

**Virginia State Planning Grant:
Report of Recommendations to the Leadership Group
September 16, 2005**

The Commonwealth of Virginia was one of ten states and territories during FY03 to receive a State Planning Grant from the Department of Health and Human Services' Health Resources and Services Administration (HRSA). The HRSA State Planning Grant (SPG) Program provides one-year grants to States to develop plans for providing access to affordable health insurance coverage to their citizens. The goal of the Commonwealth of Virginia SPG (VA-SPG) is to develop a viable, realistic option for expanding health insurance coverage to an identified population of working uninsured. The SPG Model Development Workgroup (MDG) was charged with identifying the target population and a recommended model option to expand insurance coverage (see project website for further details and a list of workgroup members: <http://www.InsureMoreVirginians.org>). Following a survey of Virginia households, commissioned by the grant, the MDG targeted small business (2-50) working uninsured ages 19-64. This report provides an overview of the results of data analysis, decision support, strategic and business planning activities of the VA-SPG project to date, culminating in a proposed insurance model to meet the primary goal of increasing health insurance coverage to a selected population of working uninsured citizens in the Commonwealth.

Overview of the Virginia State Planning Grant

The goals of the Virginia State Planning Grant (VA-SPG) call for expanding health insurance coverage to citizens who are working but, uninsured; and submit recommendations to the Governor through the Secretary of Health and Human Resources at the conclusion of the project. Project goals include the following:

1. Conduct a Descriptive Study of the Existing Data on the Current Status and Economic as well as Societal Costs of Non Insurance;
2. Perform New Data Collection and Analysis to Inform Options for Coverage Expansion for the Employed Uninsured (SHADAC Household Survey, AHRQ Business Survey);
3. Collaborate with Public and Private Sector Partners to Develop a Viable Option(s) to Provide Access to Coverage for Virginia's Working Uninsured Population and Sustain Collaboration;
4. Develop a Business Plan for Covering the Uninsured in Virginia and submit it to the Governor and Secretary of Health and Human Resources.

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The VA-SPG project is directed by the Virginia Department of Health (VDH), Office of Health Policy and Planning (VDH, OHPP) in collaboration with subcontracted partners: the Center for Health Policy Research and Ethics at the George Mason University (CHPRE), the Minnesota State Data and Information Access Center (SHADAC), the HRSA-sponsored Arkansas Center for Health Improvement, Multi-State Integrated Database (MSID), the Agency for Health Research and Quality (AHRQ) Medical Expenditure Panel Survey Insurance Component Division (MEPS-IC), the Healthcare Leadership Council and Project REACH at Virginia Commonwealth University. Mr. Robert Archer (former President, Blue Ridge Beverage Company) and the Small Business Advisory Board for Virginia have also played an integral role in the VA-SPG project.

The VA-SPG communication plan and participatory processes have included stakeholders, knowledgeable experts and key public agencies as well as outreach to the public through the SPG website: www.insuremorevirginians.org. Specialized SPG workgroups have been charged with soliciting data and input from the businesses and communities across Virginia, including those in all geographic regions, inclusive of rural and urban areas.

The Problem of Virginia's Uninsured: Current Conditions and Challenges

Current Household Health Insurance Coverage

In 2004, the Virginia Department of Health, Office of Health Policy and Planning commissioned the State Health Access Data Assistance Center (SHADAC) to survey Virginia households about health insurance coverage. SHADAC is a research center at the University of Minnesota with extensive experience conducting research on methods and trends in state/national insurance coverage. Using a standardized telephone survey (Health Care Insurance and Access Survey) with the addition of specific Virginia SPG questions, a telephone interview survey of over 4,000 representative households across Virginia was undertaken. *(Two reports summarizing the SHADAC 2004 Virginia Household Survey findings are found in Appendix A.)*

The SHADAC 2004 Virginia Health Insurance and Access Survey found continuing high rates of uninsurance in the state. At the time of the survey, about 640,000 persons (nearly 9 percent of Virginia's population) had no health insurance—a number slightly smaller than the population of Virginia Beach and Norfolk combined. Rates of uninsurance for all Virginians varied from 6.3 percent for those who were uninsured all year to 11.5 percent for those uninsured at some point during 2004. Specifically, 11.4 percent of working age adults were uninsured at a point in time but ranged from 8.2 percent for all year to 14.6 percent for some point in time over the year. Children (≤ 18 years old) experienced a 6.4 percent rate of uninsurance for point in time and had a range of uninsurance of 4.1 percent for all year to 8.6 percent for some point in the year.

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Seniors (>= 65 years old) experienced rates of uninsurance of .8% to 1% for the year. In addition, about 8 in 10 of the state's insured population fear they won't be able to continue to afford health insurance.ⁱ Nationwide, the number of Americans without health insurance for all of 2003 was a record high 45 million, or 15.6 percent of the population (the highest percentage since 1998). In 2003-2004, about 85 million, or about 32 percent of the population, were uninsured for some period of time.ⁱⁱ

One of the unique features of the work of this project has been the collection of sub-state information to discern differences among regions within the Commonwealth. Some regions of Virginia fared better than others in their rates of uninsurance. Uninsurance rates at the time of the survey varied across five geographic regions, ranging from 7.3 to 12.1 percent. At the time of the survey, the state's Central Region had the highest rate of uninsurance.

