

**Report of the
Joint Legislative Audit and Review Commission
To the Governor and
The General Assembly of Virginia**

**Options to Extend Health
Insurance Coverage to
Virginia's Uninsured
Population**



**HOUSE DOCUMENT NO. 19
2007**

In Brief

Options to Extend Health Insurance Coverage to Virginia's Uninsured Population

House Joint Resolution 158 (2006) directed JLARC to analyze the number and demographics of Virginia's uninsured population, assess the costs incurred from treating the uninsured, and present options for extending health insurance coverage to Virginians who are currently uninsured.

Between nine and 16 percent of Virginians were uninsured in 2005. Low-income Virginians represented 60 percent of the uninsured, and more than 80 percent of the uninsured lived in households with at least one employed person.

In 2005, an estimated \$1.45 billion of care for the uninsured was uncompensated, with health care providers donating between \$536 and \$538 million to uninsured patients.

While multiple policy options are available to address various segments of the uninsured population, the State may want to focus on options that provide financial assistance to low-income Virginians, given the gap between the cost of insurance and their available resources. Four options that would likely be most cost effective to the State are (1) an employer incentive, (2) a Medicaid expansion to parents up to the federal poverty level, (3) small employer subsidies, or (4) a State reinsurance program for small employers.

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Director

Philip A. Leone

JLARC Staff for This Report

Hal Greer, Division Chief

Aris Bearse, Project Director

Jenny Breidenbaugh

Rebecca Velarde, Intern

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COMMONWEALTH of VIRGINIA

Philip A. Leone
Director

Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building, Capitol Square
Richmond, Virginia 23219

(804) 786-1258

January 26, 2007

The Honorable Thomas K. Norment, Jr.
Chairman
Joint Legislative Audit and Review Commission
General Assembly Building
Richmond, Virginia 23219

Dear Senator Norment:

House Joint Resolution 158 enacted by the 2006 General Assembly directed JLARC to study options for extending health insurance coverage to Virginians who are currently uninsured. Staff were directed to analyze the number and composition of uninsured Virginians, assess the costs of treating the uninsured, and develop policy options to facilitate access to health insurance while requiring Virginians to assume personal responsibility for obtaining a minimum level of coverage.

The Governor's Health Reform Commission is currently using the findings of this report as it considers options for improving access to health care in Virginia.

On behalf of the Commission staff, I would like to thank the staff at the Virginia Health Care Foundation, the Department of Medical Assistance Services, the Virginia Hospital and Healthcare Association, and the Virginia Association of Health Plans for their assistance during this study.

Sincerely,

A handwritten signature in black ink, appearing to read "Philip A. Leone".

Philip A. Leone
Director

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JLARC Report Summary:

Options to Extend Health Insurance Coverage to Virginia's Uninsured Population

Key Findings

- Between 8.9 and 15.5 percent (632,000 to one million) of non-elderly Virginians were uninsured during 2005. Of these uninsured, approximately 60 percent were low income, more than 80 percent lived in a household with at least one person employed, 50 percent worked for an employer with fewer than 100 employees, and more than 40 percent of the uninsured were between the ages of 19 and 34. (Chapter 2).
- Without employer-sponsored insurance, most low-income Virginians are unable to afford private health insurance, but only a small portion of low-income adults are eligible for Medicaid. (Chapters 1 and 2)
- In 2005, an estimated \$1.45 billion of care for the uninsured was uncompensated, with health care providers donating between \$536 and \$538 million to uninsured patients. (Chapter 3)
- Multiple policy options are available to address various segments of the uninsured population. These options include subsidies, Medicaid expansion, establishment of a market exchange, leveraging the State health plan, an individual mandate, an employer incentive, limited benefit insurance policies, and a single payer system. For the most part, these options are not mutually exclusive, and some combination of them would be needed to address the entire uninsured population. (Chapters 4 through 6)
- Given the gap between the cost of insurance and the resources available to low-income Virginians, the State may want to focus on options that address this segment of the uninsured population by providing them with the financial assistance necessary to obtain health care coverage. Four options that likely would be the most cost effective for the State are an employer incentive, Medicaid expansion, small employer subsidies, or a State reinsurance program. (Chapter 7)

House Joint Resolution 158 (2006) directed the Joint Legislative Audit and Review Commission (JLARC) to study options for extending health insurance coverage to Virginians who are currently uninsured. In addressing the policy options, JLARC was directed to analyze the number and demographics of uninsured Virginians, assess the costs incurred from treating the uninsured population, and examine health insurance expansion programs and plans in other states. JLARC, in partnership with the Virginia Health Care Foundation, contracted with the Urban Institute, an independent, non-profit research institution, to analyze the number and demo-

graphics of the uninsured as well as the cost imposed by them. The study mandate is included as Appendix A.

VIRGINIA'S UNINSURED POPULATION

The exact number of uninsured Virginians is unknown. Recent surveys provide different estimates of the number and rate of uninsured Virginians due to differences in sampling methodology and survey design. Estimates of the percentage of Virginia's population that is uninsured range between 8.9 and 15.5 percent. The most commonly cited source for estimates of the uninsured is the Current Population Survey (CPS), conducted by the U.S. Census Bureau. The CPS estimates that 15.5 percent of Virginia's population was uninsured in 2005. Based on the CPS, 19 other states had a lower non-elderly uninsured rate than Virginia.

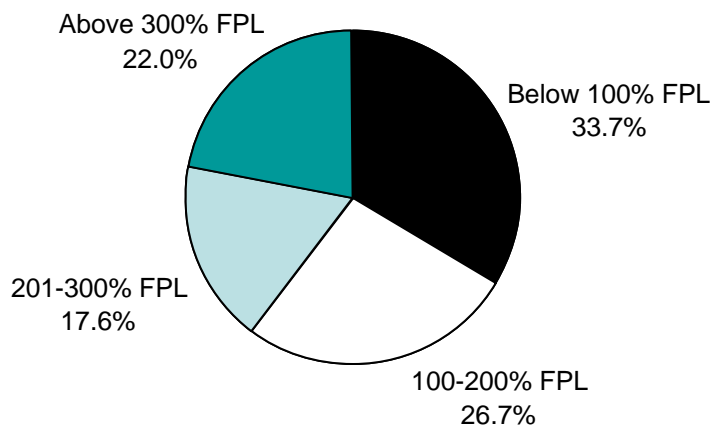
Federal Poverty Level

The 2005 federal poverty level (FPL) for a family of four was \$19,350. The income level for a family at 200 percent FPL was \$38,700.

Low-income Virginians had the highest uninsured rate and accounted for the majority of all uninsured Virginians, according to data from the CPS. As shown in the graphic below, approximately 60 percent of the more than one million non-elderly Virginians estimated to be uninsured had family incomes below 200 percent of the federal poverty level (FPL). An estimated 34 percent were below the FPL, and 27 percent were between 100 to 200 percent FPL. Only 22 percent of the uninsured were above 300 percent FPL. Nearly 40 percent of individuals below the FPL were uninsured, while only six percent of individuals above 300 percent FPL were.

Along with income level, age is a key determinant of insurance status. Young adults (19-34 years) represented more than 40 per-

Most Uninsured Virginians Are Low Income



Note: Low-income Virginians are defined as having income below 200 percent of the federal poverty level (FPL).

Source: Urban Institute analysis of 2004-2005 CPS data.

cent of Virginia's uninsured population. Older Virginians (55-64) represented only nine percent of the uninsured population, and children represented nearly 17 percent.

Another major factor that determines insurance status is the size of the employer for which the household wage earner works. More than 80 percent of the uninsured lived in a household with at least one person employed. About one-half of the uninsured lived in a household with a wage earner who worked for an employer with fewer than 100 employees or was self employed. In contrast, only 32 percent lived in a household with a wage earner who worked for a large employer (100 or more employees).

AFFORDABILITY GAP IS PRIMARY REASON FOR LACK OF INSURANCE

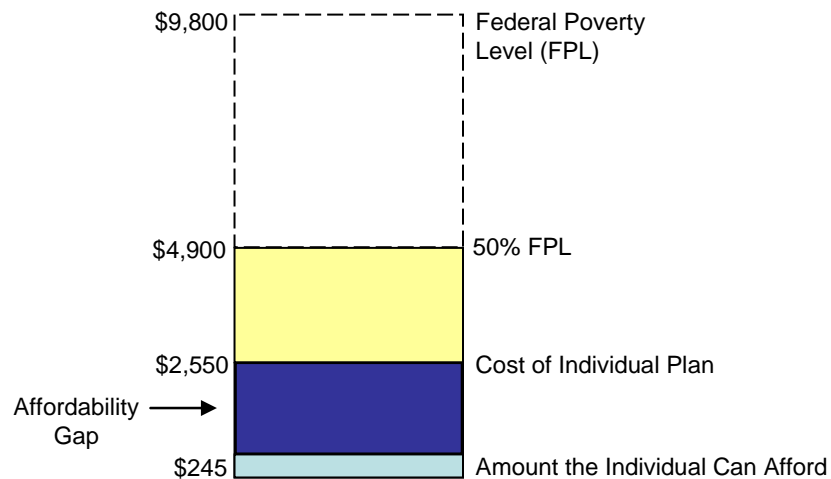
Inability to afford health insurance is the primary reason that individuals are uninsured. In Virginia, less than 48 percent of small employers (two to 50 employees) offer health insurance to their employees. Moreover, most low-income adults are not eligible for Medicaid coverage. Low-income adults who are eligible are parents up to 24 percent FPL on average (\$3,168 for a parent with one child), pregnant women, and aged, blind, or disabled adults.

For these low-income adults without employer or governmental assistance, the gap between income available to spend on health insurance and the cost of insurance is substantial. For example, an individual with income at 100 percent FPL would have an income of \$9,800. However, the average annual premium cost in the individual market was about \$2,550 in 2005. The cost of insurance would be more than 25 percent of the individual's income, and studies have estimated that low-income individuals are not able to spend more than five percent of their income on health insurance. This affordability gap is illustrated in the graphic on the next page.

Furthermore, the cost of health insurance is increasing faster than wage growth and inflation, which suggests that the affordability gap may grow even larger. Health insurance premiums rose by 87 percent nationally between 2000 and 2006. Factors contributing to the increase in health care costs include increased consumer demand; use of new, higher priced technologies; more intensive diagnoses; and defensive medicine (for example, ordering more tests than may be medically necessary in order to avoid lawsuits).

There are other reasons why individuals are uninsured. Many young, healthy individuals do not believe that they need to purchase health insurance because they are rarely in need of medical

Low-Income Virginians Face Affordability Gap for Private Health Insurance



Source: JLARC staff analysis of data provided by the Bureau of Insurance.

care. Others may be temporarily uninsured due to job loss or change. Finally, a number of individuals are eligible for Medicaid or the Family Access to Medical Insurance Security (FAMIS) plan but are not enrolled. Despite substantial outreach efforts in recent years, it is estimated that up to 108,000 uninsured children were eligible for Medicaid or FAMIS in 2005 but not enrolled. This figure is based on the CPS estimate of uninsured children in Virginia.

UNCOMPENSATED CARE COSTS \$1.45 BILLION

Pursuant to a contract with JLARC and the Virginia Health Care Foundation, the Urban Institute conducted an analysis of the cost of the uninsured in Virginia using data from the national Medical Expenditure Panel Survey (MEPS). The analysis showed that the uninsured received \$3.5 billion in medical care in 2005. Approximately one-third (\$1.1 billion) was paid out of pocket by the uninsured, and about \$920 million was paid through insurance payments on behalf of the part-year uninsured. The remaining \$1.45 billion was uncompensated care. The Urban Institute estimated that \$538 million of that uncompensated care was donated by providers, and the remainder was paid through other sources such as workers' compensation and automobile and homeowner liability insurance policies.

A separate analysis by JLARC staff that relied on patient-level data from Virginia hospitals and survey data regarding donated care by physicians' offices, community health centers, and government clinics reached a similar estimate regarding the amount of

care donated by providers in Virginia. The analysis indicated that \$536 million was donated to the uninsured by health care providers in Virginia.

Insured patients in Virginia likely pay more for their health care due to losses absorbed by providers through uncompensated care for the uninsured. Based on the estimates that health care providers donated \$536 to \$538 million to uninsured patients, and 5.4 million Virginians had private insurance, the cost of health care per insured Virginian was as much as \$100 higher in 2005 due to uncompensated medical treatment of the uninsured.

While health care providers, governments, and insured patients bear the burden of uncompensated care costs for the uninsured, the uninsured bear the cost of poorer health and suffer higher mortality rates. Studies have shown that the uninsured population has a five to 15 percent higher mortality rate than the insured population, and that the number of excess deaths among uninsured adults between the ages of 25 and 64 nationally is about 18,000 per year. Furthermore, poorer health due to a lack of health insurance results in lost productivity through more sick days and lower work performance.

MAKING HEALTH CARE MORE ACCESSIBLE TO LOW-INCOME VIRGINIANS WILL LIKELY REQUIRE THE INVESTMENT OF STATE FUNDS

With low-income individuals unable to afford the cost of health insurance, most options to provide them with access to health care coverage will require the investment of State funds in order to make coverage affordable. Options to make health care coverage more available to low-income households include Medicaid expansion, direct subsidies to low-income individuals, subsidies to small employers/employees, and reinsurance subsidies to reduce the cost of health insurance policies.

Medicaid Expansion. Virginia could expand its Medicaid program by increasing income eligibility levels for currently covered groups such as parents and extending coverage to additional groups such as childless adults. Expansion would be the most direct means of extending coverage to those individuals least able to afford it but would require the State to share in the cost.

Direct Subsidies to Low-Income Individuals. Virginia could subsidize the cost of private health insurance for low-income individuals who are not eligible for Medicaid. Subsidies should enable more low-income individuals to purchase insurance who otherwise would not be able to afford it, but the State likely would incur most of the cost of the program.

Subsidies to Small Employers. Virginia could subsidize small employers who agree to pay a portion of their low-income employees' health insurance costs through either tax incentives or direct payments. Subsidies should enable more low-income individuals to purchase insurance who would not otherwise be able to afford it. The State would incur a major portion of the cost of such a program but would share the financial responsibility with employers and employees.

Reinsurance of Health Insurance Policies for Low-Income Individuals. Virginia could subsidize the cost of health insurance for low-income employees by having the State assume the risk for high-cost claims. This should lower the price of premiums and make policies affordable for individuals for whom it would not otherwise be affordable. The State likely would incur most of the cost of the program but could require participating small employers to also share in the cost of providing health insurance to their employees.

NON-SUBSIDY OPTIONS FOR SMALL EMPLOYERS WOULD BE LESS COSTLY BUT MAY NOT BE AS EFFECTIVE

One way to reduce the number of uninsured is to increase the number of small employers that offer health insurance to their employees. Two potential options to encourage higher participation are to make the provision of insurance more affordable or attractive for small employers by leveraging the State employee health plan or establishing a market exchange. These options would not require much State investment, but neither may offer sufficient incentive to small employers to help fund their employees' insurance.

Allow Small Employers to Utilize the State's Health Plan. Virginia could allow small employers to join the State Health Plan or the Local Choice Plan. The goal would be to reduce the cost of insurance for employers and employees by including them in a larger risk pool and giving them the benefit of potentially lower provider reimbursement rates negotiated by the State. An additional option would be for the State to use its market strength to require medical care providers to offer the same provider reimbursement rate to small employers that are currently offered to the State through an insurance plan that could be purchased by small employers.

Market Exchange or "Connector" for Small Group and Individual Markets. Virginia could establish a health insurance exchange that would serve as a market for insurers and small employers wishing to purchase insurance. A small employer could designate the exchange as its employer health plan, and its individual employees could purchase from among the health plans offered through the exchange. Employees could pay their share of the cost with pre-tax

dollars, and the employer could make a pre-tax contribution to its employees' health insurance. This option would allow the employer to avoid the costs of administering a plan but might not provide sufficient incentive for employers to begin contributing to their employees' insurance costs.

MANDATES, INCENTIVES, AND OTHER OPTIONS MAY HELP TO REDUCE THE UNINSURED RATE

Several other options for expanding health care coverage have been tried or proposed in other states. These options include an individual mandate, an employer incentive, expanding eligibility for coverage under parents' policies, reduced benefit plans, or a single payer system.

Individual Mandate. Virginia could require that all residents obtain affordable health insurance or pay a penalty. Low-income individuals would need to be exempted from the mandate or provided with a subsidy to help them meet the mandate. Such a mandate should help to reduce the uninsured rate among those who can afford coverage but, without other initiatives, would not address those who cannot afford insurance.

Employer Incentive. Virginia could impose a tax on businesses that choose not to offer employer-sponsored insurance to their employees. Depending on the amount of the tax, this could be an effective tool for increasing the portion of employers offering insurance to their employees. However, the costs imposed by the imposition of such an incentive could strain employers financially.

Expanding Eligibility for Coverage Under Parents' Policies. Virginia could expand eligibility for coverage under parents' plans by increasing the age limit and removing the full-time student requirement. This option may facilitate access to insurance and encourage more young Virginians to obtain coverage and would not impose any costs on the State.

Allow Sale of Limited Benefit Insurance Policies. Virginia could allow the sale of no-mandate or reduced-mandate insurance policies. The goal would be to make health insurance plans less costly and more affordable for at least some portion of the uninsured by reducing benefits.

Single Payer With Universal Coverage. Virginia could establish a single payer system in which the State would provide health care coverage for all residents. This option would ensure coverage for all Virginians and eliminate uncompensated care costs but would require the imposition of a tax on individuals and businesses in order to fund it.

STATE MAY WANT TO FOCUS ON ADDRESSING THE LOW-INCOME UNINSURED

The extent to which the State seeks to address the issue of uninsured Virginians is a policy choice. Pursuant to the study mandate, HJR 158, this study identifies and considers several illustrative options for potentially extending insurance coverage to more Virginians.

The multiple policy options discussed in this report address various segments of the uninsured population. With the exception of the universal coverage option, the options are not mutually exclusive, and some combination of them would be needed to address the entire uninsured population. While each segment of the uninsured population is of concern, the State may want to focus on policy options that could be implemented to address low-income uninsured Virginians. Four options that would be the most cost effective for the State because the State would share financial responsibility with the federal government and private employers are an employer incentive, Medicaid expansion, small employer subsidies, and a reinsurance program. Each of these options makes health insurance more affordable.

- An employer incentive could help about 200,000 low-income uninsured adults in working families obtain health insurance, depending on the number of employers that choose to offer coverage instead of paying the tax.
- A Medicaid expansion for parents with incomes up to 100 percent FPL could provide health care coverage to about 65,000 uninsured adults.
- A small employer subsidy program could potentially provide access to health insurance for about 175,000 low-income uninsured adults in working families.
- A reinsurance program for small employers could potentially provide access to health insurance for about 175,000 low-income uninsured adults in working families.

Extending Medicaid eligibility to parents with incomes up to 100 percent FPL might be the logical first step in extending coverage to more low-income Virginians. This is one of the segments of the uninsured population least able to afford insurance, and given that they are a mandatory coverage group under Medicaid, the federal government would have to pay half the cost of insuring them. Most other states extend eligibility to parents with incomes well in excess of the average 24 percent FPL eligibility limit in Virginia.

The Governor's Health Reform Commission may wish to use this report as a starting point in its consideration of options to improve access to health care.

Overview of Health Care Coverage in Virginia

In Summary

The private health insurance market provides coverage for most Virginians, and 80 percent of insured Virginians receive contributions toward the cost of their health care from their employer. Several factors make providing coverage to more Virginians a challenge, including rising health care costs, decreasing enrollment in employer-sponsored insurance, and the high cost of coverage for medically needy individuals. Health insurance is unaffordable for many low-income Virginians because premium costs would expend a significant portion of their income. While lack of insurance is a barrier to quality health care for many Virginians, the State has an extensive safety net that includes 53 free clinics and 73 community health centers which provide free or reduced-cost care to uninsured, low-income individuals. Furthermore, Medicaid and FAMIS provide health care coverage for more than 790,000 non-elderly low-income Virginians.

House Joint Resolution 158 (2006) directed the Joint Legislative Audit and Review Commission (JLARC) to study options for extending health insurance coverage to currently uninsured Virginians. In addressing the policy options, JLARC was directed to assess the number and demographics of the population of uninsured Virginians, assess the costs incurred from treating the uninsured population, and examine health insurance expansion programs and plans in other states. JLARC staff, in partnership with the Virginia Health Care Foundation, contracted with the Urban Institute, an independent, non-profit research institution, to analyze the number and demographics of the uninsured as well as the cost imposed by them. The study mandate is included as Appendix A.

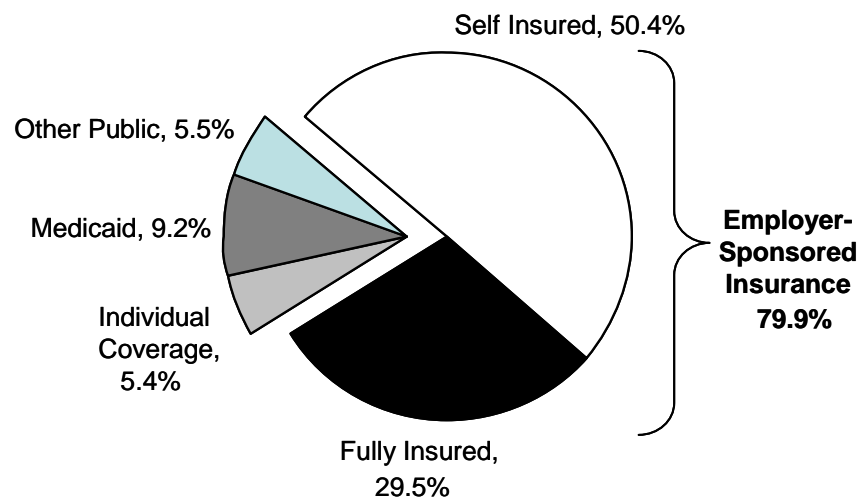
VIRGINIA'S HEALTH INSURANCE MARKET

Most Virginians receive health care coverage through the private market. The private health insurance market consists of the large group, small group, and individual markets. In the large (51 or more members) and small (two to 50 members) group markets, employers who offer coverage to their employees generally contribute a significant portion of the health insurance cost on behalf of their employees. Approximately 80 percent of insured non-elderly Virginians obtain their insurance through this voluntary arrangement, referred to as employer-sponsored insurance. About five percent of the insured purchase their insurance through the individual market, while nearly 15 percent have health care cover-

age through Medicaid or another public health insurance program (Figure 1).

The Bureau of Insurance, a division of the State Corporation Commission (SCC), is responsible for regulating the commercial health insurance industry in Virginia. The bureau approves premium rate increases for plans offered by insurance carriers based on medical claims paid the previous year. Insurance carriers must disburse at least 60 percent of their premium revenues for medical claims. In addition, the bureau is responsible for ensuring that all mandated benefits are included or offered in the health plans sold by insurance carriers. The bureau does not have authority over employee health plans in which the employer covers all medical claims of its employees. These self-funded plans are governed by the federal Employee Retirement Income Security Act of 1974 (ERISA).

Figure 1: Insured Non-Elderly Virginians Are Largely Covered Through Their Employer



Source: Kaiser Family Foundation analysis of 2004-2005 Current Population Survey data.

Large Group Market

The large group health insurance market consists of employers with more than 50 employees. According to the 2004 Medical Expenditure Panel Survey (MEPS), a federally sponsored national survey, an estimated 30 percent of all private employers in Virginia had more than 50 employees, and approximately 98 percent of these large employers offered health insurance coverage to their employees. When providing health coverage to their employees, employers may choose to assume the risk of their employees' medi-

cal claims costs or purchase coverage from an insurance carrier who would then assume the risk.

Fully-Insured Group Plans. In fully-insured group plans, insurance is purchased from an insurance carrier that assumes the risk to pay all covered health claims and administers the plans for the employer. Fully-insured plans are also required to offer coverage to certain groups, such as dependent children. Approximately 37 percent of all employer-sponsored plans in Virginia are fully insured.

The Virginia Bureau of Insurance, a division of the SCC, is responsible for regulating plans sold by insurance carriers in the State. The bureau approves annual rate increases for insurance plans based on the total amount of medical claims paid the previous year. Insurance carriers are required to disburse at least 60 percent of their premium revenues for medical claims.

The *Code of Virginia* also requires that fully-insured plans include certain mandated benefits. These mandated benefits include coverage for medical services such as childhood immunizations, infant hearing screening, and mental health and substance abuse services.

Self-Insured Group Plans. Self-insured plans, in which the employer assumes the risk, are an attractive option for large employers who have the financial resources to cover the medical claims of their employees. These plans are not subject to State insurance regulations and have greater flexibility in plan design. In a self-insured plan, the employer pays the medical claims for its employees' health care and assumes all associated risks. Employers with self-insured plans often hire an insurance company to serve as a third-party administrator of the plan and to negotiate rates with providers, but the insurance company does not assume any financial risk. About 63 percent of Virginians covered by employer-sponsored insurance are enrolled in self-insured plans. Self-insured plans are not subject to State law or any of the State-mandated benefits because of the federal Employee Retirement and Income Security Act of 1974 (ERISA), which supersedes state laws relating to voluntary employee pension and health benefit plans.

ERISA sets minimum standards for most voluntary health plans in private industry. ERISA requires plans to provide participants with information about plan features and funding, establishes fiduciary responsibilities for those who manage and control plan assets, and requires plans to establish grievance and appeal processes. There have been a number of key amendments to ERISA since it was enacted. In 1986 the Consolidated Omnibus Budget Reconciliation Act (COBRA) was enacted, providing some workers

and their families with the right to continue their health coverage for up to 18 months after termination of their job. Another amendment to ERISA, the Health Insurance Portability and Accountability Act (HIPPA), was enacted in 1995 and provides certain protections for employees who have pre-existing medical conditions.

Small Group Market

Employers with 50 or fewer employees may purchase health insurance for their employees through the small group market. Because few small employers have the financial resources to cover the risk of their employees' medical claims, nearly all small group plans are fully insured. With the exception of the State's Standard and Essential plans (discussed below), premiums for insurance policies in small group plans are experience rated (that is, premiums are based on the experience of medical claims for members in the group). Therefore, health insurance premiums for employers vary depending on the age and health status of their employees, and the existence of a few high-risk members in a small group could cause premiums to increase for every member in the group.

As of October 2006, 39 insurance carriers were licensed to provide small group plans in Virginia. However, small employers in certain areas of the State (particularly rural areas) have little choice in insurance carrier because few insurers serve those regions, according to the Bureau of Insurance. Few insurance carriers serve these regions because it is difficult for them to establish a network with so few providers. Less than half of all small employers in Virginia provide employer-sponsored coverage to their employees.

The essential and standard small group health plans were developed to assist high-risk groups in obtaining affordable health coverage. The State requires that insurance carriers offer these plans in order to participate in the small group market. As opposed to other small group health plans, premiums in these State-designed plans are based on a modified-community rating in which premiums may not be higher than 20 percent above the average group price. The essential and standard plans were intended to have fewer mandated benefits than regular small group plans and therefore lower premiums, but they were ultimately established with many of the same mandates. Consequently, these plans are not significantly cheaper than other small group plans, and enrollment has been low. In 2005, 109 groups representing 644 individuals were enrolled in the essential plan, while the standard plan had 456 groups with 2,841 individuals enrolled. As of July 1997, the essential and standard health insurance plans developed by the State were expanded to the entire small group market in Virginia.

Individual Market

The individual health insurance market provides coverage options for those individuals who do not have access to insurance through an employer. Individual policies are generally more expensive to the individual than group plans. An estimated five percent (301,070) of Virginians are insured through individually purchased health insurance plans. In 2005, 24 insurance carriers provided coverage in Virginia's individual market. Individual health insurance policy premiums are experience rated, so premiums for high-risk individuals are relatively expensive.

Virginia law requires open enrollment in the individual health insurance market so that all individuals (including high-risk individuals) can purchase coverage. Individuals cannot be denied coverage or have their policies canceled based on age, health, or medical history. Currently, open enrollment is available only through Anthem Blue Cross Blue Shield. Anyone is eligible for open enrollment unless their employer provides at least partial hospitalization or other health coverage. Pre-existing conditions cannot be excluded from coverage in the individual market, but may be subject to a 12-month waiting period, as defined in statute.

State Employee Health Plan and the Local Choice Program

Employees of the Commonwealth of Virginia are eligible to enroll in the State employee health plan (COVA), and local government employees may be able to purchase coverage from the State through the Local Choice program. The State employee health plan is self-insured by the Commonwealth of Virginia. The plan is administered primarily by Anthem Blue Cross Blue Shield and also through Kaiser Permanente in Northern Virginia. As of July 2006, more than 83,500 active State employees were enrolled plus about 26,000 retirees and 19,000 dependent family members. Annual expenses for State employee health benefits in FY 2005 were more than \$631 million, including claims and administrative fees. Annual premiums and interest payments from employees and the State were more than \$641 million in FY 2005.

In 2006, the annual premium for individual coverage in the State's COVA Care plan was \$5,016, with the employee portion being \$480. The annual premium for family coverage was \$13,572, with the employee paying \$1,680 of this amount.

