VIRGINIA STATE PLANNING GRANT
PHASE ONE

FINAL REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

SEPTEMBER 2005

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REPORT ACRONYMS

Agency for Health Research and Quality	AHRQ
Arkansas Center for Health Improvement, Multi-State Integrated Database	MSID
Behavioral Risk Factor Surveillance Survey	BRFSS
Center for Health Policy, Research and Ethics, George Mason University	CHPRE, GMU
Centers for Disease Prevention and Control	CDC
Current Population Survey	CPS
Employee Benefit Research Institute	EBRI
Federal Poverty Level	FPL
Fiscal Year	FY
Health Resources and Services Administration	HRSA
Medical Expenditure Panel Survey-Insurance Component	MEPS-IC SURVEY
State Health Access Data Assistance Center	SHADAC
Survey of Income and Program Participation	SIPP
Virginia Department of Health, Office of Health Policy and Planning	VDH OHPP
State Planning Grant	SPG
Virginia State Planning Grant	VIRGINIA SPG

ACKNOWLEDGMENTS

The Virginia Department of Health (VDH) Office of Health Policy and Planning (OPPP) wishes to acknowledge the support, creativity, and many hours of hard work by a large number of organizations and individuals toward ensuring the success and of its first State Planning Grant to increase health insurance coverage among Virginia's employed uninsured. A complete list of all the members of the Virginia State Planning Grant Leadership Team, Data Workgroup, Model Development Workgroup, Business Task Force, and Community Outreach Workgroup can be found on the project website at www.InsureMoreVirginians.org. Acknowledgement of specific contributions made by technical consultants and contractors is found within the report.

EXECUTIVE SUMMARY

The Commonwealth of Virginia was one of ten states and territories during FY2003 to receive a State Planning Grant from the Department of Health and Human Services' Health Resources and Services Administration (HRSA). The goal of the Commonwealth of Virginia SPG (Virginia SPG) is to develop a viable, realistic option for expanding health insurance coverage to an identified population of working uninsured. The Virginia SPG framework involved a partnership with the business community which represented an unprecedented approach to the development of health insurance policy in Virginia.

The Virginia SPG has involved a number of other health policy watershed events. The health insurance household survey was the most comprehensive ever conducted in the Commonwealth. Health policymakers, researchers, statisticians and others assured the survey was designed to capture the unique characteristics of the Commonwealth. For example, because Virginia is ranked eighth in the nation in terms of refugee resettlement, the survey was conducted in other languages. The Medicare Expenditure Panel Survey-Insurance Component likewise captured new data. For the first time its findings were the result of actual Virginia-specific data, and not mere interpolated extractions from larger surveys. Most important, the workgroup format allowed the business community, safety net community, research community, and health insurance model experts to be responsible for leading specific tasks as well as educating one another on particular topics. This “marketplace of ideas” approach assured there were no disenfranchised groups and that the proposed model represented the best model for Virginia.

Overview of the Virginia State Planning Grant

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

1. Conduct a Descriptive Study of the Existing Data on the Current Status and Economic as well as Societal Costs of Non Insurance;
2. Perform New Data Collection and Analysis to Inform Options for Coverage Expansion for the Employed Uninsured (2004 Virginia Health Care Insurance and Access Survey Household Survey, AHRQ Business Survey);
3. Collaborate with Public and Private Sector Partners to Develop a Viable Option(s) to Provide Access to Coverage for Virginia’s Working Uninsured Population and Sustain Collaboration;
4. Develop a Business Plan for Covering the Uninsured in Virginia and submit it to the Governor and Secretary of Health and Human Resources.

The Virginia SPG project is directed by the Virginia Department of Health (VDH) Office of Health Policy and Planning (VDH OHPP) in collaboration with subcontracted partners: the Center for Health Policy Research and Ethics at the George Mason University (CHPRE), the Minnesota State Data and Information Access Center (SHADAC), the HRSA-sponsored Arkansas Center for Health Improvement, Multi-State Integrated Database (MSID), the Agency for Health Research and Quality (AHRQ) Medical Expenditure Panel Survey Insurance Component Division (2003 AHRQ, MEPS-IC Survey), the Healthcare Leadership Council and

Project REACH at Virginia Commonwealth University. Mr. Robert A. Archer (Board of Directors, Virginia Chamber of Commerce) and the Small Business Advisory Board for Virginia have also played an integral role in the Virginia SPG project.

On behalf of the Virginia Department of Health, Office of Health Policy and Planning, for further information or questions about the final report, contact Dr. PJ Maddox, Director, Office of Research, Center for Health Policy, Research and Ethics at George Mason University (703-993-1982). For questions about Virginia's initiatives under the State Planning Grant, please contact Ms. Rene Cabral-Daniels, Director of the Office of Health Policy and Planning, Virginia Department of Health (804-864-7434).

SECTION 1. UNINSURED INDIVIDUALS AND FAMILIES

*The purpose of this section is to summarize Virginia's SPG research on uninsured **individuals and families.** Questions 1.1 through 1.3 address the **quantitative** research work undertaken through the Virginia SPG. Data presented includes those from the State Health Access Data Assistance Center (2004 Virginia Health Care Insurance and Access Survey) survey of Virginia Households, the Current Population Survey and CDC's BRFSS surveys.*

In 2004, the VDH OHPP commissioned the State Health Access Data Assistance Center (SHADAC) to survey Virginia households about health insurance coverage. SHADAC is a research center at the University of Minnesota with experience conducting research on methods and trends in state/national insurance coverage. Using a standardized telephone survey (Health Care Insurance and Access Survey) with the addition of specific Virginia SPG questions, a telephone interview survey of over 4,000 representative households across Virginia was undertaken.