Figure 1. Rates of Uninsurance by Region, Virginia 2004



Source: 2004 Virginia Health Care Insurance and Access Survey

In Virginia, and nationwide, there are uninsured citizens in just about every demographic group. The uninsured are most often low-income, young, non-white, and employed (working in small businesses). The Commonwealth's low-income population has one of the highest rates of uninsurance. The proportion of families without health insurance living at or below 150 percent of the Federal Poverty Level (FPL) is 20 percent or more. Among uninsured adults of all ages, nearly 60 percent reside in lower income households.ⁱⁱⁱ

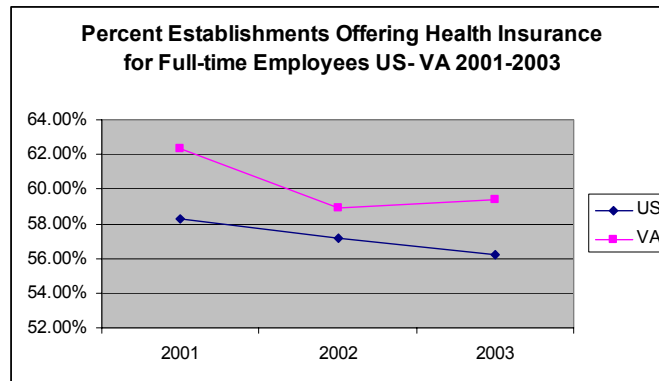
Increases in Medicaid and FAMIS (SCHIP) enrollment since 2001 have helped to lower uninsurance rates of children and pregnant women, while higher rates of unemployment and an influx of new immigrants have led to an increase in the uninsured adult population. Private, employment related insurance accounts for the majority of coverage across the Commonwealth. Yet, many low-wage workers do not have access to affordable insurance, primarily because their employers do not offer it.^{iv}

Young adults can typically be insured at low-cost because they are relatively healthy and

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infrequently seek health care services. However, this same population is less inclined to purchase health insurance because of their good health and perception that they have a very low risk of being in poor health. This perception and inclination to purchase insurance is only exacerbated with lower income young adults. A majority (65.4%) of the uninsured in Virginia in 2004 had neither requested nor received information about the state's public health insurance programs. When asked why they did not participate in employer-sponsored coverage, a significant proportion of Virginia's uninsured workers felt coverage was too expensive (28.9%), or did not want it/felt the benefits offered were inadequate (17.2%).^v In Virginia and nationwide, recent increases in the rate of uninsurance has been influenced by several factors, including the erosion in employer-sponsored private health insurance coverage (driven primarily by rising health care costs) and to some extent a weak economy and rising unemployment in certain industries.^{vi}

Figure 3. Percent Establishments Offering Health Insurance for Full-Time Employees, US-VA 2001-2003



Source: Agency for Healthcare Research and Quality, Center for Financing Access and Costs Trends, 2003 Medical Expenditure Panel Survey- Insurance Component

Employer Based Health Insurance

Small businesses represent over 75 percent of all businesses and employ nearly a third of all workers (more than 828,000 persons) in the Commonwealth of Virginia. Individuals working in companies with less than 50 employees are about twice as likely to be uninsured as individuals working in companies with more than 50 employees. In 2003, only 59.4% of all businesses offered health insurance to their employees. Small businesses have much lower health insurance offer rates. For businesses with less than 50 employees, only 47.7% of these businesses offered health insurance. Just 40 percent of very small employers (less than 10 workers) offered health insurance to their employees. By industry, very small employers in the retail and other services sector had the lowest offer rate (35%) followed by agriculture and construction (38%).^{vii}

(2004 AHRQ, MEPS-IC Survey Data Tables and additional analyses are included as Appendix B.)

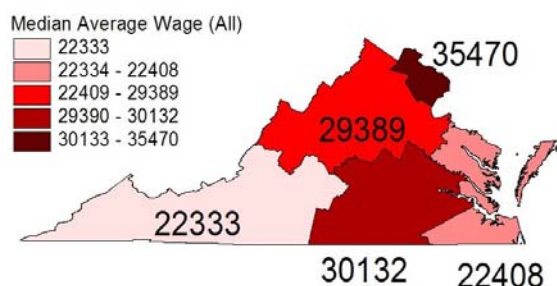
In 2003 in Virginia, the average proportion of the average family premium contributed by employees was about 30 percent; for workers in firms with less than 50 employees, the average employee contribution was slightly higher.^{viii} A 2005 key informant survey of small businesses in Virginia found that, for those employers that offered insurance, more than half used co-payments or deductibles to offset the costs of coverage. For those small firms not offering coverage, the most frequently cited reason for not doing so was the high cost of insurance.^{ix} As a result, premium assistance was ranked as the best public policy option by these employers to assist them in offering health insurance. Among Virginia employers that primarily employ low-wage workers (employees making less than \$9.50 per hour), nearly two-thirds of small employers (≤ 50 employees) did not offer their employees coverage in 2003.^x

Economic Trends

In recent years, Virginia's employment and personal income picture has improved. The state's unemployment rate has declined since 2002 (to about 3.8% in June 2005), and the number of employed workers has steadily risen (to over 3.8 million in 2004). According the quarterly census and wage survey conducted by the Virginia Employment Commission, the average numbers of business establishments and average weekly employee wage have increased. Furthermore, personal and household income in Virginia has remained steady or risen in recent years. In 2003, annual per capita personal income was \$33,730 (up from \$31,087 in 2000), while annual median household income was \$48,224 (2002).^{xi}

In 2003, the median annual wage in Virginia was \$28,586, with individuals working in smaller firms receiving lower wages on average. The median wage for workers employed in firms with fewer than 50 employees was \$22,315. Among very small firms (fewer than 10 employees) the median annual wage was just \$19,125. Furthermore, employees with average annual incomes of \leq \$29,855 and who work for businesses with ≤ 50 employees accounted for only 29 percent of enrollees with single coverage and 24 percent of enrollees in family health coverage plans. As such, these employees pay about two percent of their take-home pay for single coverage and 8 percent for family coverage.^{xiii} The distribution of businesses by size and average median wage follows.