In July 2006, the State employee health plan began offering a high deductible health plan to employees. Only 170 State employees are enrolled in this option.

The 1989 General Assembly passed legislation creating the Local Choice program. This program allows school divisions, local governments, and other governmental entities to purchase health insurance coverage through the State employee health plan. Local Choice participants are placed in a separate rating group pool from State employees, so their claims experience does not affect the premium price for State employees. In FY 2004, 234 groups were enrolled in the Local Choice, providing coverage for nearly 39,000 individuals. An estimated 60 percent of enrollees were employees, while the remaining 40 percent were family members.

Health Savings Accounts With High Deductible Health Plans

One recent development in the health insurance market was the implementation of health savings accounts (HSAs) for high deductible health plans (HDHPs). The federal Medicare Prescription Drug Improvement and Modernization Act of 2003 created HSAs to allow individuals to save money in a tax-free account and pay for health care expenses from the account. Individuals enrolling in HSAs must also purchase a high deductible health plan that covers health care costs which exceed the deductible amount. In 2006, the minimum deductible for an eligible HDHP was \$1,050 for an individual and \$2,100 for a family.

According to the Kaiser Family Foundation annual employer health benefits survey, seven percent of employers offered HDHPs in 2006. Nationally, 1.4 million employees opened HSAs for HDHPs offered by employers, and approximately 850,000 HDHPs were sold in the individual market. Nationally, the average deductible was \$2,011 for individual and \$4,008 for family coverage.

CHALLENGES TO PROVIDING HEALTH CARE COVERAGE

Increasing costs, decreasing enrollment in employer-sponsored health insurance, and the high costs for insuring unhealthy individuals pose challenges to providing health care coverage for all Virginians.

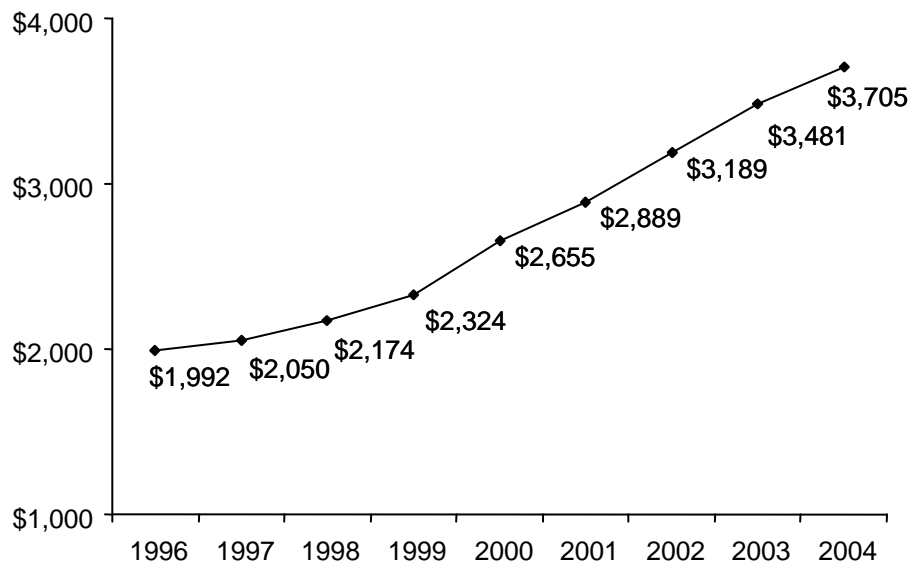
Increasing Costs

Nationally, health care costs and insurance premiums have increased substantially in recent years. Health insurance premiums are based on medical claims costs experienced in the previous year, so as health care service expenses increase, so do insurance premiums. Factors contributing to the increase in health care costs include increased consumer demand; use of new, higher priced technologies; more intensive diagnoses; defensive medicine (for

example, ordering more tests than may be medically necessary in order to avoid lawsuits); and general inflation. In the United States, health care expenditures increased from \$1.4 trillion in 2000 to \$1.9 trillion in 2004, a 38 percent increase. From 2000 to 2006, health insurance premiums rose by 87 percent nationally, substantially more than inflation (18 percent) and wage growth (20 percent). The average annual premium for an employee with employer-sponsored insurance was almost \$2,000 in 1996 but more than \$3,700 in 2004, an 86 percent increase (Figure 2).

Increases in health care costs occurred in Virginia as well. Group health premiums in the private market increased from an average \$223 a month in 2004 to \$250 a month in 2005, a 12 percent increase. Similarly, the average annual cost per employee for the State employee health plan rose by almost 12 percent from 2004 to 2005.

Figure 2: Average Annual Premium Cost Per Employee Increased 86 Percent From 1996 to 2004



Source: Medical Expenditure Panel Survey, U.S. Department of Health and Human Services, 1996-2004.

Enrollment in Employer-Sponsored Insurance Has Decreased

Over the last ten years, the proportion of small and large employers that offer health insurance coverage has increased both nationally and in Virginia. However, eligibility and enrollment rates for employer-sponsored insurance have decreased for both full-time and part-time employees. Employees' eligibility for employer-

sponsored coverage decreased by an estimated four percent nationally from 1996 to 2002. Similarly, employees' enrollment in employer-sponsored insurance decreased by approximately seven percent. The enrollment rate for employees who were eligible for employer-sponsored insurance decreased by nearly five percent.

According to the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality, decreasing rates of employee eligibility and enrollment in employer-sponsored insurance may be attributable to several factors including the increasing cost to employees, decreasing incomes, increasing price-consciousness, Medicaid expansions, and a rising rate of enrollment in spouses' plans. Based on results from the agency's Medical Expenditure Panel Survey (MEPS), the employee share of premiums increased 96 percent from 1996 to 2004, from an average \$342 to \$671 annually for individual coverage.

Unhealthy Individuals Face High Costs Due to Experience Rating

As required by the *Code of Virginia*, nearly all health insurance premiums in the individual and small group markets in Virginia are experience rated. Insurance carriers charge higher premiums to those individuals and groups that have a greater risk of experiencing high medical claims. Conversely, low-risk individuals who have few medical claims are charged lower premiums.

Studies have shown that states that allow experience rating have lower average premiums than states that require community rating (in which all groups or individuals covered by an insurer are charged the same rate based on the average risk among all groups or individuals in the pool). However, while experience rating may lead to lower average premium costs, it also may price high-risk groups and individuals out of the market.

In the small group market, a few employees with serious health care problems may cause premiums to increase substantially for all employees in the group. The increase in premiums may make the cost of health insurance unaffordable for the employer and employees. Carriers are required to provide written notice at least 60 days in advance if premiums are increasing by more than 35 percent. This allows the employer to seek a lower-cost plan, if available.

As discussed previously, high-risk individuals are guaranteed coverage in the individual market if they can afford it due to Virginia's open enrollment policy. However, these policies may be unaffordable for many individuals because the premiums are based on factors such as age and medical history. In addition, individuals

with pre-existing medical conditions may face a 12-month waiting period before they can enroll. Therefore, for practical purposes, insurance may not be available for those individuals who may be most in need of medical care.

CONSIDERATIONS IN EVALUATING POLICY OPTIONS TO COVER THE UNINSURED

When evaluating policy options to extend coverage to the uninsured, three concepts are frequently considered by policymakers: the limited portion of income that low-income Virginians can afford to spend on health insurance, "crowd-out" (replacement of private insurance with public coverage), and adverse selection (the concentration of high-risk individuals in an insurance pool).

Low-Income Individuals Limited to Spending Five Percent of Their Income on Health Insurance

Studies have examined the affordability of health insurance for low-income individuals and families. These studies indicate that low-income individuals generally cannot afford to spend more than about five percent of their income on health insurance. This five percent assumption is often used by health policy experts when evaluating the feasibility of policy options. Furthermore, federal statute sets a maximum level for premiums and cost sharing within the State Children's Health Insurance Program (SCHIP) at five percent of family income.

- A 1997 study, supported by the Robert Wood Johnson Foundation, found that participation rates in subsidized health insurance programs dropped as premium costs increased. The study showed that when premiums were equal to one percent of income, nearly all uninsured would participate. When premiums were equal to three percent of income, approximately 35 percent would participate. However, when premiums reached five percent of income, only 18 percent participated.
- A 2006 Urban Institute analysis of health insurance affordability in Massachusetts found that for individuals above 300 percent of the federal poverty level, six percent of income is the maximum affordability level for health insurance premiums. This finding was based on an analysis of median medical spending nationally.

Crowd-Out

Crowd-out is the phenomenon in which individuals who would otherwise acquire health insurance in the private market enroll in

publicly financed and administered health programs due to the lower cost. Crowd-out is typically associated with the expansion of Medicaid or SCHIP because raising the income eligibility level allows a greater share of the population to be covered by the public health insurance programs. A portion of these newly eligible individuals may have already been enrolled in private insurance but choose to enroll in the public program because it is less expensive.

To avoid crowd-out and thus reduce the need for additional state resources, some expansion programs implement a waiting period during which the individual or family is not eligible for coverage. Also, some programs require that eligible individuals be uninsured for a specified length of time before they qualify for coverage. In addition, cost sharing, through co-payments or deductibles, may encourage individuals to retain private insurance.

Adverse Selection

Adverse selection occurs when higher cost (less healthy) groups or individuals join an insurance pool thereby raising the premium rate for the existing members of the pool due to the higher risk of the pool. The lower cost, healthier members of the pool then have an incentive to leave the pool because they can obtain insurance at a lower cost outside of the pool (unless a state requires that all policies be community rated). As a result, only the higher cost members of the pool remain, further driving up the premium rate for the pool. As the premium cost rises, more members of the pool will decide to leave the pool because they can obtain insurance more affordably outside of the pool. This cycle (often referred to as a "premium death spiral") will continue to occur until only high-cost members remain in the pool or the pool collapses because even the high-risk members cannot afford the premium.

CURRENT HEALTH CARE PROGRAMS AND INITIATIVES IN VIRGINIA

Through public health insurance and safety net programs, Virginia provides insurance coverage and health care services for certain low-income individuals and families.

Government Programs Insure Many Virginians

Several government programs provide health insurance coverage to many Virginians. In 2005, government programs covered about 790,000 non-elderly Virginians. Medicaid is the largest of Virginia's government programs for the non-elderly. Medicaid and the Family Access to Medical Insurance Security (FAMIS) program both provide insurance to low-income individuals, with FAMIS eli-

gibility restricted to children under 19 and pregnant women (through the FAMIS MOMS program). Medicare provides coverage to non-elderly disabled individuals in addition to nearly all elderly individuals aged 65 and over.

Medicaid. Virginia's Medicaid program provided coverage to more than 746,000 non-elderly individuals in 2005. The Medicaid program is funded with 50 percent State general funds and 50 percent matching federal funds. Total Medicaid spending in FY 2005 was more than \$3.7 billion, not including nursing facility services.

The purpose of the Medicaid program is to provide basic medical care coverage to low-income individuals, particularly families with children. (Medicaid is also the largest payer of nursing facility services for the elderly.) There are different income eligibility rules for individuals depending on their status (that is, child 19 or under, parent, pregnant, aged, blind or disabled). Virginia's income guidelines for Medicaid eligibility are among the most stringent in the nation. Table 1 shows Virginia's Medicaid and FAMIS income eligibility guidelines.

Table 1: Virginia's Medicaid and FAMIS Eligibility Levels

Coverage Group	% Federal Poverty Level		
	Federal Minimum Eligibility	Medicaid	FAMIS
Pregnant Women	133%	133%	166%
Infants (0-1 years)	133	133	200
Children (1-5 years)	133	133	200
Children (6-18 years)	100	133	200
Parents	NA ¹	24	NA
Aged, Blind, and Disabled	NA ²	80	NA

¹ States must cover parents whose income is below Aid to Families with Dependent Children standards as of July 1996.

² States provide Medicaid for this group, which receives Supplemental Security Income (SSI); however, since 1972, states have the option of imposing more restrictive eligibility criteria than those imposed by SSI through Section 1902(f) of the Social Security Act. Virginia is one of 11 states that exercise this option.

Source: Kaiser Family Foundation and The Statistical Record of the Virginia Medicaid Program, State Fiscal Year 2005.

Virginia has expanded Medicaid for children aged six to 18 years. The January 2002 JLARC report, *A Review of Selected Programs in the Department of Medical Assistance Services*, recommended raising Medicaid eligibility for children from six to 18 to 133 percent of the federal poverty level (FPL) to allow siblings in most families to be covered under the same program regardless of age. In September 2002, the expansion was implemented.

Federal Poverty Level

The 2005 federal poverty level (FPL) for a family of four was \$19,350. The income level for a family at 200 percent FPL was \$38,700.

Virginia implemented the Health Insurance Premium Payment (HIPP) program in July 1995. Under this program, the State pays health insurance premiums for families who have access to employer-sponsored insurance provided that at least one family member is Medicaid eligible. The State reimburses the family for either the family's portion of the premium or the State's Medicaid managed care rate, whichever is lower. The advantage of HIPP is that the entire family receives health insurance coverage. As of November 2006, 1,400 families were enrolled.

FAMIS. FAMIS is Virginia's SCHIP (State Children's Health Insurance Program), which is a federal program that requires state matching funds, similar to Medicaid. The SCHIP program was enacted by Congress in 1997 to provide coverage to children and some parents with income levels too high to qualify for Medicaid, but for whom private health insurance is still too expensive. FAMIS provides coverage to children 19 and under living in families with income levels between 133 and 200 percent FPL. Children in a family of four with a household income of \$40,000 or less qualified for FAMIS in 2006. In August 2005, Virginia expanded eligibility to pregnant women to 150 percent FPL, and to 166 percent FPL in September 2006.

The federal government pays 65 percent of the costs of Virginia's FAMIS program. In FY 2005, FAMIS expenditures totaled \$70.1 million, which includes a 65 percent federal match. In November 2006, the monthly enrollment in FAMIS was more than 44,300.

In recent years, Virginia has engaged in significant outreach efforts to enroll eligible children and has streamlined processes for children's public health insurance. Outreach efforts have included promotional materials to reach additional families and children, such as brochures, television and radio commercials, and collaboration with other State agencies. Streamlining has included simplifying resource and income verification requirements and accepting applications online. The result of these efforts was a 51 percent increase in children's Medicaid and FAMIS enrollment from January 2002 to July 2006.

FAMIS Select is a voluntary program for families with FAMIS-eligible children who have access to employer-sponsored insurance. Instead of enrolling the child in FAMIS, Department of Medical Assistance Services (DMAS) pays \$100 per month per child up to the total cost of the family premium. FAMIS Select is cost effective for the State because \$100 per child is less than the average rate that would be paid to enroll a child in FAMIS. As of November 2006, 305 children were enrolled in FAMIS Select.

Premium assistance payments are only for the FAMIS-eligible children; however, the program helps the entire family afford coverage. For example, a family with three FAMIS-eligible children would receive \$300 a month toward the family's portion of the premium. This makes the employer-sponsored coverage more affordable for the entire family. FAMIS Select has allowed 233 non-FAMIS-eligible children and adults to receive coverage.

Medicare. Medicare is a federal public health insurance program for the aged (65 and over) and the disabled. In Virginia, there were about 967,000 Medicare enrollees in 2004. The majority (808,137) were aged 65 or over. Medicare provided health coverage to about two percent of Virginia's non-elderly population.

Safety Net for Virginians Who Lack Health Insurance

While hospital emergency rooms provide much of the health care for uninsured individuals, Virginia's free clinics, community health centers, and local health departments offer a wide range of health care services to poor, uninsured individuals. There are 53 free clinics operating 67 sites throughout Virginia. According to the Virginia Association of Free Clinics, North Carolina is the only state with more free clinic sites than Virginia. There are 73 community health centers located in medically underserved areas throughout the State. In addition, the Virginia Department of Health operates 119 local health departments throughout the State which provide immunizations, family planning, and dental services to low-income residents. These free clinics, community health centers, and local health departments provide a crucial safety net for many Virginians without health insurance.

Hospital Emergency Rooms Are Required to Treat Those Who Need Care. Hospital emergency rooms provide a substantial amount of care to uninsured Virginians. Hospitals are required to provide stabilizing treatment to all patients in need of immediate care pursuant to the federal Emergency Medical Treatment and Active Labor Act of 1985. According to Urban Institute analysis of the Medical Expenditure Panel Survey, approximately 13 percent of the full-year uninsured visited the emergency room at least once in 2005, and hospitals donated \$113 million for their care in emergency rooms.

Free Clinics Provide Care at Little to No Cost. Free clinics are private, non-profit organizations that provide health care to low-income, uninsured individuals through the use of volunteer health professionals. The free clinics are managed by community-based or faith-based organizations, which organize volunteer physicians, nurses, dentists, pharmacists, and other health professionals to provide care. In 2005, free clinics provided care to 61,457 low-

income, uninsured Virginians at a cost of \$16.8 million. The Virginia Association of Free Clinics estimates that the amount of “billable” health care services provided in 2005 was \$86 million (that is, the amount that would have been charged to patients without the volunteer services of health professionals and the donated prescription medications).

Most of the funding for free clinics comes from private sources. In 2005, 71 percent of the funding came from charitable foundations, businesses, churches, civic organizations, and individuals. Local governments contributed just over \$1 million, and the federal government contributed just under \$1 million to Virginia free clinics. The State appropriated about \$1.3 million in FY 2007, primarily for the acquisition and provision of prescription medications and pharmacy services. Patient donations and fees accounted for nearly \$800,000 of free clinic revenues.

Community Health Centers Provide Care to Individuals in Medically Underserved Areas of the State. Community health centers are non-profit organizations that provide comprehensive primary health care services to anyone in the community, regardless of ability to pay. In addition to treating patients, community health centers also promote public health awareness and disease prevention for the communities they serve. In 2005, Virginia centers provided care to 196,077 patients, 84 percent of whom were at or below 200 percent FPL and 34 percent of whom were uninsured.

Funding for community health centers comes from patient payments (including out-of-pocket payments, Medicaid and Medicare, and private insurers), federal grants, and other sources. In 2005, community health centers received \$28.9 million in grants from the Bureau of Primary Care, which is a division of the Health Resources and Services Administration within the U.S. Department of Health and Human Services. These grants enabled community health centers to provide \$21.9 million in sliding fee discounts to low-income patients.

Local Health Departments Provide Care to Low-Income Families. The Virginia Department of Health operates 119 local health departments throughout the State. In addition to epidemiological and inspection services (such as restaurant and drinking water inspections), local health departments also offer clinical services such as immunizations, family planning, and nutrition services to women and children. Approximately 70 percent of the departments offer dental services to low-income children. In FY 2006, local health departments provided \$171 million in public health services to 368,261 patients. The departments are jointly funded by the State and local governments.

The Uninsured Population in Virginia

In Summary

An estimated nine to 16 percent of Virginians are uninsured. More than half of the uninsured are low income. Affordability is the primary reason why Virginians lack health insurance coverage. About three-fourths of the uninsured live in households with no availability of employer-sponsored coverage, and in most of these families, at least one family member is working. While most large employers provide insurance to their employees, the majority of small employers do not. Virginians are uninsured for other reasons, including a temporary loss of coverage due to life transitions, a belief that they do not need insurance, and a failure to enroll in public health insurance programs.

House Joint Resolution 158 requests that JLARC "analyze the number of uninsured Virginians, the duration of periods without insurance, and their eligibility for employer-based and private health insurance coverage or government health care programs," and consider demographic factors in conducting the analysis. Analysis of the size of the uninsured population in Virginia as well as its demographic characteristics provides a basis for an examination of policy options to address the problem of the uninsured.

JLARC staff and the Virginia Health Care Foundation (VHCF) agreed to collaborate in the assessment of the number and composition of the uninsured given the foundation's prior efforts to address this question. In 1996 and 2001, VHCF conducted surveys to determine the number and demographics of the uninsured in Virginia. Given the challenges of conducting a new survey, and that several surveys attempting to measure the number of uninsured have been conducted recently, the decision was made to analyze the results of these surveys to address the study issues instead of conducting a new survey. The VHCF contracted with the Urban Institute to analyze recent survey results and report its findings to the foundation and to JLARC staff.

BETWEEN NINE AND 16 PERCENT OF VIRGINIANS ARE UNINSURED

The exact number of uninsured Virginians is unknown because estimates of the uninsured are based on a sample of the population. Recent surveys provide different estimates of the number and rate of uninsured Virginians due to differences in sampling methodology and survey design.

Surveys of the Uninsured Present a Range of Estimates

Several national and State surveys have attempted to measure the number of persons without health insurance. Some surveys measure the number of full-year uninsured individuals, others measure the number of uninsured individuals at a given point in time, and still others measure the number of individuals who lacked health insurance at any point during the previous year. The most commonly cited source on the number of uninsured is the Current Population Survey (CPS), conducted by the U.S. Census Bureau, which reports the number of full-year uninsured by state.

Depending on the source of the survey, Virginia's full-year uninsured rate for non-elderly individuals ranges from approximately nine to 16 percent.

- The 2004-2005 CPS estimates that 15.5 percent (1 million) of Virginians were uninsured for the full year.
- The 2005 National Health Interview Survey estimates that 12.1 percent (805,376) of Virginians were uninsured when surveyed in 2005.
- The 2004 Virginia Health Care Insurance and Access Survey estimates that 8.9 percent (632,138) of Virginians were uninsured at a specific point in time.

Current Population Survey (CPS). The CPS is conducted annually and includes a measure of the number of uninsured nationally and in each state. Between February and April each year, approximately 76,000 households are asked about household characteristics including health insurance coverage. The size of the Virginia survey sample was 7,430 adults and children in 2006. While the survey seeks to determine how many respondents did not have insurance for the entire previous year, health policy experts have concluded that it instead tends to capture how many do not have insurance at the point in time of the survey. This conclusion is based on the fact that the rate of uninsured determined from the CPS survey is similar to the rate found in other point-in-time surveys.

National Health Interview Survey (NHIS). The NHIS is conducted by a division of the Centers for Disease Control and Prevention and measures the national uninsured rate; however, until the most recent release it was not designed for state-specific estimates. Nationally, approximately 38,500 households were interviewed in 2005. From each family, one child under 18 and one adult were randomly selected, and information was collected on the insurance status of each at a specific point in time.

Virginia Health Care Insurance and Access Survey (VHCIAAS). The VHCIAAS was a one-time Virginia survey conducted in 2004 by the State pursuant to a State Planning Grant from the Health Resources and Services Administration in the U.S. Department of Health and Human Services. Phone interviews were conducted with 4,000 randomly selected Virginia households to measure health insurance coverage at a specific point in time.

Medical Expenditure Panel Survey (MEPS) and Survey of Income and Program Participation (SIPP). Both the MEPS and SIPP are federally sponsored national surveys that yield national estimates of the uninsured at a particular point in time. However, by interviewing respondents multiple times each year, both surveys are considered to yield more accurate estimates of the number of people uninsured all year. The MEPS interviews participants every three to five months. The SIPP is a longitudinal survey that interviews the same people every four months about their health insurance coverage during the previous four months. The 2003 MEPS reported an estimated 18.7 percent national non-elderly uninsured rate. The 2002 SIPP yielded an estimated 17.1 percent national non-elderly uninsured rate.

Current Population Survey (CPS) Results Are Basis of This Report

While it is difficult to determine with certainty which surveys provide the most accurate measure of the uninsured, the remainder of this report relies primarily on the results of the CPS for several reasons. First, the CPS is the most well-established survey of the uninsured and has been conducted annually since 1980. It is the survey most commonly cited by health policy experts who are examining the issue of the uninsured. In addition, the survey has a large sample size for each state and has a high response rate. Finally, it provides more extensive breakdowns of various sub-populations of the uninsured.

In contrast, the other surveys mentioned have potential limitations. The most recent NHIS survey was the first edition to include state-level estimates, and the Virginia sample size was small. While the VHCIAAS survey was extensive, its low response rate compared to other surveys is a potential concern. Both the MEPS and SIPP are extensive national surveys, but neither provides state-specific estimates of the number of uninsured.

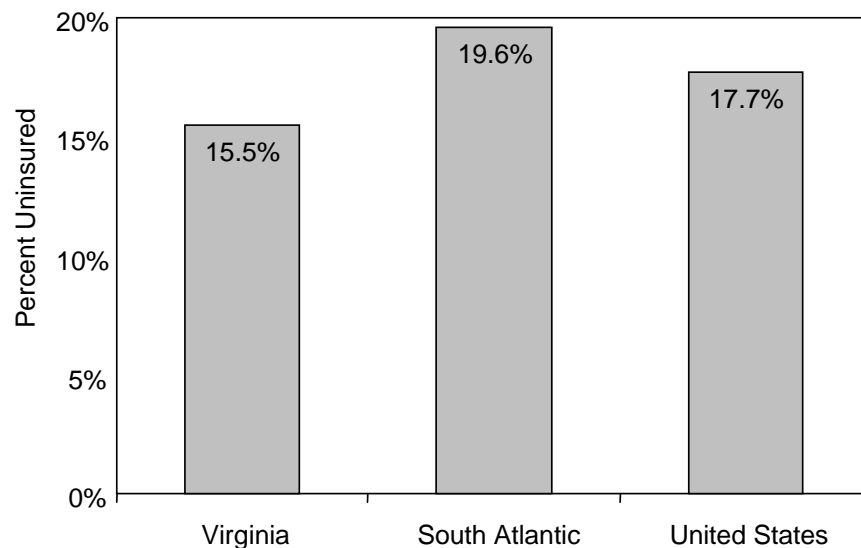
Virginia's Uninsured Rate Is Below the National Average and Has Fluctuated Over Time

State Ranking

Virginia has the 20th lowest non-elderly uninsured rate among the 50 states and the District of Columbia from 2004 to 2005.

The CPS estimate of 15.5 percent uninsured in Virginia is less than the national and South Atlantic states' estimated rates. Nationally, the non-elderly uninsured rate is an estimated 18 percent (Figure 3). The South Atlantic states have an average uninsured rate of almost 20 percent. (The South Atlantic Census region includes Delaware, Maryland, the District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, and Florida.)

Figure 3: Virginia's Uninsured Rate Is Below the National and Regional Averages

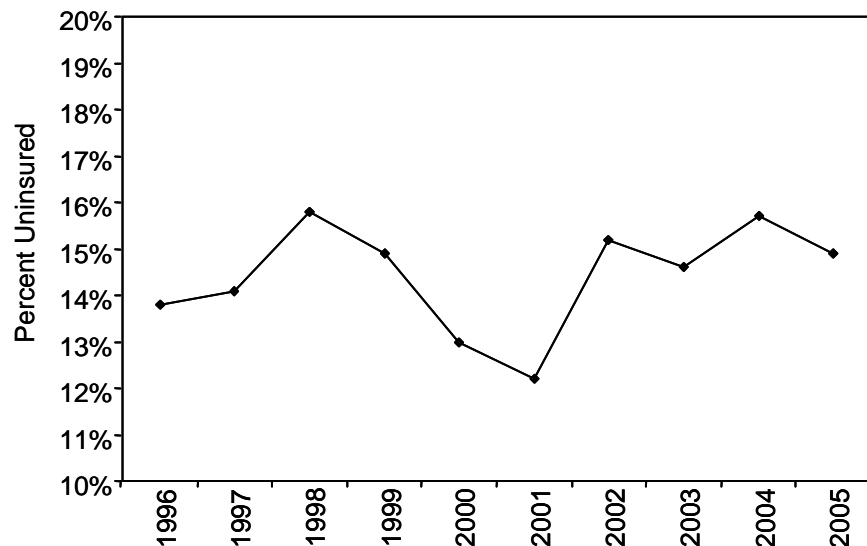


Source: Urban Institute analysis of 2004-2005 CPS data.

Based on CPS survey results, the average uninsured rate over the previous ten years has been 14.4 percent. Since 1996, the rate of uninsured non-elderly Virginians has ranged between a low of 12.2 percent in 2001 to a high of 15.8 percent in 1998 (Figure 4).

As mentioned previously, the VHCF conducted surveys in 1996 and 2001 to assess the number of uninsured in the State. The 1996 survey found that 13 percent of Virginia's population was uninsured. The 2001 survey indicated that 14.9 percent of the State's population was uninsured.

Figure 4: Virginia's Uninsured Rate Has Fluctuated Between 12.2 and 15.8 Percent Over the Past Ten Years



Source: Current Population Survey, Historical Health Insurance Table HI-6.

WHO ARE THE UNINSURED?

Low income

Low-income individuals and families are defined in this report as those with income at or below 200 percent of the federal poverty level.

The uninsured rate in Virginia varies widely among sub-populations in the State. Sub-populations with the highest uninsured rates include low-income individuals, 19- to 24-year-olds, households with no full-time workers, households in which at least one member works for a small employer or is self-employed, and Hispanic Virginians.