Two reports summarizing the 2004 Virginia Health Care Insurance and Access Survey findings are found in Appendix C. In addition, technical reports, including the survey instrument, survey description, sampling plan and other extant data sources utilized by the Virginia Data Work Group are located on the SPG website at www.InsureMoreVirginians.org.

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

Table 1: Rates of Uninsurance in Virginia

Virginia Health Care Insurance and Access Survey	CPS	BRFSS
8.9%	13%	12.1%

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

1.2 What are the characteristics of the uninsured?

Table 2: Virginia Uninsurance Rates by Income

Income *	Uninsured (%) *		Income by FPL **	Uninsured (%) **	
$10,000 to $19,999	120,531	(12.5%)	<100%	183,458	(20.3%)
$20,000 to $29,999	128,552	(13.4%)	100-133%	65,454	(19.0%)
$30,000 to $39,999	89,339	(9.3%)	134-150	44,250	(28.8%)
$40,000 to $49,999	114,251	(11.9%)	151-200%	82,991	(14.8%)
$50,000 to $59,999	94,595	(9.8%)	201-250%	87,859	(16.1%)
$60,000 to $69,999	62,453	(6.5%)	251-300%	79,007	(13.6%)
$70,000 to $79,999	43,408	(4.5%)	>300%	96,598	(2.4%)
$80,000 to $89,999	40,113	(4.2%)			
$90,000 to $99,999	20,861	(2.2%)			
under $9999	114,847	(11.9%)			
$100,000 and over	132,716	(13.8%)			

Sources: * Current Population Survey, 2003; ** 2004 Virginia Health Care Insurance and Access Survey.

Table 3: Virginia Uninsurance Rates by Age

Age *	Uninsured (%) **		Age **	Uninsured (%) **	
1 to 14 years old	130,065	(13.5%)	0-5 years old	39,130	(6.4%)
15 to 18 years old	33,437	(3.5%)	6-18 years old	81,919	(6.5%)
19 to 44 years old	564,770	(58.7%)	19-24 years old	143,972	(25.5%
45 to 64 years old	225,549	(23.5%)	25-34 years old	128,965	(14.7%)
65 years and older	7,844	(0.8%)	35-54 years old	166,667	(7.9%)
			55-64 years old	71,485	(7.6%)
			65 + years old	7,479	(1.0%)

Sources: *Current Population Survey, 2003; ** 2004 Virginia Health Care Insurance and Access Survey.

Table 4: Virginia Uninsurance Rates by Gender

Gender *	Uninsured (%) *		Gender **	Uninsured (%) **	
Female	432,176	(44.9%)	Female	294,621	(8.0%)
Male	529,489	(55.1%)	Male	344,996	(9.9%)

Sources: * Current Population Survey, 2003; **2004 Virginia Health Care Insurance and Access Survey.

Table 5: Virginia Uninsurance Rates by Family Composition

Family Composition *	Uninsured (%) **		Family Composition *	Uninsured (%) **	
Husband-wife	527,551	(54.9%)	Married	270, 681	(5.7%)
Other Female Head	246,428	(25.6%)	Living with partner	36,038	(16.2)
Other Male Head	187,686	(19.5%)	Widowed	17,317	(6.1%)
			Divorced	59,069	(11.9%)
			Separated	37,103	(21.7%)
			Never Married	204,962	(17.4%)

Sources: * Current Population Survey, 2003; **2004 Virginia Health Care Insurance and Access Survey.

Table 6: Virginia Uninsurance Rates by Health Status

Health Status *	Uninsured (%) *		Health Status **	Uninsured (%) **	
Excellent	241,947	(25.2%)	Excellent	130,182	(5.0%)
Very Good	318,571	(33.1%)	Very Good	177,439	(8.4%)
Good	281,509	(29.3%)	Good	190,937	(12.0%)
Fair	110,350	(11.5%)	Fair	96,854	(16.7%)
Poor	9,288	(1.0%)	Poor	24,971	(12.8%)

Sources: * Current Population Survey, 2003; ** 2004 Virginia Health Care Insurance and Access Survey.

Table 7: Virginia Uninsurance Rates by Employment Status

Employment Status	Uninsured (%)	
At work	506,591	(60.9%)
Not in labor force	240,205	(28.9%)
Unemployed-seek FT	73,172	(8.8%)
Unemployed-seek PT	2,878	(0.3%)
With job, not at work	8,754	(1.1%)

Source: Current Population Survey, 2003

Availability of private coverage:
According to 2003 data, 59.4% of all employers in VA offered insurance; 79.4% of employees were eligible for health insurance, and of those, 76.24% enrolled. (2003 AHRQ, MEPS-IC Survey 2003)

Availability of public coverage:
Based on findings from the 2004 Virginia Health Care Insurance and Access Survey, 18.3% of Virginian's children (0-18 years old) receive their health care through public programs while 9.5% of Virginia's adults (19-64 years old) receive their health care through public programs.

Table 8: Virginia Uninsurance Rates by Race/Ethnicity

Race/Ethnicity	Uninsured (%) *		Race/Ethnicity	Uninsured (%)**	
American Indian, non Hispanic	3,286	(0.3%)	American Indian	6,000	(22.3%)
Asian or Pacific Islander, non-Hispanic	56,457	(5.9%)	Asian	13,382	(8.6%)
Black, non-Hispanic	205,878	(21.4%)	Black	149,433	(11.1%)
Hispanic	191,404	(19.9%)	Hispanic	108,440	(27.4%)
Other	0	(0.0%)	Mixed	38,733	(12.1%)
White, non-Hispanic	504,641	(52.5%)	White	304,322	(6.4%)

Sources: * Current Population Survey, 2003; ** 2004 Virginia Health Care Insurance and Access Survey.