Figure 4: Median Average Wage (in dollars) by Region, 2003



Source: Agency for Healthcare Research and Quality, Center for Financing Access and Costs Trends
2003 Medical Expenditure Panel Survey- Insurance Component

Rapidly rising health care costs in Virginia and nationwide have helped to strengthen the likelihood of insurance coverage associated with higher income levels. For Virginia individuals with annual incomes \$75,000 or higher, the proportion with health insurance coverage in 2003 was about 96 percent, a slight decline from 98 percent in 2001. The rate of coverage also fell for Virginia residents earning between \$20,000 and \$25,000 annually, from 81 percent in 2001 to 74 percent in 2003. For those Virginians making between \$10,000 and \$20,000 a year, the proportion of uninsured remained fairly stable at around 68 percent.^{xiii} In 2003, the take-up rate for health insurance for Virginia workers making less than the median annual wage of \$28,586 was 26 percent, compared to 67 percent for those who made more than \$28,586.^{xiv}

Health Insurance Premium Price Trends

For four straight years (2000-2004), workers and employers (nationwide and in Virginia) saw double-digit increases in health insurance premiums; with average increases of 8 to 10 percent expected in 2005. These increases (nearly four times the rate of inflation) have brought the annual premium price for a typical family of four in the United States to nearly \$10,000 and about \$3,700 for single coverage. Premiums in Virginia have increased in a similar fashion, increasing at a rate 2.4 times the average rise in earnings.^{xv}

The growth in the cost of coverage is making health insurance unaffordable. A recent study found that for each one percent rise in health spending relative to personal income, the number of uninsured people increases by 246,000.^{xvi} Another study projects rising health care costs will result in more than three-fourths of large companies nationwide shifting more of the cost of health insurance coverage on to their employees in 2006, with about one-fourth likely to reduce wage increases for employees in lieu of dropping coverage.^{xvii} Albeit a large employer, one high visibility example of this trend is General Motors, who recently announced it will eliminate

25,000 jobs in the United States, in large part due to financial losses stemming from rising health care costs. In the second quarter of 2005, GM's losses amounted to more than \$1.1 billion.^{xviii}

Consequences of Uninsurance

A 2004 report estimated the total medical care expenditures associated with the uninsured nationwide to be approximately \$125 billion.^{xix} In 2003, the Institute of Medicine (IOM) concluded that the greatest economic losses associated with being uninsured are attributable to worse health and shorter life span, not just higher health care costs. It estimated the annual economic value of foregone health for over 40 million uninsured to be between \$65 and \$130 billion.^{xx} A recent study estimated the cost of uncompensated care provided to the uninsured and those unable to pay for care will be more than \$60 billion by 2010. In Virginia, uncompensated care costs in 2005 will be just under \$1 billion (\$995.3 million), and by 2010 are expected to rise to nearly \$1.4 billion.^{xxi} (*See Costs and Consequences of Uninsurance: A Technical Briefing Paper in Appendix C for further details.*)

Considering the economic impact on individuals and households, the lack of health insurance has been found to be a factor in individual financial hardship. The result of declining coverage and increased cost sharing has left many American families with medical debt. In Virginia, about 5 percent of the uninsured in 2004 established bankruptcy due to medical expenses.^{xxii} Thus, the economic consequences of uninsurance warrant serious efforts to expand coverage.

Addressing the Problem: Options Considered

Prior Efforts to Address the Uninsured in Virginia

In recent years, the Commonwealth has engaged in many activities in an attempt to increase insurance coverage. Like many states, Virginia has enacted a series of insurance market reforms aimed at improving the affordability and availability of coverage for small groups and individuals. These reforms include guaranteed renewability of all policies for all groups and individuals, limits on pre-existing condition waiting periods; credits for waiting periods served in previous coverage for all groups and individuals; no exclusions from any size group, guaranteed issue of all products (including state-established essential and standard plans for groups of 2-50 employees); modified community rating on the essential and standard plans for groups with 2-25 employees; and guaranteed issue of all policies, and no pre-existing condition exclusions for eligible individuals who have left group coverage, are not available for other coverage, and have exhausted COBRA eligibility. Medical Savings Accounts (MSAs) were established by the General Assembly in 2002 (House Bill 414).

More recent developments include a 2004 law allowing insurers to extend coverage to dependent children of group insured individuals, regardless of the child's age, and a 2003 law that allows

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cost sharing arrangements with essential and standard health service benefit plans. Recent legislation not enacted include bills that allow self-employed individuals to buy in to the state employee health plan, direct the Secretary of Health and Human Resources to establish a plan for unemployed residents in Virginia, and create consumer choice benefit plans that would not be subject to mandated benefits.

In 1990, the General Assembly, recognizing that health care costs have resulted in problems of access and affordability, created the Special Advisory Commission of Mandated Health Insurance Benefits (Commission) to analyze the social and financial impact of current and proposed mandated health benefits. Today, Virginia is among the top states in terms of the number of health insurance mandates (including mandated offers and providers), ranking third behind Connecticut and Maryland. Findings of a 2004 commission led by Lieutenant Governor (and Democratic gubernatorial candidate) Tim Kaine led to proposed (not yet enacted) legislation to provide tax credits to small businesses that offer health insurance plans to workers.