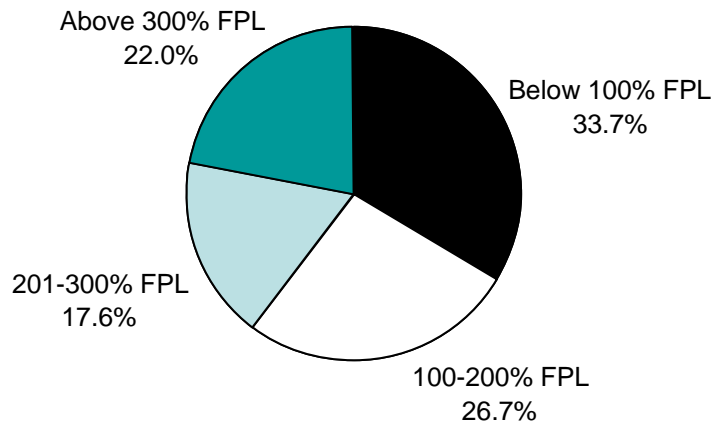
Since the elderly (65 and older) are mostly insured, estimates of the uninsured include only Virginians under the age of 65 years (non-elderly). Nationally, an estimated 1.3 percent of the elderly population was uninsured in 2005. A large majority (more than 95 percent) is covered by Medicare or another public health insurance program, and 60 percent have private health insurance coverage.

Higher Proportion of Low-Income Virginians Are Uninsured

Approximately 60 percent of the more than one million non-elderly Virginians estimated to be uninsured have family incomes at or below 200 percent FPL.

Low-income Virginians have the highest uninsured rate and account for the majority of all uninsured Virginians. Approximately 60 percent of the more than one million non-elderly Virginians estimated to be uninsured have family incomes at or below 200 percent of the federal poverty level (FPL) (Figure 5). The 2005 FPL was \$19,350 for a family of four; 200 percent FPL was \$38,200. An estimated 34 percent are at or below the FPL.

Figure 5: Most Uninsured Virginians Are Low Income

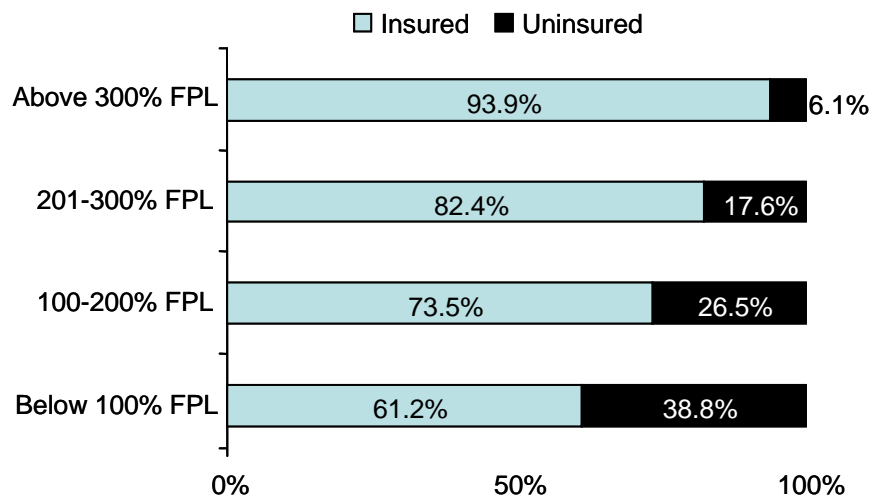


Source: Urban Institute analysis of 2004-2005 CPS data.

Virginians at or below the FPL are most at risk for being uninsured. The uninsured rate is about 39 percent for Virginians at or below the FPL and 27 percent for those between 100 to 200 percent FPL (Figure 6). Only an estimated six percent of Virginians above 300 percent FPL are uninsured.

Similar to the trend among all non-elderly adults, low-income children represent both the majority of uninsured children and are more at risk for being uninsured. According to the CPS, more than

Figure 6: Higher Proportion of Low-Income Virginians Are Uninsured

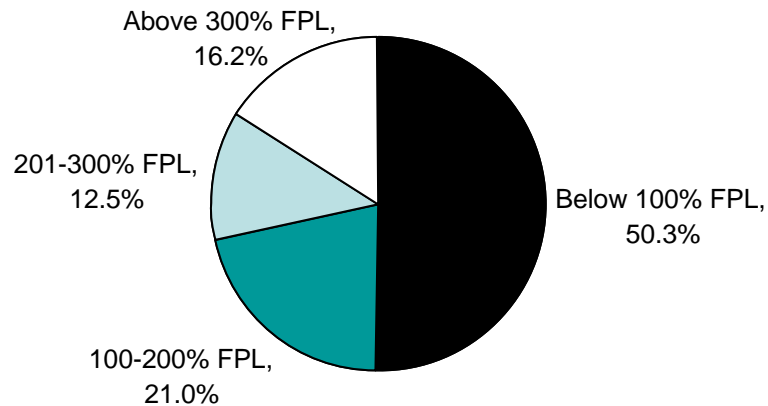


Source: Urban Institute analysis of 2004-2005 CPS data.

half of the uninsured children (85,600) are below the FPL, and more than 70 percent (121,400) are at or below 200 percent FPL (Figure 7).

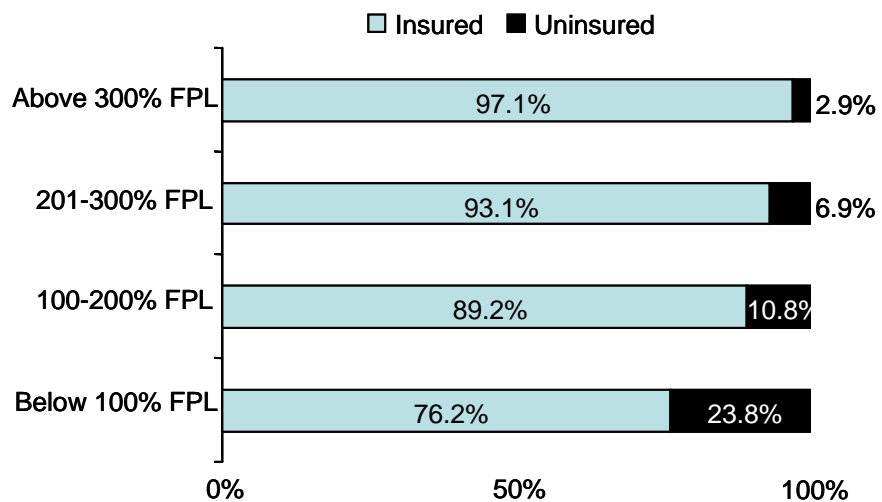
Children at or below the FPL are those most likely to be uninsured (Figure 8). The uninsured rate for children below the FPL is an estimated 24 percent, while it is only about three percent for children above 300 percent FPL.

Figure 7: Nearly Three-Fourths of Uninsured Children Are Low Income



Source: Urban Institute analysis of 2004-2005 CPS data.

Figure 8: Nearly One-Fourth of Children At or Below the FPL Are Uninsured



Source: Urban Institute analysis of 2004-2005 CPS data.

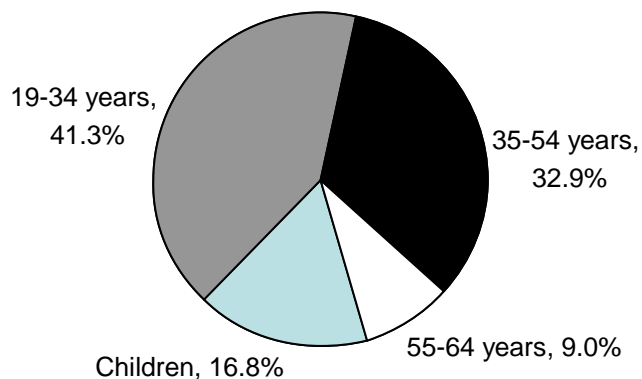
A Higher Proportion of Young Adults Are Uninsured than Other Age Groups

Adults accounted for an estimated 83 percent of all non-elderly uninsured Virginians. Approximately 41 percent of uninsured Virginians are between 19 and 34 years of age, the greatest share of the uninsured by age group (Figure 9). The second largest group of uninsured is 35- to 54-year-olds (33 percent). The smallest proportion of non-elderly uninsured is 55- to 64-year-olds (nine percent). Children accounted for the remaining 17 percent of the uninsured.

Among all non-elderly Virginians, the 19- to 24-year-old age group has the highest proportion of its population that is uninsured (Figure 10). An estimated 32 percent of 19- to 24-year-old Virginians are uninsured. Second most likely to be uninsured are those aged 25 to 34 years (24 percent).

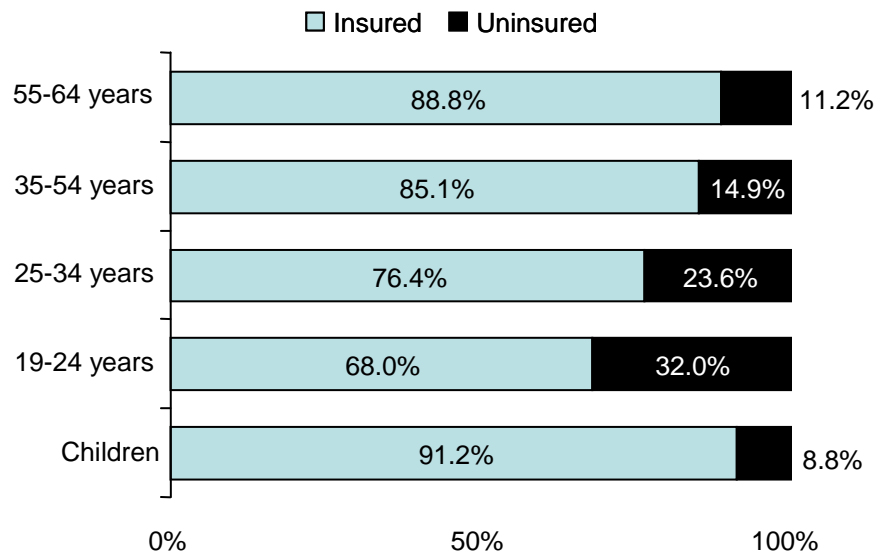
Non-elderly adults have a higher uninsured rate than children. In 2004-2005, an estimated 18.3 percent of non-elderly adults were uninsured, compared to 8.8 percent of children. Virginia's uninsured rates for non-elderly adults and children are lower than both the South Atlantic states (22.6 percent for non-elderly adults and 12.5 percent for children) and national rates (20.5 percent for non-elderly adults and 11.4 percent for children).

Figure 9: More Uninsured Virginians Are Between 19 and 34 Years Old Than Other Age Groups



Source: Urban Institute analysis of 2004-2005 CPS data.

Figure 10: Young Adults Have the Highest Uninsured Rate



Source: Urban Institute analysis of 2004-2005 CPS data.

Most Uninsured Do Not Have Children, and a Higher Proportion of Males Are Uninsured

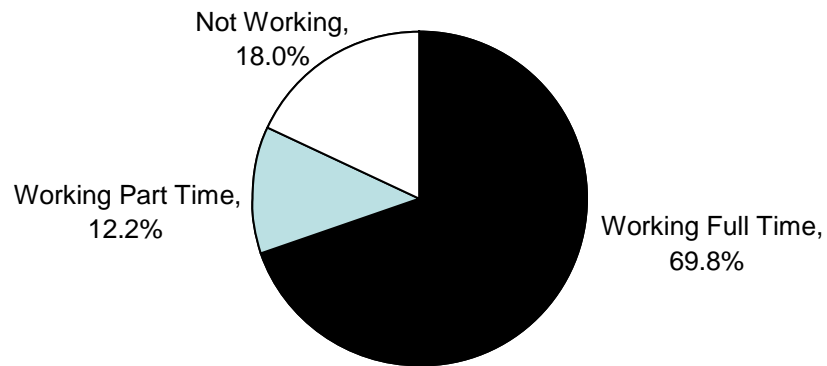
The uninsured disproportionately do not have children. An estimated one-fourth of uninsured non-elderly adults are parents with children under the age of 19. An estimated 21 percent of adult Virginians who do not have children under the age of 19 are uninsured compared to 13 percent of adults with children under the age of 19.

Males account for 55 percent of the estimated uninsured population in Virginia. Of all non-elderly males, 17 percent are estimated to be uninsured while 14 percent of all non-elderly females are uninsured.

Most Uninsured Virginians Live in Households With at Least One Member Working

Employment status and whether the employer offers coverage are important factors in determining an individual's risk of being uninsured. Although a majority of Virginians receives health insurance coverage through their employer, many uninsured Virginians are in households with at least one full- or part-time worker. An estimated 70 percent of uninsured Virginians are in households with at least one full-time worker while only 18 percent are in households in which no one is employed (Figure 11).

Figure 11: More Than 80 Percent of Non-Elderly Uninsured Live in Working Households



Source: Urban Institute analysis of 2004-2005 CPS data.

Individuals in families with no full-time worker are most at risk of being uninsured in Virginia. In non-working families, the uninsured rate is 29 percent. In families in which there is at least one full-time worker, the uninsured rate is only 13 percent.

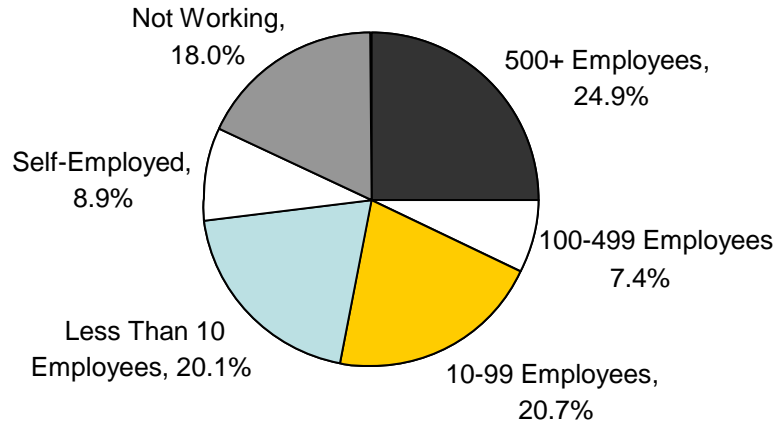
Uninsured children tend to live in households with at least one parent working full or part-time. An estimated 65 percent of uninsured children live in a household in which at least one parent works full time, and five percent have at least one parent who works part time. The remaining 30 percent of uninsured children do not have a parent working.

Those Working for Employers With Fewer Than 100 Employees Are More Likely to Be Uninsured

The size of the employer is also an important factor in determining an individual's and family members' risk of being uninsured. About one-half of the uninsured population in Virginia lives in a family in which at least one member of the household works for an employer with fewer than 100 employees (includes the self-employed). In contrast, less than one-third of uninsured non-elderly Virginians are in households in which at least one family member works for an employer with 100 or more employees (Figure 12).

Individuals in households with a wage earner(s) who works for a firm with fewer than ten employees are most at risk of being uninsured. Almost 40 percent of non-elderly individuals in these households are uninsured (Figure 13). In addition, about one-fifth of households in which there is a wage earner(s) working for an

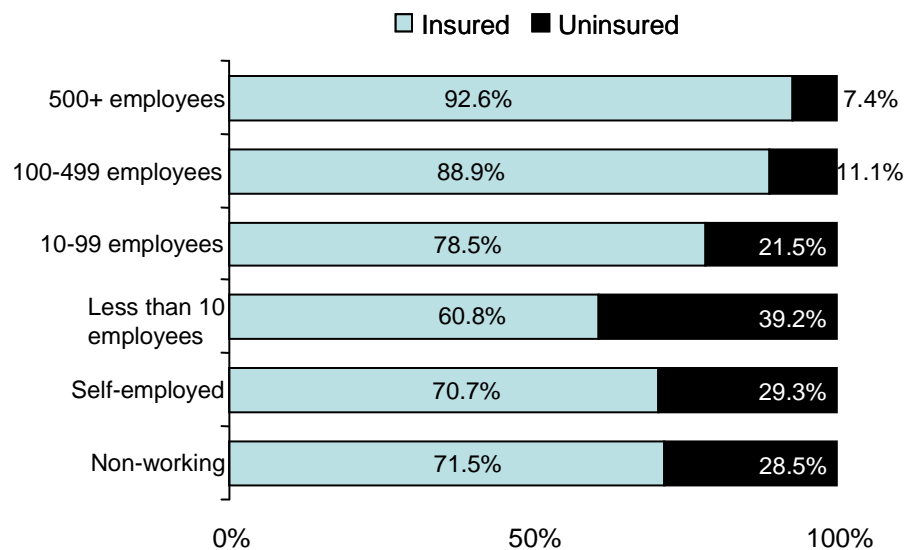
Figure 12: Distribution of Uninsured Virginians by Employer Size



Source: Urban Institute analysis of 2004-2005 CPS data.

employer with between ten and 99 employees are uninsured. Non-elderly Virginians in households in which at least one person works for an employer with 500 or more employees are least likely to be uninsured (7 percent). Other high-risk groups are the self-employed households (29 percent) and non-working households (29 percent).

Figure 13: A Higher Proportion of Those Working for Employers With Fewer Than 100 Employees Are Uninsured



Source: Urban Institute analysis of 2004-2005 CPS data.

Most Uninsured Are U.S. Citizens

Most uninsured Virginians are U.S. citizens, but non-citizens are much more likely to be uninsured. Of the more than one million estimated uninsured non-elderly Virginians, about 83 percent are U.S. citizens. However, it is estimated that 40 percent of the 451,000, or 180,000, non-U.S. citizens in Virginia are uninsured.

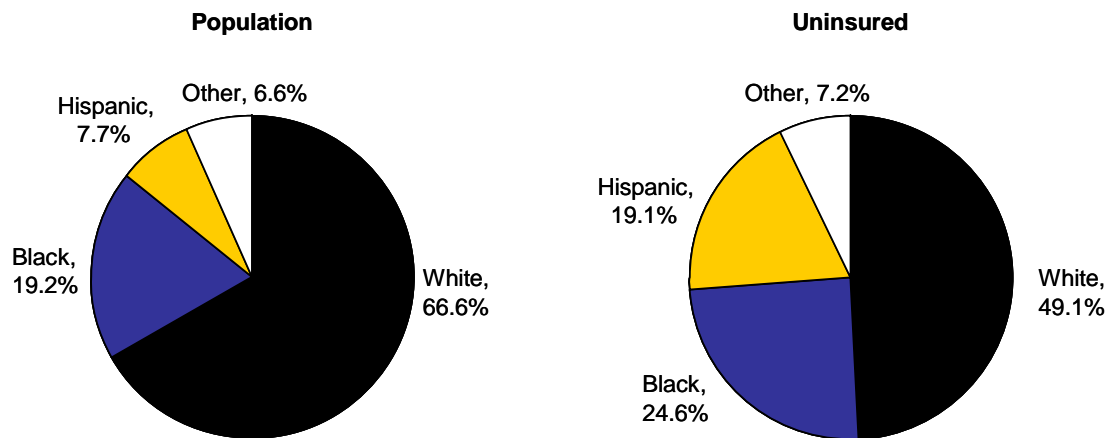
The uninsured rate for citizens and non-citizens is likely to grow due to a new federal Medicaid requirement that beneficiaries prove their citizenship and identity to become eligible for the program. This requirement is intended to prevent ineligible illegal aliens from obtaining benefits, but it may also result in some eligible beneficiaries (citizens) losing their health insurance coverage. Some citizens are losing Medicaid benefits due to difficulty obtaining proper documentation of citizenship and identity. Since the proof of citizenship requirements were implemented on July 1, 2006, children's enrollment in Virginia's Medicaid program dropped by 11,918 over the subsequent four months. According to staff at DMAS, the magnitude of this drop in enrollment is due to the new citizenship requirement, and many of those dropped from enrollment are citizens who have not yet been able to produce proof of citizenship and identity. During the same period, enrollment in FAMIS increased likely because it is not subject to the new requirements.

A Higher Proportion of Hispanic Virginians Are Uninsured

Some race/ethnicities are overrepresented among the uninsured (Figure 14). For example, an estimated 19 percent of the uninsured are Hispanic Virginians while they constitute only seven percent of Virginia's population. An estimated 49 percent of uninsured Virginians are non-Hispanic white although the proportion of uninsured non-Hispanic white Virginians is less than the overall proportion of non-Hispanic white Virginians (approximately 67 percent).

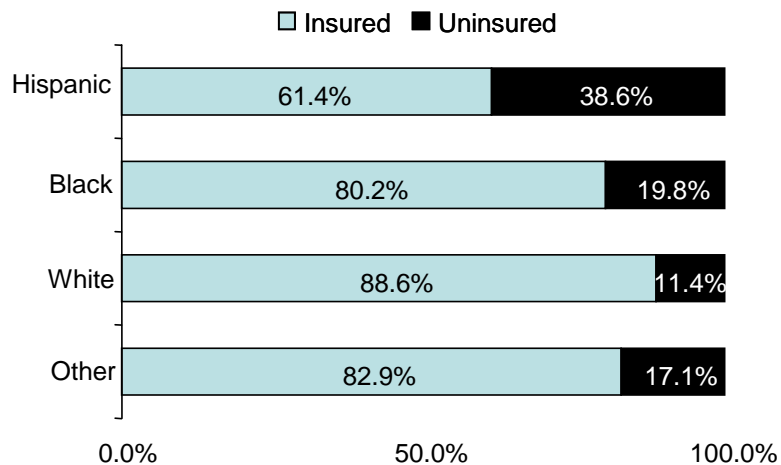
The uninsured rate for Hispanics is approximately twice the rate for any other race/ethnicity. An estimated 39 percent of all Hispanic Virginians are uninsured compared to 20 percent of black Virginians and 11 percent of non-Hispanic white Virginians (Figure 15).

Figure 14: Hispanic and Black Virginians Are Overrepresented Among Uninsured



Source: Urban Institute analysis of 2004-2005 CPS data.

Figure 15: Hispanic Virginians Are Most Likely To Be Uninsured



Source: Urban Institute analysis of 2004-2005 CPS data.

WHY DO VIRGINIANS LACK HEALTH INSURANCE?

The unaffordability of health insurance coverage is the primary reason why Virginians lack coverage. Affordability is a problem for both employed and unemployed Virginians, especially for low-income Virginians and for those whose employers do not offer coverage. Additionally, a portion of uninsured low-income Virginians are eligible for public health insurance but not enrolled. Some uninsured choose not to be covered because they believe they do not need health insurance. Others lose coverage temporarily due to life transitions.

Health Insurance Is Not Affordable for Many Virginians

Many Virginians cite affordability as the primary barrier to purchasing health insurance coverage. The cost of premiums continues to rise, which exacerbates the barrier and makes coverage unaffordable for a growing number of individuals, families, and employers. Furthermore, a large proportion of the uninsured are low income, and the gap between the cost of coverage and what they can afford is substantial.

Cost of Insurance Is Increasing. The cost of health insurance coverage is increasingly prohibitive for some individuals, families, and employers. According to the Kaiser Family Foundation's annual report on employer health benefits (the Kaiser report), from 2000 to 2006, premiums rose by 87 percent nationally, while inflation rose 18 percent and wages increased by 20 percent. The report also found the national average annual cost of employer-sponsored coverage to be approximately \$4,200 for individuals in 2006, with the employee contributing about \$600. According to the Virginia Bureau of Insurance, the average annual cost of an employer-sponsored plan in Virginia is \$3,000 for an individual. Kaiser reports that for a family of four, the average annual cost is nearly \$11,500 with the employee paying almost \$3,000.

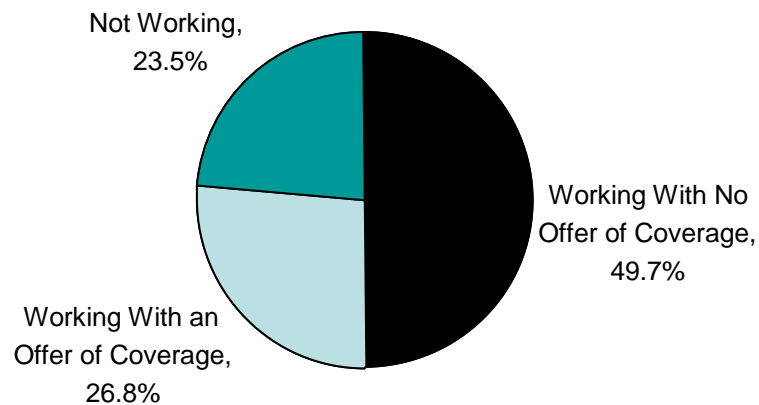
Premiums are increasing. From 2000 to 2006, premiums rose by 87 percent nationally, compared to inflation (18 percent) and wage growth (20 percent).

The cost of health insurance in the individual market is lower on average than employer-sponsored coverage; however, the cost remains prohibitive for many. According to the Kaiser report, the average annual cost of an individual health insurance policy is more than \$1,750 nationally. The Bureau of Insurance reports that the average annual cost for an individual plan in Virginia is about \$2,550. Kaiser reports that for a family, the average annual cost is more than \$3,300 in the individual market. (The Bureau of Insurance was not able to provide the average cost to a family of an individually purchased plan in Virginia.) The premium cost of a plan purchased through the individual market varies substantially based on factors such as age, health status, and the comprehensiveness of the coverage.

Several factors may explain the cost discrepancy between employer-sponsored and individually purchased plans. First, individual coverage tends to be less comprehensive. For example, employer-sponsored plans are required to cover pre-existing conditions while individual plans are not. Second, the annual deductible is typically higher for individual plans. Nearly 70 percent of individual plans have a deductible of \$1,000 or higher. Third, those who purchase individual plans tend to be younger and healthier.

Nearly Three-Fourths of the Uninsured Are in Households With No Offer of Employer-Sponsored Insurance. According to analysis by the Urban Institute, nearly half of uninsured Virginians live in households that have at least one family member working but no offer of employer-sponsored insurance. Approximately 24 percent of uninsured Virginians live in households that have no working member, and nearly 27 percent of the uninsured have at least one offer of employer-sponsored insurance in the household (Figure 16).

Figure 16: Nearly Half of Uninsured Families Are Not Offered Health Insurance by Their Employer



Source: Urban Institute analysis of the 2005 Current Population Survey Contingent Workers and Alternative Employment Supplement and Annual Social and Demographic Supplement.

Most of the employers that do not offer coverage to their employees are small. According to the Medical Expenditure Panel Survey, nearly all large employers in Virginia (98 percent) offer health insurance coverage, but fewer than half (48 percent) of small employers (less than 50 employees) offer health insurance.

With Few Exceptions, Only Adults Below 24 Percent of the Federal Poverty Level Qualify for Medicaid. Public health insurance is an option for only a small proportion of low-income adults. Only six percent of uninsured adults are eligible for public health insurance. Medicaid provides health insurance coverage for Virginia's parents with income up to 24 percent of the FPL (\$4,644 for a family for four in 2005). Other Medicaid-eligible groups of adults include the blind and disabled.

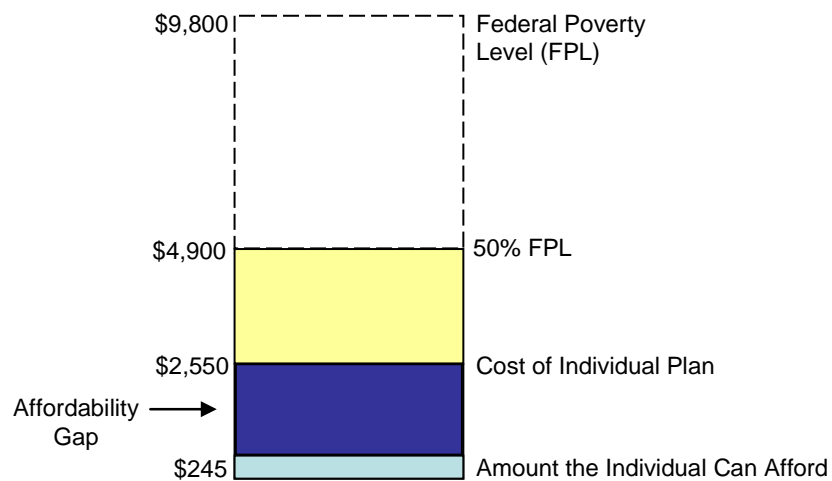
Large Gap Exists Between the Cost of Health Insurance and Income for Most Low-Income Virginians. Without an employer contribution or public financial assistance through Medicaid or another program, low-income individuals must pay the full cost of health insurance. However, that cost is prohibitive relative to their income

Only six percent of uninsured adults are eligible for public health insurance in Virginia.

levels. For example, adults with an income at 50 percent of the FPL (\$4,900) would have to spend about half of their income on health insurance (given the Bureau of Insurance estimate of average cost of \$2,550). Such a policy would also likely include a relatively high deductible. Low-income adults with income equal to 150 percent of the FPL (\$14,700) would still not be able to afford insurance; they would have to spend 17 percent of their income on a \$2,500 policy and also meet the deductible.

As discussed in Chapter 1, studies have concluded that it is difficult for low-income families to spend more than five percent of their income on health care expenses. Therefore, the gap between what low-income households can afford to spend on insurance and the cost of health insurance is substantial (Figure 17).

Figure 17: An Uninsured Adult at 50 Percent of the FPL Would Spend More Than Half of His/Her Salary to Purchase Coverage



Source: JLARC staff analysis of Bureau of Insurance data and literature review.

