VIRGINIA STATE PLANNING GRANT
PHASE II

FINAL REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

SEPTEMBER 2006

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Health Resources and Services Administration's State Planning Grants Program
in partnership with the Virginia Department of Health,
Office of Health Policy and Planning**

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Improving Access to Quality Health Care for All Virginians

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ACKNOWLEDGMENTS

The Virginia Department of Health (VDH) Office of Health Policy and Planning (OPPP) wishes to express its gratitude for the energy, creativity, and time invested by the following members of the Greater Richmond Health Coverage Steering Committee:

Tom Bridenstine	**Managed Care Ombudsman**, Virginia Bureau of Insurance
Karen Cameron	**Executive Director**, Central Virginia Health Planning Agency
Denise Daly	**Executive Director**, R.E.A.C.H.
Claudia S. Dodge	**State Secretary and Legislative Chair**, Virginia Association of Health Underwriters
Mike Eisenmann	**Director**, Virginia Department of Business Assistance
Sheryl Garland	**VP for Community Outreach**, VCU Health System
Ed Gerardo	**Director of Community Health**, Bon Secours Richmond Health System
Suzanne Gore	**Policy Analyst**, Virginia Department of Medical Assistance Services
Mike Jurgensen	**Director of Health Policy and Medical Economics**, Medical Society of Virginia
Bill Nelson, MD	**Director**, Chesterfield Health District
Karen Remley, MD	**Medical Director for External Quality**, Anthem Blue Cross and Blue Shield
Mark Wysong	**Vice President for Managed Care**, HCA Central Atlantic Region

The consistently high level of discussion from this group resulted not only in the development of an improved end product, but also provided the impetus for a strategically important change in direction for the Virginia State Planning Grant Program as it enters its final year of funding.

The VDH OPPP also wishes to acknowledge the dedication, time, and energy of our contractors. This effort would not have been possible were it not for the behind the scenes research, administrative, and organizational support provided by Stephen A. Horan, Ph.D. and his staff at the Community Health Resource Center. You kept the Greater Richmond Health Coverage Steering Committee firing on all cylinders! Additionally, we want to acknowledge P.J. Maddox, Professor and Chair, Department of Health Administration and Policy and her staff at George Mason University Center for Health Policy, Research and Ethics for their invaluable contributions of data analyses and website support.

EXECUTIVE SUMMARY

The purpose of the executive summary is to provide an overview of the project work conducted under the HRSA grant, including a description of the insurance situation in the State as revealed by the data collection activities (survey work, focus groups, key informant interviews, etc.), and the policy options selected to increase health care coverage in the State. The executive summary should also briefly describe recommendations for Federal action to support State efforts to provide health insurance for the uninsured. The summary should be no more than 2-3 pages in length.

In 2003, Virginia was awarded $969,729 from the HRSA State Planning Grant (SPG) Program. The goals of Virginia's first round of funding (SPG I) called for expanding health insurance coverage to working uninsured citizens (and their families) who are employed in small Virginia businesses (businesses employing between 2 and 50 employees), and in households with incomes between 100% to 300% of the Federal Poverty Level (FPL). To do this, Virginia collected data and solicited stakeholder input about the feasibility of various models and their strategies for increasing health care coverage to the working uninsured. After considering current conditions in Virginia and the feasibility and impact of all available options, four options were examined in depth. These were:

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

Building upon other efforts already underway in Virginia, in order to expand the prospects of insurance coverage among Virginia's working uninsured, SPG I recommendations included a Model Product that was a limited benefit coverage option to be offered in the small business market (firms with </=50 employees) with the option of including a public subsidy tax credit as an incentive for employer participation. The SPG I Model Product was not developed with the intent to replace the need for publicly subsidized coverage (i.e., Medicaid, FAMIS) for low-income individuals or to 'destabilize' the current small group market, but rather to expand the private insurance market and ensure coverage options to individuals that may not have a private sector alternative to public coverage. One of the principles guiding the development of the SPG I Model Product is that it be implemented in an environment requiring that the cost of model coverage be shared by and be affordable and sustainable to target employees and employers. Review of trends and research on insurance coverage among the low income during SPG I yielded important information for planning considerations, specifically, a very low price tolerance for health insurance premiums in low-income families—as low as 1-2 percent of take-home pay. Hence, the SPG I Model Product was designed with low price tolerances as the primary driver for take-up decisions. The findings and activities from Virginia's first round of State Planning Grant funds (SPG-I) were described in detail in the "Virginia State Planning Grant Phase One: Final Report to the Secretary of Health and Human Services" (September 2005).

In 2004, Virginia was awarded $190,000 from HRSA through its SPG Continuation Limited Competition Grant Program (SPG II). The findings and activities from SPG-II are described in this report. One of the primary goals of SPG II was the establishment of a community-based participatory process for decision-making in health coverage expansion options in one region of the State. This was accomplished through the activity of the Greater Richmond Health Coverage Steering Committee. The Steering Committee was comprised of community leaders who were business people, health care providers, insurance brokers, and representatives of other public and private agencies with an interest in the issue. The Steering Committee was asked to evaluate and improve the potential of alternative health coverage options for the working uninsured in the Greater Richmond Region.

One of the major tasks that the Greater Richmond Health Coverage Steering Committee undertook was to assess the feasibility of the SPG-I Model Product as a viable option for improving health coverage in the region. The VDH OHPP and its contractors, Stephen A. Horan, Ph.D. and his staff at the Community Health Resource Center (CHRC) and P.J. Maddox, Professor and Chair, Department of Health Administration and Policy and her staff at the George Mason University Center for Health Policy, Research and Ethics (CHPRE) provided the Steering Committee with information and in-depth analyses of data in the following areas:

Potential Demand for the Model Product

Potential demand for the Model Product within the target market is a function of multiple factors, including but not limited to:

1. The number of uninsured adults who:
    a. Have household income between 100 and 300 percent of poverty;
    b. Are uninsured;
    c. Work full time or nearly full time in firms with 2-50 employees; and
    d. Are willing to buy the Model Product

2. The number of employers who:
    a. Employ 2 to 50 individuals;
    b. Do not already offer insurance;
    c. Have not offered insurance for 12 months;
    d. Are willing to offer the Model Product to their employees; and
    e. Are willing to pay for a portion of the Model Product.

CHRC staff developed a model for estimating how many employees meeting the above criteria might be offered the Model Product by employers meeting the above criteria. CHPRE engaged the services of Mercer Oliver Wyman to produce an actuarial analysis of the SPG-I Model Product. The contract actuary developed a model for estimating how many of these employees might actually buy the product under different employer contribution scenarios. In combining these two analytic approaches, the Steering Committee was able to test demand under different scenarios.

Price Considerations of the Model Product

The contract actuary produced a range of price estimates for the SPG I Model Product under a range of scenarios which differ by number of family members covered, level of cost sharing, and annual maximum benefit. CHRC compared these price estimates for the Model Product to a sample of market price estimates for actual products as listed in a recent consumer publication and presented these price comparisons to the Steering Committee for review and discussion.

Benefit Considerations of the Model Product

The SPG I Model Product was purposely designed to be a low cost option and as originally proposed, did not include mental health benefits or dental benefits (although a dental benefit rider could be priced separately at a premium cost ranging from $26 to $74 per month). Based on experience both in Virginia and in other states, "bare-bones" products have not attracted as much market interest as people hoped. Additionally, Virginia has statutory and regulatory requirements (including one of the richest mandated benefits packages in the nation) that must be met by commercial health insurance products. Any decision to move forward with the SPG I Model Product would require careful analysis of compliance with existing statutes and regulations, and associated decisions about whether any exemptions which might be pursued are justified with respect to consumer protection, competitive fairness, market impact, and other factors. The Steering Committee was provided with an overview of Virginia's mandated benefits and provided the opportunity to discuss the viability of the SPG I Model Product within the region in light of these issues.

Pending Legislation and the Model Product

Virginia had a number of bills and resolutions introduced in the 2006 General Assembly which had the potential for directly or indirectly influencing the viability of the SPG-I Model Product. Once such bill was HB 479, which proposed to create a health insurance tax credit for small employers. CHRC tracked these bills as they progressed through the 2006 Legislative Session and provided updates to the Steering Committee.

Conclusion

The work of the Greater Richmond Health Coverage Steering Committee resulted in two significant revisions to the SPG I Model Product. Additionally, the regional Steering Committee ended up recommending something that was not expected at the beginning of the process—the creation of a vehicle to promote health coverage education for individuals and small businesses throughout the Commonwealth.

SECTION 1. UNINSURED INDIVIDUALS AND FAMILIES

The purpose of this section is to describe (1) who the uninsured are in your State; (2) what strategy was used to obtain this information; and (3) how these findings are reflected in the coverage options that your State has selected or is currently considering. In discussing your survey findings, please be sure to link the results directly to your State's coverage expansion strategy.

More detailed survey findings (reports, spreadsheets, etc.), as well as survey instruments and other descriptions of the research methodology, should be referenced in Appendix II.

*Questions 1.1 through 1.3 focus on the **quantitative** research work conducted by the State. If possible, please use the Current Population Survey definitions and data breaks, even if alternate data sources are used. This will allow comparisons across all states in the summary report.*

Using funds from Virginia's first round of State Planning Grant funds (SPG-I), the Virginia Department of Health (VDH) Office of Health Policy and Planning (OHPP) commissioned the State Health Access Data Assistance Center (SHADAC) to survey Virginia households about health insurance coverage. Using the standardized Health Care Insurance and Access Survey with the addition of specific Virginia SPG questions, a telephone interview survey of over 4,000 representative households across Virginia was undertaken. These survey findings were reported in the "Virginia State Planning Grant Phase One: Final Report to the Secretary of Health and Human Services" (September 2005) and can also be found on the Virginia SPG website at www.InsureMoreVirginians.org. This report is focused on the findings and activities from Virginia's second round of State Planning Grant funds (SPG-II). Since these funds were not used for any additional statewide data collection efforts, the only area where there have been updates and/or the availability of national data released since the 2004 Virginia Health Care Insurance and Access Survey is section 1.1. Please refer to the "Virginia State Planning Grant Phase One: Final Report to the Secretary of Health and Human Services" (September 2005) for responses to all other questions in this section.

