LESSONS LEARNED FROM OTHER STATES & VIRGINIA: CHALLENGES AND OPPORTUNITIES IN EXPANDING HEALTH INSURANCE COVERAGE

A Virginia Planning Grant Briefing Paper

Introduction

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

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

To be successful, most state approaches lower the effective price of coverage (providing subsidies for purchase of private insurance or by making reduced-price coverage available) and/or lower or eliminate other coverage barriers such as restrictive eligibility rules. *(NCSL, March 2004)*

In addition, a 2002 study by the National Academy of State Health Policy concludes that for voluntary coverage to have a significant impact, health benefits must be comprehensive, well marketed, with a simple eligibility process *(NASHP, November 2002)*.

While not all state efforts to increase health insurance coverage have been successful, most state efforts have been undertaken to address at least one of the following goals:

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

The first approach, **improving access to <u>private</u> health insurance**, is the focus of this report and typically includes the following options for states:

1) *Subsidizing or Reducing the Cost of Private Coverage:*

- <u>Create premium assistance / private insurance buy-in programs</u> (funded by Medicaid and/or SCHIP)
- <u>Make state-funded reinsurance available</u> (Reduce price of private insurance for low-income uninsured and small employers by having state cover portion of health insurers' high-cost or catastrophic claims)
- <u>Provide health insurance tax credits or deductions to purchase coverage</u>
- <u>Allow sale of no-mandate insurance policies exempt from state-mandated benefit requirements</u>
- <u>Authorize tax-free health savings accounts (HSAs)</u> for covered individuals to offset part of cost of deductibles, co-payments or other non-covered expenses
- <u>Allow group purchasing arrangements for health insurance</u> such as association health plans

2) *Eliminating Barriers to Getting Insurance:*

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

3) *Compelling Employers to Provide Coverage for Certain Groups:*

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

The second approach, **expanding government insurance programs**, typically includes the following state options:

1) *Expanding the Medicaid and/or SCHIP Programs*
2) *Strengthening Outreach and Enrollment for the Medicaid and/or SCHIP Programs*
3) *Establishing or Expanding State High-Risk Pools that Make Individual Coverage Available*
4) *Sponsoring a State-Only (use of no federal funds)*:

- Health insurance program for uninsured low-income individuals
- Universal health insurance plan covering all state residents

See *Appendices A and B* for what Virginia has done/is considering to expand government insurance programs and increase non-insurance access to care options.

Approaches for Expanding Private Coverage for the Working Uninsured

The following state approaches may represent the best options for expanding insurance coverage under the mission of the Virginia State Planning Grant—*to improve access to health insurance for the working uninsured*.

Publicly Funded Reinsurance Programs

Purpose
To reduce steep premium increases for small employers with high claims experience.

Current Examples

State	Program/Start Date	State-Subsidized	Eligible Population
New York	*Healthy New York / 2001*	Yes	Small businesses (50 or fewer employers) whose 30% of employees earn less than $32,000 and uninsured workers, sole proprietors, uninsured individuals, low-income working families (<250% FPL). Plan contracts only with HMOs.

As of August 2004, the *Healthy New York* had about 67,000 active enrollees and was averaging 5,500 new enrollees per month. As of December 2003, 59% were working individuals, 21% were small-group employees, and 21% were sole proprietors. According to an independent evaluation in 2003, the program financed about 3.6% of medical claims costs in 2002 through its corridor reinsurance arrangement (before the program lowered the lowered the corridor). For 2003, state reinsurance payments were projected to reach $12 million. *(SCI, October 2004*) In addition, premium affordability is still a challenge (premiums still exceed 5% of income).

Louisiana	*LaChoice / 2004*	Yes	Pilot program modeled after NY. Small businesses (10 or fewer employees).

Other Examples

State-subsidized:	AZ (Health Care Group of Arizona)
Conventional:	CT (Small Employer Health Reinsurance Pool); ID (Small-Group and Individual Reinsurance Pools); MA (Small Group and Nongroup Health Reinsurance Plans; NM (Health Insurance Alliance)

Lessons Learned
- Many state pools are inactive or have low enrollment
- May be too early to determine effectiveness of these programs
- Very substantial subsidies may be needed to significantly affect uninsurance rates
- Substantial marketing efforts are needed to advertise the program
- Key to success are low (subsidized) premiums, high benefits, significant insurer participation
- Spouses of covered individuals may drop coverage to participate; Issues of "crowd-out" are raised
- Programs are vulnerable to adverse selection when trying to address market irregularities. Programs must be designed carefully to succeed. State can protect against adverse selection by balancing program rules and market rules. *(SCI, October 2004; NCSL, March 2004)*

Regulatory Implications for **Virginia**
- Legislature would need to create an authority to adopt such programs
- To determine financial risk, an actuarial analysis of the covered population is required

Tax Incentives

Purpose

The states listed provide tax relief, either through tax deductions or credits, to an employer or individual who purchases health insurance for themselves, their family, or their employees. A tax incentive is a credit or a deduction that reduces the cost of purchasing health insurance through a reduction in an individual or employer's tax burden.