Young, Healthy Adults May Believe They Do Not Need Health Insurance

Some of the uninsured do not have health insurance because they are young and healthy and believe that they do not need it. These individuals are often referred to as "young immortals" due to their attitude that they will never be seriously injured or sick. As noted previously, young adults have the highest uninsured rate in Virginia by age group. Those between 19 and 24 years have an uninsured rate of 32 percent, and those between 25 and 34 years have an uninsured rate of almost 24 percent.

While young, healthy adults may believe they do not need health insurance, analysis of hospital data shows that uninsured young adults actually visit the emergency room more frequently than other age groups. This phenomenon occurs across different income levels (Table 2). For every 100 adults between the ages of 19 and 39 years, there were about 22 visits to the emergency room during the year. Low-income young adults visited the emergency room more frequently.

Table 2: Young Adults Visit the ER More Frequently Than Other Age Groups

Age	Visits to Emergency Room by Income Level ¹			
	100% FPL and Below	101-200% FPL	Above 200% FPL	Average (% FPL)
19-39 years	37.0	20.6	14.2	21.7
40-64 years	25.9	15.5	12.1	16.2

¹ Per 100 people.

Source: Urban Institute analysis of 2001-2003 Medical Expenditure Panel Survey-South data.

Significant Portion of the Uninsured Are Without Coverage for Less Than 12 Months

Temporary lack of health insurance coverage due to life transitions is another reason why Virginians are uninsured. Most uninsured Virginians are without coverage for 12 months or more, but a substantial portion is short-term uninsured. Reasons for temporary lack of insurance include reaching age 19 and losing Medicaid/FAMIS eligibility, losing eligibility for coverage through a parent's employer-sponsored plan, and job loss or change.

However, a majority of the uninsured appear to be long-term uninsured. The Virginia Health Care Insurance Access Survey estimated that 71 percent of Virginia's uninsured population was long-term uninsured, and the MEPS reports that 59 percent of the uninsured are long-term uninsured. Estimates for long-term uninsured are based on calculations of those without insurance for the entire year. According to estimates from the VHCIAS, low-income uninsured are more likely to be long-term uninsured than other income groups. The survey estimated that more than three-fourths of low-income uninsured are long-term uninsured.

On average, short-term uninsured adults are covered for slightly more than six months of the year. Short-term uninsured children are covered for more than seven months of the year.

Virginia's uninsured rate for 2005 would decrease by 2.4 percentage points if those Virginians eligible for public health insurance were to enroll.

Uninsured May Be Eligible for Public Health Insurance but Do Not Enroll

While only a small proportion of uninsured non-elderly adults is eligible for public health insurance, a significant proportion of uninsured children is eligible. Medicaid and FAMIS offer public health insurance coverage to children at or below 200 percent FPL, and Medicaid covers parents at or below 24 percent on average. Analysis by the Urban Institute and JLARC staff estimates that nearly 16 percent of the uninsured are eligible for Medicaid or FAMIS but not enrolled, based on the estimated uninsured rate of 15.5 percent. If Virginia were to enroll the estimated 160,000 non-elderly adults and children who are eligible for public health insurance, the non-elderly uninsured rate for 2005 could decrease by 2.4 percentage points.

Children's Enrollment in Medicaid and FAMIS Has Greatly Increased, but Many Eligible Children Remain Uninsured. Despite outreach efforts to enroll eligible children, a large proportion of uninsured children are still not enrolled in Medicaid or FAMIS. Based on the CPS estimate of the number of low-income uninsured children, up to two-thirds of all uninsured children (108,300) were eligible for Medicaid or FAMIS but not enrolled in 2005.

Over the last several years, the State has conducted significant outreach to enroll eligible children in Medicaid and FAMIS. These efforts resulted in a 51 percent increase in children's Medicaid and FAMIS enrollment from January 2002 to July 2006 (almost 145,000 additional children).

Individuals Who Are Eligible for Medicaid or FAMIS May Not Be Enrolled for a Variety of Reasons. Uninsured individuals or families may be eligible for Medicaid or FAMIS yet be either unaware of their eligibility or not interested in enrolling. According to the VHCIAS, almost 88 percent of uninsured non-elderly in Virginia said that they would enroll in a public health insurance program if eligible.

A 2002 survey by DMAS of insured and uninsured low-income parents in Virginia explored their opinions about children's public health insurance programs (Table 3). The survey found that two-thirds of low-income parents are aware that there are public health insurance programs for their children. However, almost 40 percent have reservations about or disagree with government programs.

Some families move in and out of Medicaid and/or FAMIS eligibility. Due to the strict income eligibility guidelines, an individual may lose Medicaid benefits when a family member changes jobs or

starts a new job. For example, one-sixth of children who were estimated to be short-term uninsured receive Medicaid for the portion of the year for which they were insured.

**Table 3: Low-Income Parents' Opinions
About Public Health Insurance**

Opinion About Public Health Insurance	Percent of Parents Who Agree
Recognize their need but have reservations about government programs	23%
Understand that government programs can help them and are grateful	33
Disagree with government programs and have misconceptions about who qualifies	14
Strong sense of independence and are not worried or under financial pressure	30

Source: DMAS, Statewide Virginia Head of Household telephone survey, September 2002.

Cost of Providing Health Care to the Uninsured

In Summary

Uninsured Virginians used about \$3.5 billion in health care services in 2005, and \$1.45 billion of this amount was uncompensated. Health care providers donated between \$536 and \$538 million for the care of uninsured Virginians, while the remainder of uncompensated care was funded by public subsidies and other public and private sources. Uninsured adults accounted for 88 percent of the uncompensated care costs. Insured Virginians' health care costs likely are higher due to the amount of uncompensated care for uninsured Virginians. Health care costs per privately insured Virginian are up to \$100 more per year due to uncompensated care for the uninsured. The cost of premature mortality of the uninsured population is estimated to have been between \$1.7 and \$2.7 billion in 2005.

Uninsured patients incur medical costs that health care providers, federal, state and local governments, and insured patients help pay due to the inability of the uninsured to pay the full amount of their bills. The uninsured also impose costs on society through diminished health and higher mortality rates. Estimates of these costs are provided in this chapter, along with estimates of the burden imposed on health care providers, taxpayers, and insured individuals. While not all of these costs would necessarily be recoverable if all uninsured Virginians were provided health insurance, the estimates provide a benchmark for weighing the cost of proposed options to expand health care coverage against the benefit of reducing uncompensated care costs.

HOW MUCH UNCOMPENSATED CARE DO UNINSURED VIRGINIANS RECEIVE?

Uncompensated care is the value of medical care received minus out-of-pocket payments and insurance payments on behalf of patients. It is ultimately paid for by health care providers (through lost income), citizens (through taxes to support government subsidies to health care providers), and insured patients (through higher premiums). To determine the magnitude of uncompensated care that the uninsured receive in Virginia, JLARC partnered with the Virginia Health Care Foundation and the Urban Institute, an independent, non-profit economic and social policy research organization. The Urban Institute, which has conducted similar studies for several other states, analyzed data from the Medical Expenditure Panel Survey (MEPS) to develop estimates for un-

compensated care in Virginia in 2005. These estimates are presented below.

Urban Institute Analysis of Medical Expenditure Panel Survey

The estimates of uncompensated care for the uninsured in Virginia are based on data from the Household Component of the Medical Expenditure Panel Survey (MEPS). The MEPS is a nationally representative survey conducted by the Agency for Healthcare Research and Quality, a part of the U.S. Department of Health and Human Services. The survey collects information on health care use and expenditures, insurance coverage, sources of payment, health condition, and other demographic information from the respondents. The respondents' information is validated with information from medical providers, pharmacies, and insurance companies.

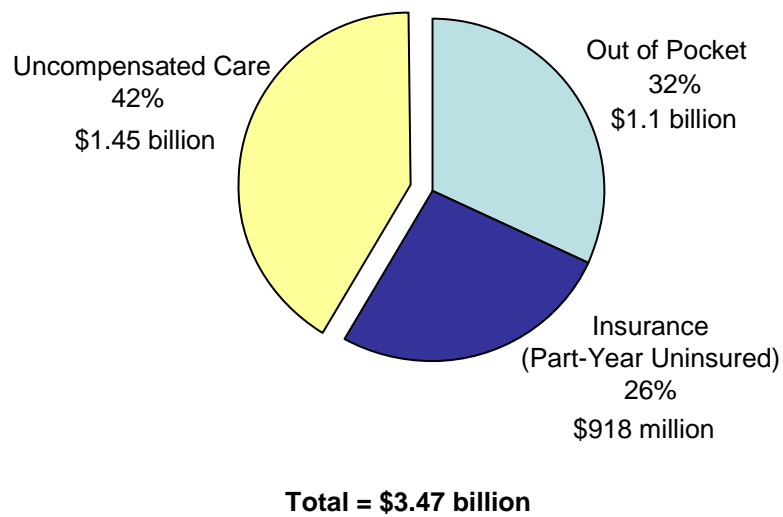
Because MEPS is not specific to Virginia, uncompensated care costs for Virginia were estimated based on MEPS data from the South Census region. The data were re-weighted to approximate Virginia's uninsured population using the 2003 and 2004 Current Population Surveys (CPS), which are Virginia-specific. Factors such as educational attainment, income level, employment status, and the uninsured rate were used to re-weight the MEPS sample so that it looked like a representative sample of Virginia's population.

The MEPS survey for this analysis was conducted between 2001 and 2003. Medical expenditures were inflated to 2005 dollars using data on growth in per-capita medical expenditures. Appendix B provides more details of the methodology used by the Urban Institute to develop the estimates presented in this chapter.

Uninsured Virginians Had Uncompensated Care Costs of \$1.45 Billion in 2005

The Urban Institute study found that about \$3.5 billion was spent on medical care for Virginia's uninsured in 2005. Approximately one-third (\$1.1 billion) of this amount was paid for out of pocket by uninsured patients. Approximately \$920 million was paid for through insurance payments on behalf of the part-year uninsured. The remaining \$1.45 billion was estimated to be uncompensated care and consisted of donated care from health care providers plus payments from other public and private sources (Figure 18). These public and private sources include workers compensation, automobile and homeowner liability insurance, government assistance programs, and other miscellaneous sources.

Figure 18: Health Care Spending on Uninsured Patients in Virginia by Source of Payment (2005)



Source: Urban Institute analysis of re-weighted 2001-2003 Medical Expenditure Panel Surveys.

Health care spending was analyzed on both full-year and part-year uninsured individuals. Part-year uninsured individuals were defined as those individuals who were insured for between one and 11 months of the year. Full-year uninsured patients represented about 60 percent of the sample but accounted for nearly 80 percent of the uncompensated care costs. This is to be expected given the insurance payments made on behalf of some of the part-year uninsured patients.

The MEPS sample of full-year and part-year uninsured individuals represented a population of nearly 1.3 million adults and 350,000 children. Adults accounted for 79 percent of the uninsured population but 88 percent of the uncompensated care costs. Therefore, uninsured adults received more medical care on average than uninsured children, as would be expected given the relationship between health care needs and age.

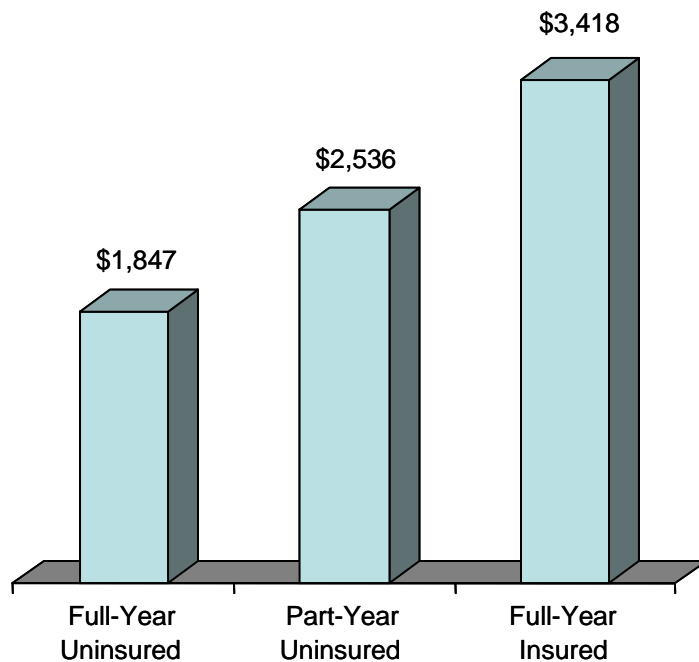
Uninsured Virginians Used Less Health Care Than Insured Virginians on Average

While uninsured Virginians are estimated to have accounted for \$1.45 billion in uncompensated care costs in 2005, they received less health care than insured Virginians. Per capita medical expenditures on full-year uninsured Virginians were just over one-half the per capita expenditures on Virginians who were insured for the full year. Virginians who were uninsured for part of the

year received about 75 percent as much medical care as those who were insured for the full year.

Figure 19 shows the per capita medical expenditures for the three groups. These figures show spending from all sources, not just out-of-pocket expenses. Full-year uninsured Virginians spent approximately \$662 out of pocket for medical care per person in 2005 while part-year uninsured Virginians spent approximately \$700 out of pocket.

Figure 19: Per Capita Health Care Spending by Insurance Status (2005)



Source: Urban Institute Analysis of re-weighted 2001-2003 Medical Expenditure Panel Surveys.

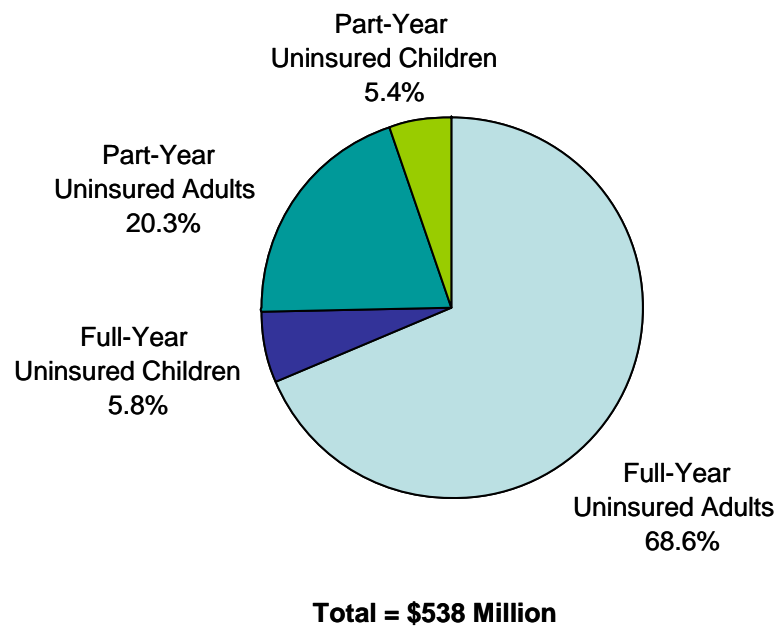
Health Care Providers Donated \$538 Million in Medical Care to the Uninsured

Hospitals, physicians, and community health centers provide a substantial amount of care to uninsured patients. While some of this care is reimbursed through out-of-pocket payments, State and local subsidies, and other sources, much of the care is uncompensated. Hospitals, physicians, and other health care providers perform some charity care for indigent patients for which they do not expect payment, but they also provide services to other patients from whom they expect but do not receive full payment. Most of these patients are uninsured. In 2005, Virginia health care providers "donated" \$538 million in medical care to the uninsured, ac-

cording to the Urban Institute's analysis. Some of this donated care was for hospital emergency room treatment. Hospitals are required to treat all patients in need of immediate care per the federal Emergency Medical Treatment and Active Labor Act of 1985.

Similar to the overall uncompensated care breakdown, adults who were uninsured for the full year accounted for most of the care donated by providers. The full-year uninsured accounted for \$400 million (74 percent) of all donated care to the uninsured. Uninsured adults accounted for \$478 million (89 percent) of the donated medical care (Figure 20).

Figure 20: Donated Medical Care to Uninsured Virginians (2005)



Source: Urban Institute Analysis of re-weighted 2001-2003 Medical Expenditure Panel Surveys.

Hospital emergency rooms are the last resort for medical care for many uninsured Virginians because they will receive treatment there regardless of ability to pay. The Urban Institute analyzed the MEPS data to determine the extent to which the uninsured receive treatment at hospital emergency rooms. Based on its analysis, \$153 million was spent on emergency room care for full-year uninsured patients, \$40 million of which was paid for out of pocket by the patients. Therefore, uncompensated emergency room care for Virginians uninsured for the full year totaled \$113 million. (Part-year emergency room uncompensated care costs could not be calculated from the MEPS data.)

Federal, State and Local Funds Helped to Cover the Cost of Uninsured Patients

Three primary sources of government funding compensate hospitals for their care of indigent patients. The major source is the Medicaid Disproportionate Share Hospital (DSH) program, which provides federal matching funds to hospitals, with the two State teaching hospitals receiving the majority of these funds. The Virginia Indigent Health Care Trust Fund is a State program that provides funds to private acute care hospitals to compensate for indigent care. The final program is the State and Local Hospitalization Program, which provides a capped amount of funding for indigent patients who do not qualify for Medicaid. Funding from all three sources totaled \$159 million in 2005 (Table 4). These funds are included in the total uncompensated care estimate of \$1.45 billion.

Table 4: Government Funds to Assist Hospitals With Uncompensated Care Costs

Fund	2005 Amount (\$ in millions)
Medicaid Disproportionate Share Hospital (50% federal, 50% State)	\$139.3
State and Local Hospitalization Fund (state and local)	12.7 ¹
Indigent Health Care Trust Fund (state and private hospitals)	7.1 ²
Total	\$159.1

¹ \$10.7 million State General Fund and \$2 million local match.

² \$4.3 million State General Fund and \$2.8 million from private hospitals.

Source: JLARC staff analysis of Virginia Department of Medical Assistance Services and Virginia Hospital and Healthcare Association data.

The Medicaid DSH program is administered in Virginia by the Department of Medical Assistance Services (DMAS) and provides funding to hospitals that serve a disproportionate share of low-income patients. Most Medicaid DSH funding is distributed to the Virginia Commonwealth University (VCU) Health System and to the University of Virginia (UVA) Health System. In 2005, VCU received \$87 million and UVA received \$30 million in Medicaid DSH funds. This funding is intended to compensate for all indigent care at these hospitals.

The State and Local Hospitalization Program is a cooperative effort between the State and localities that provides payments on behalf of low-income patients who are not Medicaid recipients. The program requires a local match not to exceed 25 percent of program benefit expenditures. All localities are required to participate

in the program. Unlike the Medicaid DSH program and the Indigent Health Care Trust Fund, which provide lump sum payments to hospitals, the State and Local Hospitalization Program provides benefits on a per-patient basis. However, the program is not an entitlement, and when funding is depleted, patients no longer benefit from the program. In 2005, this program paid hospitals \$12.7 million (\$10.7 million from the State general fund, \$2.0 million from local funds). An additional \$23.5 million in claims were approved by DMAS but not paid due to funds being depleted.

The Virginia Indigent Health Care Trust Fund distributes funds to private hospitals that provide more than the average share of charity care compared to that provided by all private hospitals in the State. The program is administered by DMAS and is funded through State general fund appropriations and contributions from hospitals that make a profit and provide less than the average share of charity care. Indigent Health Care Trust Fund payments from the general fund to hospitals totaled \$4.3 million in 2005.

Free Clinics Donated More Than \$86 Million in Medical Care to the Uninsured

Free clinics in Virginia reported donating \$86 million worth of medical care to low-income, uninsured patients in 2005. This care is not included in the Urban Institute's estimate of uncompensated care costs because patient usage of free clinic services is not captured in the MEPS data. The 53 free clinics in Virginia provided medical services to 61,457 low-income patients in 2005. Funding for the free clinics comes from a mix of private and public sources, with private sources (such as civic groups, foundations, religious organizations, local businesses, and individuals) accounting for more than 71 percent of free clinic funds. The federal government, the State, and localities in Virginia each contributed about \$1 million to the free clinics.

VIRGINIA HOSPITAL DATA YIELD ESTIMATE OF DONATED CARE SIMILAR TO THAT OF URBAN INSTITUTE

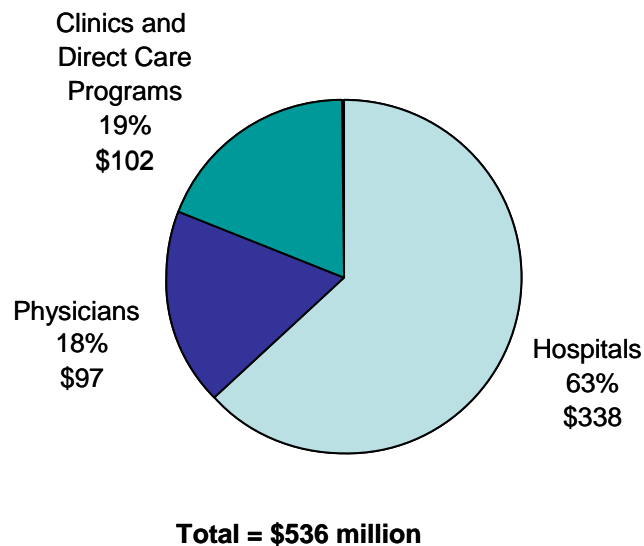
The Urban Institute analysis used national survey data (weighted to fit Virginia's uninsured population) to estimate donated care costs from health care providers in Virginia. Another means to estimate the amount of donated care provided to the uninsured is to examine actual patient-level data from Virginia hospitals. Appendix B describes the methodology in detail.

JLARC staff analyzed patient-level data from a sample of Virginia hospitals to determine how much uncompensated care they provide to uninsured patients. The analysis revealed that 73 percent

of all bad debt (unpaid medical bills) and charity care costs (free care provided to low-income patients) resulted from uninsured patients. Applying this percentage to the Virginia Hospital and Healthcare Association's estimate of total donated care in 2004 produced an estimate of the amount of donated care provided by Virginia hospitals attributable to uninsured patients (adjusted to 2005 dollars) in 2005; the amount is estimated to have been \$338 million.

Hospitals account for only a portion of the donated care. Care is also donated to the uninsured in physicians' offices, community health centers, and government clinics. While there are no patient-level data regarding the amount of donated care provided by these facilities, the Kaiser Commission on Medicaid and the Uninsured has estimated that, nationally, 63 percent of donated care to the uninsured is provided by hospitals, 19 percent by clinics and direct care programs, and 18 percent by physicians. If Virginia providers donate care in similar proportions, then along with the \$338 million provided by hospitals, about \$102 million would have been provided by clinics and direct government programs and \$97 million by physicians (Figure 21). The total donated care estimate through this analysis is \$536 million, which is consistent with the \$538 million estimate of provider donated care calculated by the Urban Institute.

Figure 21: Uncompensated Care by Provider (2005), \$ in Millions



Source: JLARC staff analysis and data from the Kaiser Commission on Medicaid and the Uninsured. May 10, 2004.

INSURED PATIENTS FACE HIGHER PRICES DUE TO UNCOMPENSATED CARE FOR UNINSURED PATIENTS

Insured patients in Virginia likely pay more for their health care due to losses absorbed by providers through uncompensated care for the uninsured. Given that health care providers are estimated to have had uncompensated care costs of \$536 to \$538 million, it is reasonable to assume that a portion of this cost was shifted onto insured patients. There is no consensus among health care policy experts as to the extent of cost-shifting from uninsured patients to insured patients, given the complexity of the health care market. Insurance and government assistance also complicate pricing behavior.

The price of health care for insured patients is determined through contractual negotiations between insurance carriers and health care providers. Insurance companies attempt to negotiate lower prices for their customers in order to minimize their claim amounts and thus provide competitive rates for their insurance products. Conversely, health care providers attempt to negotiate higher rates in order to cover the cost of treating patients and to keep their operations viable. The result of the negotiation is the price charged to insurance companies for medical claims, and ultimately, the price paid by patients through insurance premiums, co-payments, deductibles, and co-insurance.

The existence of uncompensated care resulting from the treatment of uninsured individuals raises the cost of doing business for hospitals and physicians. If the providers did not have uncompensated care, costs would be lower, and insurance companies would be able to negotiate lower prices for their customers in a competitive environment. These lower prices would be reflected in lower premiums and other health care costs for consumers.

In 2005, health care providers donated over \$530 million in care to the uninsured. Privately insured individuals represented 72 percent of Virginia's population, or about 5.4 million people. Therefore, donated care for the uninsured was about \$100 per privately insured Virginian per year. Assuming that insurance companies and self-insured employers could have captured these cost savings, insured individuals could have saved as much as \$100 on their health care costs on average. This represents about three percent of the per capita health expenditures for full-year insured individuals.

Donated care for the uninsured was about \$100 per privately insured Virginian per year.

However, it is likely that not all cost savings would be passed on to privately insured individuals. The reduction in uncompensated care costs would also reduce pressure on federal and State governments to increase Medicare and Medicaid reimbursement rates,

which are typically below reimbursement rates for privately insured patients. Also, depending on competition in regional markets, providers could keep some of the savings. Finally, insurance companies would be expected to gain from the reduction in negotiated prices with providers and not pass on all savings to the consumers. (However, the Bureau of Insurance has control over premium rate increases in Virginia, and insurance claims must equal at least 60 percent of revenues.)

UNINSURED VIRGINIANS BEAR THE COST OF POORER HEALTH

Along with the uncompensated care costs, there are also costs associated with the poorer health and shorter life expectancy of the uninsured. Uninsured individuals receive less health care than insured individuals, which causes them to have poorer health on average and higher mortality rates. The higher risk of death of uninsured individuals represents an economic loss to those individuals. This loss of "health capital" has been estimated by the Institute of Medicine, a division of the National Academy of Sciences.

As reported earlier, uninsured Virginians receive only about half as much health care as insured individuals. This diminished health care results in poorer health. Surveys have shown that uninsured individuals are less likely to report being in "excellent" or "good" health. National studies have also shown that the uninsured population has a 5 to 15 percent higher mortality rate than the insured population, and that the number of excess deaths among uninsured adults between the ages of 25 and 64 is about 18,000 per year.

Value of life

There is wide variation in estimates of the value of a year of life. The \$160,000 estimate used by the Institute of Medicine is based on the average of 42 independent studies using the contingent valuation method, which measures consumers' willingness to pay.

The value of lost years of life and health is difficult to measure. One effort was described in a study released by the Institute of Medicine's Committee on the Consequences of Uninsurance. Based on the value of \$160,000 for a year of perfect health and the excess risk of death among the uninsured population, the study determined the aggregate cost nationally of foregone health to be between \$65 and \$130 billion for the 41 million uninsured in 2000.

There is also a cost to society from the poorer health of uninsured individuals. Poorer health results in more sick days and lower work performance. One study estimated that health problems cost the nation \$260 billion in lost productivity annually. Based on Virginia's proportion of the national working age population, estimated lost productivity in Virginia resulting from health problems would be \$6.6 billion annually. Insuring more Virginians could produce a healthier population overall, and productivity would likely be increased.

Making Health Care More Accessible to Low-Income Virginians

In Summary

With low-income individuals unable to afford the cost of health insurance, effective options to provide them with access to health care coverage will require the investment of State and/or employer funds in order to make coverage more affordable. Options to make health care coverage available to low-income households include Medicaid expansion, direct subsidies to low-income individuals, subsidies to small employers/employees, and reinsurance subsidies to reduce the cost of health care policies. Implementation of one or a combination of these options should help to make health care coverage more accessible and reduce the number of uninsured in Virginia.

Low-income individuals account for the majority of uninsured individuals in Virginia. Therefore, policies aimed at providing health insurance to these individuals would have the greatest effect on the number of uninsured Virginians. Medicaid and FAMIS (Family Access to Medical Insurance Security) provide insurance to a number of low-income Virginians, but many others do not qualify for these programs. Four options for assisting this group of low-income Virginians with obtaining health insurance are described in this chapter:

- expansion of Medicaid/FAMIS,
- direct subsidies to low-income individuals,
- subsidies to small business owners/employees, and
- reinsurance of health insurance policies.

Low-income Virginians generally do not have sufficient funds to purchase private health insurance due to the cost of the premiums. Therefore, effective policy options will require financial assistance from the government and/or employers.

OPTION: EXPAND MEDICAID/FAMIS

In 2005, Medicaid and FAMIS (Virginia's State Children's Health Insurance Program (SCHIP)) provided health insurance for about 790,000 Virginians. Expanding Medicaid and/or FAMIS would allow Virginia to cover more low-income uninsured while expanding the use of federal matching funds. In recent years, many other

states have expanded Medicaid eligibility to provide health care coverage to more low-income adults and children.

Medicaid/FAMIS Expansion Could Be Implemented in Several Ways

Medicaid and/or FAMIS could be expanded to insure more individuals by increasing income eligibility levels for existing covered groups, making additional groups eligible for the program, allowing certain groups to buy in to the program, or by increasing enrollment for individuals who are already eligible. Federal regulations classify Medicaid recipients into three coverage groups: mandatory, optional, and non-categorical. The ease of expanding coverage varies depending on the coverage group.