Insurance Expansion Efforts in Other States

Most state efforts to increase health insurance coverage have been undertaken to address at least one of the following goals:

- Improving access to private health insurance
- Expanding government-sponsored health insurance
- Comprehensive insurance coverage expansion (involving a combination of private and public options)

As a result, most states have pursued public solutions to insurance coverage expansion. *A detailed analysis of lessons learned from other states with implications for Virginia can be found in Appendix D (Insurance Coverage Expansion Options: Lessons Learned from Other States).*

In accordance with the mission of the Virginia State Planning Grant—to improve access to health insurance for the working uninsured, the following model approaches were determined by the Model Development Workgroup (MDWG) to represent the best options for consideration to expand private insurance coverage:

Subsidizing or Reducing the Cost of Private Coverage:

- Create state-funded premium assistance / private insurance buy-in programs
- Make state-funded reinsurance available (Reduce price of private insurance for low-income uninsured and small employers by having state cover portion of health insurers' high-cost or catastrophic claims.)
- Provide health insurance tax credits or deductions to purchase coverage
- Allow sale of no-mandate insurance policies exempt from state-mandated benefit requirements

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- Authorize tax-free health savings accounts (HSAs) for covered individuals to offset part of cost of deductibles, co-payments or other non-covered expenses
- Allow group purchasing arrangements for health insurance such as association health plans

Eliminating Barriers to Getting Insurance:

- Put in place small group rating reforms to control variability in premium rates for small employers
- Enact individual health insurance market reforms
- Establish/broaden state continuation-of-coverage (COBRA-like) laws
- Allow other groups to join state employee health benefit plans
- Expand definition of ‘dependent’ in health insurance policies (e.g., raise eligible age)

Compelling Employers to Provide Coverage for Certain Groups:

- Enact employer mandate to offer health insurance to some/all employees
- Other: Require college students to be insured; Require provision of health insurance as condition of state contracts

Public Program Expansion:

- Expand income and group eligibility for Medicaid and establish Medicaid premium assistance or buy-in program
- Expand income and group eligibility for the State Children’s Health Insurance Program (FAMIS) and establish FAMIS premium assistance or buy-in program
- Strengthen outreach and enrollment efforts for Medicaid and FAMIS
- Establish/expand state-only high-risk pools and other health insurance programs

According to a March 2004 study of state approaches for expanding health insurance coverage by the National Conference of State Legislatures (NCSL), successful expansion programs have in common the following elements:

- Provision of substantial premium subsidies
- Build upon existing programs and systems
- Minimization of administrative requirements for expansion program partners (i.e., insurers and employers)

In particular, the NCSL study found that most successful state approaches have lowered the effective price of coverage—either by making reduced-price coverage available or by providing subsidies for purchase of private insurance—and/or have lowered or eliminated other coverage barriers such as restrictive eligibility rules.^{xxiii}

Why a Private Sector Remedy in Virginia?

While many states have pursued a mix of public and private expansion options through their

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SPG initiatives, the VA-SPG has been undertaken with a primary directive to design a private-sector solution to the problem of the uninsured in Virginia. The proposed insurance product, however, is not intended to replace the need for publicly subsidized coverage (i.e., Medicaid, FAMIS) for low-income individuals or ‘destabilize’ the current small group market, but rather to expand the private insurance market and ensure coverage options to individuals that may not have a private sector alternative to public coverage.

At the beginning of this project, Virginia was also engaged in a public sector expansion coverage initiative through the Robert Wood Johnson (RWJ) Foundation State Coverage Initiatives (SCI) program. The SPG and SCI teams established an agreement early on to work in concert with one another to avoid duplication of efforts. Through SCI, the Commonwealth received a grant for \$900,000 for its proposal to target Medicaid coverage expansion for pregnant women up to 200% of FPL and to increase participation in the premium assistance option of FAMIS. As a result of the work done through the SCI grant, a waiver was submitted to the Centers for Medicare and Medicaid Services (CMS) for FAMIS MOMS and FAMIS Select. Through FAMIS Select, a child approved for FAMIS would have the option to enroll in private/employer based health insurance. The child’s family would receive premium assistance \$100 per child per month toward the cost of the family coverage premium. The necessary funds to implement FAMIS MOMS at up to 150% of FPL and the FAMIS Select programs were authorized by the 2005 General Assembly and took effect on August 1, 2005.

The Rising Cost of Expanding Public Coverage

Virginia, like many other states, has been experiencing increased costs for public insurance programs. Nationwide, although the percentage of those without health insurance coverage was unchanged between 2003 and 2004, the proportion of people covered by government insurance programs rose (from 26.6% to 27.2%) while those covered by employment-based health plans declined (from 60.4% to 59.8%). Most of the increase in the proportion on public coverage was driven by Medicaid (up 0.5% to 12.9%) and military health care.^{xxiv}

Since 1997, Medicaid nationwide has grown nearly twice as fast as Medicare. In 2005, Medicaid spending (\$325 billion estimated) is projected to surpass the cost of Medicare (\$290 billion estimated in 2005). Between 2001 and 2004, total Medicaid spending increased by over 50 percent, and accounted for 17 percent of all U.S. health care expenditures in 2003 alone. High rates of Medicaid growth are expected to continue due to caseload growth and medical inflation; neither of which can be controlled by states. By June 2004, enrollment in the Virginia FAMIS and SCHIP expansion programs was reported in excess of 58,000 children.^{xxv}

Projections for Medicaid cost growth far exceed overall state budget growth and continue to

place pressure on the ability of states to fund other important spending priorities such as education. As a result, governors are forced to propose budget cuts that could affect all enrollees and increase the already rising number of uninsured and underserved Americans. Federal budget pressures to slow spending, and federal rules that limit states ability to shape and control their programs, are also severely impacting Medicaid programs. Medicaid critics also argue that its expansion is adding to the federal budget deficit—about \$412 billion in 2004.

One important trend that is likely to affect future health insurance coverage in Virginia is federal reform of Medicaid. President Bush has called on the newly-formed Medicaid Reform Commission to recommend ten billion dollars in cuts to the Medicaid program over the next ten years, including the scaling back of intergovernmental transfers that have enabled states to maximize Medicaid dollars. Additionally, current authorization for SCHIP expires in 2007 at which time observers say major reforms will be proposed to limit this program as well. Presently, governors are concerned that the burden of these anticipated reductions will fall to individual states at a time when they are experiencing revenue shortfalls with increasing Medicaid costs.