Current Examples

State	Start Date	Deduction/Credit	Amount	Eligible Population
Oklahoma		Credit	100%	Employers whose eligible employees elect to participate in state-certified basic benefit plan
Maine	1999	Credit	Lower of: $125 per employee with dependent coverage; or 20% of dependent premiums	Small employers with less than five low income employees.
Arizona		Enterprise Zone Credit		New qualified employment positions including health insurance coverage; employer pays 50% of the premium.
Montana	2005	Credit		Small businesses to allow them to join together to negotiate lower-cost worker health insurance. The initiative is to be funded from a $1 per pack cigarette tax revenues.

Other Examples

Several states (AR, CA, DE, GA, ID, IL, MN, NJ, SC, WI) allow self-employed individuals to deduct the full amount of their health insurance premium payments from state income tax. North Carolina is considering legislation that would give a tax credit to small employers (25 or fewer employees) that pay at least half of their employees' health insurance premiums.

Virginia's Consideration of this Approach

Current Legislation	Summary	Status
SB 1255 Sponsor: Lambert Introduced 1/18/2005	Amends code to provide income tax credits for small businesses (<50 employees) for cost of health insurance premiums	Died in Committee on Finance; not carried over to 2005

Lessons Learned

- Appear to have minimal impact on increasing coverage, in part because the value of the tax incentives relative to the price of coverage is so small.
- Tax subsidies must be substantial (60% or more) to have a significant impact on uninsurance rates.

(NCSL, March 2004)

Regulatory Implications for **Virginia**

- Legislature would need to examine the impact on state revenues.

Sale of No-Mandate or "Mandate-Lite" Benefit Policies

Purpose

States hope that by dropping the requirement to cover some or all mandated health benefits, the price of coverage will drop, and as a result, more employers and individuals will buy coverage.

Current Examples

Colorado:	Enacted in 2003, program exempts the state-designated, Basic Group Health Benefits Plan from covering 6 of the state's health benefit mandates.
Montana:	One-year demonstration project allows health insurance carriers to offer a limited coverage individual health benefit plan or managed care plan.
North Dakota:	Exempts insurers from providing coverage for 9 state mandates in their basic small employer health insurance policies.
Massachusetts:	Proposed plan (2004) would eliminate insurance mandates to entice small businesses to offer insurance and penalize employers that fail to offer coverage.

Similar legislation is being considered in Illinois, Indiana, Kentucky and Georgia.

Virginia's Consideration of this Approach

In 1990, a special advisory commission was established to examine the social and financial impact and medical efficacy of existing or proposed mandated health insurance benefits. The Commission developed guidelines for review of legislation mandating health insurance coverage. The guidelines establish a systemic process for evaluation of legislation addressing mandated health insurance benefits and reviews bills at the request of the committee of jurisdiction within the General Assembly.

Current Legislation	Summary	Status
HB 1362 Sponsors: Marshall, Hogan, Hurt Introduced 1/22/2004	Would amend and reenact provisions related to Advisory Commission on Mandated Health Insurance Benefits. Proposed moratorium on new health insurance mandates until 2009.	12/10/04 House: Withdrawn from Commerce and Labor
HB 935/ SB 679 Sponsors: Marshall / Martin	Permits companies offering accident or sickness insurance policies or plans to offer a policy or plan that does not offer or provide all of the existing state-mandated health benefits.	Passed in House, but stricken in Senate at patrons request.

Lessons Learned

It is not clear that waiving benefit mandates increases coverage rates; different studies have yielded conflicting results. A 2002 Congressional Budget Office study estimated that the exemption from state mandates would lead to a 5% savings in insurance costs for people in no-mandate plans, resulting in an estimated 5.1% increase in the number of firms offering coverage. A 1998 study concluded that state mandates are associated with a 0.4% rise in adult uninsurance for each additional mandate, and that 20-25% of the uninsurance is due to benefit mandates. Negative effects are strongest among small employers. *(NCSL, March 2004)*

Regulatory Implications for **Virginia**

- New legislation would be required to resurrect a limited benefit plan.

Tax-Free Medical Savings Accounts

Purpose

Medical savings accounts (MSAs) are accounts for covered individuals and their families that assist to finance part of the cost of insurance deductibles, co-payments and other medical expenses not covered by their health insurance plans.

Current Examples

Most states with income taxes have laws allowing for the same type of tax deductibility for MSA plans as allowed under federal law.

