense categories represents nearly \$1 in every \$4 budgeted in the government's General Fund.

SPG findings through these activities indicate that the impact of the uninsured on the local government is significant as reflected in the amount of financial subsidization that is required to keep the hospitals operational. The rate of requested increase in subsidy payments to the hospitals has exceeded 10% per year for the last three years, and represents \$1 in every \$3 of their revenue budget. The local government is the only source for these funds given the structure of the Medicaid program, and the absence of DSH monies. Further analysis is needed to determine the financial impact of substituting a dollar of insured coverage for a dollar of uncompensated care subsidy.

The effect on the community as a whole to maintain this spending level on health care is the opportunity costs of money directed away from spending for education, public safety, and other infrastructure improvements.

The SPG project team has accomplished the identification and implementation of a Pharmacy Benefits Management (PBM) program within the Medicaid program effective July 1 to generate savings which might be redirected to expansion effort. Initial analysis determined that “usual and customary” prices were being paid for pharmaceuticals provided at local pharmacies under contract to serve Medicaid clients. PBM program estimates are that savings in the range of \$500,000 to \$750,000 will accrue in the first year of the program. Other potential savings through program re-design and redirected to coverage expansion were identified as part of the activities completed under this objective.

Outstanding Activities from Original Grant

The outstanding activity for Objective #4 is to confirm the accuracy of expenditure data that has been collected and complete the report on potential savings through program redesign. Completion of this work has been folded into the Supplemental Objectives described below.

Supplemental Funding Project Objectives

Supplemental State Planning Grant funding was received from HRSA to expand upon the work completed in Objectives # 4, as stated in the previous discussion. During the course of the project it became clear that the dominant force in benefits design was the government employees’ insurance (GEI) program. Additional work would have to be performed to determine under what circumstances access to this form of benefit –a shadow plan - would be a feasible and cost effective solution to expand coverage in the private sector. In addition, what impact would the development of a “shadow plan” have on the structure and benefits of the GEI package? What re-design might be necessary to minimize the overall costs to the government to operate both programs?

Supplemental Objective 1: Identify and develop the specifics of a benefits structure that is most appropriate in a GEI and private employer “shadow” program and estimate premium pricing under various scenarios of participation by employees and their dependents; consider how a buy-in from the private sector to a “shadow plan” would impact premium simulations and administrative logistics for the government.

Progress to Date: The consulting firm of Mercer Government Human Services Consulting was engaged to perform the actuarial work to accomplish this objective. Data analysis is still being completed by the consultant. Meetings were held with government agencies to ensure the availability of all data components.

Expected Completion Date: July 30, 2004.

Supplemental Objective 2: Define the parameters for legislative, regulatory, and administrative requirements of insurance products which will expand small firm and self-employed access to coverage using the premium simulations from Supplemental Objective 1; and in addition set benchmarks for expanding a managed care network to support persons in publicly funded health plans.

Progress to Date: Although premium simulation information is not yet available from Supplemental Objective 1, the broad outlines for changes in legislative, regulatory, and administrative requirements has been completed. Activities and tasks have been completed to specify how a managed care network to expand and coordinate care of publicly funded health programs within the Community Health Centers, the Department of Health, and the hospitals would be implemented. Toward that objective, full membership status for the Community health Centers has been approved by the PPO board of directors. Discussions are underway with the Joint Commission to understand operational requirements for accreditation of the expanded network, and also with the Division of Banking and Insurance for any regulatory requirements that must be satisfied.

Expected Completion Date: July 30, 2004.

Supplemental Objective 3: Further quantify the projected economic impact that would occur by expanding affordable insurance coverage in the territory.

Progress to Date: The expected trade-off for the government in implementing the expansion options described above is a significant reduction in uncompensated care subsidy payments made primarily to the hospitals. Additionally, pressure on the Medicaid program should be reduced. As soon as the expenditure data is re-confirmed and the simulation work is completed for the Supplemental Objective 1, this final portion of the work can be completed.

Expected Completion Date: August 15, 2004.

Final Report to the Secretary

The final report to the Secretary will be completed by 30 September. The report will summarize the quantitative and qualitative data collection methodologies and identify the key findings used to develop the policy options for expanding affordable insurance coverage in the territory. The policy options at the conclusion of the process will represent more than 1000 hours of committee work, community presentations, and data analysis effort.

While final work quantitative work is pending for completion of the Supplemental Objectives, the government will report to the Secretary the following three expansion options:

- Expand employer based coverage with a strategy to pool small firms
- Develop a private/public partnership to assist with the highest risk levels to lower premium expense for employers

- Better coordinate public insurance programs to make use of existing funding and reduce unnecessary utilization of resources in order to expand coverage potential

3.4 Expected Expenditures to Complete Outstanding Activities

The original VI HRSA State Planning Grant was in the amount of \$930,992. Supplemental Funding provided an additional \$103,595. The balance remaining to be drawn is \$33,595. Use of these funds will complete all outstanding Supplemental Objective activities.