Table 9: Virginia Uninsurance Rates by Immigration Status

Immigration Status	Uninsured (%)	
Foreign born, not a citizen of the United States	187,613	(19.5%)
Foreign born, U.S. citizen by naturalization	43,627	(4.5%)
Native, born abroad of American parent or parents	9,150	(1.0%)
Native, born in Puerto Rico or U.S. outlying area	4,326	(0.4%)
Native, born in the United States	716,949	(74.6%)

Source: Current Population Survey, 2003

Table 10: Virginia Uninsurance Rates by Geographic Location

Type Region	**Uninsured (%)**	
Metropolitan Statistical Area (MSA)	510,751	(12.0%)
Non-MSA	128,867	(8.4%)
SPG Regions/Health Service Areas	**Uninsured (%)**	
Northwestern	79,621	(8.4%)
Northern	149,900	(7.3%)
Southwestern	149,900	(9.9%)
Central	153,460	(12.1%)
Eastern	140,182	(8.2%)

Source: 2004 Virginia Health Care Insurance and Access Survey.

The county with the highest rate of uninsurance is Accomack County in the Eastern Region with a total rate of uninsured at 20.3% and 19.3% for those under the age of 18 years old. The county with the lowest rate of uninsurance is Goochland County in the Southwestern Region with a total rate of only 6.0% and 3.6% rate of uninsurance for those under 18 years old.

The following maps depict county-wide uninsurance data for the state of Virginia:

Figure One: Percent of Total Population Without Health Insurance, 2000

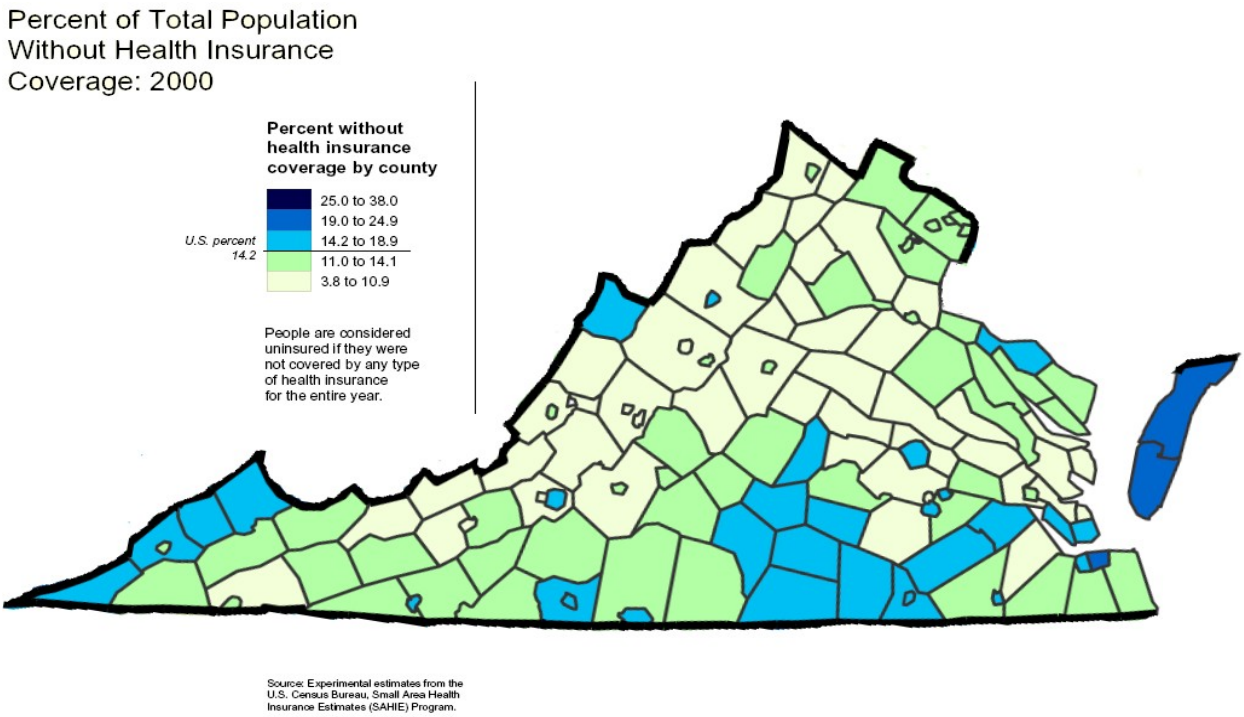
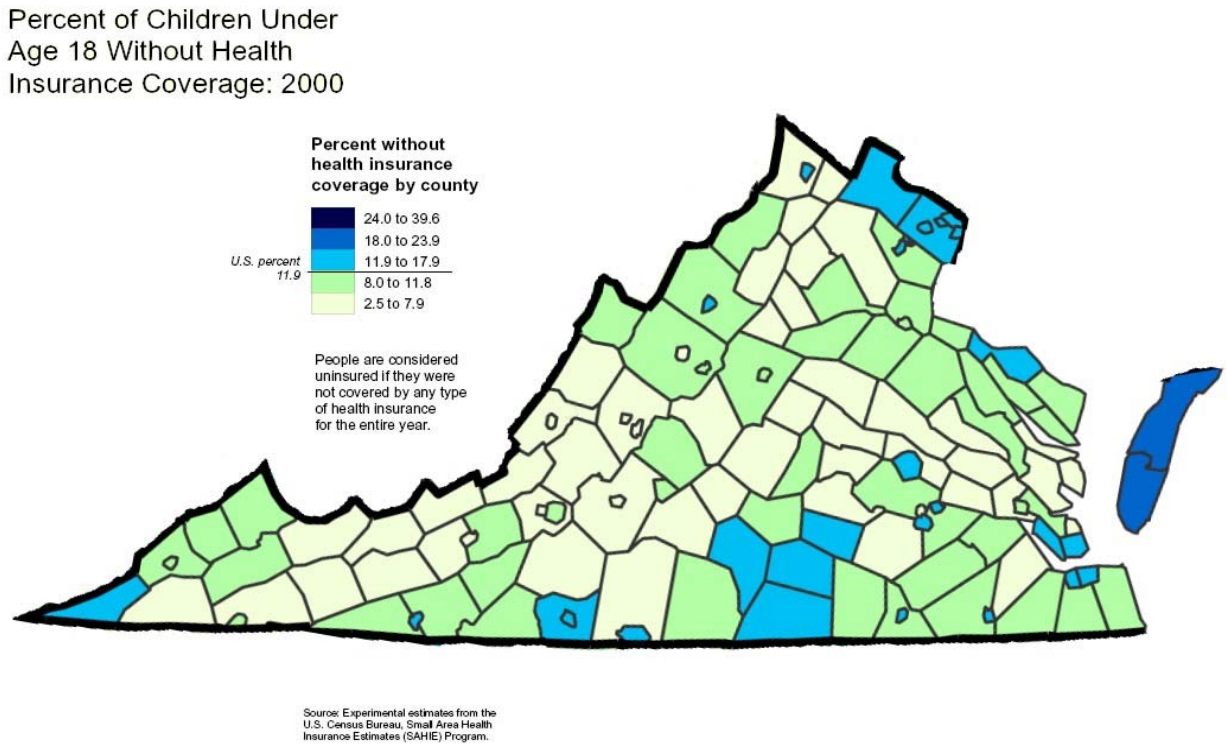