Increase Income Eligibility Levels for Mandatory or Optional Coverage Groups. States may increase the federal eligibility requirement for mandated coverage groups or extend benefits to optional coverage groups through an amendment to the State Plan for Medical Assistance Services (State plan). Federally mandated coverage groups include low-income families with children, pregnant women, Supplemental Security Income recipients, recipients of adoption and foster care assistance, and certain individuals with Medicare. State-option coverage groups include institutionalized individuals below a specified income level; aged, blind and disabled individuals with income at or below the federal poverty level (FPL); low-income women with breast or cervical cancer; and medically needy populations.

Medicaid expansion to mandatory and optional coverage groups requires an amendment to the State plan. The Centers for Medicare and Medicaid Services (CMS) must approve amendments to the State plan, a process that takes approximately 90 days or longer.

Many states have expanded Medicaid eligibility for low-income parents, a mandatory coverage group. However, Virginia has not, and the State's income eligibility for low-income parents remains one of the lowest in the nation: at or below 24 percent FPL on average. In 2006, only two states had lower income eligibility levels for working parents, and only nine states had lower income eligibility levels for non-working parents. The national median eligibility level for working parents was 65 percent FPL. The lowest was Arkansas with 18 percent FPL, and the highest was Minnesota with 275 percent FPL. The national median eligibility level for non-working parents was 42 percent FPL. The lowest was Alabama with 12 percent FPL, and the highest was Minnesota with 275 percent FPL.

Only two states have lower Medicaid eligibility levels than Virginia for low-income working parents.

Expand Coverage to Non-Categorical Groups. Adults without children is the most common non-categorical population to which states extend Medicaid coverage. As of January 2004, 14 states and the District of Columbia extended coverage to adults without children, including Pennsylvania, New York, Delaware, Arizona, and Utah, among others. Virginia does not currently offer Medicaid coverage to any non-categorical populations.

Medicaid expansion for non-categorical populations, such as adults without children, requires a federal waiver from CMS, or states can fully fund coverage without a waiver. Section 1115 of the Social Security Act grants the Secretary of Health and Human Services broad authority to authorize states to experiment with projects that would promote greater coverage through Medicaid. Section 1115 waivers must be budget neutral, so the cost to the federal government is supposed to remain the same as without the waiver. The Health Insurance Flexibility and Accountability (HIFA) waiver is a type of section 1115 waiver that encourages states to increase the number of individuals with coverage using existing resources. This requires states to come up with cost savings to offset the increased cost of covering more individuals. States have been able to successfully demonstrate budget neutrality, and therefore have received HIFA or other section 1115 waivers, by proposing such measures as converting to a managed care system, redirecting federal Disproportionate Share Hospital (DSH) funds, or limiting coverage and/or imposing cost-sharing on existing Medicaid enrollees. Therefore, Virginia could explore obtaining a section 1115 waiver to expand Medicaid coverage to the poorest childless adults.

Logical First Step Might Be to Extend Coverage to Low-Income Parents At or Below 100 Percent of FPL. If the State decides to proceed with expanding coverage to more low-income adults, a logical first step might be to extend coverage to parents at or below 100 percent FPL. The State could have provided coverage for this group of nearly 65,000 parents in 2005 at a cost of \$101.5 million (total cost would have been \$203 million but the federal government would have funded 50 percent) (Table 5). The effective cost to the State would have been offset by a reduction in the cost of uncompensated care, which was estimated to be \$92 million for this group of adults in 2005.

In this illustrative estimate, uncompensated care costs are likely underestimated because low-income uninsured individuals pay a lower proportion of their medical costs out-of-pocket than higher-income individuals. Thus, their portion of uncompensated care costs is probably higher than their proportion of the uninsured population. Furthermore, this cost estimate assumes all eligible

Table 5: Expanding Medicaid Coverage to Parents Below 100 Percent of the Federal Poverty Level: An Illustrative Example

Affected Population	
Number of uninsured parents below 100% FPL	64,691 ¹
Income level	\$9,800
Cost Estimates for Affected Population	
Cost of uncompensated care ²	\$92.2 million
Total cost to provide coverage ³	\$203.0 million
Total cost of coverage to State (Total cost minus 50% federal match)	\$101.5 million
Net Cost (Total cost minus uncompensated care cost)	\$9.3 million

¹ Includes uninsured adults who are already eligible for Medicaid but not enrolled.

² Includes both part-year and full-year uninsured.

³ Based on weighted average cost of \$3,138 per enrolled adult.

Source: JLARC staff analysis of The Statistical Record of the Virginia Medicaid Program (State Fiscal Year 2005) and Urban Institute analysis on uncompensated care.

low-income adults would enroll in Medicaid, which is unlikely in the absence of substantial outreach efforts.

Establish Medicaid/FAMIS Buy-In Program. Another option that could be considered is a Medicaid buy-in program. Buy-in programs increase access to health insurance coverage by allowing individuals above the eligibility level to purchase coverage through Medicaid and FAMIS. Typically, these buy-in programs are subsidized on a sliding scale, as individuals just above the Medicaid or FAMIS eligibility level would receive the largest subsidies, and the subsidies would decrease for individuals with higher family income levels. The buy-in program may be limited to individuals or families above the eligibility level, yet within a certain income range, for example, 200 to 300 percent FPL. Subsidies for buy-in programs may be financed through a federal section 1115 waiver or state funds.

Increase Enrollment of Individuals Who Are Eligible for Medicaid or FAMIS. An estimated 16 percent (160,000) of uninsured Virginians were eligible for health coverage through Medicaid or FAMIS in 2004-2005. This figure is based on the CPS estimate of low-income uninsured Virginians. The State could reduce the number of uninsured by intensifying efforts to enroll eligible individuals. Such initiatives do not require federal approval.

Streamlining eligibility or increasing outreach are two ways to increase enrollment. Streamlining may include simplifying the application process, providing full-year coverage, and eliminating face-to-face interviews. Outreach efforts may include placing out-

reach workers in schools, free clinics, or other community centers and paid media advertisements.

Since 2000, Virginia has engaged in substantial outreach efforts to enroll eligible children and streamlined processes for children's public health insurance. The result was a 51 percent increase in children's Medicaid and FAMIS enrollment from January 2002 to July 2006. The same level of outreach efforts have not been directed toward eligible adults.

Benefits of Expanding Medicaid/FAMIS

The primary benefit of expanding Medicaid to low-income individuals is that it would extend coverage to the segment of the uninsured population most in need of coverage and with the least ability to afford it. With as many as 30 percent (255,400) of uninsured adults in Virginia potentially at or below the FPL, a program to extend coverage to them could substantially reduce Virginia's uninsured population. Federal matching funds would pay for half of the cost of extending coverage to low-income parents, and the State may be able to obtain federal assistance in expanding coverage to childless adults. Moreover, extending Medicaid coverage is the most direct way to insure Virginians who are presently uninsured, and with the existing program already in place, the additional administrative costs likely would be minimal.

Based on the proportion of uninsured parents at or below the FPL and total uncompensated care costs estimated to be \$1.27 billion resulting from uninsured adults, uncompensated care costs could decrease by as much as \$92 million a year if this group were to be insured.

Possible Challenges to Expanding Medicaid

The primary challenge of expanding Medicaid coverage to more low-income adults is the potential cost to the State. For low-income parents, the State likely would only have to provide 50 percent of the funding with the federal government providing a 50 percent match. However, the portion of funding that the State would have to assume is less certain for extending coverage to childless adults. The availability of federal funds to assist with providing coverage to this segment of the low-income adult population is uncertain. As mentioned previously, one possibility would be for the State to find federal Medicaid funds that are currently allocated to Virginia for other purposes that could be redirected to help fund the expansion of coverage of low-income childless adults. Another possibility would be to modify existing programs to reduce costs and then allocate those funds to coverage expansion. Either option would re-

quire approval of a section 1115 waiver by CMS. Staff at the Department of Medical Assistance Services (DMAS) have indicated that savings do not exist to fund such a program.

In addition, some policymakers are concerned that providing Medicaid discourages acceptance of personal responsibility. Under the current Medicaid program, the personal contribution required of those eligible is minimal. One possible solution that some other states have adopted to address this challenge is to require the payment of premiums or co-payments for certain services based on a sliding scale.

A final challenge is that extending coverage to more low-income adults could lead to "crowd-out." As discussed in Chapter 1, crowd-out occurs when individuals who otherwise would have acquired private health coverage enroll in a public insurance program due to the lower cost, which then increases the public expense and reduces the market for private insurers. While crowd-out might be an issue to some extent with the proposed expansions of coverage, it would likely be minimal given the low income levels of these adults and the unlikelihood that they have access to coverage through an employer.

Other States' Experiences With Expansion of Medicaid/SCHIP

As discussed previously, most states extend Medicaid coverage to a substantially higher proportion of low-income parents than Virginia, and a substantial number of states are now extending coverage to childless adults as well. Below are specific examples of programs initiated in four other states.

Iowa. To address the problem of uninsured adults, the state implemented IowaCare in July 2005. IowaCare is a section 1115 Medicaid waiver that expands coverage to non-elderly adults without children and parents up to 200 percent FPL. This is not an entitlement program and enrollment is capped. Projected enrollment is 30,000 for the first year, and enrollment was more than 15,500 in October 2006. Eligible participants are required to pay premiums ranging from 0.5 to 5 percent of annual income based on a sliding scale.

Minnesota. Minnesota has extended health insurance to optional and mandatory coverage groups beyond the federal minimum income requirement (Table 6). Medicaid covers low-income parents up to 100 percent FPL. Additionally, the MinnesotaCare program provides coverage to low-income parents with incomes between 100 and 275 percent FPL as well as to childless adults up to 175 percent FPL.

More than 615,000 Minnesotans are covered by Medicaid and MinnesotaCare at a cost of approximately \$5.6 billion a year. About one-fifth of those individuals were enrolled in MinnesotaCare as of September 2005. Total payments for health care through MinnesotaCare were \$409 million in FY 2005, of which the state pays 55 percent. The Medicaid program averaged approximately 480,700 enrollees per month in 2005. The program cost \$5.2 billion in FY 2005, with the state paying 50 percent.

Table 6: Minnesota Extends Health Care Coverage to Adults and Children Beyond Federal Minimum

Coverage Group	Income Eligibility Level (% FPL)		
	Federal Minimum	Minnesota Medicaid	MinnesotaCare
Pregnant women	133%	275%	NA
Infants to 2 years	133	280	NA
Children (2-5 years)	133	150	275%
Children (6-18 years)	100	150	275
Children (19-20 years) ¹	0	100	275
Parents	0	100	275
Adults without children	0	0	175

¹ In Minnesota statute, a child is defined as an individual under 21 years of age.

Source: Minnesota House of Representatives Research Department, Medical Assistance and MinnesotaCare, February 2006.

New Jersey. In September 2005, the New Jersey legislature renewed its commitment to provide health care coverage to low-income parents. The state's NJ Family Care program began providing coverage to parents with income up to 100 percent FPL beginning in 2005 and up to 115 percent FPL in 2006. In 2007, the program will extend coverage to low-income parents with income up to 133 percent FPL.

New Jersey also recognized slow growth in children's coverage. In order to boost enrollment, the 2005 legislation also streamlined the application and renewal process, expanded outreach enrollment efforts (especially to hospitals and schools), reduced income verification requirements, and adopted 12-month continuous eligibility for Medicaid and SCHIP that guarantees children a full year of coverage.

New York. New York's Health Care Reform Act of 2000 expanded Medicaid to cover parents and adults without children. Enrollment in the Family Health Plus (FH Plus) program began in October 2001. To be eligible, individuals must be non-elderly adults, not be eligible for Medicaid, and not have an offer of health insurance

coverage from their employer. Parents are eligible up to 150 percent FPL, and adults without children are eligible up to 100 percent FPL. FH Plus participants are guaranteed at least six months of coverage, are enrolled in a comprehensive benefits package, and are responsible for co-payments for certain services.

The number of participants is approaching the state's enrollment goal of 600,000 low-income adults. In January 2006, nearly 526,000 adults were enrolled. In 2004, the program cost more than \$1.4 billion. Through a section 1115 waiver, the federal government provides a 50 percent match for state funds.

OPTION: PROVIDE DIRECT SUBSIDIES TO LOW-INCOME INDIVIDUALS TO PURCHASE HEALTH INSURANCE

Health insurance is not affordable for many low-income individuals who do not qualify for Medicaid. Providing subsidies to low-income individuals would make insurance more affordable and increase the rate of insurance among the poor. Maine, Massachusetts, Oklahoma, and Utah are four states that have direct subsidies for low-income individuals.

Subsidies for low-income individuals could provide access to private health insurance for those who cannot afford to pay the full market price. The goal of such a program would be to provide a subsidy to fund the gap between what the individual could afford to pay for health insurance and the cost of the insurance plan. As discussed in Chapter 1, studies have indicated that it is difficult for low-income households to allocate more than five percent of their income to health insurance. Given the five percent assumption, an individual who earns 150 percent FPL (\$14,700) would have \$735 available to spend on health insurance annually. With the average annual premium costing about \$2,550 in the individual market (based on data provided by the Bureau of Insurance), the gap between what the individual could afford and the cost (needed subsidy amount) would be about \$1,815 annually.

One option for the State would be to target such a subsidy program to low-income adults with incomes between 100 and 200 percent FPL. Subsidies could be provided on a sliding scale based on the gap between income and the cost of insurance. Table 7 provides an illustrative estimate of what such a subsidy program might cost if it is assumed that the average income of adults in this group is 150 percent FPL. This cost estimate is based on the assumption that these adults do not receive a contribution from their employer for insurance, and it therefore probably overestimates the cost. Those who are eligible for employer assistance would need to be excluded from the program or the amount of the subsidy reduced by the amount of the employer contribution.

Table 7: Providing Direct Subsidies to Adults Between 100 and 200 Percent of the Federal Poverty Level: An Illustrative Example

Affected Population

Number of uninsured adults between 100-200% FPL	234,300
Income level at 150% FPL	\$14,700
Maximum affordability level for health insurance (5% of income)	\$735

Cost Estimates for Affected Population

Cost of uncompensated care	\$354 million
Average cost of individual health policy	\$2,550
Subsidy to make policy affordable	\$1,815
Total cost of subsidy	\$425 million
Net Cost of Subsidy (Total cost minus uncompensated care cost)	\$71 million

Note: Does not account for fact that some portion of these low-income adults would be eligible to receive premium assistance through their employer, which would reduce the total cost of the subsidy.

Source: JLARC staff analysis.

Benefits of Implementing Direct Subsidies

Providing a subsidy to a targeted segment of low-income Virginians in order to make insurance affordable would be one of the most effective means to reduce the uninsured population. As shown in Table 7, approximately 234,300 uninsured adults are estimated to have incomes between 100 and 200 percent FPL and cannot afford health insurance without assistance. Therefore, a subsidy program that targeted this segment of the population could substantially reduce the rate of uninsured. Additionally, a subsidy program would encourage participation in the private insurance market rather than expanding government health coverage programs.

Challenges to Implementing Direct Subsidies

The major challenge of instituting a direct subsidy program is the potential cost to the State. For such a program to be effective, low-income individuals would need a substantial subsidy. As shown in Table 7, the cost of insuring all low-income individuals with income between 100 and 200 percent FPL could be as much as \$425 million. That cost would be offset to some extent by the availability of employer-sponsored assistance to some of those individuals and by a reduction in uncompensated care costs. As shown in Table 7, the uncompensated care cost of the uninsured adults with income between 100 and 200 percent FPL is estimated to be \$354 million. This option would have administrative costs because the provision of a subsidy would require an administrative structure to implement it.

Other States' Experiences With Direct Subsidies to Low-Income Individuals

Several states have recently adopted programs that provide subsidies to lower income adults so that they will be able to afford health insurance. Below are brief descriptions of four such programs.

Oklahoma. As part of Oklahoma's Employer/Employee Partnership for Insurance Coverage (O-EPIC) program, adults with income at or below 185 percent FPL will be able to receive subsidized individual insurance beginning in 2007. Eligible adults will include those who do not receive employer assistance, sole proprietors not eligible for small group health coverage, and unemployed individuals who are currently seeking work. O-EPIC will provide subsidies sufficient to reduce premiums for eligible participants to approximately three percent of monthly household income.

Maine. The Dirigo Health Reform Act, which passed Maine's legislature in 2003, aims to control health care costs, improve the quality of the health care system, and provide every citizen with access to health care by 2008. One of the program initiatives is a subsidy for individuals with income up to 300 percent FPL to assist them in the purchase of coverage in a new state health plan. The subsidy amount is on a sliding scale depending on income level. During the first year, 9,000 individuals enrolled in the program at a cost of \$29 million.

Massachusetts. The Massachusetts Health Care Reform Bill, signed into law in April 2006, creates the Commonwealth Care Insurance Program, among other initiatives. The program provides health insurance premium assistance on a sliding scale for individuals up to 300 percent FPL. Beginning in October 2006, about 60,000 individuals at or below the FPL were automatically enrolled in the program. Those up to 100 percent FPL do not pay deductibles or monthly premiums; however, they have co-payments for some services. Approximately 150,000 individuals from 100 to 300 percent FPL will be enrolled beginning January 2007. These individuals will pay a monthly premium ranging from \$18 to \$106 per month, based on a sliding scale.

The subsidy program is administered by the Commonwealth Health Insurance Connector, a state entity created by the health care reform legislation. Massachusetts will fund the program and other initiatives included in the legislation using state general funds, federal matching funds through a section 1115 waiver, transferred funds from providers' uncompensated care funds, and employer contributions. The entire plan is expected to cost \$1.2 billion over the next three years.

Utah. The Utah Premium Partnership for Health Insurance provides premium assistance for both low-income working adults and children. The program, which was implemented in November 2006, provides a \$150 subsidy per month for 1,000 adults with incomes up to 150 percent FPL. The program is funded through state and federal resources, including SCHIP matching funds and tobacco settlement funds. The state appropriation for FY 2006 is \$890,000. Program enrollment is limited based on availability of funds.

OPTION: PROVIDE SUBSIDIES TO SMALL EMPLOYERS

Another option that would make health insurance more affordable for low-income Virginians is to provide subsidies to small business owners who agree to offer health insurance to their employees. Subsidies to small business owners would assist the working poor, which make up a large proportion of Virginia's uninsured population. Montana and Oklahoma have small employer subsidy programs.

Similar to direct subsidies to low-income individuals, subsidies to small business owners increase the number of insured individuals by making health insurance premiums more affordable for low-income individuals. Generally, the small employer subsidy option is one in which the state, employers, and employees share in the cost of health insurance, but employer participation is optional.

Under this option, the State could subsidize small employer premium costs through either a tax incentive or direct payment. Employers who participate would be required to contribute a certain amount toward their employees' premiums, and employees would pay the remainder. The goal is for the State to provide sufficient financial assistance so that employers will be able to offer health insurance to their employees at an affordable price for both the employer and employee.

The magnitude of the subsidy and the required employer contribution toward the premiums for participating businesses would affect the extent to which such a program would be successful in insuring more Virginians. Based on other states' experience, the subsidy provided to employers must be substantial in order for small employers to participate. Otherwise, employers will likely decide that the cost of providing health insurance to employees remains too high, or they will not pay a sufficient share of the cost per employee to make the insurance affordable for their employees.

Other issues that would need to be considered in designing a subsidy for small employers include the size of employers that would be eligible and whether or not to restrict the subsidy to low-income

employees. The offer rate of employer-sponsored health insurance is strongly correlated to employer size. By limiting the program to very small businesses (for example, fewer than ten employees), the State could potentially target employers and employees most in need of the subsidy and limit the cost of the program. By restricting the subsidy to low-income employees of small businesses, the program would avoid providing subsidies to those individuals who likely could afford health insurance without any assistance from the State.

Benefits of Implementing Small Employer Subsidies

There are several potential benefits associated with the small employer subsidy option. The major benefit of the option is that it would target the working poor and make health insurance more affordable for them. Full-time employees of businesses with fewer than 100 employees (and their families) account for an estimated 36 percent of Virginia's uninsured adult population, and low-income adults account for 58 percent. Therefore, the program could potentially benefit an estimated 175,000 low-income Virginians if the program was extended to employers with fewer than 100 employees (depending on the proportion of small business employees that are low income).

Another benefit of the small employer option is that it would require employers and employees to share responsibility with the State in providing health insurance. The option recognizes that employers are a crucial component of the health insurance market in Virginia, and it rewards them for participation. The program would also require employees to contribute to the cost of their health care. This option would also encourage participation in the private insurance market as opposed to having low-income workers rely on public coverage programs.

A final benefit of the small employer option is that it would be fairly easy for the State to administer. The program would build on the existing structure of employer-sponsored health insurance.

Challenges to Implementing Small Employer Subsidies

The primary challenge of such a program for small employers is the cost to the State of providing the subsidies. According to a study conducted by the America's Health Insurance Plans Center for Policy and Research, the average cost for individual coverage in a small group health plan was \$2,952 in Virginia in 2006. The subsidy would need to be large enough to keep the employer and employee shares affordable. Experience in other states shows that

such subsidies have to be substantial for employers to agree to participate.

According to a 2005 survey conducted by the Virginia Department of Business Assistance (VDBA), small businesses indicated they would be inclined to provide health insurance if the premium costs were below \$150 per month. Table 8 illustrates the amount of State subsidy that might be required to induce employer participation while making insurance affordable for the employee. This example is based on the premium cost of individual coverage in a typical small group plan in Virginia and the maximum affordability level of five percent of household income. The total cost of the subsidy would depend on the size of the employer that would be eligible for the program, the number of these employers participating in the program, and the number of low-income Virginians working for these employers. This example is based on including all employers with fewer than 100 employees because the data do not allow the estimation of the number of uninsured who work for employers with 50 or fewer employees. The reduction in uncompensated care costs due to these individuals obtaining insurance is estimated to exceed the cost to the State of providing the subsidy.

Table 8: Illustrative Example of Small Employer Subsidy Required to Induce Employer Participation (Per Employee)

Affected Population	
Estimated number of low-income uninsured working for small employers (2-99 employees)	174,300
Annual amount small employers are willing to pay, according to VDBA study	\$1,800 (\$150 per month X 12)
Income level at 150% FPL	\$14,700
Employee share (5% of income)	\$735
Cost Estimates for Affected Population	
Cost of uncompensated care	\$263 million
Average cost of individual coverage in small group plan	\$2,952
Difference to be paid for by State and employee	\$1,152
State subsidy required per employee to make policy affordable	\$417
Total cost to State if all small employers and their employees participated in the program	\$72.7 million
Net Cost (Total cost minus uncompensated care cost)	-\$190.3 million

Source: JLARC staff analysis of data from America's Health Insurance Plans and the Virginia Department of Health State Planning Grant.

A potential limitation of the small employer subsidy option is that it excludes the self-employed and non-working populations, which also represent a significant proportion of Virginia's uninsured population. These groups represent nearly 30 percent of uninsured Virginians. However, the State could supplement its small employer program with an individual subsidy program as Oklahoma has done.

Other States' Experiences With Subsidies to Small Employers

Oklahoma and Montana both implemented small employer subsidy programs in 2005. Both programs involve shared responsibility for the cost between the state, employer, and employee.

Oklahoma. Oklahoma subsidizes small business employees and spouses through the Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC). O-EPIC offers a subsidy for low-income individuals working for small employers and their spouses. O-EPIC participants must have income at or below 185 percent FPL and work for a firm with 50 or fewer employees. Participating employers are required to

- pay at least 25 percent of the premium,
- offer a plan that includes hospital and physician services and pharmacy benefits,
- choose a plan with a deductible no higher than permitted for state employees, and
- allow the enrollment of spouses.

Individual enrollees must contribute up to 15 percent of the premium cost as well as pay deductibles and co-payments unless that amount is more than three percent of their income. If the enrollee's premium cost exceeds three percent, the state will pay the difference. The state subsidizes the remainder of the cost, which is generally 60 percent of the premium cost. Oklahoma expects to enroll 35,000 to 45,000 individuals.

Funding for O-EPIC is provided through a 55-cents-per-pack cigarette tax implemented in January 2005 and federal Medicaid and SCHIP savings through a HIFA waiver. O-EPIC budgeted \$50 million a year from the tobacco tax, but the tax is generating only about \$35 million a year. The program is estimated to cost \$105 million a year, with the additional \$70 million paid for through Medicaid savings.

Montana. Montana's premium assistance program, Insure Montana, is a two-part initiative begun in July 2005 to assist small businesses with the cost of health insurance coverage. First, small businesses that currently provide health insurance coverage are eligible for refundable tax credits. Second, small businesses unable to afford coverage for employees are eligible to participate in a purchasing pool and receive premium assistance.

Under the premium assistance program, employers pay 50 percent of the premium, and Insure Montana reimburses them for half of their contribution. Employees are responsible for the remaining 50 percent of the premium; however, lower income employees may be eligible for additional assistance with their employee share through Insure Montana based on a sliding scale.

Until June 2006, only businesses with two to five employees were eligible for Insure Montana. Eligibility has since been expanded to employers with up to nine employees. Eligible employees are defined as those who work 30 hours per week or more. Also, no employees of the business, excluding the business owner, can earn more than \$75,000 a year.

Insure Montana is funded by tobacco tax revenues. In FY 2006, the premium assistance program expended approximately \$500,000 of the more than \$1.5 million appropriation. The program goal is to enroll 350 businesses; however, as of May 2006 only 178 small businesses were enrolled. Insure Montana offered a staggered enrollment process in order to not overwhelm the system and expects to fully expend the 2007 appropriation.

OPTION: REINSURE HEALTH INSURANCE POLICIES FOR LOW-INCOME INDIVIDUALS

A final option for assisting low-income individuals is to have a public reinsurance program. While the other three options subsidize health insurance consumers and employers, this option subsidizes the cost of health insurance by having the state cover a portion of health insurers' high-cost claims. Due to the subsidy, insurance companies are able to pass along the savings to individuals through more affordable policies. New York, Louisiana, and Arizona all have state reinsurance programs.

The reinsurance option is another potential means to make health care more affordable to Virginians who otherwise cannot afford to purchase it. Unlike the direct subsidy options discussed previously, the State could assume responsibility for paying high-cost claims of participants in the program. This transfer of responsibility for high-cost claims would reduce the risk required to be assumed by insurers offering coverage under this program, and it would enable

them to provide more affordable insurance policies to program participants. For example, the State could agree to pay for all claims of program participants between \$10,000 and \$100,000, thereby leaving the insurer only responsible for reimbursing claims below \$10,000 or above \$100,000. The Bureau of Insurance approves premiums offered by insurance carriers and could assure that savings from the program are passed on to consumers.

The State would have flexibility in determining which Virginians would be eligible to participate in such a program. It could be limited to small employers with a requirement that participating employers pay a portion of their employees' health insurance premiums. Another option would be to extend such a program to all working low-income individuals who do not have access to insurance through their employer.

Benefits of Implementing Public Reinsurance Option

Based on New York's experience, a reinsurance program would appear to be effective in making insurance more affordable for low-income individuals. If the State were to assume responsibility for a substantial portion of the high-cost claims, then insurers would have less risk and be able to offer a substantially more affordable product to participants. Therefore, a reinsurance program could substantially expand the number of insured individuals and increase participation in the private market. The program could also be structured so that employers and employees would be required to share responsibility with the State in providing health insurance.

Challenges to Implementing Public Reinsurance Program

The major challenge of implementing a reinsurance program would be funding the required subsidy. The amount of the subsidy would have to be substantial in order for the State to assume a sufficient amount of risk in order to reduce policy premiums to an affordable level. In addition, there would be some year-to-year uncertainty as to the cost of the program because it would depend on the number of high-cost claims.

Other States' Experiences With Reinsurance Programs

Several other states have developed reinsurance programs to reduce the cost of insurance and increase health insurance coverage rates. Below is a discussion of programs developed in New York, Louisiana, and Arizona.

New York. New York established a reinsurance program in January 2001 called Healthy NY. The goal of the program is to reduce

the cost of insurance for the working poor in the state by subsidizing a portion of the risk ordinarily assumed by insurance carriers. It is available to low-income sole proprietors and individuals who work for employers that do not offer insurance. It is also available to low-income employees of small employers that decide to participate in the program. A small employer may participate in the program if it has less than 50 employees, has not offered insurance in the previous 12 months, and 30 percent of the employees have incomes below an inflation-adjusted threshold.

Healthy NY is offered by all health maintenance organizations in New York and some other health plans. Premium rates are cheaper because the State reimburses health insurance carriers for 90 percent of all claims of plan participants between \$5,000 and \$75,000. The State of New York estimates that Healthy NY small group policies are 18 to 35 percent lower than other small group policies on average, and that Healthy NY individual HMO policies are 35 to 58 percent lower than other HMO policies available in the individual market.

The program is funded with a combination of state funds and federal matching funds through a section 1115 waiver. A portion of the state funds is generated through a state tobacco tax. The amount budgeted for the program was \$89.4 million in 2003, \$49.2 million in 2004, and \$22 million for the first half of 2005. As of December 2005, nearly 107,000 individuals were enrolled in Healthy NY. Approximately 56 percent were low-income working individuals, 18 percent were sole proprietors, and 26 percent small business employees. In 2005, 21 insurance carriers participated across the state.