This said, the Commonwealth of Virginia has maintained a restrained approach to use of public expansion programs and maintains stringent eligibility criteria for state public assistance programs. The state is also under tight budget pressures to contain costs in these programs. The Department of Medical Assistance Services implemented cost containment measures that realized cumulative Medicaid cost savings of over \$925 million from 2000-2004.^{xxvi}

These conditions, in addition to previous agreements and coordination with the SCI project to avoid duplication of efforts, provided direction to SPG efforts for development of a politically and economically acceptable insurance product that would be appealing in the private sector market.

Principles/Criteria for Selection of Target Population and Model Option

The following principles and criteria guided the Model Development Workgroup in the identification of the target population for the proposed model private insurance expansion in Virginia. Model options to expand coverage were reviewed based on their ability to:

- Have the greatest impact on improving continuous coverage for the target population.
- Not duplicate existing coverage options for the target population or adversely impact the coverage of other populations with limited resources.
- Have a significant impact on reducing health care costs for the target population.
- Have a significant impact on improving the health status of the target population.

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- Be implemented in an environment requiring that the cost of model coverage be shared by and be affordable and sustainable to target employees and employers as well as state government.
- Be implemented in an environment dictating that available public subsidies for model coverage be budget-neutral.
- Reduce target employee low productivity, absenteeism, turnover, and other employer costs associated with lack of health care coverage and disease prevention.
- Otherwise, be easily understood, economically attractive and politically feasible to target employers, health insurance brokers, and state government.

For identifying the target population, it was necessary to decide:

- Which *employers* would be affected (e.g., small vs. large employers; employers in certain industries), and
- Which *employees* would be affected (e.g., partially insured vs. completely uninsured; part-time vs. full time; employee vs. dependents; other determinants such as income and age)

For selecting the insurance product to be covered, it was necessary to decide:

- Which benefits would be covered,
- The price/cost of the covered benefits to targeted employers and employees (as well as to state government)
- How the recommendation would be funded, by determining the financial:
 - contribution level of employers and employees, and
 - incentives for employers and state government

Addressing the Problem: Recommended Model Option

An overview of the recommended model option to expand insurance coverage can be found in Appendix E.

Target Population Selection

Guided by the project's goals, and based upon the best available state and national data, the priority target population for the proposed health insurance expansion includes working uninsured citizens (and their families) who are:

1. Employed in small Virginia businesses (businesses employing between 2 and 50 employees). *Rationale:* Currently in Virginia, over half (51.7%) of all workers aged 19-34 years and eighty percent of all workers 35 to 64 years employed in Virginia businesses

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with 50 or fewer employees are uninsured. Just under a third of very small employers (those with less than 11 employees) in Virginia offer health insurance to their workers. Individuals working in companies with less than 50 employees are twice as likely to be uninsured as individuals working in companies with more than 50 employees.^{xxvii} More tenuous profit margins and market characteristics make insuring small groups expensive and difficult for both insurers and small businesses. Additionally, small businesses are more susceptible to failure; even as they are the backbone of economic growth in their communities.

2. In households with incomes between 100% to 300% of the Federal Poverty Level (FPL).

Rationale: The proportion of Virginia families without health insurance living at or below 150% FPL equals or exceeds 20 percent. The proportion is highest for households living at 134-150% FPL (nearly 29%). Rates at which employers offer health insurance in Virginia for workers at or below 150% Federal Poverty Level (FPL) are significantly lower (under 50%) than offer rates for workers above 150% FPL (over 60%).^{xxviii} Employment and family income are the two most important factors for health insurance coverage. Working low-income households have difficulty accessing and affording health insurance coverage.

Factors Affecting Insurance Coverage Decisions

Review of trends and research on insurance coverage among low income yielded important information for planning considerations, specifically, a *very low* price tolerance for health insurance premiums in low-income families—as low as 1-2 percent of take-home pay. An SPG project analysis of family decision making indicates the cost of insurance predicts individual/family decisions to “take” insurance, considering perceived need and availability of insurance through the employer. The SPG prototype product is designed with low price tolerances as the primary driver for take-up decisions, while ensuring the proposed product meets BOI Health insurance regulatory requirements.

Recommended Insurance Expansion Option and Prototype Product Design

After considering current conditions in Virginia and the feasibility and impact of all available options, *four options were examined in depth* by the Model Development Workgroup (MDWG) before a final recommendation was made. Those considered were:

- Small group market reforms
- Consumer-driven health plans
- Tax incentives
- Sale of ‘mandate-light’ or no-mandate policies

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Building upon other efforts already underway in Virginia, in order to expand the prospects of insurance coverage among Virginia's working uninsured, the State Planning Grant Model Development Work Group recommends a limited benefit coverage option to be offered in the small business market (firms with ≤ 50 employees) with the option of including a public subsidy tax credit as an incentive for employer participation.

Why the MDWG Thinks This Option May Work

Most proposals to assist low-income workers and families have not attempted to work with or thorough employers.^{xxix} Given the target population of interest in Virginia (working uninsured in small businesses) with sensitivity to affordability to those with low incomes, a limited- benefit, private insurance product with employer financed premium support and optional incentives is proposed.

The prototype insurance model was developed as a small group market product, along with a recommendation for extensive education and outreach (marketing) to businesses, brokers and individuals. In addition, there is the option of offering tax incentives for small businesses for a portion of the individual premium.

The proposed insurance product will be issued in the small group market as defined by the Virginia BOI and preferably offered under the state's standard insurance underwriting rules and regulations. A group model was selected in order to reach a large number of uninsured, spread insurance risks, and keep costs low.

In attempting to expand access to health insurance coverage, an important consideration is how to subsidize the worker's contribution to build on rather than crowd out or destabilize the private market. Additionally, features and implementation guidelines are proposed to ensure that the employer based private insurance market is not undermined. This as neither federal nor state government interventions are likely to replace the contributions employers now make toward health coverage for low wage workers.