Virginia's Consideration of this Approach

Initiative	Description	Target Population	Context and History	Further Information
Medical Savings Accounts (MSAs)	Participants in MSAs make tax-free deposits on a regular basis that are used to cover routine medical care up to the amount of the deductible. Used in connection with a high deductible plan, with deductible amounts set in law.	Individuals and firms up to 50 employees.	MSAs were developed as a pilot project by the federal government under HIPAA, passed in 1996. **HB 414** was passed by the 2002 Session of the Virginia General Assembly to address the implementation of the Virginia Medical Savings Account Plan. Virginia's experience with MSA's mirrors other states experience, in that wide participation in these types of plans has not been realized. In 2002, the State Corporation Commission estimated that a minimum of 3,000 individuals participated in high deductible plans with MSA's in Virginia. In addition, Virginia has experienced a reduction in the number of insurers offering coverage options with MSA's. MSA demonstration programs expired in December 2003.	2002 MSA report: http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/83ae7c2f3cd8670385256cef006adf17?OpenDocument&Highlight=0,MSA 2003 High Deductible Plans with MSA report: http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/83ae7c2f3cd8670385256cef006adf17?OpenDocument&Highlight=0,MSAs

Lessons Learned

It is unclear whether MSAs have had a measurable impact on health coverage rates. An initial study of the use of MSAs by the U.S. General Accounting Office found that demand for MSAs was low in part because of the perceived complexity of the combination high-deductible plan/MSA insurance product for both insurers and insurance agents. Tax deductibility appears to primarily benefit middle and upper income employees who are less likely to be uninsured. *(NCSL, March 2004*)

Consumer-Driven Health Plans

Purpose

Considered a possible successor to medical savings accounts, consumer-driven health plans are defined generally as an employer-funded personal benefit account in which the employee is responsible for paying a certain deductible. Coverage is for major health care expenditures and offers employees provider choice and flexibility and accessible consumer health care information services, often via the Internet.

Health Savings Accounts (HSAs)

Created by 2003 Medicare Modernization Act; HSAs must be coupled with a high-deductible health plan ($1000/individual; $2000/family); maximum out-of-pocket is $5000 and $10,000 respectively. Starting in 2004, full deposits are allowed. HSAs make everyone eligible for income tax credits (up to $2600/individual; $5150/family).

Most employers with HSA plans will see their health care costs drop 5-10 percent; some predict small business (2-50 employees) can cut premiums up to 50 percent by implementing HSAs. HSAs may attract disproportionately healthy employees; many employers worry that sicker employees staying in traditional plans will drive up costs and fracture the insurance market. Most employers are taking a 'watch and see' approach. HSAs are complex and hard to understand; confusion exists over the difference between HSAs and MSAs.
HSAs cannot provide first-dollar coverage except for preventive care. They may delay one obtaining needed care. Most HSAs will not eliminate elevated medical expenditures (most spending above deductible of HSAs).

Current Examples

As of early 2005, HSA and MSA-related legislation exists in over 30 states. At least 6 states (including Virginia) have enacted HSA laws. Some states have first-dollar mandates for benefits that may not fit definition of preventive services. ***Virginia's*** *Consideration of this Approach*

Current Legislation	Summary	Status
HB 1492ER Sponsor: Brink Companion to **SB 1097ER**	Revises state code related to Health Savings Accounts. Includes requirement for Dept of Taxation to develop a system of income tax deductions or credits for employers contributing to HSAs, and providers who provide care to HSA holders at reduced cost or without compensation; and to eligible individuals who qualify under federal and state definitions as the working poor.	Approved by Governor 3/31/2005. Effective 7/1/2005.
HJR 818ER (amendment as substitute) Sponsor: House committee on Rules (Hamilton) Introduced 2/3/2005	Requests that the Medical Society of Virginia, Virginia Association of Health Plans, Virginia Hospital and Healthcare Association, Board of Medicine, and Virginia Department of Health meet and report on high deductible health insurance plans and quality initiatives.	Passed House and Senate 3/16/2005.

Health Reimbursement Accounts (HRAs)

HRAs may be offered with any insurance plan and for any amount of money (negotiable between employer and employee). These accounts can be used to pay for services not covered by other plans; it does not have to be used along with a high deductible plan.

HRAs may be funded or unfunded, but if funded must be employer money. Employers do not have to pre-fund the account; amount of money to be used via the account is pre-established with the employee. Firms of any size can fund HRAs for their employees.

Employees must spend their HRA amounts before tapping flexible spending account balances. If employer goes out of business, the employee loses his funding for the HRA. If employee leaves business, the HRA can be used to subsidize COBRA. Healthy employees can accumulate a significant nest egg over time—a feature that critics fear will undermine traditional health plans.

Lessons Learned

- Plans are too new to have an established track record
- Some companies are combining HSAs and HRAs as an employee option and as another way to assist employees in directing their own health care.
- AETNA has begun offering such plans with rates based on age. Survey of over 300 mostly-large employers found that 19 percent already offer a HRA or HSA; another 14 percent plan to do so in 2005 or 2006.

Regulatory Implications for **Virginia**

In general, these types of plans are politically popular and have broad legislative support.

Group Purchasing Arrangements

Purpose

Allowance of most group purchasing arrangements permit small employers to band together to purchase health insurance and negotiate provider discounts in order to gain the same administrative efficiencies and purchasing clout as large employers.

Association health plans allow individuals and small businesses to buy-in to a plan sponsored by an association. These plans may suffer from adverse selection in Virginia due to liberal underwriting policies.