Louisiana. Louisiana implemented a pilot reinsurance program (LA Choice) modeled after Healthy NY. Small employers with ten or fewer employees are eligible for the program, and enrollment is capped at 20,000 enrollees. LA Choice covers a portion of claims costs between \$30,000 and \$90,000. Louisiana uses a portion of its Medicaid Disproportionate Share Hospital funds to finance the program.

Arizona. Arizona's public reinsurance program (Healthcare Group of Arizona) is different from those offered by New York and Louisiana. Instead of covering a portion of individual claims within a certain amount, the program provides aggregate stop-loss protection for insurance carriers. If an insurance carrier's total claims during the year exceed a specified amount, the state will cover the excess amount. The program is available to sole proprietors and small businesses with less than 50 employees who have not offered insurance for the past six months. Since July 2005, Healthcare Group is funded solely by member premiums. As of October 2006,

the program enrolled over 23,000 individuals and 8,000 small business groups. Of the businesses enrolled, more than 92 percent had three or fewer employees.

Non-Subsidy Options for Small Employers

In Summary

One way to reduce the number of uninsured is to increase the number of small employers that offer health insurance to their employees. These employees represent a significant portion of Virginia's uninsured population. Two potential options to encourage more small employers to offer health insurance include (1) making small employer health plans more affordable by leveraging the State employee health plan and (2) establishing a "connector" or market exchange as a mechanism for small employers to contribute to their employees' health insurance through pre-tax dollars without having to assume any administrative responsibility. These options would not require much State investment, but neither may offer sufficient incentive to small employers to help fund their employees' health insurance.

Much of the national discussion regarding how to reduce the uninsured population centers on options that encourage small employers to extend coverage to their employees. This is largely due to survey results which show that (1) a substantial portion of the uninsured (estimated to be 41 percent in Virginia) lives in households in which the wage earner works for an employer with fewer than 100 employees, and (2) small employers offer insurance at a substantially lower rate than large employers.

One option to increase insurance offer rates among small employers is to provide them with financial assistance through subsidies or tax credits, as discussed in Chapter 4. However, other options have been considered that do not require a substantial government investment. One of those options is the concept of pooling, in which small employers join together to form larger pools for purposes of negotiating lower insurance rates and achieving economies of scale in administration. However, pools do not appear to be sustainable in states such as Virginia in which small group plans are experience rated. Experience rating means that less healthy groups benefit from joining the pool but healthier, lower-risk groups do not and find that they can purchase insurance more cheaply on their own. Therefore, they leave the pool and the remaining high-risk groups then have to pay high premiums based on the pool's overall high risk.

Two other options to encourage small employers to offer insurance have also been proposed. They include providing small employers with some of the benefits of the State's health plan and establishing a market "connector" or exchange for small employers.

OPTION: ALLOW SMALL BUSINESSES TO UTILIZE THE STATE EMPLOYEE HEALTH PLAN

One option to make health insurance more affordable for small businesses is to allow employees of small businesses to join the State employee health plan so that they may benefit from the economic clout of the large plan. State employee health plans are typically among the largest plans in a state, and therefore enjoy the purchasing power to obtain low provider reimbursement rates for plan members and are able to spread the risk over a larger number of individuals.

Small Businesses Could Access the State Employee Health Plan Through Different Means

Allowing small businesses access to the State employee health plan could lower the cost of health insurance for many small business employees. This could be accomplished by either (1) allowing small businesses to join the pool of State employees, (2) allowing small businesses to join the pool of local government employees in the Local Choice program, or (3) by providing small employer groups with the lower reimbursement rates of the State employee health plan. Under each option, small employer participation could be contingent upon the employer paying a substantial share of its employees' insurance premiums. These options are discussed separately below.

Allow Small Employers to Join State Employee Health Plan. Under this option, small employers (for example, businesses with 2-99 employees) would be able to provide their employees health coverage through the State employee health plan. Employees of small businesses that participate in this option would be part of the same risk pool as State employees and would be offered the same choice of insurance policies.

The Virginia Department of Human Resource Management (DHRM) would administer the policies for small business employees. Given that the Virginia State employee health plan is self funded, the State would need to reassess the risk pool with the addition of the small business employees that join the plan.

Allow Small Employers to Join the Local Choice Program. The Local Choice program, implemented in 1990 and administered by DHRM, enables localities in Virginia to purchase health insurance through the State employee health plan. Local government employees in the plan are offered the same choice of insurance policies that are offered to State employees, but they are kept in a separate risk pool. Localities with 50 or fewer employees are community rated with other small localities in the pool.

Another option would be to allow small employers to join the Local Choice program. The risk of employees of small businesses participating in the program would then be pooled with small local government employees in the program. Employees of small businesses would also be offered the same choice of insurance policies.

Provide Small Employers With Access to Policies Based on State Provider Reimbursement Rates. Another option would be for the State to use its market strength to require medical care providers to offer the same reimbursement rates to small employers that are currently offered to the State. Insurers would then be invited to develop insurance plans to serve those participating in the program that would be priced more cheaply to reflect the benefit of the lower reimbursement rates. Under this option, small employers would not join the State pool but would have the opportunity to purchase insurance policies offered in this program. The small employers participating would not receive the benefit of the State pool's risk rating but would be able to purchase a more affordable insurance product due to the lower reimbursement rates.

Benefits of Leveraging the State Employee Health Plan for Small Employers

The primary benefit of providing access to the State's health plan would be to make providing insurance more affordable and attractive so that small employers who currently do not provide insurance to their employees might be encouraged to do so. Allowing small employers to join the State employee or Local Choice pool should make offering insurance more attractive to small employers because the cost of the employee policies likely would be cheaper and the administrative cost for the employer would be less. The cost of policies should be cheaper because the employees would benefit from the larger pool's risk rating, and the plan would be able to obtain lower provider reimbursement rates.

If the option was limited to providing small employers with access to insurance plans that are priced based on the State's reimbursement rates, then the potential to attract small employers based on lower cost policies due to these lower reimbursement rates would be the major potential benefit. This option would not create a significant additional administrative burden for the State.

Challenges of Leveraging the State Employee Health Plan for Small Employers

The primary challenges of allowing small business employees to join either the State employee or Local Choice pool are possible higher premiums for State and local government employees and a

greater administrative burden for the State. Because the State employee health plan and the Local Choice program spread risk over a large number of individuals, high-risk groups would have the most incentive to participate in the plan. Low-risk groups could possibly obtain lower premiums in the small group market from a commercial insurance carrier, but high-risk groups likely would be better off in the State employee or Local Choice pool. These additional high-risk individuals would likely require the State to raise premiums for members in the pool to cover the additional risk.

Allowing small employers to join the Local Choice program could harm the viability of the program for small localities. Because the small locality pool is community rated, the addition of high-risk groups would cause premiums to increase, and localities with lower overall risks may be able to purchase cheaper coverage outside of the pool. If low-risk groups leave the pool, the average risk in the pool would increase, and premiums would increase even more. Eventually, the Local Choice program could consist of only high-risk groups, and coverage through the program would be expensive compared to the rest of the small group insurance market.

In addition, the program could be difficult to administer because the State would need to manage the plans for possibly thousands of small employers. According to staff at DHRM, collecting payments from these small employers could be problematic as employers drop out of the plan or go out of business. The State would also need to monitor the eligibility of these businesses, which could require additional State resources. According to one health policy expert, the State does not currently have an administrative structure to monitor such a program.

The primary challenges to giving small employers the same reimbursement rates as under the State employee health plan include attracting insurance carriers to market the product and obtaining agreement from health care providers to accept the lower reimbursement rates for these additional employees. Being required to price these policies more cheaply may discourage insurance carriers from offering or actively marketing the plans. Health care providers would need to agree to the lower reimbursement rates for patients in these plans or members of the plans might not have adequate access to care.

A final challenge of these options is that the cost of health insurance may not be reduced sufficiently to attract small employers to offer insurance. While the cost may be slightly less under these program options, small employers will still have to pay a substantial amount in order to provide coverage to their employees, especially ones with a high-risk rating.

Other States' Experiences with Utilizing State Employee Health Plan

Both West Virginia and Connecticut have programs that extend the benefits of the state employee health plan to small employers. Both are discussed below.

West Virginia. The West Virginia Small Business Plan (SBP) is a public/private partnership that seeks to provide more affordable health care coverage to small business employees by providing them with the opportunity to take advantage of the state's lower provider reimbursement rates. SBP provides less expensive coverage by obtaining agreement from health care providers to charge insurance carriers providing policies through this plan the same rates that it charges the state health plan. State employees' reimbursement rates are estimated to be 20 to 25 percent lower than market rates in West Virginia. Providers accept these rates because state employees constitute a large share of health care customers in the state.

Enrollees in SBP remain separate from the state employees' pool. Coverage in SBP can be offered through private insurance carriers, who must agree to lower profit margins for these plans than is allowed for other small group plans. Currently, only one carrier offers the plan.

To be eligible, a small business must have been in operation for at least one year, not offered insurance to its employees for the past year, have from two to 50 employees, and pay 50 percent of the premium for each enrolled employee. Once an employer is enrolled, 75 percent of eligible employees must enroll in SBP. Only full-time employees are eligible. If an employee chooses not to participate because he or she already has coverage, the individual does not count towards the 75 percent of eligible employees.

Individuals began enrolling in SBP in January 2005, and by November 2005, 650 individuals from 134 businesses were enrolled. As of June 2006, approximately 1,000 individuals were enrolled in the program. The majority of enrollees are employees of small businesses with ten or fewer employees.

SBP does not require the use of state funds. However, West Virginia received a \$1.3 million grant from the Robert Wood Johnson Foundation, which it is using to create and promote the plan.

Connecticut. In 1998, Connecticut created the Municipal Employees Health Insurance Program (MEHIP) to assist cities and towns in providing affordable health insurance coverage for municipal employees. In subsequent years, MEHIP was expanded to include

community action agencies and nonprofit organizations, and in 2003, the program was extended to small businesses with one to 50 employees. The MEHIP utilizes the state's marketing and billing structure to reduce premiums through administrative efficiency.

While small businesses can utilize MEHIP for purchasing insurance, they are still subject to small employer insurance laws. For example, insurers are required to use modified community rating for small employer policies. Also, policies issued to small employer groups are subject to an annual per-contract premium tax.

The program requires no state funding because all costs are paid for through members' premiums. In October 2006, 89 small employers enrolled 167 employees and 140 spouses and dependents. Currently, four insurance carriers offer ten coverage plans to small employers.

OPTION: ESTABLISH HEALTH INSURANCE "CONNECTOR" FOR SMALL GROUP AND INDIVIDUAL MARKETS

Another option to increase health insurance offer rates by small businesses is to establish a health insurance market exchange in which employees would act as individuals in the purchase of health insurance but would retain the benefits of participating in an employer plan. In addition, small employers could contribute to their employees' insurance without having to purchase or administer a small group plan. Massachusetts is the only state to develop such an exchange, which it calls the "connector."

The concept of a connector is the establishment of a market exchange in which insurers can offer a variety of policies for purchase, and employees of small employers as well as other individuals who do not have access to employer-sponsored insurance can shop for and purchase health insurance. A State agency or a private entity chartered by the State would need to be established to administer the exchange. This administrative authority would be responsible for ensuring that comprehensive information was available about plans being offered so that consumers would be able to make informed decisions about which health plans to select.

With an exchange, a small employer would be able to designate the exchange as its employer health plan. It would then have the option of sending its employees to the exchange to select their preferred policy. However, the employer would still have the ability to contribute to the purchase of the policy with pre-tax dollars. In addition, employees would be considered to be insured under an employee plan and therefore could pay their share of the premium with pre-tax dollars as well.

The connector would also provide an insurance option for employees who work part-time for multiple employers or work for different employers during the year. These part-time and seasonal employees could designate the connector as their employer health plan and then combine contributions received from multiple employers to subsidize a single, portable health care policy.

Benefits of Implementing a Market Exchange

One of the primary potential benefits of establishing a connector would be to encourage more small employers who do not offer health insurance to their employees to do so through this market exchange. The primary incentive provided to them by the connector would be the ability to offer their employees health insurance with a pre-tax employer contribution but without any employer responsibilities regarding the purchase or administration of an employer plan.

The connector option would also provide employees with more information, choices, and flexibility. Participating employees would have more information about plans and more plan options to choose from than if obtaining insurance through a small employer. In addition, the insurance would not be tied to the employer and would be portable if the employee changed jobs. Along with this greater choice and flexibility, employees would be able to pay their shares of the premium with pre-tax dollars as if enrolled in a traditional employer plan.

Challenges to Implementing a Market Exchange

One of the primary challenges of implementing a connector in Virginia is that without other initiatives to make insurance more affordable, the elimination of the administrative burden on small employers may not be a sufficient incentive to increase the number of small employers contributing to health insurance for their employees. Employers who chose not to contribute to insurance for their employees prior to the establishment of a connector would not necessarily be likely to do so after its development. In addition, there would be administrative costs associated with the establishment and operation of the entity that would administer the connector. Finally, the establishment of a connector would limit or even eliminate the small group market and adversely impact insurers that sell those type of products.

Massachusetts "Connector" Establishes Market Exchange for Small Employers and Individuals

The recently enacted health care reform in Massachusetts established an entity called the Commonwealth Health Insurance Connector Authority (Connector). The Connector is a new state authority that helps individuals and small businesses purchase affordable, high quality health insurance. Beginning in January 2007, employees without access to employer-sponsored insurance can purchase coverage through the Connector using pre-tax dollars. The Connector attempts to lower the cost of health insurance by lowering the administrative burden on small businesses. Also, it makes health insurance portable for employees. Part-time and seasonal workers will be allowed to combine their employers' contributions towards their health insurance. In addition, employees who are not offered employer-sponsored insurance will be allowed to purchase insurance through the Connector using pre-tax dollars.

Massachusetts will fund its health care reform through the state general fund, federal funds, transferred funds that used to go to providers for uncompensated care, and employer contributions. Overall, the plan is expected to cost \$1.2 billion for three years, but most of this funding is earmarked for premium assistance to low-income individuals.

Mandates, Incentives, and Other Options

In Summary

Other options for expanding health insurance coverage have been tried or proposed in other states. These options range from minor statutory changes to address particular segments of the population to a major overhaul of the existing system to provide universal coverage. Increasing young adults' access to their parents' policies and allowing the sale of limited benefit policies would require only minor statutory changes but may also have a limited impact on increasing the number of insured Virginians. Individual mandates and employer incentives would place greater responsibility on employers and individuals for health care and could lead to significantly higher coverage rates. Finally, adoption of a single payer model would virtually eliminate the uninsured but would involve considerable challenges, including the need to raise additional funds through taxes or other means.

Additional policy options for increasing the insurance rate have been tried or proposed in other states. These policies range from modest changes to address certain segments of the uninsured population to a major overhaul of the insurance system to provide universal coverage. Policy options discussed in this report are not mutually exclusive and could be implemented in combination to address the uninsured population. Five additional policy options are discussed in this chapter:

- individual mandate,
- employer incentive,
- expanding eligibility for coverage under parents' policies,
- limited benefit plans, and
- single payer.

OPTION: INDIVIDUAL MANDATE

The individual mandate, as the term implies, requires that all residents for whom it is affordable obtain health insurance. The rationale for implementing such a mandate is that individuals who do not have health insurance place a burden on the rest of society when they need medical treatment and are unable to pay the full amount of their bill. Many of the uninsured have at least moderate family income levels. In Virginia, approximately 220,000 non-elderly residents with a family income level above 300 percent of

the federal poverty level (FPL) are uninsured. Low-income uninsured individuals could be exempted from the mandate, or premium assistance could help them meet the mandate.

One means to enforce such a mandate would be through the tax system. For example, the personal exemption on the State income tax could be eliminated for individuals who did not have health insurance during the year. Alternatively, the State could impose a fine on individuals who do not meet the mandate. The penalty would need to be sufficiently punitive to induce most individuals to purchase insurance (that is, the penalty needs to be at a level at which individuals would prefer to pay for health insurance rather than the penalty).

A key issue for such an option would be determining at what level of income the purchase of health insurance would be considered to be affordable if coverage is to be mandated without a subsidy to low-income individuals. The State would not want to impose a mandate and potential sanctions on individuals who could not afford coverage. Collections from penalties assessed on individuals who did not obtain affordable coverage could be used to address uncompensated care costs or to provide premium assistance for low-income individuals.

A variation of the individual mandate is the establishment of a requirement that individuals who choose not to obtain insurance set aside funds that could be used to reimburse medical providers in the event of unforeseen medical costs. This could be achieved by requiring that each individual without health insurance establish an escrow account that could be accessed by medical providers if the individual incurred medical expenses he or she could not otherwise afford to pay. The amount required to be placed in the escrow account could be based on a sliding scale with lower income individuals required to place less funds in the account.

Benefits of Implementing an Individual Mandate

The mandate and associated penalty would establish a strong incentive for individuals with the financial means to purchase health insurance. Given the substantial portion of uninsured Virginians who could afford it (about 20 percent), such a mandate would likely reduce the number of uninsured by a substantial amount. With less uninsured, uncompensated care costs would be reduced. However, this proportional increase in the number of insured Virginians would not necessarily lead to a corresponding reduction in uncompensated care costs because this segment of the uninsured population is likely to be able to pay a higher proportion of their medical bills than those uninsured with lower incomes. Requiring that uninsured individuals pay into an escrow account could also

help to reduce uncompensated care costs by requiring that funds be set aside to pay providers if uninsured individuals incur substantial medical costs.

Challenges of Implementing an Individual Mandate

In order to mandate that residents obtain affordable health insurance, the State would need to define affordability. Unless the State is willing to provide premium assistance to low-income residents, the mandate could only be applied to residents above a certain income level (for example, 300 percent FPL). Furthermore, different individuals will face different health insurance costs depending on their age and health status. Older Virginians and Virginians with pre-existing conditions may not be able to obtain affordable health insurance (as defined by the State) despite having moderate income levels, and therefore the mandate would not apply to them (nor would this policy benefit them).

Since most low-income Virginians cannot afford private health insurance, an individual mandate would not assist them in obtaining coverage unless premium assistance were also offered. Low-income Virginians (at or below 200 percent FPL) represent 60 percent of the uninsured population, and individuals between 200 and 300 percent FPL represent another 18 percent. Therefore, the mandate might affect only about 22 percent of the uninsured population.

An equity issue should also be considered with individual mandates. The mandate would place a greater burden on individuals whose employers do not offer insurance. Employees with an offer from their employer only need to pay the employee portion of the premium to meet the mandate, while those without an employer offer would need to pay the full price. This equity issue could be resolved if the individual mandate were coupled with an employer mandate.

Finally, Virginians would lose personal freedom if an individual mandate was enacted. Currently, a portion of Virginians choose not to purchase health insurance even though they could afford it. Under the mandate, these individuals would be required to pay for their choice of not being insured.

The same challenges would not necessarily all apply to an escrow requirement. By using a sliding scale, more Virginians could be required to establish accounts. However, the amount low-income individuals would be able to afford to place in an escrow account likely would not be sufficient to cover major medical expenses.

Individual Mandate Would Likely Lead to Growth in High-Deductible Health Plans

Because high-deductible health plans (HDHPs) generally have lower premiums than traditional health insurance plans, they would likely be the most affordable option for individuals to comply with the mandate. Depending on the affordability criteria set by the State, an HDHP may be the only option available to Virginians just above the income threshold. Furthermore, the existence of lower-priced HDHPs could provide a rationale for the State to lower the income threshold for affordability.

Table 9 illustrates how a HDHP could be the only affordable option for an individual. For a young, healthy adult, the average annual premium cost of a traditional individual insurance policy in 2006 is \$1,656. The average annual premium cost of a HDHP for this same individual is only \$756. For a person at the 200 percent FPL income level (\$19,600), the cost of the traditional plan would equal eight percent of his or her income while the HDHP would be only four percent. For a person with an income level at 300 percent FPL (\$29,400), the premium costs represent six percent and three percent of income, respectively.

All Massachusetts Residents Must Have Health Insurance by July 2007

One of the components of the recently enacted health care reform legislation in Massachusetts is an individual mandate, requiring that all residents have health insurance by July 2007. The mandate does not define what type or how much coverage an individual must have.

Table 9: Affordability of Health Insurance for Young, Healthy Adults (Typical Plans, 2006)

	Traditional Individual Policy ¹	High-Deductible Policy ²
Yearly Premium	\$1,656	\$756
Percent of Income for Person at		
100% FPL (\$9,800)	16.9%	7.7%
200% FPL (\$19,600)	8.4%	3.9%
300% FPL (\$29,400)	5.6%	2.6%

¹ Anthem Individual Key Care Preferred for male aged 35 years.

² Golden Rule Single HSA Saver for male aged 35 years.

Source: Pilzer, Paul Zane. *The New Health Insurance Solution*. 2005.

The legislation stipulates that the individual mandate is only enforceable if affordable coverage is available. Massachusetts legisla-

tors have stated that an affordable premium should be between \$200 and \$250 a month. However, the legislation does not define "affordable." The Commonwealth Health Insurance Connector Authority is responsible for determining which individuals cannot afford insurance.

Individuals who can afford coverage but remain uninsured will be penalized. In tax year 2007 these individuals will lose the personal exemption on their state income taxes. In subsequent years, they will be fined 50 percent of the cost of coverage for each month without insurance.

OPTION: EMPLOYER INCENTIVE

Employer incentive policies, often referred to as "pay-or-play" policies, require employers to contribute to employees' health insurance costs or else pay a tax. The proceeds of the tax could then be used to offset uncompensated care costs. According to a survey conducted by the National Federation of Independent Businesses, most employers want to offer health insurance benefits to their employees to attract and retain workers, as well as to keep them healthy and productive. The tax provides an additional incentive for employers to pay for health benefits.

Most of the uninsured live in households with at least one working member, so this option could have a significant effect on coverage rates and access to health care. Since nearly all large employers already offer employer-sponsored coverage, this tax would most affect small businesses, of which less than one-half offer insurance to their employees in Virginia.

Employer incentive taxes are not a mandate for employers, which is prohibited by the federal Employee Retirement and Income Security Act of 1974 (ERISA). As is discussed in Chapter 1, ERISA is the federal law governing employee benefit plans, and it supersedes any state laws relating to such plans. An employer mandate requiring businesses to pay at least 50 percent of the cost of employee health premiums would directly regulate how businesses structure their employee benefit plans and thus violate ERISA. The employer incentive, however, is simply a tax on employers whose obligation may be waived if they offer employer-sponsored insurance.

A state implementing an employer incentive tax would need to decide on the appropriate amount of the tax, which businesses the law would apply to, and the proportion of health insurance costs that must be offered to employees. A state would also need to determine what categories of employers would be subject to the tax. The amount that employers must contribute in order to avoid the

tax could be set on a sliding scale depending on the size of the business.

Benefits of Implementing an Employer Incentive

An employer incentive should encourage more employers to offer health insurance to their employees. With 50 percent of uninsured Virginians living in working households but with no offer of employer-sponsored health insurance, more employers offering health insurance should increase the number of insured Virginians. The extent to which an employer tax would increase employer-sponsored insurance offer rates would largely depend on the amount of the tax incentive.

Even if many businesses choose to pay the tax instead of offering insurance to their employees, the State would still benefit from the additional revenue. This revenue could be used to offset uncompensated care costs generated by uninsured workers or to provide premium assistance to low-income workers.

A final benefit of the employer incentive option is that employers who currently offer health insurance to their employees could experience reduced insurance costs. Businesses that do not offer employer-sponsored insurance place a burden on other businesses through uncompensated care costs of their employees. The cost of employer-sponsored insurance is higher than it would be if uncompensated care costs were reduced. Thus, an increase in offer rates by employers should produce downward pressure on health insurance premiums.

Challenges to Implementing an Employer Incentive

Challenges to the employer incentive option include the effect on Virginia businesses and possible legal challenges due to ERISA. Many employers do not offer employer-sponsored coverage because of the high cost of health insurance. As health insurance costs have increased, the percentage of employees eligible for coverage has declined. Because many businesses, especially small businesses, cannot afford to offer health insurance, requiring them to pay a tax or provide health insurance could place a financial strain on them.

Employer incentives to offer employer-sponsored health insurance could be challenged under federal law. ERISA prohibits states from enacting any laws that relate to employee benefit plans. While the tax relates to employee benefit plans, it does not place any demands on existing plans or dictate the nature of the plans. Rather it is a tax on businesses (which states are allowed to impose) that may be avoided if insurance is offered to employees.

Most legal scholars now believe that ERISA does not prohibit states from implementing pay-or-play taxes, but some disagree.

Other States' Experiences With the Employer Incentive Option

Recently enacted health reform in Massachusetts included an employer incentive provision. Hawaii is the only state that requires employers to offer health insurance coverage to their employees. Both states are discussed below.

Massachusetts. The Promoting Access to Healthcare bill does not include an employer mandate, but it does include incentives to ensure that employers help finance health care. The legislation requires a fair share contribution to be paid by employers that do not provide coverage and have 11 or more employees. The contribution is up to \$295 annually per full-time equivalent employee, beginning in 2007. The state expects to collect \$45 million in the first year, but the amount will decrease as more businesses offer coverage.

Employers with 11 or more employees who do not provide health insurance or offer to contribute towards the purchase of coverage may be assessed an additional “free rider” surcharge. If a business’s employees use state-funded services through the uncompensated care pool a total of five times per year or one employee receives uncompensated care more than three times, the employer will be assessed the surcharge. If the uncompensated care exceeds \$50,000, the surcharge will be between ten and 100 percent of the cost of the care.

Hawaii. Hawaii is the only state with an employer mandate to provide health insurance to employees. Prior to ERISA, Hawaii passed the Prepaid Health Care Act which requires that nearly all employers provide health insurance to their employees. The U.S. Congress exempted Hawaii from ERISA in 1983, with the stipulation that Hawaii cannot make substantive changes to the act.

ERISA dictates exemptions, comprehensiveness of plans, and maximum allowable employee contributions. Employees exempt from the mandate include government service workers (because they already receive coverage from the state), seasonal employees, insurance and real estate agents who are paid exclusively by commission, and sole proprietors. Employer-sponsored insurance must be equal to that provided by the plan with the largest number of subscribers in the state. An employee’s contribution is either 50 percent of the total premium or 1.5 percent of his or her salary, whichever is lower.

Several provisions of Hawaii's employer mandate have lessened its overall effectiveness, especially during economic recessions. For example, employees who work fewer than 20 hours a week are exempt, as are dependents. Therefore, some employers hire multiple part-time workers instead of full-time workers in order to avoid providing coverage.

OPTION: EXPAND ELIGIBILITY FOR COVERAGE UNDER PARENTS' POLICIES

Extending the age limit for dependency status on family health plans and not limiting eligibility to students is a simple option for addressing the problem of uninsured young adults. Many individuals lose their insurance coverage when they reach the age of 19 because they no longer qualify as dependents under their parents' policies, and they are no longer eligible for Medicaid or FAMIS. For many young adults, it may be less expensive and easier to obtain coverage through their parents' employer-sponsored insurance policies than by purchasing an individual policy.

Under current Virginia law, parents can keep their children on their group health insurance policies until the age of 25, if they are full-time students. In addition, insurance carriers may opt to extend the age limit or disregard student status of dependents if agreed to by the group policy holder (that is, the employer in most cases).

Increasing the age limit and eliminating the student requirement would require that insurance carriers offer coverage to dependents up to the age limit established regardless of their student status. Whether employers paid a portion of the premium costs for these dependents would depend on the terms of the insurance arrangement between the employer and the parent.

Benefits of Expanding Eligibility Under Parents' Policies

The primary benefit of implementing this option is that it would make it easier for young adults, who are one of the groups with the lowest rates of insurance, to acquire health insurance. Young adults (aged 19 to 30 years) account for nearly one-third of Virginia's uninsured population. Also, the option would be easy to implement because it builds on the existing system of covering dependents through group policies.

This option would make health insurance more affordable for many young adults if their parents' employers offered premium assistance. Even without premium assistance, this option might make health care more affordable for less healthy young adults

who would likely have to pay a higher price for insurance in the individual market.

Challenges of Expanding Eligibility Under Parents' Policies

The effectiveness of this option would be limited by the fact that most large employers have self-insured health plans, which are not subject to State law. Therefore, this option would not apply to dependents of parents insured through these plans. Approximately 63 percent of private insurance policies in Virginia are through self-insured plans.

Another potential challenge to this option is that less healthy young adults would likely be drawn into their parents' group health plans, which could raise the overall risk level in the pool and cause premiums in the pool to increase. Because healthy young adults are more likely to find affordable individual coverage, there could be a disproportionate share of less healthy young adults entering the pool.

New Jersey Allows Dependents to Be Covered Up to 30 Years of Age

As of May 2006, New Jersey increased the age that children can be covered by their parents' insurance from 18 to 30 years. No other state has increased the dependency age as high as New Jersey, although six other states have implemented similar laws (Colorado, Illinois, New Mexico, South Dakota, Texas, and Utah).

Eligible individuals are those less than 30 years old, not married, without dependents, not eligible for Social Security, and living in New Jersey or enrolled full-time at an institution of higher education. Unlike similar laws in other states, New Jersey does not require individuals to live with their parents or be enrolled in a college or university in order to participate.