1.1 What is the overall level of uninsurance in your State?

Estimates of uninsurance in Virginia over the past two years have ranged from 9% - 15% of the total population due to differences in survey methodology and definitions of uninsurance. When comparing uninsurance rates over time and between states, demographers typically rely on the Census Bureau's Current Population Survey (CPS). Based on the CPS data, it is estimated that 14% (or just over one million) of Virginians are uninsured.

Table 1: Rates of Uninsurance in Virginia

Virginia Health Care Insurance and Access Survey (2004)	CPS (2004)	BRFSS (2005)
8.9%	14%	11.1%

Sources: State Health Access Data Assistance Center (2004 Virginia Health Care Insurance and Access Survey), point in time estimates. Current Population Survey (CPS, 2004), point in time estimates; (BRFSS, 2005), prevalence statistics.

The Virginia Health Care Foundation is currently working with the Urban Institute, the Joint Legislative Audit and Review Commission (JLARC), the Department of Medical Assistance Services (Virginia's Medicaid agency), and other entitles to more closely examine these differences and to provide an updated estimate and profile of Virginia's uninsured for 2006.

SECTION 2. EMPLOYER-BASED COVERAGE

The purpose of this section is to document your State's research activities related to employer-based coverage: (1) what is the state of employer-based coverage? (2) how was the information obtained (surveys, focus groups, etc.)?; and (3) how are the findings reflected in the coverage options that have been selected (or are being considered) by the State?

Using funds from SPG-I, the VDH OHPP collected extensive data and information regarding employer-based coverage. This included:

- The development of a profile of the five regions of the Commonwealth, with an emphasis on employer-based coverage using data from the Virginia Employment Commission, the 2003 AHRQ MEPS-IC survey, and the 2004 Virginia Health Care Insurance and Access Survey by the Center for Health Policy Research and Ethics at the George Mason University (CHPRE).
- A 2005 Virginia Small Business Key Informant Survey by the CHPRE.
- A 2005 Virginia Business Health Insurance Survey by the Virginia Department of Business Assistance.

Findings from these data and information gathering efforts were reported and all of the questions from this section were addressed in the "Virginia State Planning Grant Phase One: Final Report to the Secretary of Health and Human Services" (September 2005). The only update relevant to this section since the September 2005 report comes from "Compensation Data 2006 – Virginia", an annual survey of compensation practices in Virginia conducted by Compdata Surveys in partnership with the Virginia Chamber of Commerce. Key findings from this survey include:

- Seventy-six percent (76%) of Virginia's businesses incurred an increase in their employer-sponsored health insurance premiums over the last year.
- 43.3 percent of Virginia employers increased their employees' portion of premium costs in 2006.
- Nearly one-third of Virginia employers reported increasing deductible levels and almost two in ten increased the employee co-insurance level.
- 15.3 percent of employers switched health insurance carriers; some became self-insured.
- Some employers (7.6 percent) reduced benefits.
- 20.1 percent of employers reported offering consumer driven health plans (HSAs, HRAs, MSAs) with six percent of employers saying they plan to offer such a plan in 2007.
- Virginia employers spend an average of 22 percent of their total payroll dollars on voluntary benefits. Almost half of this amount, or 10 percent, is spent on health insurance, while 5.3 percent is spent on pension plans and 3.2 percent is spent on other non-mandated benefits. In addition, employers spend about 1.3 percent of their payroll on dental insurance, 0.9 percent on disability insurance and 0.9 percent on life insurance.

SECTION 3. SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE

The purpose of this section is to document your State's research activities related to the State's health care marketplace. The State should discuss (1) findings relating to the marketplace; (2) how the information was obtained; and (3) how the findings affected policy deliberations in the State.

All of the questions from this section were addressed in the "Virginia State Planning Grant Phase One: Final Report to the Secretary of Health and Human Services" (September 2005). The only changes to this section since the September 2005 report is an update on publicly funded health coverage and on health insurance premium price trends.

Update on Publicly Funded Health Coverage

The Commonwealth's public insurance programs consist of Medicaid and the Family Access to Medical Insurance Security (FAMIS [SCHIP]) and its related Medicaid Expansion Programs. Virginia has submitted federal waivers to cover low-income pregnant women (FAMIS MOMS and FAMIS Select) as part of its efforts to cover the uninsured through FAMIS.

The Virginia Medicaid total population in FY05 was comprised of 473,178 children, 109,736 caretaker adults, 86, 824 elderly persons, and 163,197 persons who are blind or have a disability. Information on the number of children enrolled in the Children's Health Insurance Program and the number of pregnant women enrolled in Medicaid and in the FAMIS MOMS program as of June 30, 2006, is shown in the table below.

Table 2: FAMIS and Medicaid Expansion Program Enrollment

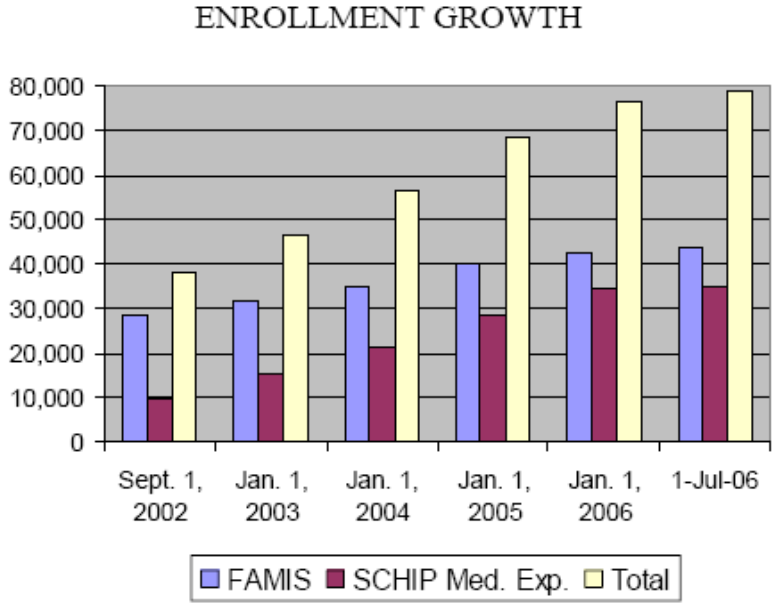
PROGRAM	INCOME	# Enrolled as of 06-30-06	% of Total Enrollment
FAMIS - Children < 19 years	> 133%, ≤ 200% FPL	43,804	10%
MEDICAID Expansion – Children 6-18 years	> 100%, ≤ 133% FPL	34,941	8%
SCHIP Subtotal	78,745	18%	
MEDICAID - Children < 21 years	≤ 133% FPL	352,133	82%
Total Children	**430,878**	**100%**	
MEDICAID for Pregnant Women	< 133% FPL	17,148	98%
FAMIS MOMS	133%, < 150% FPL	408	2%
Total Pregnant Women	**17,556**	**100%**	

Source: VaMMIS (Virginia Medicaid Management Information System) 07-01-06

Enrollment of new children into Virginia's Title XXI program (FAMIS and SCHIP Medicaid Expansion) has been increasing steadily since September 1, 2002. The steady increase in enrollment is the result of aggressive outreach efforts at the State and local level, as well as the implementation of programmatic improvements. Below is a graph that compares FAMIS and SCHIP Medicaid Expansion enrollment of children from September 1, 2002 (implementation of

program changes), January 1, 2003, January 1, 2004, January 1, 2005, January 1, 2006, and July 1, 2006.

Figure 1: FAMIS and Medicaid Expansion Enrollment Growth



FAMIS Plus and FAMIS covered approximately 99.5% (430,878) of uninsured children. Approximately 1,895 children in Virginia are potentially eligible for FAMIS or FAMIS Plus but are not yet enrolled and do not have other health insurance.

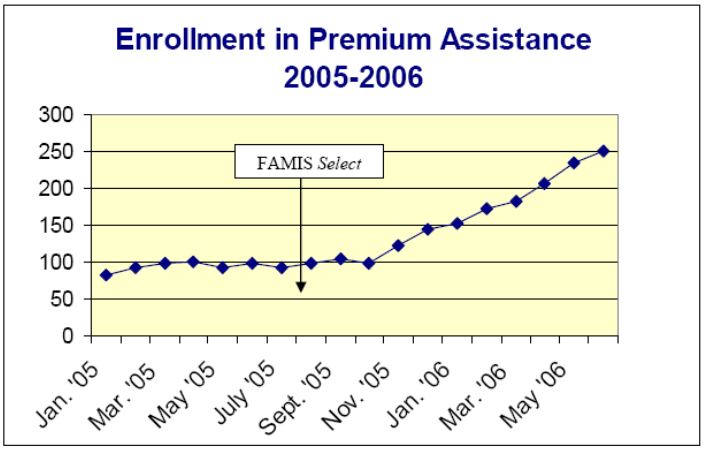
Premium assistance for employer-sponsored insurance is available through the FAMIS program. The former premium assistance program, ESHI, was replaced with the new FAMIS *Select* program on August 1, 2005 following approval of Virginia's HIFA Waiver by the Centers for Medicare and Medicaid Services July 1, 2005. FAMIS *Select* is a voluntary option available to families with children approved for FAMIS coverage who have access to an employer-sponsored or private health insurance plan. Instead of covering the child through the FAMIS plan, DMAS pays the policyholder $100 per month for each FAMIS *Select* child, up to the total cost of the family premium, to help cover the cost of the family policy. This amount is less than the average capitated rate that would be paid to enroll a child in a FAMIS Managed Care Organization and is therefore cost-effective for the Commonwealth. If the family chooses FAMIS *Select* the child will:

- Receive the health care benefits included in the employer-sponsored or private policy;
- Pay the out-of-pocket expenses required by the employer-sponsored or private policy;
- Receive coverage for childhood immunizations from FAMIS if not covered by the employer-sponsored or private policy;
- Receive $100 premium assistance per month/per child up to the total cost of the family policy;
- Remain in FAMIS Select as long as they remain eligible for FAMIS and provide monthly proof of premium payments for the employer-sponsored or private policy; and

- Be able to return to full FAMIS coverage at any time their parents decide to end participation in FAMIS *Select*.