Figure Two: Percent of Children Without Health Insurance, 2000



Source: US Census, 2000. Downloaded from http://www.census.gov/hhes/www/sahie/maps/aaUninsure2000.pdf on Sept 9, 2005)

Table 11: Virginia Uninsurance Rates by Duration of Insurance

Alternative Definitions of Insurance Rates	Definition Weighted Count (%)	
Point-in-Time	639,618	(8.9%)
Uninsured All Year	453,029	(6.3%)
Uninsured Part Year	371,739	(5.2%)
Uninsured at Some Point During Year	824,768	(11.5%)

Source: 2004 Virginia Health Care Insurance and Access Survey.

The 2004 Virginia Health Care Insurance and Access Survey found continuing high rates of uninsurance in the state. At the time of the survey, about 640,000 persons (nearly 9% of Virginia's population) had no health insurance—a number slightly smaller than the population of Virginia Beach and Norfolk combined. Rates of uninsurance for all Virginians varied from 6.3% for those who were uninsured all year to 11.5% for those uninsured at some point during 2004. Specifically, 11.4% of working age adults were uninsured at a point in time but ranged from 8.2% for all year to 14.6% for some point in time over the year. Children (</=18 years old) experienced a 6.4% rate of uninsurance for point in time and had a range of uninsurance of 4.1% for all year to 8.6% for some point in the year. Seniors (>/= 65 years old) experienced rates of uninsurance of .8% to 1% for the year. In addition, about 8 in 10 of the state's insured population fear they won't be able to continue to afford health insurance.

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

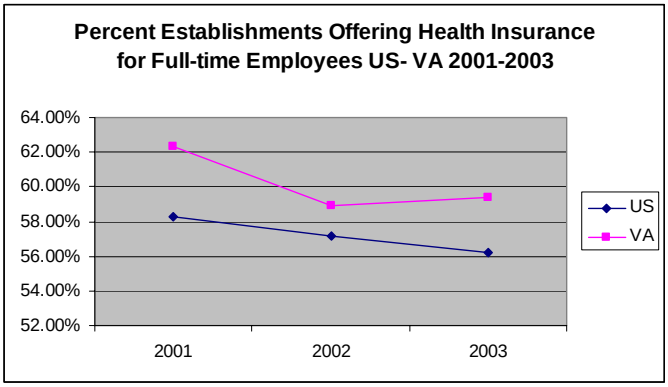
Figure 3. Rates of Uninsurance by Region, Virginia 2004

Source: 2004 Virginia Health Care Insurance and Access Survey

The Commonwealth's low-income population has one of the highest rates of uninsurance. The proportion of families without health insurance living at or below 150% of the Federal Poverty Level (FPL) is 20% or more. Among uninsured adults of all ages, nearly 60% reside in lower income households.[i] Increases in Medicaid and State Child Health Insurance Program (SCHIP) called Family Access to Medical Insurance Security (FAMIS) enrollment since 2001 have helped to lower uninsurance rates of children and pregnant women, while higher rates of unemployment and an influx of new immigrants have led to an increase in the uninsured adult population. Private, employment related insurance accounts for the majority of coverage across the Commonwealth. Yet, many low-wage workers do not have access to affordable insurance, primarily because their employers do not offer it.[ii]

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

Figure 4: Percent Establishments Offering Health Insurance for Full-Time Employees, US-VA 2001-2003



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

Across Virginia, there was an expression of concern over the stability of health insurance coverage and access to health services. Over half of those with public coverage and over a third of those with private coverage said they were worried that over the next year they will no longer be able to afford health insurance, medical care, and/or prescription drugs.