Employer contribution requirements are modest, defined, and predictable over time. Small employers typically cannot afford the cost of traditional insurance coverage. Nationwide, private-sector employer contributions for health insurance represent, on average about 7.4 percent of wages and salaries.^{xxx} The cost of the proposed prototype is within the affordability range for small business expenses. An analysis of the stability of the product over time is being analyzed by an actuary from William F. Mercer.

In this recommendation the employee's premium is subsidized by the employer. The employer's

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eligibility is determined by its size (2-50 employees) and whether it offered health insurance in the prior year (only firms not offering health insurance in the prior year are eligible to participate). A fixed contribution subsidy from the employer will be made available to all workers in businesses size (2-50) at 60 percent of the premium cost. Their non-participation indicates they are highly unlikely to offer work-based health insurance under normal market conditions.

Coverage is offered to the whole employer group through approaches acceptable to providers. Coverage will be available to all full-time permanent employees in the group. Employees could pay the difference between the total premium and the employer contributions. We note they could qualify for current-law tax advantages through a 125 flexible spending account or premium only plan (POP). To avoid adverse selection problems, participation standards would be established, as is done routinely in the normal small-group market.

Prototype Product Coverage Features¹

The (new) product would be provided by private insurance carriers to address current, unmet needs in the small business market. The intent of the new product is not to replace the need for publicly subsidized coverage (i.e., Medicaid, FAMIS) for low-income individuals or ‘destabilize’ the current small group market, but rather to expand the private insurance market and ensure coverage options for individuals that may not have a private sector alternative to public coverage. To prevent market destabilization, eligible employers must not have been offered a health insurance product to their employees within the past 12 months. Because family and dependent coverage is often problematic for many of low-income households, a family insurance rider will also be available for employee family dependents.

The average total premium cost of the prototype product has been developed to be sold for approximately \$100-\$120 per individual per month—an amount perceived as affordable based on nationwide studies and household incomes among many of Virginia’s uninsured. As with other private sector products, the new small group product is priced according to existing carrier pricing practices for premiums for adults aged 19 to 64 years. The product also includes premium cost sharing between the employer and employee, with the employer paying about 60 percent of the premium cost.

The prototype product includes the following benefit features:

- Preventative and primary care services for individual employee with household coverage available for family members (adults and children),

¹ See the benefit matrix in the Appendix for more information.

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- Maternity care and emergency room visits,
- Limited or generic prescription drug coverage,
- An option or rider to cover some basic level of dental care and dependent coverage,
- Basic hospitalization coverage (inpatient services and outpatient surgery) associated with catastrophic-related care.

To sustain its attractiveness, the product would:

- Offer first-dollar coverage on the front end for preventative and primary care,
- Require greater cost-sharing on other benefits, including co-payments for office visits and deductibles for all other services,
- Set an annual maximum out-of-pocket payment for some level of catastrophic protection,
- Reimburse health care providers in a manner similar to PPO network models.

Actuarial Analysis

An actuarial analysis of the prototype product was pending (by William F. Mercer Co.) at the time of this report. This forthcoming information is considered vital to confirming the cost and feasibility of the proposed product.

Product Promotion and Distribution

A significant part of the recommendations for expanding health insurance coverage through the private sector in Virginia includes the development of marketing and distribution strategies (especially to businesses and their employees, as well as the Virginia health insurance and broker community). Recommendations also include the importance of establishing an education program and incentives for insurance brokers. To increase brokers' incentives to sell the product, the model would provide: 1) Commission incentives for volume product sales in an 'under-tapped' market, and 2) New product information in broker bi-annual re-certification courses.

Tax Credits: An Incentive Option

To improve employee recruitment and retention, tax credits could be offered for the costs of providing limited health insurance coverage to employees and their dependents. Small employers could be offered a first dollar tax rebate on 80 percent of the cost of their contribution (e.g., 50-60%) to the monthly premium [for example: \$48 (80%) of \$60, which is 60% of a \$100 monthly premium]. As an added incentive, the tax credit could be directed to workers based on a family income maximum and would apply to employers based on size and insurance market participation. To be sustainable over time, the subsidy could target individual workers and families who cannot otherwise afford coverage (up to 300% FPL). To increase brokers' incentives to sell the product, tax credits could also be offered to them.

While the actual pay-off from use of tax credits for employment-based coverage is difficult to predict, there is considerable potential for favorable results and little downside risk.^{xxxii} A credit for personal and corporate income taxes paid by small employers who provide health insurance coverage to their employees was included in recent legislative proposals to lower health insurance costs for small business (SB 1255 in 2005).

Business Model Outline

Basic Assumptions

Employers' Contributions to Coverage. Participating employers would not receive a subsidy per se, but the contribution they are asked to make toward their worker's coverage would be fixed at an amount considerably lower than what is typically required in the commercial market. Employers would be required to contribute at least 60 percent of premium costs (\$60-\$75/ month individual premium assuming a target premium cost of \$100-\$120/month).

Table 1: Target Worker Contributions (Pre-Tax)*

Worker's Income Category (% FPL)	<100%	150	200	250	300	300% (not eligible)
Tax Credit for Target Worker Contribution (desired percentage of worker's contribution)	\$40/\$100	\$40/\$100	\$40/\$100	\$40/\$100	\$40/\$100	NA
Nominal Percentage of Income Used for Payroll Deduction *	5.1% or greater	3.4%	2.5%	2%	1.7%	NA

* Based on 2004 FPL rates and premium estimate for an exemplar young, healthy individual.

Table 2: Business Current and Target Estimates

Number of Small Employers Eligible (Not Offering Health Insurance in Prior Year)*	Businesses with <10 Employees: 56,149	Businesses with 10-24 Employees: 5,491	Businesses with <50 Employees: 62,903
Estimated # Uninsured Employees in Establishments*	247,885	147,355	499,167
Employer contribution based on \$60 /month premium contribution (assuming 70% employees participating)	\$124,934,040 (annual)	\$74,266,920 (annual)	\$251,580,240 (annual)
Total Maximum Tax Revenue Off Set	NA	NA	201,264,192** [assumes maxium/100% participation]

*Based on data from MEPS 2003 data for Virginia

**VA Insurance regulations include limits on premium increase rates for small business plans; hence a built in limit on increases of burdens to the State from tax revenue off-set.