Because of the premium assistance available through FAMIS *Select*, some families may be able to afford employer-sponsored or private health insurance for the entire family. At the end of the second quarter of 2006, FAMIS Select provided coverage for 250 FAMIS eligible children and helped families afford the family coverage for an additional 199 adults and children who were not eligible for FAMIS.

Figure 2: Enrollment in Premium Assistance



Health Insurance Premium Price Trends

Nationally, workers and employers saw double-digit increases in health insurance premiums from 2002 - 2004. However, premium increases for family coverage have dropped into the single digits at 9.2% (2005) and 7.7% (2006) over the last two years. Like the national trend, the average premium increase has fallen since 2002 in Virginia; however, 2006 still marks the fifth year in a row of double-digit increases.

Table 3: Virginia Premiums

Virginia Premiums	2002	2003	2004	2005	2006
Average premium increase	19.3%	16.3%	13.9%	10.9%	10.7%

SECTION 4. OPTIONS FOR EXPANDING COVERAGE

The purpose of this section is to provide specific details about the policy options selected by the State. A number of States have not reached a consensus on a coverage expansion strategy and are not yet in a position to answer the questions included in this section. These States should answer questions 4.1 through 4.15 as applicable, but should focus primarily on questions 4.16, 4.18, and 4.19.

The goals of SPG I called for expanding health insurance coverage to working uninsured citizens (and their families) who are employed in small Virginia businesses (businesses employing

between 2 and 50 employees), and in households with incomes between 100% to 300% of the Federal Poverty Level (FPL). Using funds from SPG I, Virginia solicited stakeholder input, especially from small employers, about the feasibility of various models and their strategies for increasing health care coverage to the working uninsured. After considering current conditions in Virginia and the feasibility and impact of all available options, four options were examined in depth by the SPG I Model Development Work Group (MDWG) before a final recommendation was made. Those considered were:

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

Building upon other efforts already underway in Virginia, in order to expand the prospects of insurance coverage among Virginia's working uninsured, the SPG I MDWG recommended a Model Product that was a limited benefit coverage option to be offered in the small business market (firms with </=50 employees) with the option of including a public subsidy tax credit as an incentive for employer participation.

The SPG I Model Product was not developed with the intent to replace the need for publicly subsidized coverage (i.e., Medicaid, FAMIS) for low-income individuals or to 'destabilize' the current small group market, but rather to expand the private insurance market and ensure coverage options to individuals that may not have a private sector alternative to public coverage. One of the principles guiding the development of the SPG I Model Product is that it be implemented in an environment requiring that the cost of model coverage be shared by and be affordable and sustainable to target employees and employers. Review of trends and research on insurance coverage among the low income during SPG I yielded important information for planning considerations, specifically, a very low price tolerance for health insurance premiums in low-income families—as low as 1-2 percent of take-home pay. Hence, the SPG I Model Product was designed with low price tolerances as the primary driver for take-up decisions

Additionally, nationally, private-sector employer contributions for health insurance represent, on average, about 7.4% of wages and salaries. The cost of the SPG-I Model Product was developed with the affordability range for small business expenses in mind. Although employers would be required to contribute a significant proportion of the premium costs in the SPG I Model Product, employer contribution requirements are modest, defined, and predictable over time. See Appendix IV for a more in-depth overview of the SPG-I Model Product.

One of the primary goals of SPG II was the establishment of a community-based participatory process for decision-making in health coverage expansion options in one region of the State. This was accomplished through the activity of the Greater Richmond Health Coverage Steering Committee. The Steering Committee was comprised of community leaders who were business people, health care providers, insurance brokers, and representatives of other public and private agencies with an interest in the issue. The Steering Committee was asked to evaluate and improve the potential of alternative health coverage options for the working uninsured in the Greater Richmond Region. One of the major tasks that the Greater Richmond Health Coverage Steering Committee undertook was to assess the feasibility of the SPG-I Model Product as a

viable option for improving health coverage in the region. The VDH OHPP and its contractors, Stephen A. Horan, Ph.D. and his staff at the Community Health Resource Center (CHRC) and P.J. Maddox, Professor and Chair, Department of Health Administration and Policy and her staff at the George Mason University Center for Health Policy, Research and Ethics (CHPRE) provided the Steering Committee with information and in-depth analyses of data in the following areas:

Potential Demand for the Model Product

Potential demand for the Model Product within the target market is a function of multiple factors, including but not limited to:

3. The number of uninsured adults who:
    a. Have household income between 100 and 300 percent of poverty;
    b. Are uninsured;
    c. Work full time or nearly full time in firms with 2-50 employees; and
    d. Are willing to buy the Model Product

4. The number of employers who:
    a. Employ 2 to 50 individuals;
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CHRC staff developed a model for estimating how many employees meeting the above criteria might be offered the Model Product by employers meeting the above criteria. CHPRE engaged the services of Mercer Oliver Wyman to produce an actuarial analysis of the SPG-I Model Product. The contract actuary developed a model for estimating how many of these employees might actually buy the product under different employer contribution scenarios. In combining these two analytic approaches, the Steering Committee was able to test demand under different scenarios.

Price Considerations of the Model Product

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Pending Legislation and the Model Product

Virginia had a number of bills and resolutions introduced in the 2006 General Assembly which had the potential for directly or indirectly influencing the viability of the SPG-I Model Product. Once such bill was HB 479, which proposed to create a health insurance tax credit for small employers. CHRC tracked these bills as they progressed through the 2006 Legislative Session and provided updates to the Steering Committee.

The work of the Greater Richmond Health Coverage Steering Committee resulted in several significant revisions to the SPG I Model Product. All of the questions from this section were addressed in the "Virginia State Planning Grant Phase One: Final Report to the Secretary of Health and Human Services" (September 2005). The following narrative addresses those questions from this section that were specifically impacted by the work of the Greater Richmond Health Coverage Steering Committee.

4.1 Which coverage expansion options were selected by the State (e.g., family coverage through SCHIP, Medicaid Section 1115, Medicaid Section 1931, employer buy-in programs, tax credits for employers or individuals, etc.)?

The work of the Greater Richmond Health Coverage Steering Committee resulted in the following changes to the SPG I Model Product:

- the inclusion of all state mandated benefits
- the reduction of the annual maximum from $250,000 to $50,000 in order to meet pricing targets.

The following data come from analyses of the SPG I Model Product after incorporation of the changes recommended by the Steering Committee. This revised model will be referred to from here on as the SPG II Model Product. The contract actuary used the following assumptions in determining estimates of product premium and employee take-up rates:

Assumptions

1. The proposed insurance product is designed to provide low cost group health insurance to employees of Virginia small employers who have been without group insurance over the past 12 months.
2. Premium rate estimates are set for a one-year period beginning January 1, 2006.

3. Premiums and employee take-up rates are estimated for both a high and low level of patient cost sharing of the insurance product. See Appendix V for what constitutes a low and high cost sharing insurance product.
4. Premium rates estimated for a popular insurance product sold by a major Virginia health insurer provide the basis for premium estimates of the proposed SPG II Model Product. SPG II Model Product estimates assume the same provider reimbursement rates, same administrative expense allowance, same profit margin, etc. inherent in the Virginia insurer's product rate structure. However, the demographics of SPG II Model Product target population are slightly more favorable than those of the population that the Virginia health insurer's product is targeting. Mercer estimates that there are relatively few children in the SPG II Model Product target population, and relatively more young adults.
5. Although the data it used was checked for general reasonability, the actuary relied on the data made available without audit.
6. Actual results may differ from the estimates provided for several reasons, including:
    a. Those who actually enroll may exhibit different demographic characteristics than the entire uninsured population.
    b. The actuary has no data that indicates the health status of the uninsured population.
    c. No correction has been made to recognize the 'pent-up' need that may have to be met in the first year of coverage.
7. Requirements set by the American Academy of Actuaries were followed and met in providing the actuarial analysis and estimation.

Potential Demand for the SPG II Model Product

The contract actuary's model for estimating employee take-up rates assumes that an employee who pays 0 percent of his premium will always join, and that an employee that has to pay 20 percent or more of his salary in premiums will never join. Calculations of employee take-up rates for the high and low-cost sharing plans assume the employer pays between half (50%) and 80 percent of the annual premium and the annual maximum is $50,000:

Table 4: Estimated Uptake Rates at Different Levels of Poverty and Employer Contribution

Employer Pays	**50%**	**60%**	**65%**	**75%**	**80%**
Percent of Poverty	**300%**	**300%**	**250%**	**200%**	**150%**
Low Cost Plan	Uptake Rate	Uptake Rate	Uptake Rate	Uptake Rate	Uptake Rate
Family of One	38%	46%	44%	48%	46%
Family of Four	27%	35%	34%	38%	35%
High Cost Plan					
Family of One	29%	37%	35%	39%	37%
Family of Four	19%	26%	25%	29%	26%

(Estimates from Mercer Oliver Wyman)

As can be seen from the above table, the contracted actuary puts the uptake rates at between 19 percent and 48 percent, depending on the level of benefits, the level of poverty, and the level of employer contribution. Using these uptake rates, a very conservative rough estimate of demand developed by CHRC for the SPG II Model Product indicates that 35,000 workers and family members between 100 and 300 percent of poverty would be covered statewide, including 5,600 in the Greater Richmond region. Such demand estimates can easily vary by 50 percent or more

depending on variations in input assumptions and data sources. Additionally, as has been experienced in Virginia and other states, the market for non-traditional products is extremely hard to predict, and is often under-predicted. Demand estimates can also be revisited to include workers outside this income band, and workers outside the 2-50 firm-size parameter. This population segment was the focus because of the state tax credit option.