Current Examples

California:	*PacAdvantage*, the country's largest nonprofit small employer health insurance purchasing pool, covered 147,000 employees and 11,000 small employer groups in the state.
Connecticut:	Connecticut Business and Industry Association (CBIA) operates a small group purchasing cooperative for employers. CBIA Health Connection allows employers with 3-100 employees to choose among various health plans. About 10,000 employees are currently covered.

As of 2001, 21 states had authorized the formation of purchasing cooperatives. Proposed legislation in Illinois would create a public-private partnership to help small businesses purchase health insurance by allowing small employers, self-employed and farmers to form health benefit cooperatives.

Virginia's Consideration of this Approach

Studies in the late 1990s by the Joint Commission and Mercer found purchasing cooperatives were not effective in achieving significant savings. Only about a three percent maximum savings was found.

Initiative	Description	Target Population	Context and History	Further Information
Local Choice Expansion (Pooled Purchasing Arrangements)	Expansion of program available to local government employees.	Small businesses, employees of Free Clinics and Community Health Centers	Local choice expansion was examined in 1999 and found to not be a viable solution, because it would not be expected to provide the price discounts needed to offset the administrative costs that would be incurred by small businesses.	External Link: http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/0b4b1e3f1b14aa958525671a00693b3f?OpenDocument See also http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/88d0e49c5627fa9c85255fda0075ec5e?OpenDocument
Health Insurance Purchasing Cooperatives (HIPCs)	Allows small employers to pool together to purchase health insurance, increasing their buying power.	Small employers	A number of bills were passed in 1999 directing studies on a variety of insurance expansion options. **SHR 489** (1999) called for a study including actuarial analysis of the impact of cost savings for small employers through HIPCs. Previous studies on HIPCs were also conducted in 1993 and 1994. Analysis conducted by Mercer indicated that the maximum anticipated savings that would result from implementation of HIPCs in Virginia would be 3.5%.	External Link: http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/79dd08181fe4637b852561570068a68b?OpenDocument See also: http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/0b4b1e3f1b14aa958525671a00693b3f?OpenDocument

Inclusion of self-employed in small group market	Would allow self-employed individuals to purchase insurance through small group market (defined as 2-50 employees in Virginia Code).	Self employed individuals	The JCHC in 2000 concluded that inclusion of self- employed individuals in the small group market might lead to adverse selection. Legislation was introduced (but failed in committee) to allow self-employed individuals to buy in to the state employee health plan.	External Link: http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/0b4b1e3f1b14aa958525671a00693b3f?OpenDocument

Current Legislation	Summary	Status
HJ 696 Sponsor: Brink Introduced 1/12/2005 Companion to **SJR 400**	Requests Secretary of Administration to prepare a program design for a voluntary public private health insurance purchasing pool for small businesses (<50 employees)	Passed by indefinitely in Rules.

Lessons Learned

There appears to be little evidence that group purchasing arrangements increase health insurance coverage rates or the ability of small employers to offer such insurance. (*NCSL, March 2004*) Recent interest in allowing more national trade group purchasing through the bypassing of state laws and regulations is under discussion.

Regulatory Implications for **Virginia**

Involvement of multiple employers would likely trigger compliance requirements with the U.S. Department of Labor Multiple Employer Welfare Arrangements (MEWA) regulations. MEWAs are designed to give small employers access to low-cost health coverage on terms similar to those available to large employers.

Small Group Rating Reforms

Purpose

Small group rating reforms are designed in part to increase the number of small employers that offer insurance by controlling the variability in premium rates.

Current Examples

New York:	Requires insurers to charge all small employers the same per-employee rate for the same coverage.
New Jersey:	Prohibits insurers from considering health characteristics when setting a group's rates and does not allow insurers to charge the oldest groups more than twice the rate charged for the youngest groups.

Virginia's Consideration of this Approach

Carriers offering plans to small businesses must meet minimum benefit packages, called essential and standard benefit plans (created in the early 1990s by medical practitioners). Essential plans are designed for children under 18, while standard plans have no age limit. These plans are intended to offer a rich array of coverage options for small business; however many such employers view them as difficult to administer. In Virginia, small employers are provided with guaranteed issue and can also participate in association-sponsored health plans.

Lessons Learned

Small group rating reforms have not appeared to raise the likelihood of small employers offering coverage or employees taking up coverage. To be widely utilized, substantial subsidies may be needed. The high-risk nature of these plans makes implementation difficult in a strict regulatory climate (i.e., ERISA, HIPAA).

Regulatory Implications for **Virginia**

Significant new legislation may be needed to create a benefit plan other than an essential or standard plan that will enjoy increased market penetration.

Individual Insurance Market Reforms

Purpose

Such reforms are intended to increase persons covered by individually purchased health plans and improve consumer protections under these plans. Typically, these reforms place restrictions on factors used to set initial or renewal rates for policies and set limits on efforts to exclude coverage for preexisting conditions or requirements to issue coverage to those no longer eligible for group coverage.

Current Examples

Over 20 states have a 'guarantee issue' requirement (i.e., they must sell coverage to anyone who applies) and limit the extent to which insurers can charge higher premiums based on experience of insured.