The two main reasons uninsured workers do not have employer-sponsored coverage are: 1) 'don't qualify' (35.8%) and 2) coverage is 'too expensive' (28.9%). These results highlight some of the barriers preventing low-income, part-time and temporary workers from obtaining employer-sponsored health insurance benefits. In comparison to those with private or public health insurance, the uninsured were more likely to report the emergency room (ER) as their usual source of care. This is of concern because the ER is a high cost and inefficient method of obtaining health care. Finally, a number of themes emerged around the issue of employer-based insurance coverage. In comparing workers who are offered coverage to those who are not, survey findings indicate:

- Workers in larger firms were more likely than those in smaller firms to be offered coverage.
- Higher wage workers were more likely than lower wage workers firms to be offered coverage. Workers in the retail, agriculture, and personal service sectors were the least likely to be offered health insurance coverage.

1.3 Summarizing the information provided above, what population groupings were particularly important in developing targeted coverage expansion options for Virginia?
The uninsured in Virginia are most often low-income, non-white young adults, employed in small businesses, and residing in an MSA.

*Questions 1.4 through 1.13 present data derived from **qualitative** research undertaken through Virginia's SPG:*

1.4 What is affordable coverage? How much are the uninsured willing to pay?
Based on findings under the Virginia SPG project, affordable coverage was estimated as a premium cost of less than 1-2% of take home pay for individuals. Business owners stated that a

premium cost of <$150 a month is affordable (Small Business Key Informant Survey, Virginia, 2005[v]).

1.5 / 1.6 Why do uninsured individuals and families not participate in public programs for which they are eligible?

According to data from recent surveys of Medicaid and FAMIS (SCHIP) households (limited to English speaking households with children and a telephone) that failed to renew their child's coverage by the Virginia Department of Medical Assistance (DMAS), most respondents thought they earned too much to remain covered. Another DMAS-sponsored survey of Medicaid-eligible families with children found a range of views about coverage among families enrolled in Medicaid or SCHIP. Some families felt they did not need Medicaid because they have other insurance, some did not trust 'government programs' and indicated that no amount of information or reassurance (i.e. through marketing) would change that view; while others enrolled in Medicaid or SCHIP reported being satisfied. Lastly, another set of families in the target market, reported their children were not covered and they were suspicious of a "government" program to provide that coverage.

1.7 Why do uninsured individuals and families not participate in employer sponsored coverage for which they are eligible?

According to a key informant survey of small businesses in Virginia conducted as part of the Virginia SPG, the cost of coverage hinders individuals and families from participating or that they have coverage through other sources (Small Business Key Informant Survey VA, 2005).

1.8 Do workers want their employers to play a role in providing insurance or would some other method be preferable?

Findings from the Small Business Key Informant Survey indicated that employees want their employers to offer health insurance at little or no cost to the employee, but found mixed sentiments among employers as to their obligation to provide coverage.

1.9 How likely are individuals to be influenced:

Findings indicate that individuals have very low cost tolerances for health insurance: Virginia findings found these to be as little as 1-2% of individual income as the threshold for choosing to purchase health insurance.

1.10 What other barriers besides affordability prevent the purchase of health insurance?

Low-income, part-time and temporary workers are less likely to be eligible for health insurance. In addition, workers in small businesses are less likely to have employer sponsored health insurance.

1.11 How are the uninsured getting their medical needs met?

Virginia is fortunate to have a strong safety net system, which includes a variety of local, regional and statewide networks of safety net providers delivering basic health care services for the low-income, uninsured and geographically isolated individuals. Virginia's safety net providers include 50 Free Clinics with 61 operating sites; the Virginia Primary Care Association's (VPCA) 26 member organizations operating 68 community health center service

sites; 65 rural health clinics; 35 local health departments; and other providers committed to serving the underserved.

1.12 What are the features of an adequate, barebones benefit package?

While the Virginia SPG did not approach the development of the proposed expansion option in terms of what would be considered an adequate "bare bones" health insurance package, the Virginia SPG believes the proposed product is a viable, realistic option for expanding health insurance coverage to an identified population of the working uninsured. Two factors influencing the design of the proposed product were affordability and compliance with existing state regulatory health insurance requirements.

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

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

The prototype product includes the following benefit features:

- Preventative and primary care services for individual employee with household coverage available for family members (adults and children),
- Maternity care and emergency room visits,
- Limited or generic prescription drug coverage,
- An option or rider to cover some basic level of dental care and dependent coverage,
- Basic hospitalization coverage (inpatient services and outpatient surgery) associated with catastrophic-related care.

To sustain its attractiveness, the product would:

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

1.13 How should underinsured be defined? How many of those defined as "insured" are underinsured?

The Virginia SPG did not address the issue of 'underinsurance' in this project, and refers interested parties to the State Health Access Data Assistance Center for definitions and publications on rates of underinsurance.

SECTION 2. EMPLOYER-BASED COVERAGE

The purpose of this section is to document Virginia's SPG research activities related to employer-based coverage.

Employer Based Health Insurance

Current state economic conditions, coupled with persistent rising health care costs (including increasing employer costs and employee cost sharing), are contributing to a trend of fewer Virginians having access to employment-based health insurance. Small businesses are incorporating a number of strategies in order to continue to offer health insurance. Health insurance is a benefit that many view as necessary to be competitive in the market to recruit and retain employees and as a key to increased productivity in the workforce (EBRI Health Care Findings, 2004). Several key strategies reported in the literature and that are likely to shape the range of options for the Commonwealth of Virginia for expanding coverage are shown in Table 12.

Table 12: Small Business Strategies Supporting Health Insurance Availability

- Increasing or adding a deductible to the insurance plan
- Requiring higher co-payments for services rendered
- Excluding certain services from the health care plan which increases out of pocket expenses (cost sharing)
- Increasing employees share of the premium costs
- Introducing tiered networks for doctors visits and hospital stays
- Restricting employee eligibility for coverage
- Dropping coverage entirely

Source: Kaiser Family Foundation, 2004 & EBRI Health Care Findings, 2004.