Coverage is paid for by the individual and does not require an employer or state contribution, and the bill's sponsor believes that coverage will be extended to 200,000 individuals. Estimated annual premiums range from \$1,200 to \$6,000.

OPTION: ALLOW SALE OF LIMITED BENEFIT INSURANCE POLICIES

Allowing the sale of limited benefit policies, such as no-mandate or reduced-mandate policies, could make health insurance more affordable for some Virginians. States regulate health insurance plans and may determine that certain benefits must be offered through these plans. These mandated benefits may include cover-

age for (1) medical screenings such as mammograms, (2) treatment of diseases such as diabetes or hemophilia, and (3) services such as dental, optometric, and chiropractic services. Mandated benefits may add to the cost of health insurance premiums, and Virginia has among the most mandated benefits.

Benefits and Challenges of Offering Limited Benefits Plans

Limited benefit plans could potentially help more Virginians afford health insurance. However, it is unclear if exempting mandates from these plans will reduce premium costs enough to have a significant impact on Virginia's uninsured population. Studies have shown mixed results on the effectiveness of these plans at reducing costs. A 2002 study by the Congressional Budget Office estimated that exempting plans from state-mandated benefits would reduce insurance costs by five percent and lead to a five percent increase in the number of employers offering coverage. Another study found that 20 to 25 percent of uninsurance is due to benefit mandates. However, other studies have found that eliminating mandates may lead to a modest reduction in cost, but the reduction in cost does not lead to a discernible effect on small employer offer rates or purchase of insurance by individuals. Other states' experience with these programs seems to indicate that these limited benefit policies do not have much effect on health insurance coverage rates.

Virginia's experience with mandated benefits suggests that these benefits have not caused significant price increases for Virginia small group health plans. Virginia has among the most mandated health benefits in the nation, yet average premiums in Virginia for the small group market are lower than in all but two states.

Other States' Experiences With Limited Benefit Plans

Several states have enacted legislation to allow for the sale of limited benefit plans. In general, these plans have not had success in attracting large numbers of enrollees. Some of these plans are discussed below.

Colorado. In 2003, the state allowed small employers to purchase basic health benefit plans, which exempt six of the state's mandated benefits.

Florida. In 2002, the state allowed for the sale of "health flex plans." These plans can limit or exclude any of the state's mandated benefits. Insurance carriers are allowed to limit enrollment in these plans and cap the total amount of claims per year. Enrollment is limited to individuals with income up to 200 percent FPL and who were uninsured for the previous six months.

Montana. In 2003, the state allowed policies to be sold in the individual market that exclude inpatient services and limit coverage for several other services. Individuals who were uninsured for the previous 90 days are eligible for enrollment in the plans.

North Dakota. In 2001, the state allowed the sale of individual and small group policies that may exclude any or all of the mandated benefits.

Virginia authorizes insurers to offer an Essential Plan and a Standard Plan, which do not include all of the mandated benefits of regular group health plans. However, while these plans were intended to be low-cost, basic health insurance products, they were ultimately designed with nearly as many mandates as regular group plans. Therefore, they are not significantly cheaper than other plans, and relatively few of these policies have been sold.

OPTION: SINGLE PAYER WITH UNIVERSAL COVERAGE

A final option for expanding health coverage is the single payer option, which would entail the most dramatic change from the current health care system in Virginia. The single payer option would eliminate the system of private health insurance because the State would provide universal coverage to residents. The State Medicaid and FAMIS programs could also be eliminated, since all non-elderly residents would be covered by the same program. The State would act as the insurer to negotiate reimbursement rates with health care providers and to pay all medical claims. This option for non-elderly adults would be similar to the federal Medicare program for individuals aged 65 and over.

To pay for this program the State could use existing Medicaid and FAMIS funds; uncompensated care subsidies such as Medicaid Disproportionate Share Hospital (DSH) funds, the Indigent Health Care Trust Fund, and the State and Local Hospitalization Program; and taxes on individuals and businesses. As the single payer for all medical claims, the State would negotiate rates with providers for procedures and services, just as the State does now for Medicaid and FAMIS recipients.

Benefits of Implementing the Single Payer Option

The primary benefit of the single payer option is that all Virginians would have access to regular health care. With no uninsured patients, there would be practically no uncompensated care costs. The uncompensated care cost (estimated to be \$1.4 billion in 2005) could be redirected toward funding the single payer system.

Universal coverage would also provide continuous coverage. Individuals would not be faced with a lack of health insurance during job transitions or through loss of employment, since insurance status would not be dependent on employment status. Under the current system, individuals with employer-sponsored health insurance may have to quit their job because of health problems that prevent them working. However, if they do so, they lose their employer-sponsored insurance when they need it most.

Another benefit of a state single payer model is that health care spending could be lowered through administrative efficiencies and increased purchasing power. Under the current system, providers are reimbursed different rates for medical treatment depending on a patient's insurance carrier, enrollment in a government health program, or insurance status. Therefore, hospitals and physicians must track a multitude of reimbursement rates for all of their patients. The complexity of the reimbursement rates adds to the cost of medical care, as providers are often forced to hire additional staff to manage patient accounts and negotiations with insurance carriers. The single payer model eliminates much of this complexity, which could allow providers to direct more of their resources to patient care rather than patient account management.

Savings could also be achieved through the increased purchasing power of a single payer system. The State could leverage its power as the sole purchaser of medical procedures, supplies, and pharmaceuticals to negotiate lower rates. However, the State's leverage over the health care industry would be constrained by the ability and willingness of providers to accept the rates.

Challenges of Implementing Single Payer Option

Funding the single payer system is the primary challenge to implementing this option. Medicaid and FAMIS funds and uncompensated care subsidies could be used to pay for part of the program, but the State would also need to raise taxes on individuals and businesses. This new tax burden would replace insurance premium costs for those individuals and employers that currently comprise the private health insurance market.

Another challenge is that the single payer system would eliminate the need for most private health insurance plans, which would displace many employees in the health insurance industry. A smaller market for private health insurance could exist along with the single payer system because some individuals may want to purchase additional coverage for benefits beyond those offered by the State system. However, the private market would most likely be severely reduced, which would result in the loss of jobs.

Another challenge to implementing the single payer option is that some physicians and hospital systems may choose not to do business in Virginia under a single payer structure. If Virginia does not provide reimbursement rates that are competitive with other states, providers could decide to relocate to another state. In addition, a portion of physicians and other health care providers may be philosophically opposed to state-run health care and may choose to relocate rather than be part of the system.

The State's leverage over the health care industry would be constrained by the ability and willingness of providers to accept the rates. If the State tried to push rates too low, providers would be unwilling to do business in Virginia, which could cause the quality of health care to decline as physicians moved out of state and hospitals cut services or closed altogether.

An unintended consequence of implementing a single payer system in Virginia is that low-income and medically-needy individuals from other states might be enticed to move to Virginia to obtain the medical benefits. These individuals would require more health services and contribute less funding for the system than average Virginians. Other Virginians would then have to subsidize the care for these new Virginians through higher taxes or some other form of payment.

Finally, annual health care costs would likely increase for wealthier Virginians. Under the single payer system, all individuals would be offered the same minimum level of coverage. However, if the system were funded through income taxes, higher income Virginians would contribute more to the funding of the system than lower income Virginians. The per capita cost of coverage would be higher than the average additional tax revenues generated by low-income Virginians to fund the program. Therefore, high-income Virginians would subsidize coverage for low-income Virginians. However, Virginians with average income levels may pay less for health coverage under the single payer system if savings are realized through administrative efficiencies and increased purchasing power.

California's Governor Vetoed a Bill to Create a Single-Payer Health Insurance System

In 2006, the California Health Insurance Reliability Act (CHIRA) passed the California General Assembly but was vetoed by the Governor. CHIRA would have created a state-run single-payer health care system to provide coverage to all California residents.

Under CHIRA, every California resident would have received a health access card, and undocumented residents would have been

covered as well. Californians would choose a primary care provider who would make referrals to specialists. The system would have offered broad coverage that included nearly all medical care prescribed by an individual's primary care provider. Patients could have chosen to pay for specialist visits out of pocket without a referral.

A new California Health Insurance Agency, headed by an elected commissioner, would have been responsible for the system. Within the agency, a health insurance fund would receive and disburse all funds for the system. A payment board would have negotiated with health care managers and providers to set compensation rates.

The bill did not contain a detailed funding plan for CHIRA; however, it suggested using a combination of revenues. Through waivers, the state hoped to utilize Medicaid and Medicare funds, which currently pay for approximately half of health care expenditures. Also, employers and employees would have paid premiums based on a percentage of their income.

California estimated that the single payer system would produce savings generated by administrative efficiencies and bulk purchasing of pharmaceuticals and medical equipment. These savings, it was estimated, would produce a net reduction in health care spending in the state.

Potential Health Insurance Options for Virginia

In Summary

The multiple policy options discussed in this report address various segments of the uninsured population in Virginia. With the exception of universal coverage, the options are not mutually exclusive, and some combination of them would be needed to address the entire uninsured population. While each segment of the uninsured population is of concern, the State may want to focus on policy options that could be implemented to address the low-income population. Given the gap between the cost of health insurance and the income that this population has available to spend on it, effective options will require the provision of financial assistance. Four options likely would be most cost-effective for Virginia because the State would share financial responsibility with the federal government and private employers. These options are an employer incentive, Medicaid expansion, small employer subsidies, or a reinsurance program.

With the broad range of policy options for addressing the uninsured and the wide-ranging characteristics of the uninsured population, Virginia policymakers may be challenged in deciding how best to address the problem of the uninsured. In considering this question, it is important to determine which uninsured groups will be served by each of the various policy options and which groups should be the focus of policy initiatives. With the exception of universal coverage, the options presented for consideration are not mutually exclusive, and implementation of some combination of these options would be needed to address the entire uninsured population in Virginia.

The extent to which the State seeks to address the issue of the uninsured Virginians is a policy choice. Pursuant to the study mandate, HJR 158, this study identifies and considers several illustrative options for potentially extending insurance coverage to more Virginians.

DIFFERENT POLICY OPTIONS MAY BE USED TO ADDRESS DIFFERENT UNINSURED GROUPS

With the exception of the single payer option for universal coverage, the policy options discussed in this report by themselves address only certain segments of the uninsured population. Decisions regarding which options to implement depend on which groups of uninsured have priority for receiving coverage. The illustrative options for consideration are not mutually exclusive, and implemen-

tation of some combination of these options would be needed to address the entire uninsured population in Virginia.

The uninsured population in Virginia consists of the following six basic groups, which have some overlap:

- **Low-income individuals.** Approximately 60 percent of the uninsured in Virginia have income up to 200 percent of the federal poverty level (FPL). Nearly 40 percent of individuals up to 100 percent FPL are uninsured, and more than 25 percent of individuals between 100 and 200 percent FPL are uninsured.
- **Employees of small businesses.** Nearly half of the uninsured population in Virginia works for employers with fewer than 100 employees or are self-employed. About 40 percent of individuals in households in which the wage earner works for a firm with fewer than ten employees are uninsured. Nearly 30 percent of self-employed households are uninsured.
- **Medically needy individuals.** Approximately 80 percent of all medical claims result from only 20 percent of all patients. Individuals in this high-risk group may be unable to afford health insurance even at higher income levels.
- **Part-time and seasonal workers.** Individuals in households in which the wage earner works part-time represent about 12 percent of Virginia's uninsured population. Approximately 30 percent of these individuals are uninsured.
- **Temporarily uninsured individuals.** Between 29 and 41 percent of all individuals who lacked health insurance in 2005 were uninsured for only part of the year.
- **Individuals who can afford insurance.** More than 20 percent of Virginia's uninsured population has a family income above 300 percent FPL. This group includes young, healthy individuals.

Exhibit 1 illustrates how each of the components of Virginia's uninsured population would be affected by the options to expand coverage discussed in this report. While the groups affected by the options are indicated, the proportion of the uninsured population that would be covered is not shown. For example, a Medicaid/FAMIS expansion only addresses the low-income group, but this group represents 60 percent of the uninsured population. Similarly, the market exchange and individual mandate options address several of the uninsured groups, but by themselves, they

Exhibit 1: Illustrative Options to Expand Health Insurance Coverage and the Uninsured Groups That Would Benefit

Option	Low-Income Individuals	Employees of Small Businesses	Medically Needy Individuals	Part-Time and Seasonal Workers	Temporarily Uninsured Individuals	Individuals Who Can Afford Insurance
Medicaid/FAMIS Expansion	✓					
Direct Subsidies	✓		✓			
Small Employer Subsidies	✓	✓	✓			
State Reinsurance	✓	✓	✓			
Leveraging State Employee Health Plan		✓	✓			
Establishing Market Exchange (Connector)		✓		✓	✓	
Individual Mandate		✓		✓	✓	✓
Employer Incentive	✓	✓	✓			
Expanding Eligibility for Coverage under Parents' Policy			✓	✓		✓
Limited Benefit Insurance Policies		✓				✓
Single Payer	✓	✓	✓	✓	✓	✓

✓ Indicates group would be affected by option

Source: JLARC staff analysis.

would likely have a limited effect on the majority of uninsured Virginians (that is, low-income Virginians). Exhibit 1 also does not indicate the relative effect on uninsured groups of the different expansion options. For example, both the individual mandate and the expansion of eligibility for children under parents' policies options would have an effect on those individuals who can afford insurance, but the individual mandate would obviously have a greater effect on this group.

STATE MAY WANT TO FOCUS ON ADDRESSING THE LOW-INCOME UNINSURED

While each segment of the uninsured population is of concern, the State may want to focus on policy options that could be implemented to address low-income Virginians. As discussed in Chapter 2, the majority of uninsured are in this low-income group. The gap between the cost of insurance and the amount of income they have available to spend for health insurance is so substantial, they will not have the ability to acquire health insurance unless they receive financial assistance to effectively lower the price of insurance. Figure 22 illustrates this gap between what a low-income individual can afford to spend on health insurance and the cost.

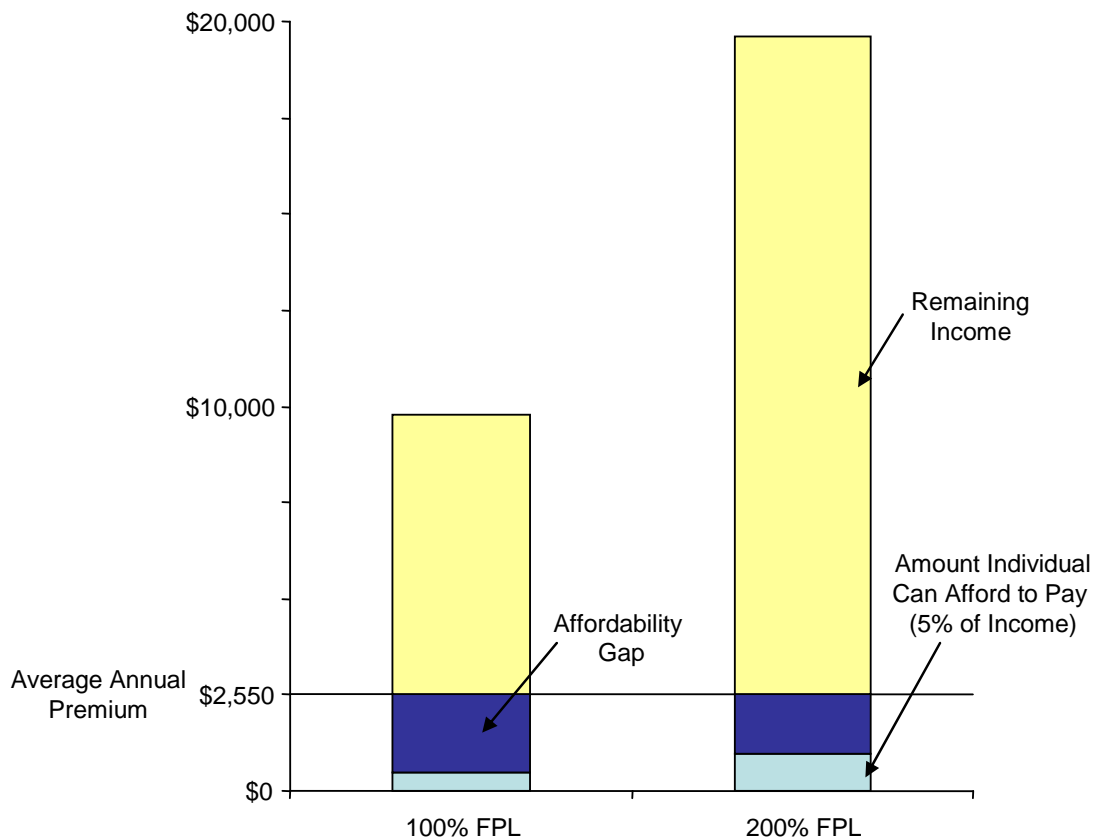
The financial assistance needed by low-income individuals to close the gap between the cost of insurance and the income they have available to spend on it would need to be provided by either employers or the government. Six options discussed in this report and shown in Exhibit 1 would directly address the low-income uninsured through financial assistance:

- Medicaid expansion,
- direct subsidies,
- small employer subsidies,
- state reinsurance,
- employer incentive, and
- single payer system.

While all of these options could be effective in addressing the low-income uninsured, four of these options likely would be the most cost effective for the State.

The employer incentive option would be the least costly option to address the low-income uninsured who are working because it would place responsibility on the employer to help fund the cost of employees' health insurance. About 200,000 of the low-income uninsured are either working full-time with no offer of employer-

Figure 22: Low-Income Virginians Face Affordability Gap for Private Health Insurance



Source: JLARC staff analysis of individual health insurance premium data provided by the Bureau of Insurance.

sponsored insurance or are the spouses of such workers, and these individuals could be able to obtain health insurance if their employers opted to provide health insurance instead of paying the additional tax. This option, however, likely would be met with strong resistance from the business community because it would be perceived as a mandate on employers and impose substantial additional costs on employers not currently offering insurance.

Medicaid expansion, small employer subsidies, and a reinsurance program are all options that should also be considered for providing the needed financial assistance to low-income uninsured because none would require the State to assume the full financial responsibility. As discussed in Chapter 4, Virginia could expand Medicaid eligibility to parents up to 100 percent FPL and have the federal government share half of the cost. This option, which has been implemented in most other states, would allow the State to assist some of the uninsured most in need of assistance given the wide gap between their income level and the cost of insurance and may be the logical first step in extending coverage to more low-

income Virginians. It is estimated that nearly 65,000 uninsured parents have income below 100 percent FPL. If all these individuals enrolled in Medicaid, it is estimated that the cost to the State could be up to \$101.5 million annually.

Implementing a small employer subsidy program or a reinsurance program would allow the State to make insurance more affordable for low-income working Virginians through shared responsibility with employers and employees. Under a small employer subsidy program, the State could assist small employers and their employees with overcoming the affordability gap by sharing with them the cost of purchasing insurance. A small employer subsidy program could potentially provide access to health insurance for about 175,000 low-income uninsured adults in working families at an estimated annual cost to the State of up to \$72.7 million (based on the assumption that small employers include employees with 2 to 99 employees). Similarly, through a subsidized reinsurance program, the State could help to make health insurance available at a reduced rate, with small employers expected to contribute to the cost of their employees' premiums.

The Governor's Health Reform Commission may wish to use this report as a starting point in its consideration of options to improve access to health care.

Study Mandate

HOUSE JOINT RESOLUTION NO. 158

Directing the Joint Legislative Audit and Review Commission to study options for extending health insurance coverage to Virginians who are currently uninsured. Report.

Agreed to by the House of Delegates, March 2, 2006

Agreed to by the Senate, February 28, 2006

WHEREAS, a 2001 Virginia Health Care Foundation survey found that 14.9% of all Virginians do not have health insurance coverage; and

WHEREAS, the Institute of Medicine of the National Academies released a report in 2004 that noted the devastating consequences of going uninsured in terms of adverse health results, early deaths, and burdensome uncompensated care; and

WHEREAS, family finances can be drastically or even catastrophically affected if one uninsured member suffers accidental injury or serious illness or the family loses its health insurance coverage, and it has been estimated that 50% or more of bankruptcies are related to costs associated with health care; and

WHEREAS, the Kaiser Commission on Medicaid and the Uninsured estimates that in 2004, hospitals and physicians provided the uninsured with \$40.7 billion in uncompensated care and that private health insurers and their policyholders subsidized an additional \$34.4 billion in care for the uninsured; and WHEREAS, rising health care costs are placing Virginia employers at a competitive disadvantage in the global marketplace; and

WHEREAS, the National Coalition on Health Care has stated that "employer health insurance premiums increased by 11.2%, nearly four times the rate of inflation" in 2004; and

WHEREAS, the size of the uninsured population continues to grow steadily from 39.6 million Americans in 2000 to 45.5 million in 2004; and

WHEREAS, currently, in other states, various groups or public-private partnerships are engaged in developing alternatives to provide greater health insurance coverage for their citizens; and

WHEREAS, in Virginia, the costs of health care are increasing at an unsustainable rate while the population of senior citizens is burgeoning and the number of uninsured grows ever larger; thus, it is imperative that solutions to this looming health care crisis be developed with all due haste; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Legislative Audit and Review Commission be directed to study options for extending health insurance coverage to Virginians who are currently uninsured.

In conducting its study, the Joint Legislative Audit and Review Commission shall:

1. Analyze the number of uninsured Virginians, the reasons they do not have health insurance, the duration of periods without insurance, and their eligibility for employer-based and private health insurance coverage or government health care programs, and in conducting this analysis consider such factors as the age, family composition, occupational status, and income of these uninsured Virginians;
2. Assess the costs incurred by the Commonwealth, its insured citizens, and health care providers for the provision of emergency room or other health care to treat the uninsured population in Virginia;
3. Evaluate programs or plans implemented in other states as well as proposals that have been made

by national organizations to expand health insurance coverage to the uninsured; and

4. Develop policy options to extend health insurance coverage to Virginia's uninsured that balance facilitating access to health insurance with requiring Virginians to assume greater personal responsibility for obtaining a minimum level of health insurance coverage.

Technical assistance shall be provided to the Joint Legislative Audit and Review Commission for this study by the Virginia Hospital and Healthcare Association, the Medical Society of Virginia, the Virginia Health Care Foundation, and the Virginia Association of Health Plans, upon request.

All agencies of the Commonwealth shall provide assistance to the Joint Legislative Audit and Review Commission for this study, upon request.

The Joint Legislative Audit and Review Commission shall complete its meetings for the first year by November 30, 2006, and for the second year by November 30, 2007, and the Director shall submit to the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the next Regular Session of the General Assembly for each year. Each executive summary shall state whether the Joint Legislative Audit and Review Commission intends to submit to the General Assembly and the Governor a report of its findings and recommendations for publication as a House or Senate document. The executive summaries and reports shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

Research Activities and Methods

Research activities undertaken as part of this review included

- analysis of national and State survey data on health insurance status and health care spending,
- analysis of patient-level hospital data,
- review of health care initiatives in other states,
- structured interviews, and
- literature and document review.

ANALYSIS OF NATIONAL AND STATE SURVEY DATA ON HEALTH INSURANCE STATUS AND HEALTH CARE SPENDING

JLARC partnered with the Virginia Health Care Foundation (VHCF) to develop estimates on the number of uninsured Virginians and the costs of providing care to the uninsured in Virginia. The Urban Institute was contracted by JLARC and the VHCF to develop the estimates based on existing national and State surveys.

To determine the number and composition of Virginia's uninsured population, the Urban Institute combined data from the 2005 and 2006 Annual Social and Economic Supplement to the Current Population Survey (CPS). By combining the two years, the sample size was increased to 7,430 individuals. For information relating to offers of employer-sponsored insurance, the Urban Institute relied on data from the 2005 Contingent Workers and Alternative Employment Supplement to the Current Population Survey. The 2004 Virginia Health Care Insurance and Access Survey was used to provide information on the proportion of individuals who were insured for less than twelve months.

The Urban Institute used data from the Household Component Medical Expenditure Panel Survey (MEPS-HC) and the CPS to develop an estimate of the amount of uncompensated care that uninsured Virginians received in 2005. The 2001, 2002, and 2003 MEPS-HC surveys were the source of the spending data used in these analyses, while the 2004 and 2005 CPS surveys were the source of data on the insurance status of Virginians.

The MEPS-HC is a nationally representative survey of the U.S. civilian noninstitutionalized population, providing detailed information on health care use and expenditures, insurance coverage, sources of payment, health status, health conditions, access to care, income, employment, and other demographic characteristics. Respondents' information about insurance coverage and medical spending is supplemented and validated with information from medical providers, pharmacies, and insurance providers.

The MEPS sample consisted of individuals under age 65 who live in the South census region. The South census region includes Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Virginia, and West Virginia. The final MEPS sample included 33,803 observations.

Several adjustments were made to the MEPS data. First, medical care expenditures and charges were inflated to 2005 dollar values using data on growth in per capita health expenditures. Because the methods of measuring expenditures in MEPS produces estimates of national health expenditures that are significantly and systematically lower than those reported in the National Health Accounts compiled by the Centers for Medicare and Medicaid Services (CMS), an additional upward adjustment of 1.25 was applied to all spending and charge values. Finally, MEPS reports expenditures (spending) on prescription drugs, but not charges for prescription drugs. Therefore, MEPS data on total charges were adjusted to include charges for prescription drugs by adding in the MEPS amount for prescription drug expenditures.

The CPS sample was also restricted to individuals under age 65 who lived in the South census region, and excluded non-elderly individuals whose only full-year coverage was Medicare. The final CPS sample included 111,800 people.

In order to estimate medical spending in Virginia based on MEPS data of the South census region, a two-stage re-weighting procedure was employed that uses data from the CPS to adjust the MEPS survey weights provided for each survey respondent so that the socio-demographic characteristics of MEPS respondents from the South region mimic the characteristics (and the medical spending behavior) of people living in Virginia. This re-weighting process adjusts for differences in population characteristics between Virginia and the South census region. The re-weighted MEPS data could then be used to generate more accurate estimates of medical spending in Virginia than would have been possible without the re-weighting.

The first re-weighting stage used the CPS South sample to estimate a statistical model of the probability of living in Virginia as a function of socio-demographic variables common to the CPS and MEPS. The variables included age, race and ethnicity, health insurance status (public, private, or uninsured), gender, education, income, labor force status, marital status, household composition, urban residence, and self-reported health. The parameters from this model were then combined with the corresponding variables from the MEPS sample to compute the probability of living in Virginia for each MEPS respondent. These predicted probabilities were then combined with the actual probability of Virginia residence observed in the CPS South sample to adjust the MEPS survey weights. The revised survey weights have the effect of making the MEPS South sample “look like” a sample of Virginia residents.

The second stage of the re-weighting methodology employed a cell-based procedure that adjusted for differences in the distributions of key personal characteristics between the re-weighted MEPS South and the CPS Virginia samples. Cases in the MEPS and the CPS Virginia samples were partitioned into cells delineated by age (adult or child), race and ethnicity (white non-Hispanic, Hispanic, African-American, and other races), and type of insurance coverage (private, public, or uninsured). The adult sample was also partitioned by employment status (employed, unemployed, or not in the labor force). This adjustment assured that the re-weighted MEPS South sample closely matched the size and distribution of the Virginia population by age, race and ethnicity, insurance coverage, and employment status.

Before re-weighting, the MEPS South sample had higher proportions of people who are Hispanic, are not high school graduates, and have low family incomes, compared to people in the CPS Virginia sample; and correspondingly lower proportions of people who are white non-Hispanic, have college or graduate degrees, and have family incomes above 400 percent of the federal poverty level.

After the MEPS respondents were re-weighted to approximate a sample of Virginia's population, the Urban Institute was able to generate estimates of average medical spending, total medical spending, and distributions by insurance status, sources of payment, and socio-demographic characteristics. The accuracy of these estimates depends on two factors: (1) the extent to which people with similar characteristics (insurance status, age, race/ethnicity, etc.) have similar medical spending behavior regardless of the state in which they live, and (2) the extent of unique state policies or institutional features that differentiate Virginia from the “average” state in the South.

The Urban Institute has done similar MEPS analyses for other states, including Massachusetts, Connecticut, and Illinois. In those states in which the Urban Institute was able to compare the MEPS estimates to independent provider data on uncompensated care, the estimates from the re-weighted MEPS data provided a reasonable basis for making inferences about medical care received by the uninsured.