Virginia's Consideration of this Approach

There is no evidence that individual reforms have improved coverage rates of the working uninsured in Virginia.

	Description	**Target Population**	**Context and History**	**Further Information**
Indigent Health Care Trust Fund (IHCTF): *Pilot Projects for the Uninsured*	Section 32.1-335 of the Virginia Code requires the Technical Advisory Panel of the IHCTF to "establish pilot health care projects for the uninsured." Appropriations Act (Item 320b) also required DMAS to use funds donated to IHCTF "for the purpose of a demonstration project in select sites across the Commonwealth to assist low income employees in purchasing employer sponsored health insurance."	Low-income employed individuals	A 2002 Virginia Joint Commission on Health Care (JCHC) report indicated that previous attempts to implement these kinds of projects were unsuccessful.	External Link: http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/b92483ffd1f2c58e85256b4f006bc66d?OpenDocument

Lessons Learned

Individual market reforms in most states do not require state funding.

Regulatory Implications for **Virginia**

State regulations may actually decrease insurer willingness to sell individual coverage.

Enact/Broaden State Continuation-of-Coverage Laws

Purpose

Continuation-of-coverage laws allow employees and their covered dependents to continue health coverage under an employer-sponsored plan after the employee leaves or is terminated. These laws generally apply to employers with fewer than 20 employees (who are not subject to federal COBRA rules requiring up to 18 months coverage).

Current Examples

Nearly all states require group insurers to offer continuation coverage. The length of time of such coverage varies from as little as 3 months (e.g., Virginia) to as much as 36 months (e.g., Nevada).

In Virginia, the employer can choose between offering 90-day continuation coverage or conversion to an individual policy. COBRA can be extended up to 36 months on age-dependent basis.

Lessons Learned

No state studies on effectiveness exist. However, studies of the federal COBRA continuation law show that such coverage should have a positive influence on coverage rates. Unless state laws for employers with fewer than 20 employees are the same as the COBRA rules for larger employers, insurers have the burden of complying with differing state and federal continuation provisions.

Regulatory Implications for **Virginia**

In 2004, Virginia code 38.2-3525 was amended to repeal the statutory requirements for continuation coverage limiting age.

Allow Other Groups to Join State Employee Health Benefit Plans

Purpose

Allows certain groups and individuals that have trouble obtaining affordable coverage (e.g., universities, colleges, public schools, cities and counties, small employers) to buy their coverage through a state's employee health benefit plan.

Current Examples

Connecticut:	Added employees of small employers in 2003 to the list of employees for whom the state is authorized to arrange group health coverage under the state employee health plan law.
West Virginia:	In 2004, the state enacted legislation creating a sub-pool under the state Public Employees Insurance Agency to create an affordable, full-coverage health insurance plan for small businesses.

In 2000, state employee health benefit plans in 30 states covered public colleges/universities; 20 covered public schools; and 22 covered cities and counties.

A New Mexico bill allows small employers who employ 50 or fewer employees over a 12-month period to voluntarily purchase health coverage through the state's employee health insurance plan. The measure also allows the state to enter into agreements with an association or cooperative representing small employers to provide outreach and assistance to small employers.

Virginia's Consideration of this Approach

Initiative	Description	Target Population	Context and History
State Employee Health Benefit Program Expansion	Buy in option for part-time state employees	Part-time state employees	**HB 525** passed in 2004, allowing part-time state employees to participate in the state employees and retired state employees health benefit plan. The full premium cost shall be paid by the employee. Effective July 1, 2004
Local Choice Expansion (Pooled Purchasing Arrangements)	Allows local governments to buy into the state employee insurance program for their employees.	Employees of local government entities	Established in 1990 by **HB 1116** in response to local governments concerns about ability to purchase health insurance for their employees Senate Joint Resolution **(SJR) 124** and House Joint Resolution **(HJR) 202** of the 1998 Session of the General Assembly directed the Joint Commission on Health Care to study various issues regarding pooled purchasing arrangements for health insurance for small employers, community health centers, and free clinics. See report: http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/0b4b1e3f1b14aa958525671a00693b3f?OpenDocument

Lessons Learned

No studies examining the effects of expanding eligibility for state employee health plans on coverage rates of other groups are known to exist.

Regulatory Implications for **Virginia**

Any further changes in coverage would require legislation.

Compelling Employers to Provide Coverage

Employer Mandate

Such a mandate (often called 'pay or play') requires employers to offer health insurance to some or all of their employees. It may also require the employer to 'reimburse' the state (i.e., tax penalty) for employees on Medicaid and SCHIP.

Hawaii is the only state with a current employer mandate requirement. At least 10 states are considering legislation.

State Example:	**Hawaii**
Lessons Learned:	Mandate has resulted in significantly more persons becoming insured.

Conditioning State Benefits and Contracts on Health Care Coverage

This policy requires employers doing business with the state to provide their employees health insurance coverage. At least 11 states are considering legislation.

Reporting Employees on Public Assistance

This policy intends to 'shame' employers into providing employee coverage. It requires public assistance applicants/beneficiaries to provide the name of their employer. New public disclosure rules under HIPAA may present an effective barrier to the implementation of such programs.