Price Considerations of the SPG II Model Product

Affordability

It is important to look at affordability from the perspective of both the employee and the employer.

Table 5: Monthly Premium Estimates for SPG II Model Product

Monthly Premium	Employee	Employee & Child	Employee & Children	Employee & Spouse	Employee & Family
Low Cost Plan	$ 135.73	$ 171.53	$ 238.79	$ 336.10	$ 370.79
High Cost Plan	$ 173.93	$ 219.79	$ 305.98	$ 430.66	$ 475.11

Table 6: Annual Premium Estimates for SPG II Model Product

Annual Premium	Employee	Employee & Child	Employee & Children	Employee & Spouse	Employee & Family
Low Cost Plan	$1,628.76	$2,058.36	$2,865.48	$ 4,033.20	$4,449.48
High Cost Plan	$2,087.16	$2,637.48	$3,671.76	$ 5,167.92	$5,701.32

The SPG II Model Product premiums were analyzed to determine the employee's share of premium as a percent of employee household income at 100%, 200%, and 300% of poverty.

Table 7: 2006 Poverty Ratios

Family Size	100% Poverty Income	200% Poverty Income	300% Poverty Income
1	$ 9,800	$ 19,600	$ 29,400
2	$ 13,200	$ 26,400	$ 39,600
3	$ 16,600	$ 33,200	$ 49,800
4	$ 20,000	$ 40,000	$ 60,000

The analysis was completed under two scenarios:

- 50/50 premium split with employer
- 80/20 premium split with employer

Table 8: Percent of Pretax Income Required for Premium Payment from Employee Assuming 50 Percent Contribution from Employer

50/50 Split Scenario	Employee	Employee & Child	Employee & Children	Employee & Spouse	Employee & Family
Assumed Family Size	1	2	3	2	4
100% Poverty					
Low Cost Plan	8%	8%	9%	15%	11%
High Cost Plan	11%	10%	11%	20%	14%
Low Cost Plan Plus 30%	11%	10%	11%	20%	14%
Low Cost Plan Plus 50%	12%	12%	13%	23%	17%
High Cost Plan Plus 30%	14%	13%	14%	25%	19%
High Cost Plan Plus 50%	16%	15%	17%	29%	21%
200% Poverty					
Low Cost Plan	4%	4%	4%	8%	6%
High Cost Plan	5%	5%	6%	10%	7%
Low Cost Plan Plus 30%	5%	5%	6%	10%	7%
Low Cost Plan Plus 50%	6%	6%	6%	11%	8%
High Cost Plan Plus 30%	7%	6%	7%	13%	9%
High Cost Plan Plus 50%	8%	7%	8%	15%	11%
300% Poverty					
Low Cost Plan	3%	3%	3%	5%	4%
High Cost Plan	4%	3%	4%	7%	5%
Low Cost Plan Plus 30%	4%	3%	4%	7%	5%
Low Cost Plan Plus 50%	4%	4%	4%	8%	6%
High Cost Plan Plus 30%	5%	4%	5%	8%	6%
High Cost Plan Plus 50%	5%	5%	6%	10%	7%

Shaded cells indicate concern about affordability for the individual at this level of premium. Figures do not include additional out of pocket costs of copays, coinsurance, and deductibles.

Based on these calculations, the SPG II Model Product may be unaffordable for employees who are near the poverty line. However, it would be moderately affordable for those at 200 percent of poverty, and highly affordable for those at 300 percent of poverty and above. For obvious reasons, it is most affordable when the employer contributes up to 80 percent of premium. In terms of employers, the SPG II Model Product might be difficult to afford for small employers with very low average wage rates, but should be moderately to highly affordable for those with average wage rates of around $30,000 and above.

Market Comparisons

The CHRC compared the six SPG II Model Product premium price level estimates with the actual rates for 88 products offered by a total of 35 employers in the Greater Richmond region.

- Range of employees 9-726
- Average number of employees 109
- Median number of employees 78

- Number of firms with fewer than 50 = 11
- Number of firms < 50 offering more than one plan = 10
- Total number of plans offered in firms < 50 = 23

The CHRC did not have enough data to compare on every benefit, but worked under the assumption that all plans had to meet Virginia's mandated benefits requirements. Additionally, conclusions need to be tempered with the fact that the SPG II Model Product premium does not include dental coverage, whereas many of premiums being compared do. Nevertheless, although it may not be the criteria for a scientific sample, it does provide some insight.