*Questions within 2.1 focus on the **quantitative** research work conducted by Virginia's SPG:*

2.1 What are the characteristics of firms that do not offer coverage, as compared to firms that do?

Employer size (including self-employed):

Small businesses represent over 75% of all businesses and employ nearly a third of all workers (more than 828,000 persons) in the Commonwealth of Virginia. Individuals working in companies with fewer than 50 employees are about twice as likely to be uninsured as individuals working in companies with more than 50 employees. In 2003, only 59.4% of all businesses offered health insurance to their employees. Small businesses have much lower health insurance

offer rates. For businesses with fewer than 50 employees, only 47.7% of these businesses offered health insurance. Just 40% of very small employers (fewer than 10 workers) offered health insurance to their employees. By industry, very small employers in the retail and other services sector had the lowest offer rate (35%) followed by agriculture and construction (38%).[vi] Table 13 provides additional information on employee health insurance rates by industry. Additional data and tables from the 2003 AHRQ, MEPS-IC Survey are included in Appendix C.

Table 13: Virginia Insurance and Uninsurance Rates by Industry Sector

Industry	# Uninsured	# Insured
Agriculture, forestry, fishing, and hunting	1,329	5,861
Public administration	12,754	n/a
Information	264	5,593
Construction	7,922	24,964
Leisure and hospitality	6,987	25,758
Manufacturing	3,388	38,370
Wholesale and retail trade	7,121	42,418
Mining	226	1,170
Missing	0	0
Not Eligible (children or nonworkers)	14,440	241,170
Armed Forces	0	0
Other Services	2,359	12,544
Educational and Health Services	7,998	90,937
Transportation	1,066	12,533
Financial activities	1,349	15,143
Professional and business services	3,468	24,010

Source: Current Population Survey, 2003

Employee income brackets:

Wages earned also varied by region, industry and size of firm. For small businesses (<50 employees), the lowest median income was between $12,000- $15,000 for retail and other services sectors, followed by professional services, whose median income was around $24,000. The highest paid industry for small businesses in the state of Virginia was agriculture, fishery, forestry, and construction and other whose median wage incomes ranged between $21,000 and $39,000. Regionally, regardless of the size of business, Northern Virginia has the highest median income ($35,470) and the Southwestern region has the lowest ($22,333). The highest median income for businesses with fewer than 50 employees was found in the Central region at $27,857 and the lowest was found in the Eastern Region at $16,500 (*2003 AHRQ, MEPS-IC Survey.)*

Table 14: Number of Part-Time and Seasonal Workers in Virginia

	Uninsured	Insured
Full time	433,849	2,794,814
Part time	122,604	649,190

Source: Current Population Survey, 2003

Geographic location:
As part of the SPG grant, geographical analysis of the location and coverage of employers and insurance coverage has been conducted. The SPG website Knowledge Center houses detailed presentations of data to support project decision-making. The importance of one sector over another re employment impact and other issues varies widely across the five study regions in Virginia, especially for geographic regions with a larger proportion of rural communities. Please see Health Insurance Coverage Maps and Graphs located on the Virginia SPG web page (www.InsureMoreVirginians.org).

Both industry and geographic factors impact small employers with seasonal and part-time jobs. These industry and regional variations affect workers who may be less likely to have insurance offers as a benefit of employment. Moreover, these lower-wage seasonal and part-time workers are not only less likely to be offered insurance but also least likely to be able to afford the cost of coverage when it is offered. Overall, the Eastern Region had the lowest employer offer rate for health insurance where only 49.26% offered health insurance and the Central Region fared the best with 68.70% employers offering health insurance. For small businesses (<50 employees) again the Eastern Region fared the worst with only 37.79% of small businesses offering health insurance with the Central Region faring the best where 59.69% of small businesses offering health insurance (*2003 AHRQ, MEPS-IC Survey).*

Other(s):
Other research finds for those employers offering coverage includes the following:

Cost of policies:
The cost of insurance has also increased substantially since 2001. By 2003, the premium price for single coverage in Virginia had risen almost 20% to $3,322. Family coverage has also seen a dramatic change in cost rising almost 21% to $9,176 by 2003. The cost of coverage also varies by region and size of business. For all businesses, the average highest premium cost for single coverage was found in the Southwestern Region where the average cost of single coverage insurance was $3,546 and the lowest was found in the Eastern Region where the average cost for a single coverage policy is $2,919. For businesses with fewer than 50 employees, the highest average cost for a single coverage policy was found in the Northern Virginia area at $3,610 and the lowest average cost is found in the Northwestern Region at $3,038 for single coverage. The same phenomenon is found for family coverage. For all businesses, the average highest premium cost for family coverage was found in Northern Virginia at $9,650 and the lowest was in the Central Region at $8,704. For businesses with fewer than 50 employees, the average highest premium for family coverage was found in the Central Region at $9,621 and the lowest was found in the Northwestern Region at $7,542 (*2003 AHRQ, MEPS-IC Survey).*

Level of contribution:
The percent of the premium paid by the employee in Virginia was determined to be about 20% for single coverage and 30% for family coverage.

Percentage of employees offered coverage who participated:
For all employers in Virginia, regardless of size, 59.4% offered health insurance; 79.4% of employees were eligible, and of those, 76.24% enrolled. (2003 AHRQ, MEPS-IC Survey)

*Questions 2.2 through 2.7 presents information from **qualitative** research efforts conducted through the Virginia SPG:*

2.2 What influences the employer's decision about whether or not to offer coverage? What are the primary reasons employers give for electing not to provide coverage?