One state—Massachusetts—has a law. At least 20 states, including Virginia have considered legislation.

Other Approaches

Comprehensive Reform

Purpose: To systematically address issues of costs, quality and access to care.

State Example: **Maine**

Under Maine's recently enacted *Dirigo* plan, the state intends to access to coverage to as many as 180,000 state residents, specifically small business employees, the self-employed, and individuals. *Dirigo Choice*, a public-private health plan for small businesses (2-50 employees), provides sliding-scale premium discounts based on ability to pay. Employers offering this product to employees and pay at least 60% of the costs are to benefit from lower rates as a result of greater risk pooling. The objective for the first year of the plan is to enroll up to 31,000 residents through their employers and 4,500 self-employed or unemployed individuals. After the first year, Maine plans to charge insurers an annual assessment only if cost savings are achieved in the system. *(SCI, January 2005)*

Lessons Learned*:* Initiative has been slow to be implemented as a lower than expected number of participating insurers and enrollees has been realized.

State Example*:* **Arkansas**

To improve private coverage for its uninsured residents, Arkansas formed the Arkansas Health Insurance Roundtable, a coalition of health care purchasers and providers, consumers, and insurers, which crafted a multi-faceted strategy to 1) implement legislation to allow insurance carriers to offer less-costly health plans without the full list of state-mandated benefits, use of community-based health insurance purchasing pools; 2) include evidence-based decision-making in proposed expansions; and 3) implement an innovative employer-state partnership to provide health insurance to low-income employees and families.

To implement the employer-state insurance partnership, the state authorized the pursuit of a federal Health Insurance Flexibility and Accountability (HIFA) waiver to provide subsidies to employers that have not recently offered health coverage to its employees at under 200% FPL. Participating employers must pay a state tax to help generate the necessary state matching funds to draw down additional federal funds under the waiver. *(NCSL, March 2004)*

Lessons Learned: As of the end of 2004, the Arkansas HIFA waiver had not been approved by the federal government; thus it is too early to know what impact the proposed partnership might have.

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APPENDIX A

Virginia: Publicly Funded Coverage Expansion Initiatives

Initiative	Description	Target Population	Context and History
Uninsured Medical Catastrophe Fund (UMCF)- External Link: http://www.dmas.virginia.gov/rcp-indigent_health_care_trust_fund.htm	The UMCF will pay for services needed to treat an acute illness or injury or the acute phase of a chronic illness. Services must be part of an approved treatment plan. The proposed treatment plan must be for a course of treatment to remediate, cure, or ameliorate the life threatening illness or injury. The treatment plan must be completed within 12 months	Eligible individuals must have income under 300% of federal poverty level, have a life-threatening illness or injury, and be uninsured for the needed treatment.	Established by the 1999 General Assembly. Funded through donations; taxpayers can contribute through tax return. UMCF has had limited benefit: Since 1999, the program has served just two persons—balance $73,174 ($67,000 contract; $13,000 approved). This program is not mandated and is subject to availability of funds.
High Risk Pool External Link: http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/23517025a9c001c085256722006c617a?OpenDocument **See also:** http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/9bec1118bb974de5852565940052eb6c?OpenDocument	A state created plan that offers coverage to individuals who have been denied coverage because of a preexisting medical condition in the individual insurance market.	Persons with high risk medical conditions	**SJR 126** (1998) directed the JCHC to study the feasibility of establishing a high-risk pool in Virginia. The study concluded that costs of coverage under Virginia's open enrollment program are comparable to those offered in other states with high risk pools and that establishment of a high risk pool would be duplicative with the state's open enrollment program. A previous study on high-risk pools was conducted in 1997.
Open Enrollment / Guaranteed Issue	Programs are administered by non-profit carrier and must provide issuance of open enrollment contracts without medical underwriting criteria such as non-renewability or cancellation due to individual's age, medical condition, job classification. The plans are often compensated by the state for losses incurred as a result of open enrollment requirements.	High-risk Individual subscribers, Medicare extended enrollees (i.e. under 65 with a disability) and high-risk individuals converting from group coverage.	Established in 38.2- 4216.1 of the Virginia Code. Originally open enrollment was established in both small group and individual market, however statutory revisions limited it to individual market in 1997, following passage of HIPAA, which provided guaranteed issue in group markets. Has been replaced with guaranteed issue more recently.