Figure 3: Monthly Premium Comparison, All Firms in Sample, Employee Only

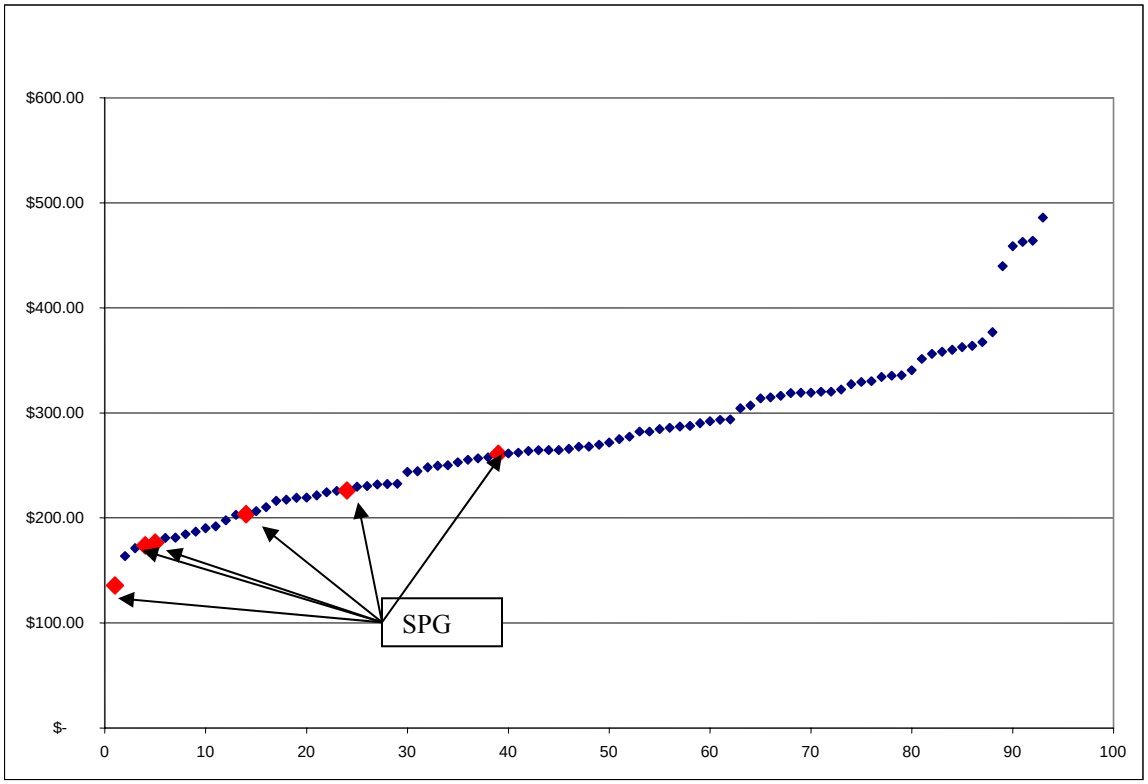


Figure 4: Monthly Premium Comparison, All Firms in Sample, Employee plus Child

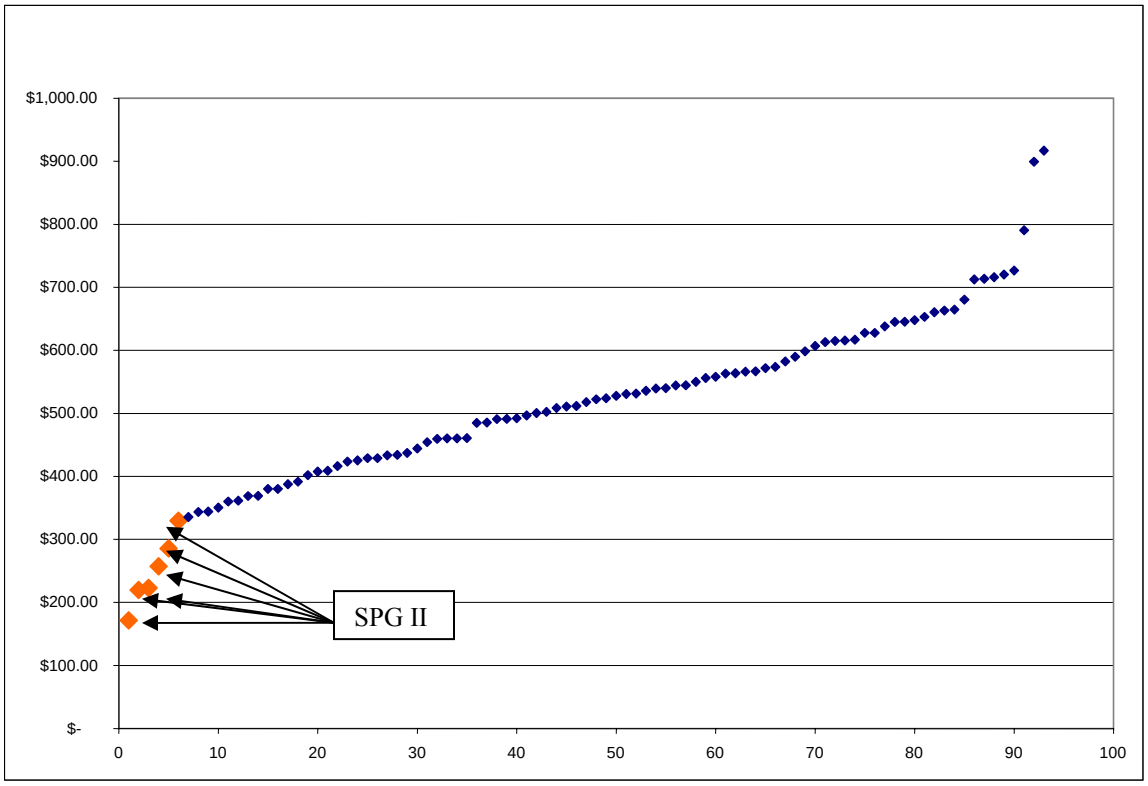


Figure 5: Monthly Premium Comparison, All Firms in Sample, Employee plus Spouse

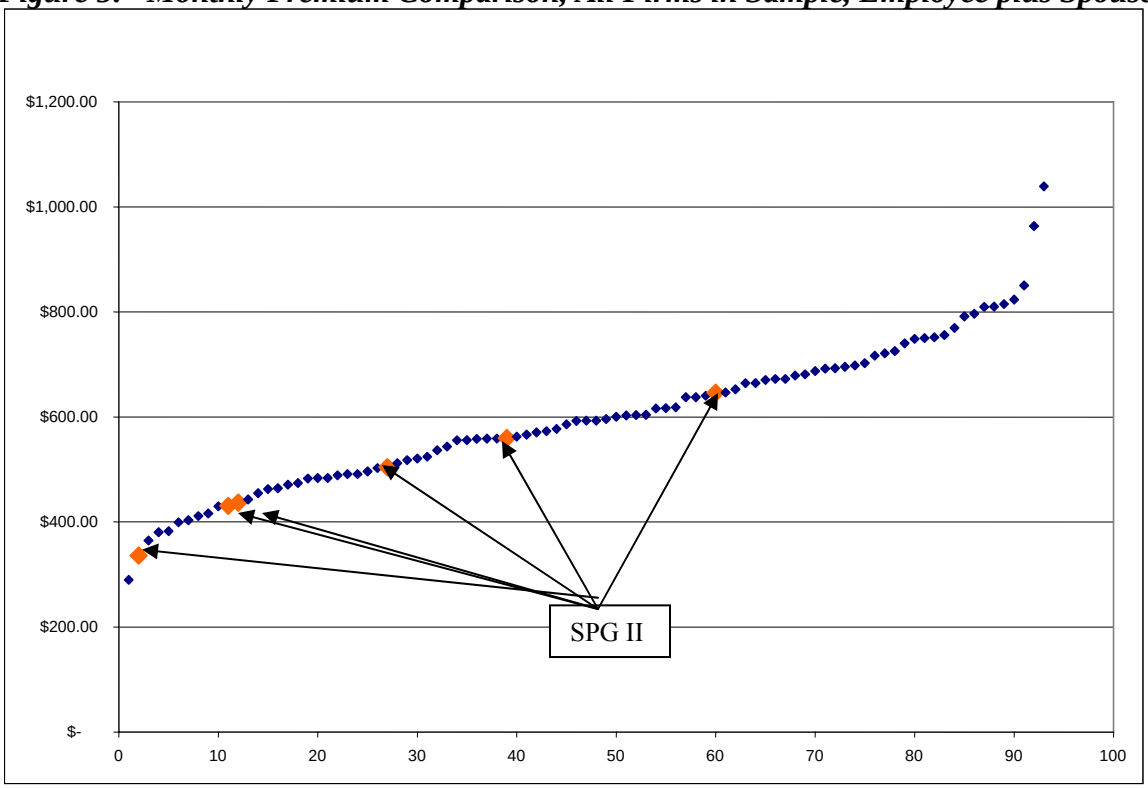


Figure 6: Monthly Premium Comparison, All Firms in Sample, Employee plus Family

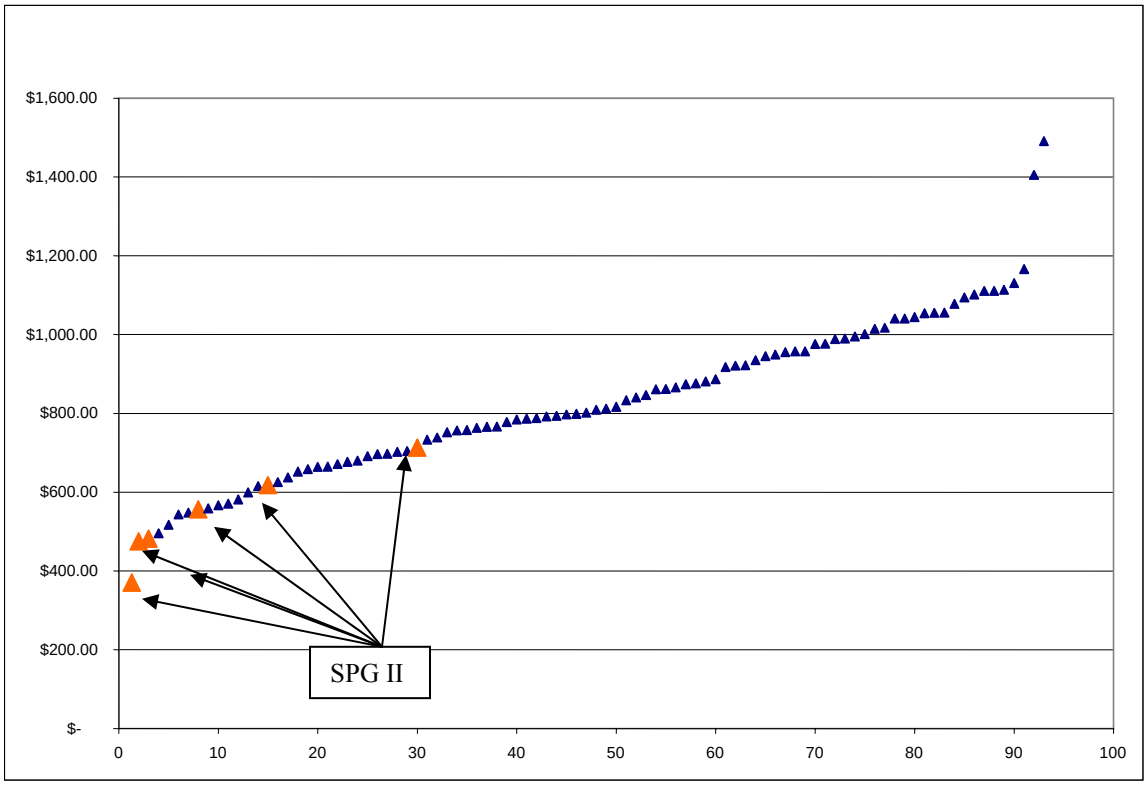


Table 9: SPG II Model Product Compared to Sample Firms <50 Employees

Plan	Employee Only Premium Rank (1=Lowest)	Employee Plus Child Premium Rank (1=Lowest)	Employee Plus Spouse Premium Rank (1=Lowest)	Employee Plus Family Premium Rank (1=Lowest)
Low Cost Plan	1	1	2	1
High Cost Plan	3	2	4	2
Low Cost Plus 30%	4	3	5	3
Low Cost Plus 50%	5	4	11	5
High Cost Plus 30%	11	5	14	6
High Cost Plus 50%	16	6	21	13

Figures show ranking of SPG premiums compared to total field of 29 (including 6 SPG plans). 1= Lowest premium, 2 = second lowest premium, etc.

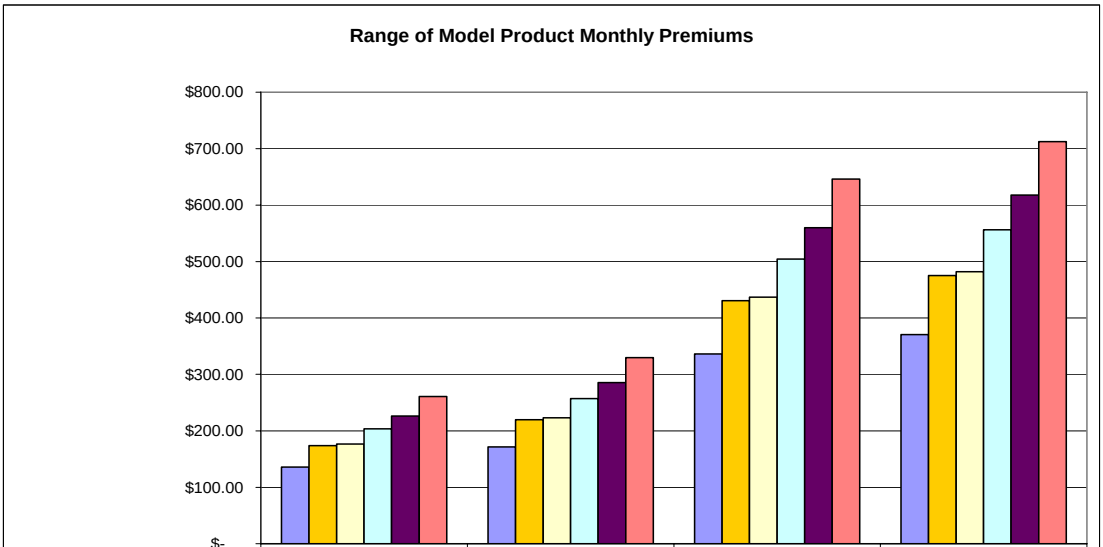
In comparing the SPG II Model Product premium prices to a sample of 88 plans from 35 area employers, the following conclusions can be drawn:

- The $50,000 annual maximum makes it distinctive if not unique in the market.
- The SPG II Model Product deductibles are at the upper range of non-HSA plans in the sample.
- The SPG II Model Product annual out of pocket maximums are at upper end of sample range.
- The SPG II co-pays and co-insurance are at upper end of sample range.