ANALYSIS OF PATIENT-LEVEL HOSPITAL DATA

In order to provide verification of the uncompensated care estimate produced by the Urban Institute's MEPS analysis, JLARC staff examined patient-level hospital data from a sample of Virginia hospitals. With assistance from the Virginia Hospital and Healthcare Association (VHHA), patient data was collected for all bad debt, charity care, and self-pay patients at the participating hospitals during their most recent fiscal year. Hospitals that participated in the data collection effort included

- Bon Secours Richmond Health System
 - Memorial Regional Medical Center
 - Richmond Community Hospital
 - St. Mary's Hospital
- Carilion Health System
 - Franklin Memorial Hospital
 - Giles Memorial Hospital
 - Carilion Medical Center
 - New River Valley Medical Center
 - Stonewall Jackson Hospital
- Community Memorial Health Center
- HCA hospitals
 - Alleghany Regional Hospital
 - CJW Medical Center
 - Clinch Valley Medical Center
 - Henrico Doctors' Hospital
 - John Randolph Hospital
 - Lewis-Gale Medical Center
 - Montgomery Regional Hospital
 - Northern Virginia Community Hospital
 - Pulaski Community Hospital
 - Reston Hospital Center
 - Retreat Hospital
- Inova Health System
 - Alexandria Hospital
 - Fair Oaks Hospital
 - Fairfax Hospital

- Loudoun Hospital Center
- Mount Vernon Hospital
- Sentara Healthcare
 - Bayside Hospital
 - Careplex Hospital
 - Leigh Hospital
 - Norfolk General Hospital
 - Virginia Beach General Hospital
 - Williamsburg Community Hospital
- University of Virginia Medical Center
- Valley Health System
 - Shenandoah Memorial Hospital
 - Warren Memorial Hospital
 - Winchester Medical Center
- Virginia Commonwealth University Health System

These hospitals accounted for 66.4 percent of the total gross patient revenues at VHHA member hospitals. Most regions of the State were represented in the sample.

The purpose of the data collection was to determine the proportion of bad debt and charity care at Virginia hospitals that resulted from medical care of uninsured patients. For each hospital, charges and patient payments were summed, and total payments was subtracted from total charges to produce the total difference between hospital charges and payments received. These charges and payments were then summed for self-pay and charity patients to determine the proportion of charges minus payments at the hospitals that resulted from uninsured patients.

The proportion of charges minus payments resulting from uninsured patients for each hospital system was weighted based on each system's net uncompensated care costs in 2004, which was estimated by the VHHA. The weighted average proportion of charges minus payments resulting from uninsured patients at these hospitals was 73 percent, which was then assumed to be the proportion of uncompensated care at Virginia hospitals resulting from uninsured patients.

To determine net uncompensated care costs at Virginia hospitals in 2005, JLARC staff relied on the 2004 estimate produced by the VHHA. The VHHA estimated net uncompensated care costs at its member hospitals to be \$441.9 million in 2004. Total charity care and bad debt charges were summed and then multiplied by the cost-to-charge ratio at each hospital to produce total uncompensated care costs. The total uncompensated care costs were then adjusted to account for payments from the Disproportionate Share

Hospital program, the State and Local Hospitalization program, and the Indigent Health Care Trust Fund to determine net uncompensated care costs.

To estimate net uncompensated care costs in 2005, the 2004 figure was inflated to 2005 dollars based on medical care inflation of 4.2 percent (Bureau of Labor Statistics). This resulted in an estimate of \$460.4 million in total net uncompensated care costs in 2005. Finally, the average proportion of uncompensated care costs from uninsured patients (73 percent) was applied to the 2005 estimate to produce an estimate of \$337.8 million in net uncompensated care costs at Virginia hospitals resulting from uninsured patients.

Because patient-level data were unavailable for physicians and other health care providers, JLARC staff relied on a national estimate of uncompensated care by provider type that was generated by the Kaiser Commission on Medicaid and the Uninsured. The Kaiser Commission estimated that in 2001, hospitals accounted for 63 percent of uncompensated care, physicians accounted for 18 percent, and clinics and direct care programs accounted for 19 percent. Based on this analysis, the estimate of \$337.8 million in uncompensated care at Virginia hospitals represented 63 percent of uncompensated care from all health care providers in the State. Therefore, physicians were estimated to have provided \$96.5 million in uncompensated care to uninsured patients, and clinics and direct care programs were estimated to have provided \$101.9 million. Total uncompensated care costs for uninsured patients from Virginia health care providers were then estimated to be \$536 million in 2005.

REVIEW OF HEALTH CARE INITIATIVES IN OTHER STATES

Several states with recent health care initiatives were reviewed for this report. JLARC staff conducted a literature review of state health care initiatives and chose states for further review based on the uniqueness of the initiative, the state's low rate of uninsured residents, or its potential applicability to Virginia. The following 14 states were chosen for further review:

- Arizona
- California
- Connecticut
- Hawaii
- Iowa
- Maine
- Massachusetts
- Minnesota
- Montana
- New Jersey

- New York
- Oklahoma
- Utah
- West Virginia

Information on health care initiatives in these states was gathered from state agency websites, press releases, and scholarly articles related to the initiatives. Telephone interviews were conducted with state officials in most cases. Demographic data relating to the uninsured populations in each state were gathered from the Kaiser Family Foundation's State Health Facts website (statehealthfacts.org).

STRUCTURED INTERVIEWS

Structured interviews were conducted with representatives from State agencies, trade associations, health care advocacy groups, and health policy experts. JLARC staff interviewed representatives from the Department of Medical Assistance Services, the Department of Health, the Bureau of Insurance, and the office of the Secretary of Health and Human Resources. Trade associations and health care advocacy groups that were interviewed included

- Virginia Association of Health Plans
- Virginia Chapter of the National Federation of Independent Businesses
- Virginia Health Care Foundation
- Virginia Hospital and Healthcare Association
- Medical Society of Virginia
- Virginia Association of Free Clinics
- Virginia Primary Care Association

Interviews were also conducted with several health policy experts, including the Dean of the University of Virginia Medical School, the President of Community Health Solutions and Community Health Resource Center, staff from the Rand Corporation, and staff from the Urban Institute.

LITERATURE AND DOCUMENT REVIEW

An exhaustive literature review was conducted to determine problems associated with being uninsured, the reliability of various estimates of the number of uninsured, trends in the health insurance and health care industries, and the effectiveness of various options to extend coverage to the uninsured. Primary sources for the literature review included the Kaiser Family Foundation, State Coverage Initiatives of the Robert Wood Johnson Foundation, *Health Affairs*, The Institute of Medicine (a division of the National Acad-

emy of Sciences), Families USA, America's Health Insurance Plans, and the Heritage Foundation. Relevant articles from newspapers and journals were also reviewed.

JLARC staff also reviewed applicable sections of the *Code of Virginia* as well as documents from the Virginia Department of Medical Assistance Services and the Bureau of Insurance.

Appendix **C**

Glossary of Acronyms

CHIRA	California Health Insurance Reliability Act
CMS	Centers for Medicare and Medicaid Services
CPS	Current Population Survey
DMAS	Department of Medical Assistance Services
DSH	Disproportionate Share Hospital
ERISA	Employee Retirement Income Security Act of 1974
FAMIS	Family Access to Medical Insurance Security Plan
FPL	Federal poverty level
HDHP	High deductible health plan
HIFA	Health Insurance Flexibility and Accountability waiver
HSA	Health savings account
MEHIP	Municipal Employees Health Insurance Program
MEPS	Medical Expenditure Panel Survey
NHIS	National Health Interview Survey
SBP	Small Business Plan
SCHIP	State Children's Health Insurance Program
SIPP	Survey of Income and Program Participation
UVA	University of Virginia
VCU	Virginia Commonwealth University
VHCF	Virginia Health Care Foundation
VHCIAS	Virginia Health Care Insurance and Access Survey
VHHA	Virginia Hospital and Healthcare Association

Appendix D

Profiles of Other States

ARIZONA

Profile of the Uninsured in Arizona

	Percent
Percent of Non-Elderly Uninsured ¹	21%
Percent of Children Uninsured ¹	16
Percent of Children in Poverty Uninsured ¹	27
Percent of Non-Elderly Adults Uninsured ¹	24
Percent of Non-Elderly Adults in Poverty Uninsured ¹	45
Employers with fewer than 50 employees that offer health insurance ²	39
Employers with 50 or more employees that offer health insurance ²	93

¹ Data from the 2004-2005 Current Population Survey.

² Data from the 2004 Medical Expenditure Panel Survey - Insurance Component.

Source: Kaiser Family Foundation and 2004 Medical Expenditure Panel Survey.

Healthcare Group of Arizona

Description	Implementation Date	Enrolled	Estimated Cost
A state-sponsored public-private reinsurance program for small businesses with less than 50 employees	1985	16,000 individuals and 6,000 small businesses	Funded solely by member premiums (as of July 2005)

Source: JLARC staff analysis and literature review.

CALIFORNIA

Profile of the Uninsured in California

	Percent
Percent of Non-Elderly Uninsured ¹	21%
Percent of Children Uninsured ¹	14
Percent of Children in Poverty Uninsured ¹	25
Percent of Non-Elderly Adults Uninsured ¹	24
Percent of Non-Elderly Adults in Poverty Uninsured ¹	49
Employers with fewer than 50 employees that offer health insurance ²	42
Employers with 50 or more employees that offer health insurance ²	95

¹ Data from the 2004-2005 Current Population Survey.

² Data from the 2004 Medical Expenditure Panel Survey - Insurance Component.

Source: Kaiser Family Foundation and 2004 Medical Expenditure Panel Survey.

California Health Insurance System

Description	Implementation Date	Expected Impact	Estimated Cost
A single-payer health care system that provides coverage to all residents of California.	None, bill was vetoed.	Insure all California residents.	Unknown

Source: JLARC staff analysis and literature review..

HAWAII

Profile of the Uninsured in Hawaii

	Percent
Percent of Non-Elderly Uninsured ¹	11%
Percent of Children Uninsured ¹	6
Percent of Children in Poverty Uninsured ¹	14
Percent of Non-Elderly Adults Uninsured ¹	13
Percent of Non-Elderly Adults in Poverty Uninsured ¹	36
Employers with fewer than 50 employees that offer health insurance ²	77
Employers with 50 or more employees that offer health insurance ²	99

¹ Data from the 2004-2005 Current Population Survey.

² Data from the 2004 Medical Expenditure Panel Survey - Insurance Component.

Source: Kaiser Family Foundation and 2004 Medical Expenditure Panel Survey.

Prepaid Health Care Act of 1974

Description	Implementation Date	Expected Impact	Estimated Cost
Requires all employers to provide health insurance to employees who work 20 or more hours per week.	January 1975	Provide employer-sponsored insurance for nearly all Hawaiian workers.	No cost to state.

Source: JLARC staff analysis and literature review.

IOWA

Profile of the Uninsured in Iowa

	Percent
Percent of Non-Elderly Uninsured ¹	10%
Percent of Children Uninsured ¹	6
Percent of Children in Poverty Uninsured ¹	12
Percent of Non-Elderly Adults Uninsured ¹	12
Percent of Non-Elderly Adults in Poverty Uninsured ¹	34
Employers with fewer than 50 employees that offer health insurance ²	34
Employers with 50 or more employees that offer health insurance ²	98

¹ Data from the 2004-2005 Current Population Survey.

² Data from the 2004 Medical Expenditure Panel Survey - Insurance Component.

Source: Kaiser Family Foundation and 2004 Medical Expenditure Panel Survey.

Iowa's Initiatives

Program	Description	Implementation Date	Expected Impact	Estimated Cost
Health Insurance Premium Payment Program	Pays premiums, deductibles, and co-insurance for Medicaid recipients and family members of recipients with access to employer-sponsored insurance, when cost effective.	1991	Covered 9,350 individuals by December 2005	Saved Iowa \$12 million in FY 2006
IowaCare	Expands Medicaid coverage to Non-Elderly adults without children and parents to 200 percent FPL	July 2005	30,000 individuals expected. Enrolled 15,500 by October 2006.	Relinquished \$66 million in inter-governmental transfers for a section 1115 waiver.

Source: JLARC staff analysis and literature review.

MAINE

Profile of the Uninsured in Maine

	Percent
Percent of Non-Elderly Uninsured ¹	12%
Percent of Children Uninsured ¹	7
Percent of Children in Poverty Uninsured ¹	15
Percent of Non-Elderly Adults Uninsured ¹	14
Percent of Non-Elderly Adults in Poverty Uninsured ¹	27
Employers with fewer than 50 employees that offer health insurance ²	39
Employers with 50 or more employees that offer health insurance ²	94

¹ Data from the 2004-2005 Current Population Survey.

² Data from the 2004 Medical Expenditure Panel Survey - Insurance Component.

Source: Kaiser Family Foundation and 2004 Medical Expenditure Panel Survey.

DirigoChoice

Description	Implementation Date	Expected Impact	Estimated Costs
A voluntary, market-based program that offers coverage for all and premium subsidies to those below 300 percent FPL.	January 2005	Expected 31,000 individuals in premium subsidy program in first year. Enrolled 15,100 by May 2006.	Expected \$52 million a year. Expended \$29 million in first year.

Source: JLARC staff analysis and literature review.

MASSACHUSETTS

Profile of the Uninsured in Massachusetts

	Percent
Percent of Non-Elderly Uninsured ¹	12%
Percent of Children Uninsured ¹	6
Percent of Children in Poverty Uninsured ¹	12
Percent of Non-Elderly Adults Uninsured ¹	15
Percent of Non-Elderly Adults in Poverty Uninsured ¹	30
Employers with fewer than 50 employees that offer health insurance ²	52
Employers with 50 or more employees that offer health insurance ²	100

¹ Data from the 2004-2005 Current Population Survey.

² Data from the 2004 Medical Expenditure Panel Survey - Insurance Component.

Source: Kaiser Family Foundation and 2004 Medical Expenditure Panel Survey.

Massachusetts's Promoting Access to Healthcare

Program	Description	Implementation Date	Expected Impact	Estimated Costs
Individual Mandate	Requires all residents to have health insurance if affordable coverage is available.	July 2007	To cover 95 percent of the uninsured in three years and achieve near universal coverage.	\$1.2 billion over three years.
Commonwealth Care Insurance Program	Provides premium subsidies on a sliding scale to individuals up to 300 percent FPL.	October 2006		
Commonwealth Health Insurance Connector	Entity that helps individuals and small businesses purchase affordable and portable health insurance.	October 2006		
Fair Share Contribution	A annual fee paid by employer with 11 or more employees that do not provide health insurance coverage.	October 2006	Ensure that employers participate in financing health care.	Collect \$45 million the first year.
Free Rider Surcharge	Free rider surcharge is paid by businesses with 11 or more employees that do not offer coverage and whose employees utilize the uncompensated care pool.	October 2006		Unknown

Source: JLARC staff analysis and literature review.

MINNESOTA

Profile of the Uninsured in Minnesota

	Percent
Percent of Non-Elderly Uninsured ¹	10%
Percent of Children Uninsured ¹	7
Percent of Children in Poverty Uninsured ¹	17
Percent of Non-Elderly Adults Uninsured ¹	11
Percent of Non-Elderly Adults in Poverty Uninsured ¹	32
Employers with fewer than 50 employees that offer health insurance ²	42
Employers with 50 or more employees that offer health insurance ²	97

¹ Data from the 2004-2005 Current Population Survey.

² Data from the 2004 Medical Expenditure Panel Survey - Insurance Component.

Source: Kaiser Family Foundation and 2004 Medical Expenditure Panel Survey.

Minnesota's Medicaid and MinnesotaCare

Description	Implementation Date	Enrolled	Estimated Cost
Public health insurance programs that extend coverage to groups beyond federal minimum requirements.	Medicaid in 1966 and MinnesotaCare in 1987.	615,000 individuals insured in 2005	\$5.6 billion a year.

Source: JLARC staff analysis and literature review.

MONTANA

Profile of the Uninsured in Montana

	Percent
Percent of Non-Elderly Uninsured ¹	21%
Percent of Children Uninsured ¹	15
Percent of Children in Poverty Uninsured ¹	32
Percent of Non-Elderly Adults Uninsured ¹	24
Percent of Non-Elderly Adults in Poverty Uninsured ¹	46
Employers with fewer than 50 employees that offer health insurance ²	28
Employers with 50 or more employees that offer health insurance ²	95

¹ Data from the 2004-2005 Current Population Survey.

² Data from the 2004 Medical Expenditure Panel Survey - Insurance Component.

Source: Kaiser Family Foundation and 2004 Medical Expenditure Panel Survey.

Insure Montana

Description	Implementation Date	Expected Impact	Estimated Cost
Small businesses with two to nine employees are eligible to participate in a purchasing pool and receive premium assistance.	July 2005	Expected to enroll 350 businesses, 178 enrolled as of May 2006.	\$1.5 million a year

Source: JLARC staff analysis and literature review.

NEW JERSEY

Profile of the Uninsured in New Jersey

	Percent
Percent of Non-Elderly Uninsured ¹	17%
Percent of Children Uninsured ¹	11
Percent of Children in Poverty Uninsured ¹	28
Percent of Non-Elderly Adults Uninsured ¹	19
Percent of Non-Elderly Adults in Poverty Uninsured ¹	49
Employers with fewer than 50 employees that offer health insurance ²	54
Employers with 50 or more employees that offer health insurance ²	96

¹ Data from the 2004-2005 Current Population Survey.

² Data from the 2004 Medical Expenditure Panel Survey - Insurance Component.

Source: Kaiser Family Foundation and 2004 Medical Expenditure Panel Survey.

Summary of New Jersey Initiatives

Program	Description	Implementation Date	Expected Impact	Estimated Cost
"18 to 30" law	Increases the age that dependents can be covered by their parents' health insurance to 30 years.	May 2006	Insure 200,000 young adults.	No cost to the state.
NJ FamilyCare	Restores parents' eligibility for public health insurance to 133 percent FPL by 2007, and other initiatives to streamline the application and increase enrollment.	September 2005	Insure low-income parents.	Additional \$20 million a year.

Source: JLARC staff analysis and literature review.

NEW YORK

Profile of the Uninsured in New York

	Percent
Percent of Non-Elderly Uninsured ¹	15%
Percent of Children Uninsured ¹	8
Percent of Children in Poverty Uninsured ¹	15
Percent of Non-Elderly Adults Uninsured ¹	18
Percent of Non-Elderly Adults in Poverty Uninsured ¹	36
Employers with fewer than 50 employees that offer health insurance ²	50
Employers with 50 or more employees that offer health insurance ²	98

¹ Data from the 2004-2005 Current Population Survey.

² Data from the 2004 Medical Expenditure Panel Survey - Insurance Component.

Source: Kaiser Family Foundation and 2004 Medical Expenditure Panel Survey.

Summary of New York Initiatives

Program	Description	Implementation Date	Expected Impact	Estimated Cost
Family Health Plus	A state health insurance program for low-income parents and adults without children.	October 2001	600,000 enrollment goal, 526,000 enrolled in January 2006.	Total \$1.4 billion in 2004 with 50 percent federal match.
Healthy New York	A state-subsidized reinsurance mechanism for small businesses with 50 or fewer employees, low-income working individuals, and sole proprietors.	January 2001	107,000 enrolled in December 2005.	\$49.2 million in 2004.

Source: JLARC staff analysis and literature review.

OKLAHOMA

Profile of the Uninsured in Oklahoma

	Percent
Percent of Non-Elderly Uninsured ¹	22%
Percent of Children Uninsured ¹	15
Percent of Children in Poverty Uninsured ¹	25
Percent of Non-Elderly Adults Uninsured ¹	25
Percent of Non-Elderly Adults in Poverty Uninsured ¹	55
Employers with fewer than 50 employees that offer health insurance ²	29
Employers with 50 or more employees that offer health insurance ²	90

¹ Data from the 2004-2005 Current Population Survey.

² Data from the 2004 Medical Expenditure Panel Survey - Insurance Component.

Source: Kaiser Family Foundation and 2004 Medical Expenditure Panel Survey.

Oklahoma Employer/Employee Partnership for Insurance Coverage

Description	Implementation Date	Expected Impact	Estimated Cost
State-federal subsidized health insurance premiums for low-income employees of small businesses, self-employed, or not working.	November 2005	Expected to enroll 35,000 to 40,000 individuals. In October 2006 1,150 enrolled.	\$105 million

Source: JLARC staff analysis and literature review.

UTAH

Profile of the Uninsured in Utah

	Percent
Percent of Non-Elderly Uninsured ¹	17%
Percent of Children Uninsured ¹	12
Percent of Children in Poverty Uninsured ¹	33
Percent of Non-Elderly Adults Uninsured ¹	19
Percent of Non-Elderly Adults in Poverty Uninsured ¹	44
Employers with fewer than 50 employees that offer health insurance ²	36
Employers with 50 or more employees that offer health insurance ²	89

¹ Data from the 2004-2005 Current Population Survey.

² Data from the 2004 Medical Expenditure Panel Survey - Insurance Component.

Source: Kaiser Family Foundation and 2004 Medical Expenditure Panel Survey.

Utah's Premium Partnership for Health Insurance

Description	Implementation Date	Expected Impact	Estimated Cost
Provides premium assistance for low-income working adults and children with access to employer-sponsored insurance	November 2006	1,000 adults and 250 children	

Source: JLARC staff analysis and literature review.

WEST VIRGINIA

Profile of the Uninsured in West Virginia

	Percent
Percent of Non-Elderly Uninsured ¹	20%
Percent of Children Uninsured ¹	9
Percent of Children in Poverty Uninsured ¹	14
Percent of Non-Elderly Adults Uninsured ¹	24
Percent of Non-Elderly Adults in Poverty Uninsured ¹	48
Employers with fewer than 50 employees that offer health insurance ²	35
Employers with 50 or more employees that offer health insurance ²	91

¹ Data from the 2004-2005 Current Population Survey.

² Data from the 2004 Medical Expenditure Panel Survey - Insurance Component.

Source: Kaiser Family Foundation and 2004 Medical Expenditure Panel Survey.

West Virginia's State Business Plan

Description	Implementation Date	Enrollment	Estimated Cost
A public/private partnership that offers small business employees health coverage at reduced prices through the state employees' lower payment rates.	January 2005	1,000 enrolled in June 2006.	No state funds needed.

Source: JLARC staff analysis and literature review.

Agency Response

As a part of the extensive validation process, State agencies and other entities involved in a JLARC assessment effort are given the opportunity to comment on an exposure draft of the report. Appropriate technical corrections resulting from comments provided by these entities have been made in this version of the report. This appendix includes the written response from the Department of Medical Assistance Services.



DEC 06 2006

COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

PATRICK W. FINNERTY
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

December 4, 2006

Mr. Philip A. Leone
Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building, Capital Square
Richmond, VA 23219

Dear Mr. Leone:

Thank you for the opportunity to review and comment on the exposure draft of the report titled *Options to Extend Health Insurance Coverage to Virginia's Uninsured Population*. I commend you and your staff's effort in its broad examination of the issues surrounding the uninsured in Virginia. This report should be a useful tool for Governor Kaine's Health Reform Commission as it continues to deliberate on these same issues. As you and your staff are acutely aware, the topic of affordable health insurance coverage, and healthcare financing generally, is extremely complex, and solutions to issues like the societal costs of healthcare for the uninsured are not easily identified nor implemented.

As the report clearly indicates, State government, through the Department of Medical Assistance Services (DMAS), plays a major role in the financing of healthcare on behalf of the Commonwealth's most vulnerable and poorest citizens. The report correctly points out that eligibility criteria in the Virginia Medicaid program are among the strictest in the country. Based on these strict eligibility policies, the report is correct that options do exist to expand Medicaid coverage to citizens currently excluded from the program by modifying these eligibility criteria.

It is important to point out, and perhaps the report should also explicitly recognize, that S-CHIP (our FAMIS program) is a block grant program – not an entitlement. Support of Virginia's current S-CHIP program already requires the full annual federal allotment so no expansion is possible with federal funding unless our annual allotment increases. S-CHIP is up for reauthorization by Congress in 2007, so future S-CHIP funding levels are unclear at this time.

Regarding the factual accuracy of the draft report, I have included an attachment with specific comments on the text of the report, and we appreciate your staff's willingness to

Mr. Philip A. Leone
December 4, 2006
Page Two

incorporate previous comments during the course of your drafting process. Due to the time allowed for our review, we have limited our comments on the draft to items directly related to programs administered at DMAS. Most of these comments are simply clarifications to statements made in the draft. If you have any questions regarding these comments, please do not hesitate to contact Steve Ford, Director of the DMAS Policy and Research Division, at (804) 786-7355 or steve.ford@dmass.virginia.gov.

Obviously, DMAS has not had the opportunity to initiate an analysis of any Medicaid expansion options, particularly the estimated costs of any expansions, within the allotted time for review of this draft report. However, DMAS stands ready to work with all interested parties to further explore whatever options the Governor and General Assembly believe appropriate in response to this report. Again, thank you for the opportunity to comment on the draft report.

Sincerely,

A handwritten signature in black ink, appearing to read "Patrick W. Finnerty".

Patrick W. Finnerty
Director

PWF/sf

Attachment

cc: The Honorable Marilyn B. Tavenner, Secretary of Health and Human Resources

Specific Comments to JLARC draft report titled: *Options to Extend Health Insurance Coverage to Virginia's Uninsured Population*

Page iv: While the report indicates that “up to 108,000 uninsured children were eligible for Medicaid or FAMIS in 2005 but not enrolled” we believe that this estimate is potentially subject to the same level of uncertainty associated with uninsured estimates across the general population. As the draft report indicates, currently accepted estimates show a variation of -37 percent relative to an upper bound of 1,000,000 uninsured in Virginia. Assuming this figure is largely based on the CPS, we must point out that one frequent criticism of the CPS is the underreporting of individuals covered by public programs. Because the CPS is a survey, the data relies on self reports, and respondents often may not want to report they are covered by programs such as Medicaid.

We appreciate the draft report’s acknowledgement that the 108,000 children is not a hard target. As part of the recent analysis by the Urban Institute and discussions with VIICF and others, DMAS has recently been advised to cease reporting the percentage enrolled as compared to a presumed target population. Because the number of uninsured is so fluid, the estimates vary, and the data sources are so different, we no longer compare our actual enrolled caseload to any estimate of remaining eligible children. These same comments apply to (old) page 31 of the draft.

Page 45: While we have not had time to review the cost estimation methodology utilized for the estimate of expanding the Medicaid population to include parents up to 100 percent FPL, assuming the estimated costs are correct, we would state that while the societal costs of currently serving the uninsured may impact the calculation of the additional or net cost of the expansion, the impact on the State budget, in particularly the DMAS Medical Program Services budget, would not be offset by the current uninsured costs, except to the extent the need for DSH or other funding (such as SLH, in another line of the budget) is diminished. This would not appear to be a dollar for dollar offset as may be implied in the draft report.

Page 47: To clarify, federal requirements mandate that reviews of eligibility must be conducted annually, a mandate which Virginia follows. While individuals are supposed to report changes in circumstances when they occur (which would trigger a review outside of the annual schedule), if there are no changes, a family will receive uninterrupted coverage for one year. Additionally, there is no federal requirement for face-to-face interviews in the Medicaid program and Virginia does not conduct face-to-face interviews routinely for the Medicaid program.

Page 47: It is true that the focus of most of the outreach efforts have been directed toward the enrollment of children, but many of these efforts have also been applied (and were intended to be applied) to all Medicaid applicants generally. In fact, many providers, such as VCU Health System, have been aggressively screening patients of all ages for Medicaid eligibility through the out-placement of eligibly workers in the healthcare provider setting for quite some time.

Page 48: The draft report states that “Staff at the Department of Medical Assistance Services (DMAS) have indicated that savings do not exist to fund such a program.” In fact this statement is based on a DMAS review of an earlier draft in which we indicated that if the draft report is implying that the state could generate savings from current Medicaid/S-CHIP programs to generate “new” funding for expansions or other programs, we would caution that these savings opportunities would need to be identified as real, achievable savings prior to utilizing such a funding method. The draft report does not identify these savings opportunities, and while DMAS continuously looks for ways to stretch the Medicaid dollar through increased efficiencies and innovative care delivery approaches, and we are ready and willing to examine potential savings options identified by others, we do not believe savings are available in the magnitude necessary to fund an expansion of the extent identified by the report (estimated at over \$100 million GF). In fact, the efficiencies generated by the Medicaid program most often are already reflected in the Medicaid forecast, which primarily dictates agency funding requests from year to year, so savings already achieved are already reflected in the Medicaid budget itself; the dollar savings amounts simply do not exist for application to other purposes.



JLARC Staff

Executive Staff

Philip A. Leone, Director
Glen S. Tittermary, Deputy Director

Division Chiefs

Robert B. Rotz, Senior Division Chief
Harold E. Greer III, Division Chief

Section Managers

Patricia S. Bishop, Fiscal & Administrative Services
Gregory J. Rest, Research Methods
Walter L. Smiley, Fiscal Analysis

Project Leaders

Aris W. Bearse	Eric H. Messick
Justin C. Brown	Nathalie Molliet-Ribet
Ashley S. Colvin	Kimberly A. Sarte
Martha L. Erwin	

Project Staff

Janice G. Baab	Pinki N. Shah
Jamie S. Bitz	Tracey R. Smith
Jennifer K. Breidenbaugh	Elisabeth M. Thomson
Eileen T. Fleck	Christine D. Wolfe
Paula C. Lambert	Kent S. Wyatt
Brad B. Marsh	
Ellen J. Miller	
Jason W. Powell	

Administrative and Research Support Staff

Joan M. Irby	Betsy M. Jackson
--------------	------------------

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Joint Legislative Audit and Review Commission
Suite 1100
General Assembly Building
Capitol Square
Richmond, Virginia 23219
804-786-1258 Fax 804-371-0101
<http://jlarc.state.va.us>