Future Issues/Options

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A hybrid approach to public subsidies for employment-based coverage (explored by IHPS) may be of interest if the President's proposed tax-credit proposals allow parents working for qualified small firms to use the tax credits for employment-based coverage.^{xxxii} Virginia may be able to combine tax credits for adults purchasing employment based coverage with premium assistance for children under Medicaid or FAMIS to make employment-based family coverage affordable for low-wage, uninsured, small-business workers and their families.

The administrative mechanism for combining contributions from multiple sources to apply public subsidies toward employment-based coverage for low-income workers presents operational and administrative challenges. It would require the Commonwealth to develop the capacity to combine contributions from multiple sources on behalf of an individual worker and family and direct those funds to the worker's health plan. This would presumably require a clearinghouse or service-bureau adjunct to Medicaid, state or federal employee health benefits programs.

Stakeholder Input on Recommended Model Option

Throughout the development process of the proposed insurance model, the Model Development Workgroup actively solicited input from a variety of stakeholders within the Commonwealth, through the work of the Business Community Task Force (BCTF) and the Community Outreach Workgroup (COWG). The recommendation proposed was developed with feedback collected from the small business community, insurance brokers and carriers, and members of the community at large, which, including representatives from community leaders and health care providers across the Commonwealth.

Business Community Input

In addition to formal input received from the BCTF, two major methods were used to obtain qualitative and quantitative data from small business owners throughout the Commonwealth on factors influencing their ability to offer health insurance to their employees and on economically feasible approaches to expand coverage to workers within their businesses and those in their peer group. A Key Informant Survey was developed using lessons learned and approaches from other states who conducted surveys of the small business community. Both qualitative data from interviews with small business owners and responses to the Key Informant (Small Business) Survey identified two main issues: The need for premium assistance (given premium costs) and concerns about administrative burden of offering health insurance. Consistent with findings from other state efforts, premium costs were identified as the primary reason for not offering health insurance to their employees.

Additionally, an electronic mail survey of Virginia small employers about health insurance,

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conducted by the Virginia Department of Business Assistance as part of the BCTF input process (July 2005), yielded 345 respondents. (*A summary of the latest survey findings is found in Appendix F.*) Highlighted findings follow:

- Nearly all (97%) of the respondents acknowledge that employee health insurance coverage is valuable and would like to offer it.
- *Over two-thirds* (67%) of the respondents consider an individual non-HMO insurance product **costing no more than \$150 per month** to be affordable and would offer it to their employees. Another 16 percent would offer the product if there were other incentives. In relation, *nearly 80 percent* of the respondents say their company would be **willing to pay \$100 or more per month** for individual coverage.
- When asked about what was most important to consider when purchasing health insurance for their employees, respondents ranked *premium amount highest* followed closely by the *nature of coverage*.
- Regarding the nature of coverage, *69 percent* of respondents would purchase the proposed prototype policy (i.e., first-dollar coverage for preventative and primary care, catastrophic protection, limited out-of-pocket payments); assuming the individual premium cost was no more than \$150 per month.
- Although most respondents remain concerned about the administrative burdens associated with offering health insurance, about half (49%) say that such burdens would not be enough to keep them from offering affordable coverage to their employees.
- About 59 percent of the respondents say that the best way for small employers to be informed about a new health insurance product is by electronic or direct mail.

Insurance Community Input

Conference calls were held with members from four insurance carriers as well as insurance brokers were held to discuss prototype product and marketing strategies, as well as obtain their views on financial feasibility, distribution, broker incentives and take-up of the product. Their views on approaches to expanding coverage without destabilizing the current market for comprehensive coverage were also discussed.

Input was solicited from both insurers and brokers about incentives that could be developed to encourage insurance brokers, who serve as the primary link between small businesses and health insurance products, to sell the product. Recognizing that commissions for this product would not be large, most felt the opportunity to offer an affordable product to those not able to participate in the market now would serve as an incentive to brokers who focus on the small business market. Feedback from insurance carriers indicated there was no equivalent product available in the Commonwealth at this time. One carrier was considering a product that provides a 'basic health insurance' product with limited coverage for preventative services and medical services,

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but does not include a catastrophic coverage option. They were also considering an expanded, creative eligibility provision for employees with work hours that vary from week to week.

Among the suggestions received from the Virginia small business community was a proposal for carriers to provide an up-front subsidy for small businesses to offset initial premium costs until a tax credit is received and/or a mechanism to assist small businesses with the administrative burden of participating in a health care insurance product. Carriers felt this would be too onerous to consider. Carriers also expressed concern about their difficulties to date in developing lower cost products, including concerns about negative connotations of proposing any product perceived to be a “stripped down” plan. Concerns about implementation, such as decisions about which companies will be eligible for the tax credit, and how to communicate to small businesses about the tax credit were also voiced by one carrier representative. Other comments included questions about whether employers would be able to choose more expensive products and receive tax benefits.

Community Input

The Community Outreach Work Group solicited comments, feedback and questions about the proposed model from communities across Virginia. The model was reviewed by staff and directors all across the state of Virginia from the following: healthcare providers (e.g., health departments, FQHCs, free clinics, health systems, physician practices), community-based non-profits, university faculty, and representatives of ethnic community groups.

Overall, reviewers agreed the proposed model is a step in the right direction, specifically noting the focus on primary and preventive care. Several noted concern that the product would probably be more appealing to workers at the higher income levels within the target population, and some wondered if small employers might still see the cost of this product as an unaffordable expense.