Nevertheless, the SPG II Model Product is very price competitive before underwriting. Although there is no way of knowing how much of the premium price in each sample firm is

related to underwriting, post-underwriting prices for the SPG II Model Product could be significantly higher as show in the table below:

Figure 7: Annual Premium Estimates with "Guestimated" Underwriting Range for SPG II Model Product



	Rates EE	EE/CH	EE/SP	FAM
SPG Low Cost Plan	$135.73	$171.53	$336.10	$370.79
SPG High Cost Plan	$173.93	$219.79	$430.66	$475.11
SPG Low Cost Plan Plus 30%	$176.45	$222.99	$436.93	$482.03
SPG Low Cost Plan Plus 50%	$203.60	$257.30	$504.15	$556.19
SPG High Cost Plan Plus 30%	$226.11	$285.73	$559.86	$617.64
SPG High Cost Plan Plus 50%	$260.90	$329.69	$645.99	$712.67

Benefit Considerations of the Model Product

The annual maximum raises questions about the financial impact on enrollees, employers, health plan providers, and health care providers. The $50,000 max clearly helps to keep premium prices down.

Table 10: Percent of Members Expected to Exceed Maximum Benefit for SPG II Model Product

Maximum Benefit	All Benefits	All Benefits, Excluding Rx	Hospital, Surgery[3]
10,000	4.62%	3.99%	3.17%
25,000	1.41%	1.24%	0.99%
50,000	0.52%	0.46%	0.39%
75,000	0.27%	0.29%	0.20%
100,000	0.17%	0.15%	0.13%
250,000	0.03%	0.03%	0.02%
500,000	0.00%	0.00%	0.00%
1,000,000	0.00%	0.00%	0.00%

1 Analysis by Mercer Oliver Wyman based on 2005 Milliman Health Cost GuidelinesTM, assuming Nationwide billed charges, based on claims probability distributions (CPDs)
2 Limited benefit plans assume $500 deductible, 20% coinsurance, no OOP maximum.
3 Includes IP facility, OP facility, and physician surgery expenses.

It is estimated that less than one percent of the typical enrolled population would incur annual medical expenses above $50,000. However, those that do exceed the cap could incur catastrophic costs. Should this occur, employers would be faced with the dilemma of whether and how to help an employee in this situation and health plans and health care providers would have to negotiate with the understanding that some enrollees could incur catastrophic costs that would not be covered by the health plan. This raises the possibility that health care providers would have to negotiate higher payments in order to assuage their risk of incurring high-dollar bad debt costs for catastrophically ill or injured patients.

Legislation and the Model Product

The 2006 General Assembly did not pass HB 479 which would have provided a state tax credit for health insurance premiums. However, it did pass HB 761 authorizing the establishment of health group cooperatives for small business and SB 487 requesting the Virginia Liaison Office to work with Virginia's Delegation on association health plan legislation.

Conclusion

The Model Product would definitely be distinctive, if not unique in the market, for its $50,000 annual maximum. It would also be highly price competitive, at least before underwriting; and moderately to highly affordable for people with income in the 200-300 percent of poverty range. However, even if it is affordable, the marketability of the product remains uncertain. Assuming regulatory approval by the State Corporation Commission, at this point it is unclear if:

- health plans would offer the product;
- health care providers would sign onto the product;
- brokers would sell the product; or if
- employers and employees would buy the product.

The Steering Committee discussed several options for the SPG II Model Product. The first option would be to "test-drive" the product with health plans, health care providers, agents, and small business operators. The second option would be to revisit the idea of coupling the SPG II Model Product with a tax credit option to help further reduce the cost or provide enough subsidy to allow raising the annual max. The third option would be to couple the SPG II Model Product with a reinsurance pool as several other states have tried. This approach would be aimed at providing security for enrollees who exceed the $50,000 max. The fourth option would be to do nothing!

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

The SPG Leadership Team will use the work of the Greater Richmond Health Coverage Steering Committee to inform its report and recommendations to the Governor. The Virginia SPG II report will be submitted to the Governor, through the Virginia Secretary of Health and Human Resources in the upcoming months. An analysis of the various options for the SPG II Model Product will be provided to the Governor for his decision regarding implementation.

4.19 How will your State address the eligible but not enrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

Health coverage is a complex issue for just about every Virginian. People who are without coverage or who need to change coverage must navigate their way through a complex array of public and private coverage options. People with coverage must navigate an equally complex world of covered services, uncovered services, premiums, co-pays, co-insurance, deductibles, out-of-pocket maximums, lifetime maximums, and more. Employers who offer health coverage to their employees face the same set of challenges as individuals, only more-so. Employers must navigate their way through not only myriad health coverage options, but also complex tax and accounting requirements which can have a profound impact on their choice of health benefits. The wrong choice can cost thousands of dollars, or even worse, leave employees without needed coverage.

During the SPG II Regional Steering Committee meetings, members repeatedly brought up the need for education for both individuals and employers in order to optimize their health coverage. Uncovered individuals who don't want coverage need education to understand the purpose of insurance and the profound impact their decision to go without can have on their lives and their community. Uncovered individuals who want coverage need education to understand the full range of choices available for themselves and their families. Individuals and families in transition due to job loss or other circumstances need education to understand the range of choices plus COBRA and the Health Insurance Portability and Accountability Act (HIPAA). Employers need education to understand the range of health benefit choices available, including the new health savings accounts, along with the tax implications of different choices. Therefore, a Virginia Foundation for Health Coverage Education is being proposed to directly address these educational needs.

The mission of the Foundation would be to help Virginians (both individuals and employers) make informed and effective choices about health coverage by serving as a source for comprehensive and objective information and education on all of the health coverage choices available to Virginians, including:

- Educating the public about the value of health coverage for personal health and financial stability and encouraging people who think coverage is unnecessary (such as many young adults) to seek coverage for themselves and their families. This kind of education could begin as early as elementary and secondary education.
- Educating consumers about the full range of health coverage options available, from Medicaid to FAMIS to Medicare to the individual market to group options and how to acquire coverage.
- Educating employers, especially small employers, about existing market options (including new options such as health savings accounts) and important tax and accounting rule changes that can have a profound impact on employer choices.

The educational strategies of the Foundation would include web-based education, telephone-based education, statewide and regional educational conferences, train-the-trainer programs, and development and distribution of educational materials for individuals, employers, and state and local educational organizations. It these strategies prove to be effective, results should include higher numbers of people with health coverage and more effective utilization of health coverage.

Funding for the proposed Foundation is being proposed to come from state funds matched with private sector grants and contributions. Private sector partners would include employers, health plans, health care providers, health insurance agents, consumer groups, and local government.

Since April 2006, the SPG Leadership Team has met with key staff from the Governor's Office, the Virginia Association of Health Plans, and the Virginia Underwriter's Association to assess support for the establishment of this type of Foundation. Budget language in support of the Foundation is presently being drafted, with plans for it to be introduced during the 2007 General Assembly Session.

SECTION 5. CONSENSUS BUILDING STRATEGY

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

The governance structure for SPG II was a regional Steering Committee comprised of people from the public, private, and nonprofit sector. The mission of the Steering Committee was to evaluate the market viability of a model health coverage product from multiple perspectives. Government representatives (for example, from the Virginia Bureau of Insurance) clarified state policies regarding health coverage regulation, and educated the group about the process for modifying state policy. Health care provider representatives educated the group on the potential impact of the model product on health care providers. A representative from a health plan raised important questions about risk management -- for example, the allocation of risk after a potential enrollee exhausts the payout maximum on the SPG II Model Product. Another representative from a nonprofit coalition of safety net providers raised questions about the affordability of the model product for low-income uninsured individuals. Each member of the regional Steering Committee weighed in on broad policy options such as the viability and impact of tax credits, and the political and operational feasibility of linking the model product to a risk pool. Overall, this was an effective way of evaluating a model product from multiple angles. Ultimately, the group recommended some adjustments to the model product. In addition, the group surfaced the issue of health coverage education, and endorsed the idea of developing a practical vehicle for promoting health coverage education in Virginia.

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

The main method for obtaining input was through regional Steering Committee meetings. On occasion, during the interim between meetings, input was obtained from Steering Committee

members through surveys on particular issues. Finally, the SPG Leadership Team, comprised of key stakeholders, were kept abreast of SPG-II activities and invited to provide input.

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

The website developed for SPG I (www.InsureMoreVirginians.org) was continued for SPG II. All work products associated with SPG II, including meeting minutes and background literature used by regional Steering Committee, were made available to the public on the website. Additionally, information found in the website's Knowledge Center, which provides access to the following information of interest targeted toward specific stakeholder groups, is regularly updated:

- **Individual or Family:** Features resources for individuals who are looking for affordable health care and/or health insurance coverage.
- **Business:** Features resources for employers looking for information and resources related to health care benefits and options.
- **Community Leaders, Legislators, and other Health Policy Makers**: Features resources for community leaders, legislators, or other health policy makers looking for research, reports, and technical assistance with improving affordable health care access.
- **Researchers**: Features data resources and sources for researchers wanting to better understand issues related to health, health access, uninsurance, and underinsurance.

Additionally, also regularly updated are the following sections found on the website:

- **News**: provides access to SPG announcements and information regarding recent developments related to the health care uninsured and access to affordable health care.
- **Calendar of Events** provides a listing of national, state, and local events addressing issues related to the health care uninsured and access to affordable health care.
- **Legislation** contains information about proposed federal and state legislation related to health care insurance coverage and access to affordable health care.

In December 2005, Governor Kaine held a press conference to announce the availability of the Virginia SPG funded publication "A Guide to Health Insurance Options for Small Businesses in Virginia" and its corresponding website found at:

http://www.InsureMoreVirginians.org/SmallBusinessGuide/

Additionally, four regional forums were held in partnership with Small Business Development Centers (SBDC's) in Virginia to promote the Guide and train individuals on the best way(s) to use the Guide. The publication has been made available to the public through all of Virginia's SBDC's and local Chambers of Commerce.