SCHIP (FAMIS) Program simplification	Program simplification measures were undertaken in September 2002, to streamline the application process and increase enrollment. These included: • Simplified joint application for children for both Medicaid and FAMIS (including a Spanish language version). • Elimination of unnecessary verification requirements. • Leveling off Medicaid eligibility at 133% of the poverty level for all children regardless of age. • Instituting a "No Wrong Door" policy so families can submit the joint application at either the local DSS or the FAMIS CPU. • Allowing an exception to the waiting period in FAMIS since the child last had insurance, if the former insurance was not really affordable. • Allowing caretaker relatives, even without legal custody, to file an application on behalf of a child. • Eliminating monthly premiums.	Children who are eligible, but not enrolled in FAMIS (up to 200% of FPL)	Additional changes to the program became effective in August 2003 as instructed by the General Assembly. These included: • Addition of new community mental health benefits • Reduction of waiting period (for children with previous private insurance) from 6 months to 4 months • Guarantee of 12 months continuous coverage • Renaming the Medicaid program for children to FAMIS Plus On May 12, 2004. Governor Warner provided a charge to increase coverage of children under FAMIS and FAMIS Plus for a target of 100,000 children enrolled during his administration**.** Per DMAS reports, this target was met. For the latest enrollment report see: http://www.famis.org/English/reports/EnrollmentReport02-05.htm Also see 2004 Quarterly Report on FAMIS: http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/660963e799f2f93d85256f5f00751ddd?OpenDocument
Outreach projects to increase enrollment in SCHIP program (FAMIS)	**Sign Up Now (SUN)-** SUN's mission is to be a resource to community-based organizations through training, technical assistance and support to community organizations that help	Children who are eligible, but not enrolled in FAMIS (up to 200% of FPL)	See 2004 Quarterly Report on FAMIS: http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/660963e799f2f93d85256f5f00751ddd?OpenDocument

	families enroll children in state health insurance. SUN also provides state level policy and program expertise to eliminate barriers; provide alternative solutions, and reforms. **Project Connect-** Administered by Virginia Health Care Foundation (VHCF), which launched the program with $1 million in private sector funds. Since July 2001, VHCF partnered with DMAS, who now funds the project. Participants in this outreach program have enrolled more than 16,000 children since 1999, with a 50% increase in enrollment last year from previous three years. **Keep 'em Covered -** Beginning November 2003, DMAS offered one year demonstration grants to 14 local DSS offices for program expansion initiatives. **Virginia Covering Kids and Families Coalition -**A four-year project launched in July 2002 with $1.35 million in funding from the Robert Wood Johnson Foundation (RWJF) plus six private sector groups. Provides funding to Radford, Tidewater and Thomas Jefferson Area United Way. **Virginia Coalition for Children's Health -** A coalition of more than 100 organizations formed in 1997. **Radford University FAMIS Outreach Project -** The project recently received funding from RWJF. In the 2–year		

	project, the group seeks to identify and document barriers faced by families after enrollment in state sponsored health insurance programs and test strategies in Southwest Virginia (Carroll, Giles, Montgomery, Pulaski and Wythe counties and cities of Galax and Radford). Findings are to be distributed to Virginia Covering Kids & Families Coalition.		
SCHIP Expansion to Low Income Parents	Section 1115 Waivers allow State programs to expand coverage under SCHIP to include low-income parents. States receive a higher percentage of federal contribution under SCHIP. Virginia's 65% versus regulatory Medicaid FMAP of 51.8%	Uninsured parents between 100% FPL and 200%FPL	Provisions under deregulation of COPN included a directive for the JCHC to study the feasibility of securing a waiver under the (SCHIP) to cover uninsured adult parents with incomes between 100 and 200% FPL. The deregulation plan (as provided **in SB 1084 / HB 2155** introduced in 2001) was not approved by the General Assembly; however, the 2002 JCHC study on the feasibility of expansion under a Section 1115 waiver was conducted. The JCHC report notes that a number of policy decisions would be necessary, including modifications to Virginia's (then SCHIP) program in order to meet requirements for a Section 1115 Waiver. At the time, DMAS stated that it was opposed to the necessary changes. The JCHC also concluded that additional financial analysis on the costs of expansion of SCHIP to include low-income parents was necessary. See: http://leg2.state.va.us/DLS/H&SDocs.NSF/4d54200d7e28716385256ec1004f3130/494c558cd23956a185256b650059527d?OpenDocument
Employer Sponsored Health Insurance (ESHI) under FAMIS	Allows families with employer sponsored health insurance to purchase the employer plan, and FAMIS will reimburse part of the monthly premiums (if deemed to be cost effective for the state). FAMIS can also be used as a supplemental policy, if the child's primary insurance does not included coverage for certain services, such as vision or dental services.	Children enrolled in FAMIS	As of 3/25/2005 Waiver pending from CMS: See http://www.cms.hhs.gov/medicaid/1115/va1115buyin.asp

Federal MEDICAID waivers	**Comprehensive State Health Reform Waivers Under 1115 Authority** Family Planning- Approved through September 30, 2007 **Specialty Service & Population Waivers Under 1115 Authority** Medicaid Buy-In Program – *Pending* **General Managed Care & Selective Contracting Waivers Under 1915(b) Authority** Medallion Program - Approved through March 21, 2004. Medallion II Program - Approved through December 25, 2004. **Home and Community Based Services (HCBS) Waivers Under 1915(c) Authority** HCBS Aged and Disabled Waiver: Approved through 7/1/93 HCBS Developmental Disorders Waiver: Approved through 9/28/03 HCBS Retardation & Developmental Disabilities Waiver: Approved through 6/30/07		As of 3/25/2005 Waiver pending from CMS: See http://www.cms.hhs.gov/medicaid/1115/va1115buyin.asp
MEDICAID / FAMIS Expansion to Pregnant Women at 200% FPL *(Initiative under RWJF SCI grant is pending.)*	Would expand income criteria for eligibility under Medicaid and FAMIS.	Pregnant women up to 200% FPL	According to Executive Directive #2 Recommendations as of October 12, 2004, Women between 133% and 200% FPL will be enrolled in SCHIP. An additional recommendation includes increasing the income standard for pregnant women to 200% FPL.