There were specific comments regarding the implications of tax credits on the Commonwealth’s budget, costs to employees, as well as concerns from providers. Several people wondered whether this prototype is “budget neutral” to the Commonwealth if there is a tax credit to employers who purchase the product. If it is not budget neutral, what are the costs to the Commonwealth? One person suggested “the major incentive for the employer is a tax incentive. Thus we are robbing Peter to pay Paul?”

Others wondered whether premiums for the lowest income workers (under 100% FPL) could be fully-subsidized. For uninsured adults with income under 100% FPL - the costs of the model may be too high to be attractive. While a \$50/mo/person premium (\$600/year) may be less than

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10 percent of family income, the other out-of-pocket expenses (e.g., deductible, coinsurance, co-pays) are too high for individuals at this income scale. Even at 200% FPL, some of the out-of-pocket expenses are very high (e.g., for a single pregnant women with \$19,140/year, the maternity co-pay plus premiums would equal 19%-24% of her annual income). For those with income higher than 200% FPL, the cost sharing may be acceptable. However, for this group, we expect that they would demand prescription drug coverage, at least generic and brands, available with a higher co-pay.

There was also a question of whether this product would be available to part-time (30 hour/week) employees (i.e., P14s) who currently have no health insurance coverage. There are a number of part time state employees who work 32 hours per week or more and to pay the entire \$300+ premium themselves on a part-time salary.

Comments and questions on the product from health care providers included:

- ✓ What are the reimbursement rates for providing services?
- ✓ The model description does not include exclusions, pre-existing conditions etc. What will the policies be for these?
- ✓ What about stabilization of rates? What happens after the first couple of years when the costs exceed premiums and the rates need to be elevated? Will this also be split between employee/employer, or worse, will the employer withdraw from program?

Marketing to both employers and employees is going to be paramount. The method of presentation to the community, particularly potential consumers, is important. The model needs to be presented in a positive light and endorsed by a well-respected spokesperson. It should be clear that this is not a public program to minimize any negative connotation that may influence take-up by employers and employees. Also, reviewers suggested there are lessons to be learned from communities' experience promoting FAMIS/FAMIS Plus and community-based health programs.

Summary

Compared to public coverage programs, employment based coverage may attract greater participation from previously uninsured employees because it is easier to sign up for and there are no 'stigma' such as those associated with public assistance programs. Also, payroll deduction is the most easy and reliable method of collecting worker contributions toward the cost of coverage. The Virginia prototype also has the benefit of low administrative overhead, inability to refuse coverage based on health status and has more comprehensive coverage (lower deductibles and co-payments or coinsurance) while pooling risk across workers of all ages and health risk levels.

APPENDICES

- Appendix A:** **State Health Access Data Assistance Center (SHADAC) Reports:**
2004 Virginia Health Care Insurance and Access Survey: Select Results
Virginia HRSA State Planning Grant Additional Analyzes: 2004 Virginia
Health Care Insurance and Access Survey
- Appendix B:** *U.S. Agency for Healthcare Quality and Research, Medical Expenditures*
Panel Survey: Insurance Component – Virginia, Select Data Findings
- Appendix C:** *The Costs and Consequences of Uninsurance: A Virginia State Planning*
Grant Technical Briefing Paper
- Appendix D:** *Insurance Coverage Expansion Options: Lessons Learned from Other*
States
- Appendix E:** *Overview of Proposed Model Option to Expand Health Insurance*
Coverage Among Employed Virginians
- Appendix F:** *Virginia Business Health Insurance Survey, Virginia Department of*
Business Assistance, July 2005.

End Notes

- ⁱ State Health Access Data Assistance Center (SHADAC). 2004 Virginia Health Care Insurance and Access Survey, March 2005.
- ⁱⁱ U.S. Census.
- ⁱⁱⁱ Ibid., SHADAC 2005.
- ^{iv} Kaiser Commission on Medicaid and the Uninsured. Health Insurance Coverage in America: 2003 Data Update. November 2004.
- ^v Ibid., SHADAC.
- ^{vi} Kaiser Family Foundation. The Uninsured: A Primer. November 2004. <http://www.kff.org>
- ^{vii} U.S. Agency for Healthcare Quality and Research. Medical Expenditure Panel Survey-Insurance Component (MEPS-IC), 2003 Virginia-Specific Data. July 2005.
- ^{viii} Ibid., MEPS-IC.
- ^{ix} L. Henry. Key Informant Survey of Small Business, 2005. GMU Center for Health Policy, Research and Ethics.
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- ^{xii} Ibid., MEPS-IC.
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- ^{xix} Hadley, J and Holahan, J. The cost of care for the uninsured: what do we spend, who pays, and what would full coverage add to medical spending? Kaiser Commission on Medicaid and the Uninsured. Issue Update/2004. www.kff.org
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- ^{xxii} Ibid., SHADAC.
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- ^{xxiv} U.S. Census Bureau. Income, Poverty and Health Insurance Coverage in the United States: 2004 Current Population Reports. August 2005. <http://www.census.gov/prod/2005pubs/p60-229.pdf>
- ^{xxv} http://www.dmas.virginia.gov/downloads/Stats_04/Chapter_10/Title_XXI_Overview--04.pdf

^{xxvi} http://www.dmas.virginia.gov/downloads/Stats_04/Chapter_12/CMICUMM-04.pdf

^{xxvii} Ibid., SHADAC.

^{xxviii} Ibid.

^{xxix} Neuschler E. & Curtis, R., “Applying Large-Scale Subsidies for Low-Income Populations to Health Insurance Coverage through Small Employers”, IHPS Project Report, May 2003.

^{xxx} US Department of Labor, Bureau of Labor Statistics, “Employer Costs for Employee Compensation, 1986-1999”, Table 5 (Bulletin 2526), March 2000.

^{xxxi} IBID, IHPS, 2003.

^{xxxii} IBID, IHPS, 2003.