Finally, the Virginia SPG website now has a section devoted to Affordable Health Insurance for Families and Children in Virginia. The focus of this page is to inform the public about commercial health insurance products designed for lower income Virginia families and children. The VDH OHPP has partnered with the Virginia Department of Medical Assistance Services (DMAS) on this effort. Virginians who apply for Medicaid but aren't able to meet the eligibility criteria are sent a letter from DMAS that directs them to the Virginia SPG website.

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

The regional Steering Committee ended up recommending something that was not expected at the beginning of the process—the creation of a vehicle to promote health coverage education for individuals and small businesses throughout the Commonwealth. This kind of creativity is what makes multi-sector committee processes worthwhile for policy development.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

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

State-specific data was extremely important to the decision-making process. It was the sub-state analysis from the 2004 Virginia Health Care Insurance and Access Survey that helped to identify Central Virginia as having the highest rates of uninsurance, making it the focus of our SPG II activities. Additionally, all discussions and decisions by the regional Steering Committee were informed by data acquired through qualitative and quantitative methods (as demonstrated in Section 4). The majority of that data was collected or assembled and analyzed through SPG grant funds

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

Virginia intentionally designed the sampling frame for the 2004 Virginia Health Care Insurance and Access Survey to allow for data analyses and reporting at the regional level. This was by far the most effective data collection activity relative to resources expended because not only did it guide decision-making at the statewide level during SPG I activities, but also guided discussion and decision making for the regionally focused activities of SPG II..

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

In the ideal world, Virginia would have liked to have had a large enough sample from the 2004 Virginia Health Care Insurance and Access Survey to have allowed for data analyses and reporting at the city/county level. Additionally, Virginia would have liked to have been able to repeat the 2004 Virginia Health Care Insurance and Access Survey at a future point in time, either after two years or even after five years of the initial survey. Both of these data collection activities were contemplated, but dismissed due to budget limitations.

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

See "Virginia State Planning Grant Phase One: Final Report to the Secretary of Health and Human Services" (September 2005). SPG-II funds were not used for additional data collection efforts.

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

As mentioned in 6.3, Virginia would ideally have liked to conduct a survey like the 2004 Virginia Health Care Insurance and Access Survey with a large enough sample to allow for data analyses and reporting at the city/county level. This type of data is extremely important for mobilizing and effecting change at the local government level. The VDH OHPP made an effort to allow localities to "buy in" to the 2004 Virginia Health Care Insurance and Access Survey, provided they could fund the oversample needed for their particular city/county. Although a number of cities and counties expressed interest, only two counties were able to come up with the requisite approvals and funds within the timeframe needed to meet the workplan timeframes of the SPG I grant. Additionally, Virginia would like to repeat the 2004 Virginia Health Care Insurance and Access Survey at a future point in time. The 2004 Virginia Health Care Insurance and Access Survey, because of its granularity at the regional level, has been tremendously useful for planning purposes. However, as with many other states that have conducted state generated estimates of uninsurance rates, the difference between the findings from the 2004 Virginia Health Care Insurance and Access Survey and those found in national surveys such as the Census Bureau's Current Population Survey continue to pose challenges for Virginia in terms of its utility for general policy development and for performance measurement/tracking of change over time.

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

One of the key organizational issues that became apparent to Virginia as a result of this grant was essentially the lack of organization around the issue of uninsurance. There were many different public and private agencies and organizations with initiatives related to improving coverage, but those efforts were not coordinated and there was not single point of focus. In fact, there were so many messages about insurance coverage being disseminated by the various entities, that most messages were being lost. As a result of its leadership and involvement with the issue of uninsurance with the HRSA SPG effort, the VDH OHPP has reorganized to include uninsurance as a formal program focus and is now being seen as the hub or clearinghouse for information about uninsurance. VDH OHPP is leading the effort to develop a Virginia Foundation for Health Coverage Education which will create an even more visible structure for coordination and information dissemination.

6.7 What key lessons about your insurance market and employer community resulted from the HRSA planning effort? How have the health plans responded to the proposed expansion mechanisms? What were your key lessons in how to work most effectively with the employer community in your State?

See "Virginia State Planning Grant Phase One: Final Report to the Secretary of Health and Human Services" (September 2005).

6.8 What are the key recommendations that your State can provide other States regarding the policy planning process?

See "Virginia State Planning Grant Phase One: Final Report to the Secretary of Health and Human Services" (September 2005).

6.9 How did your State's political and economic environment change during the course of your grant?

During the course of SPG II, Virginia elected its 70th Governor. While serving as Virginia's Lieutenant Governor in the previous administration, Governor Kaine established a Commission on Small Business Health Insurance Costs comprised of small business owners, state legislators, and medical and insurance professionals. The Commission was charged with making recommendations that would reduce the pressure of rising health insurance costs on small businesses and allow them to insure more of their employees. Governor Kaine brings this passion and concern for affordable health care to his current administration. Inaugurated on January 2006, Governor Kaine has already established a Health Reform Commission with four workgroups. One of those workgroups is focused on access to care and has essentially adopted the process used in SPG II, only applying it to a broader area of focus. The Access to Care workgroup has been tasked with using survey data to identify age groups, regions, or populations where uninsurance rates are high and develop recommendations to the Commission on how to increase insurance rates in these areas through innovative pilots, demonstrations, individual or small group insurance market reforms, or other mechanisms. The Governor has established a new position within VDH, Deputy Commissioner of Health Policy. The newly appointed Deputy is tasked with overseeing the Governor's Health Reform Commission and its four workgroups.

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

The project goals for SPG II did not change.

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

In 2005, Virginia received notification that it would receive a third and final round of SPG funds in the amount $175,000 through the SPG Continuation Limited Competition Grant Program (SPG III). As a result of SPG II recommendations, Virginia has significantly changed its project goals for this third and final round of SPG funds. SPG III will primarily focus on establishing a Virginia Foundation for Health Coverage Education. The successful completion of this project would allow the work begun through SPG funds to be sustained and expanded upon for many years to come.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

7.1 What coverage expansion options selected require Federal waiver authority or other changes in Federal law (e.g., SCHIP regulations, ERISA)?

None.

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

None

7.3 What additional support should the Federal government provide in terms of surveys or other efforts to identify the uninsured in States?

See "Virginia State Planning Grant Phase One: Final Report to the Secretary of Health and Human Services" (September 2005).

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

See "Virginia State Planning Grant Phase One: Final Report to the Secretary of Health and Human Services" (September 2005).

SECTION 8. OVERALL ASSESSMENTS OF SPG PROGRAM ACTIVITY

(Please provide as many concrete examples as possible)

8.1 What is the likely impact of program activities in the near future? What were the major impediments and facilitators for improved outcomes? Include specifics about changes in budgetary environment, changes in political leadership etc.

As mentioned in 6.9, the current Governor of Virginia brings a passion and concern for affordable health care to his current administration and has established a Health Reform Commission with four workgroups. One of those workgroups is focused on access to care and has essentially adopted the process used in SPG II, only applying it to a broader area of focus. Hence, the likelihood of program activities to have an impact in the near future is great.

8.2 What is the state's current view of most feasible expansion options? What direction was deemed most feasible and why?

Based on the recommendations of the many entities involved in both SPG I and SPG II, the most feasible option would be to expand the private insurance market and ensure coverage options to individuals that may not have a private sector alternative to public coverage.

8.3 What do you foresee to be the sustainability of programs implemented as a result of the SPG program, or the likelihood that programs currently under consideration will be implemented?

The Virginia SPG II report will be submitted to the Governor, through the Virginia Secretary of Health and Human Resources in the upcoming months. An analysis of the various options for the SPG II Model Product will be provided to the Governor for his decision regarding implementation. The present administration is a proponent of giving tax credits to small businesses. Hence, coupling the SPG II Model Product with a tax credit option to help further reduce the cost or provide enough subsidy to allow raising the $50,000 annual max is a definite possibility. However, an attempt to introduce tax credits by the Governor in the previous

General Assembly was unsuccessful and it is uncertain at this time whether the present administration will make another attempt on this issue during the upcoming Session.

As previously stated, since April 2006, the SPG Leadership Team has met with key staff from the Governor's Office, the Virginia Association of Health Plans, and the Virginia Underwriter's Association to assess support for the establishment of a Foundation for Health Coverage Education. This was one of the recommendations of the SPG II regional Steering Committee. Budget language in support of the Foundation is presently being drafted, with plans for it to be introduced during the 2007 General Assembly Session. Virginia is optimistic that this Foundation will become a reality, which would allow the SPG funded activities to not only be sustained, but to expand over time.

8.4 Did your SPG program activity create an impetus to change your state's Medicaid program via a waiver, changes in eligibility or cost-sharing?

No. At the time of inception of the Virginia SPG program, Virginia was also participating in the SCI program. Virginia's SCI program was focused on the state's Medicaid program and making recommendations regarding waivers and expansions. Hence, the Virginia SPG made a conscious decision not to explore those options.

8.5 Please describe the realities of state decision-making regarding insurance expansion in terms of things that facilitate and inhibit policy changes.

State decision-making regarding insurance expansion is heavily impacted by the overall political climate in Virginia. Virginia as a whole, regardless of the political leanings of its leadership, has never been receptive to public program expansions. Hence, the range of "options" put on the table is often constricted by these realities.

8.6 Concretely, what was the value of the funding data collection analysis? How were the results used to shape political thinking and build consensus on ways to cover the uninsured? What is the value of data being re-collected and at what frequency?

Funding the data collection analysis was one of the most valuable aspects of the SPG Program. As mentioned in 6.1, state-specific data was extremely important to the decision-making process. It was the sub-state analysis from the 2004 Virginia Health Care Insurance and Access Survey that helped to identify Central Virginia as having the highest rates of uninsurance, making it the focus of our SPG II activities. Additionally, all discussions and decisions by the regional Steering Committee were informed by data acquired through qualitative and quantitative methods (as demonstrated in Section 4). The majority of that data was collected or assembled and analyzed through SPG grant funds

Also as previously mentioned, Virginia would like to repeat the 2004 Virginia Health Care Insurance and Access Survey at a future point in time. The 2004 Virginia Health Care Insurance and Access Survey, because of its granularity at the regional level, has been tremendously useful for planning purposes. However, as with many other states that have conducted state generated estimates of uninsurance rates, the difference between the findings from the 2004 Virginia Health Care Insurance and Access Survey and those found in national surveys such as the Census Bureau's Current Population Survey continue to pose challenges for Virginia in terms of its utility for general policy development and for performance measurement/tracking of change

over time. Should funds be made available for this purpose, Virginia would recommend that this state-specific data be collected at a minimum of once every five years.