The 2005 Small Business Key Informant Survey in Virginia found that, for those employers that offered insurance, more than half used co-payments or deductibles to offset the costs of coverage. For those small firms not offering coverage, the most frequently cited reason for not doing so was the high cost of insurance.[vii] As a result, premium assistance was ranked as the best public policy option by these employers to assist them in offering health insurance. Among Virginia employers that primarily employ low-wage workers (employees making less than $9.50 per hour), nearly two-thirds of small employers (</= 50 employees) did not offer their employees coverage in 2003.[viii] Results from a *beta* test of the key informant interview indicated that business decision-making is driven largely by cost. Most business did not think of health care as part of the operating budget *per se*, but did believe that their ability to offer insurance was driven by the productivity of the employee.

2.3 How do employers make decisions about the health insurance they will offer to their employees? What factors go into their decisions regarding premium contributions, benefit package, and other features of the coverage?

The cost of the health insurance product was identified as the number one driving force impacting decision making of an employer to offer health insurance (Small Business Key Informant Survey, 2005; Virginia Business Health Insurance Survey, Virginia Department of Business Assistance, 2005).

2.4 What would be the likely response of employers to an economic downturn or continued increases in costs?

Respondents to the Small Business Key Informant Survey indicated that they would have to reevaluate the offering of health insurance, and possibly shift more costs to employees and/or decrease coverage should costs increase.

2.5 What employer and employee groups are most susceptible to crowd-out?

Low wage workers (defined as making no more than $9.50 an hour) working for small businesses have seen a dramatic decline in being offered health insurance. In 2003, only 38.6% of small businesses with at least 50 % of their employees classified as low income offered health insurance to their employees (*2003 AHRQ, MEPS-IC Survey).*

2.6 How likely are employers who do not offer coverage to be influenced by:

<u>Expansion/development of purchasing alliances</u>:

Not considered because of priority principles adopted for model option consideration (i.e. prioritizing options compatible with the current regulatory environment).

<u>Individual or employer subsidies</u>:

Premium assistance was ranked as the best public policy option by small employers to assist them in offering health insurance.

Additional tax incentives:
According to the Virginia Business Health Insurance Survey sponsored by the Virginia Department of Business Assistance in July of this year, 16% of the respondents indicated that they would offer a health insurance product if there were other incentives such as a tax incentive. An optional business tax incentive is proposed under the proposed expansion product.

2.7 What other alternatives might be available to motivate employers not now providing or contributing to coverage?
Affordability is the greatest motivator for small employers, who often have limited affordable options for health insurance for their employees. Small businesses in Virginia indicated that the ability to purchase a health insurance product with a premium cost of </= $150.00 a month would be a motivating factor. (Virginia Business Health Insurance Survey, Virginia Department of Business Assistance, 2005).

SECTION 3. HEALTH CARE MARKETPLACE

The purpose of this section is to describe Virginia SPG research activities related to understanding the State's health care marketplace.

Access to Hospital and Nursing Home Care
Virginians enjoy access to hospitals and nursing facilities serving most communities across the state. In 2003, there were 76 acute care hospitals with 42 located in urban areas and 34 located in rural areas. Sixty-two of the 76 hospitals are not-for profit and fourteen are proprietary. During the past several years Virginia has seen several rural hospitals convert to critical access hospitals.

There are also six psychiatric hospitals, four rehabilitation hospitals and 36 ambulatory surgical centers. Two out of three ambulatory surgical centers are proprietary with all but one located in urban areas. All Virginia hospitals provide some charity care with more than $652,000,000 provided in 2003 based on gross charges.

Virginias 245 licensed nursing homes are primarily proprietary in structure with 172 proprietary and 73 not for profit. Ninety-six nursing homes are located in rural areas with 149 in urban areas.

Medicaid/Medicare Enrollment
Public insurance options provide coverage for approximately 9.5 % of Virginia residents (2004 Virginia Health Care Insurance and Access Survey). Like many other states around the country, Virginia has experienced an increase in the number of individuals who are eligible for its Medicaid program. Since 2002, public assistance insurance programs in Virginia are experiencing enrollment increases, following period of declining enrollment in the late 1990's. While some of the increases in enrollment can be attributed to expansion of eligibility for individuals under the Aged Blind and Disabled (ABD) categories and FAMIS outreach programs, some of these increases can be attributed to economic conditions.[*] Enrollment rates

[*] Virginia Office of Planning and Budget , Official Medicaid Expenditure Forecasts FY2005-2007

for indigent adults increased by 9.4% in 2004. Projections for Virginia's Medicaid programs anticipate a 13.67% increase in expenditures for 2005, and an additional 9.49% in 2006 with costs to the Commonwealth of $4.776 billion by 2007[†]. According to US Census data obtained from the Weldon Cooper Center for Public Service, rates of individuals living in poverty in Virginia have been increasing over the past few years, from 8.3% in 2000 to 10% in 2003[‡]. These trends are consistent with national trends.[§]

Healthcare System Capacity

As mentioned earlier, Virginia is fortunate to have a strong safety net system, which includes a variety of local, regional and statewide networks of safety net providers delivering basic health care services for the low-income, uninsured and geographically isolated individuals. However, Virginia's teaching hospital centers, like other academic facilities across the country, are burdened with significant financial challenges threatening their future viability. The Virginia Joint Commission on Health Care released a report in 2000 that indicated that provision of uncompensated care for uninsured individuals poses the greatest financial threat to these centers, which provide valuable specialty and tertiary care services to Virginians.