Current Legislation	Summary	Status
HB 2284 Sponsor; Brink Introduced 2/5/2005	Relates to ESHI under FAMIS and requires DMAS to submit federal waiver for ESHI program. Removes requirement for wrap around benefits except immunizations for ESHI	Signed into law by the governor on 3/31/05

APPENDIX B

Virginia Consideration of Non-Insurance Options to Improve Access to Care

Uncompensated Care Coverage

Initiative	Description	Target Population	Context and History
Indigent Care Health Care Trust Fund (IHCTF) External Link: http://www.dmas.virginia.gov/rcp-indigent_health_care_trust_fund.htm	Redistributes funds collected from hospitals and appropriated monies (60% state, 40% hospital contributions) to those hospitals with high levels of uncompensated care.	Hospitals providing care to uninsured individuals.	As a follow up as a part of revision of the Certificate of Public Need legislation, a 2001 study by the Virginia Joint Commission on Health Care (JCHC) found that the program was operating at about $10 million, significantly less that amounts spent on indigent care under the Medicaid DSH (Disproportionate Share Program). The report also found that the program's funding has been consistently underspent. JCHC also provided recommendations from various groups for models to revise the program as well as policy options.
Mission of Mercy Dental Project External Link: http://198.65.229.210/public/VDHF/VDHF_MOM.html	Day projects coordinated by a group of partnering organizations to provided limited dental care.	Indigent Virginians. Projects are conducted in identified, underserved areas of the state where there are not enough dental practitioners to adequately address the oral health needs of the community. Any individual who is able to show up on site is considered eligible.	Three MOM projects have been held in Wise, VA, two projects on the Eastern Shore, and one in Annandale. For each MOM project, there are hundreds of volunteers who participate. To date, 5,365 patients have been provided with over $1.8 million worth of free dental care. Virginia's MOM projects have broken records for the largest two and three day dental outreach clinics ever conducted in the United States.

Enhancing the Community Safety Net

Initiative	Description	Targeted Population Group	Context and History
HCAP (Health Community Access Programs)			
		Inova Fairfax Hospital 2000-2003: Common information system, mental health provider in community health center, general coordination. **VCU/REACH** 2001-2004: Common information system, perinatal care, medication assistance, FAMIS/FAMIS-Plus outreach and enrollment, advocacy and general coordination. www.reachva.org **Danville** 2001-2004: Volunteer physician program/case management for persons with chronic disease. www.projectaccessdan.org **Hampton Roads/PICH** 2003-2006: Pharmacy assistance / bulk pharmacy to serve local safety net provider patients. **Winchester/Valley Health System** 2002-2005: Perinatal care for migrant workers.	
Prescription Drug Benefit Programs			In 2006 legislative session, the Virginia Health Care Foundation received an additional $350,000 to increase prescription assistance workers through free clinics and community health centers.
Franklin /Southampton Medication Assistance Program (MAP)	Provides assistance to individuals applying for medication assistance under various pharmaceutical company programs	Applicants must live in either Franklin County or Southampton County. There is no age limit for eligibility, but there are income limits, based on the pharmaceutical company to which the applicant is applying.	Supported with grant funding from the Franklin / Southampton Charities. Benefits vary based on programs.
Medication Assistance Program for the Mount Rogers Planning District	Provides assistance to individuals applying for medication assistance under various pharmaceutical company programs		Participation is based on individual or total family income. Individuals must not have any other prescription drug coverage. Prescriptions are limited to medication available through the Pharmacy Connect Program *(see below)*

Pharmacy Connect of Southwest Virginia Program	Provides assistance to individuals applying for medication assistance under various pharmaceutical company programs	Applicants must live in the following areas: Buchanan, Dickenson, Lee, Russell, Scott, Tazewell or Wise counties, or the City of Norton.	The program is administered by Mountain Empire Older Citizens, Inc. (MEOC), in partnership with 6 other agencies. Benefits and income criteria vary according to the pharmaceutical program to which the applicant is applying.

Other Virginia Reports of Interest:

The Working Poor in Virginia (1990)
http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/5d659b699ec2333885255fda0075cd69?OpenDocument

Measures That Increase Access to Affordable Health Care Coverage for Individuals and Their Families (1996)
http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/57b7d2335312a4b08525628a00500948?OpenDocument

Study of the Indigent Uninsured (1997)
http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/33ce4acd714da6cc8525680e006c8521?OpenDocument

Access to Health Care for African Americans in Virginia (2001)
http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/0da37a03c1824453852569e50059f7ae?OpenDocument