8.7 In terms of the data collection activities pursued through the SPG grant, are there certain ones you would do differently based on experience?

As mentioned in 6.5, Virginia would ideally have liked to conduct a survey like the 2004 Virginia Health Care Insurance and Access Survey with a large enough sample to allow for data analyses and reporting at the city/county level. This type of data is extremely important for mobilizing and effecting change at the local government level. The VDH OHPP made an effort to allow localities to "buy in" to the 2004 Virginia Health Care Insurance and Access Survey, provided they could fund the oversample needed for their particular city/county. Although a number of cities and counties expressed interest, only two counties were able to come up with the requisite approvals and funds within the timeframe needed to meet the workplan timeframes of the SPG I grant. If we were to do this survey again, sufficient lead time would be provided to allow cities and counties to get the approvals and funds needed to increase the sample size sufficiently for analyses to be conducted at the city/county level.

8.8 How have stakeholder groups evolved over time? In hindsight, what are the central components to putting and keeping together a successful steering committee?

Stakeholder groups in Virginia have become more diverse over time, incorporating more and more "non-traditional" partners in the public health arena. These include entities such as the Chambers of Commerce, Small Business Development Centers, and Health Underwriters/Insurance Brokers.

In Virginia, as in most places, the same key stakeholders are invited to the table for a multitude of initiatives. Their time is limited, but their input is invaluable. Hence, each meeting of stakeholders must have clearly articulated objectives and a strong team to provide background research, administrative, and organizational support before each meeting. When stakeholders are given well organized, thought provoking analyses of data and information at each meeting, it energizes the group and leads to effective discussion.

8.9 What activities will be discontinued as a result of the SPG grant coming to a close?

Virginia received notification that it received a third and final round of SPG funds in the amount $175,000 through the SPG Continuation Limited Competition Grant Program (SPG III) in 2005. These funds will support activities through August 2007. Hence, at this point, there are no activities that will be discontinued as a result of the SPG grant coming to a close.

8.10 Highlight specific lessons about potential policy options that could be used by HHS and states to shape future activities.

Virginia should be in a better position to answer this question within the next year because of the large number of policy driven items currently in the works. However, as previously mentioned, Virginia would recommend that HHS make funding available to states to allow state-specific data to be collected at a minimum of once every five years.

8.11 Please comment on how helpful the site visit, availability to talk/email with AcademyHealth staff, and general technical assistance of AcademyHealth was to your project?

The site visit by AcademyHealth staff was particularly helpful during the initial stages of Virginia's SPG activities, because they were able to provide a meaningful nexus between SPG and the Virginia SCI efforts. Additionally, the wealth of resources and materials made available through the AcademyHealth SCI website has been a tremendous help.

8.12 Please comment on how helpful the HRSA SPG grantee meetings were to your project?

The HRSA SPG grantee meetings were more helpful toward the earlier stages of involvement with SPG because it provided valuable opportunities to learn from the experiences of other SPG grantees. Once Virginia selected its model option and began focusing its efforts on that, the grantee meetings had less utility. Although it was helpful to see the big picture in terms of upcoming federal legislative and national initiatives, this did not have direct bearing on the day to day activities of the Virginia SPG.

8.13 Please comment on how helpful the technical assistance from SHADAC was to your project?

Lynn Blewett and her team at SHADAC were extremely helpful in providing support to understand the complex sampling frame, analytic methods utilized and interpretation of the data given experiences in other states from the CSCS household survey.

8.14 Please comment on how helpful the Arkansas Multi-State Integrated Database System was to your project, (if applicable).

The Arkansas Multi-State Integrated Database System was initially very helpful in looking at data nationally and in Virginia. However, this database system was not updated with new data in a timely fashion and its utility quickly dissipated.

8.15 Please comment on how useful the Agency for Healthcare Research and Quality's technical assistance and survey work (e.g. MEPS-IC) was to your project.

Jim Branscombe and his team at AHRQ were very helpful in setting up the sub-state/regional analyses of Virginia's MEPS-IC survey data.

8.16 Please comment on the long-term effect (if any) of your state's SPG program on future efforts to improve coverage via:

- ***a. Data collection - e.g. surveys, focus groups, etc.***
- ***b. Data analysis – e.g. modeling, actuarial analysis***
- ***c. Political understanding/education***
- d. ***Approaches and structure for collaboration***

The long term effect of Virginia's SPG program remains to be seen. Virginia should be much better able to answer this question within the next year because of the large number of items currently in the works.

APPENDICES

Appendix I: **Baseline Information**

Appendix II: **Links to Research Findings and Methodologies**

Appendix III: **SPG Summary of Policy Options**

Appendix IV: **Overview of Proposed Model Option to Expand Health Insurance Coverage Among Employed Virginians**

Appendix V: **Definitions of Low and High Cost Sharing Insurance Products**

APPENDIX I: BASELINE INFORMATION

Please provide the following baseline information about your State (if possible). Also include any additional baseline information especially relevant to your coverage expansion strategies.

See "Virginia State Planning Grant Phase One: Final Report to the Secretary of Health and Human Services" (September 2005).

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

Indicate the Web site addresses for any additional sources of information regarding your State's research work, including detailed data spreadsheets, cross-tabs, focus group and key informant interview summary reports, survey instruments, and summaries of research methodology.

The Virginia SPG web site is located at http://InsureMoreVirginians.org. The following are the specific locations of documents found at the Virginia SPG website:

- **For statewide insurance survey data reports:**
  http://gunston.doit.gmu.edu/chpre/vauninsured.html

- **For SPG Data Analyses reports:**
  http://gunston.doit.gmu.edu/chpre/researchresources.html

- **For regional survey data reports:**
  http://gunston.doit.gmu.edu/chpre/vamap.html

- **For SPG I:**
  - Data Work Group reports and working documents:
    http://gunston.doit.gmu.edu/chpre/datawg.html
  - Model Development Work Group reports and working documents:
    http://gunston.doit.gmu.edu/chpre/modelwg.html
  - Business Task Force reports and working documents:
    http://gunston.doit.gmu.edu/chpre/businesstf.html
  - Community Outreach Work Group reports and working documents:
    http://gunston.doit.gmu.edu/chpre/communitywg.html
  - Final reports:
    http://gunston.doit.gmu.edu/chpre/SPG-I-FinalReport.html

- **For SPG II:** http://gunston.doit.gmu.edu/chpre/SPGII-activities.html

APPENDIX III: SPG SUMMARY OF POLICY OPTIONS

Using the following chart, please list the policy options considered and/or implemented under the HRSA SPG, including original grant and continuation grants. For each policy option described, please include data on a cumulative basis per fiscal year (FY), e.g. FY 2006 starts October 1, 2005 and ends September 30, 2006.

The following is a list of the four policy options that were seriously considered by the Model Development Work Group during SPG I. as well as one option that was recommended. The recommended option was revisited and refined during SPG II. None of the policy options have yet been implemented.

Option considered	**Target Population**	**Estimated Number of People Served**	**Status of approval (for example waivers submitted or legislation proposed) Please provide month and year when waiver or legislation was proposed and if approved, month and year of approval**	**Status of implementation (please include month and year program or initiative began)**	**If implemented, most recent estimate within the federal fiscal year (Oct.1 – Sept 30) of number people served. Please provide the month and date of the point in time estimate provided.**
1. Put in place small group rating reforms to control variability in premium rates for small employers.	Individuals employed in small Virginia businesses (2 to 50 employees)	Could potentially impact 800,000+ employees working in the 120,000+ small businesses in Virginia	N/A – option was considered, but not selected	N/A	N/A
2. Consumer-driven health plans	Individuals employed in small Virginia businesses (2 to 50 employees) and individuals in households	Although targeted at a specific audience, could potentially impact all Virginians	N/A – option was considered, but not selected	N/A	N/A

	with incomes between 100% to 300% of the Federal Poverty Level (FPL)				
3. Tax incentives for small businesses	Individuals employed in small Virginia businesses (2 to 50 employees)	Could potentially impact 800,000+ employees working in the 120,000+ small businesses in Virginia	The 2006 General Assembly did not pass HB 479 which would have provided a state tax credit for health insurance premiums for small businesses. The Governor may choose to propose this again and/or couple it with the SPG II recommended Model Product. during the 2007 General Assembly Session.	N/A	N/A
4. Sale of 'mandate-light' or no-mandate policies	Individuals employed in small Virginia businesses (2 to 50 employees) and individuals in households with incomes between 100% to 300% of the Federal Poverty Level (FPL)	A demand estimate was beyond the scope of SPG I. This was visited in SPG II and resulted in a shift in the recommended model option.	N/A – this was originally proposed in SPG I with the option of coupling it with tax incentives for small businesses. The concept of a 'mandate-light' policy was revised in SPG II. See below.	N/A	N/A
5. Sale of full benefits package with $50,000 cap to keep premiums in the affordable	Individuals employed in small Virginia businesses (2 to 50 employees)	Estimated demand statewide would be 35,000+	The Virginia SPG II report will be submitted to the Governor, through the Virginia Secretary of Health and Human	N/A	N/A

range for the target population	and in households with incomes between 100% to 300% of the Federal Poverty Level (FPL)		Resources in the upcoming months. An analysis of the various options for the SPG II Model Product will be provided to the Governor for his decision regarding implementation, including coupling it with tax credits for small businesses.		

(Please list each item in separate rows of chart. Additional rows may be added to the chart.)