Regulatory Environment

Virginia's General Assembly has demonstrated significant concern about the impact of mandated insurance benefits on businesses in the Commonwealth. As early as 1990, the General Assembly has required a process for reviewing legislation mandating health insurance coverage to be examined its social and financial impact as well as efficacy. In 2003, the State Corporation Commission issued a report examining data from more than 44% of insurers offering policies in the individual and group markets. Based on this data from 2001, roughly 12.61% of claims costs were attributable to mandated benefits, offers or providers for individual contracts. Costs attributable to mandates under group certificates were higher, representing 20.75% of claim payments. Mandated benefits were found to represent slightly more than 1% of the average premium dollar; however mandated coverage offers and providers represent a higher impact on premium costs.

Managed Care and Private Group Market Products

In 2002, the Commonwealth of Virginia had an estimated HMO penetration rate of 15.6% compared to the national rate of 25.7% with over 1.1 million HMO enrollees in the Commonwealth.[ix] Traditional managed care programs, although not a predominant feature in the Virginia health care delivery marketplace, are concentrated within two regions, namely, South Central and Hampton Roads regions, with very different underlying demographics and distribution of employment sectors. It is fundamental to understand the relative impact of insurance expansion on managed care delivery systems.

Individual Market Products

Twenty-five carriers are listed with the state to offer individual health insurance plan coverage. Virginia has a requirement that these plans must meet a minimum benefit package or explicitly state otherwise. Guaranteed issue products are available in the individual market (replacing open

[†] Virginia Office of Planning and Budget , Official Medicaid Expenditure Forecasts FY2005-2007
[‡] http://www.census.gov/hhes/poverty/histpov/hstpov21.html
[§] US Census Poverty report

enrollment) and through association health plans. The report issued on this matter by the Virginia Joint Commission on Health is available on the Virginia SPG website.

Virginia has examined a number of options to expand coverage to self-employed individuals and enhance the ability for small businesses to obtain insurance coverage. Options that have been previously examined include inclusion of self-employed in small group market (defined as 2-50 employees in Virginia Code) and health insurance purchasing cooperatives for small employers. The Joint Commission reports concluded that inclusion of self- employed individuals in the small group market might lead to adverse selection and that health insurance purchasing pools would lead to only a 3.5% savings for small employers. Other coverage options to small business include expansion of the Local Choice option, currently available to local governments to buy into the state employee insurance program. Local Choice expansion was found to potentially present administrative problems. Local Choice expansion, however, has not been found to 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.

Availability of Products for Small Businesses

Forty-four carriers are listed with the state to offer health insurance plan coverage to small businesses. Carriers offering plans to small businesses must meet minimum benefit packages, called essential and standard benefit plans. Essential plans are designed for children under 18, while standard plans have no age limit. In Virginia, small employers are provided with guaranteed issue and can also participate in association-sponsored health plans.

Alternative health benefit options including Medical Savings Accounts, Health Reimbursement Accounts and Flexible Savings Accounts are also available to businesses in Virginia. The Virginia 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 about 3,000 individuals participated in high deductible plans with MSA's in Virginia. Virginia also experienced a reduction in the number of insurers offering coverage options with MSA's.

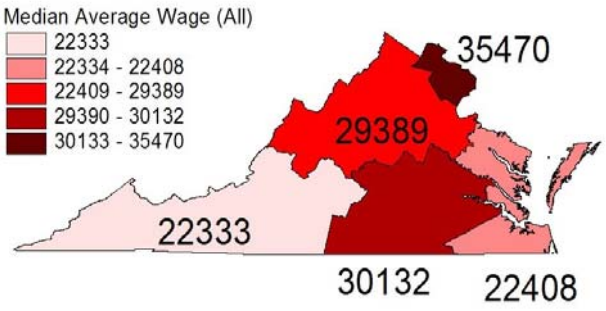
Economic Trends

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

In 2003, the median annual wage in Virginia was $28,586, with individuals working in smaller firms receiving lower wages on average. The median wage for workers employed in firms with fewer than 50 employees was $22,315. Among very small firms (fewer than 10 employees) the median annual wage was just $19,125. Furthermore, employees with average annual incomes of </= $29,855 and who work for businesses with </= 50 employees accounted for only 29 percent

of enrollees with single coverage and 24 percent of enrollees in family health coverage plans. As such, these employees pay about two percent of their take-home pay for single coverage and 8 percent for family coverage. [xi] The distribution of businesses by size and average median wage follows.

Figure 5: Median Average Wage (in dollars) by Region, 2003



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

Rapidly rising health care costs in Virginia and nationwide have helped to strengthen the likelihood of insurance coverage associated with higher income levels. For individuals with annual incomes $75,000 or higher, health insurance coverage in 2003 was about 92%. The rate of health insurance coverage fell for individuals annual earnings under $25,000. Approximately 76% of this income group reported having health insurance in 2003.[xii] For Virginia workers, the take-up rate for health insurance in 2003 for those who made less than the median annual wage of $28,586 was 26%, compared to 67% for those who made more than $28,586.[xiii]

Health Insurance Premium Price Trends

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

The growth in the cost of coverage is making health insurance unaffordable. A recent study found that for each one percent rise in health spending relative to personal income, the number of uninsured people increases by 246,000.[xv] Another study projects rising health care costs will result in more than three-fourths of large companies nationwide shifting more of the cost of health insurance coverage on to their employees in 2006, with about one-fourth likely to reduce wage increases for employees in lieu of dropping coverage.[xvi] Albeit a large employer, one high visibility example of this trend is General Motors, which recently announced it will eliminate 25,000 jobs in the United States, in large part due to financial losses stemming from rising health care costs. In the second quarter of 2005, GM's losses amounted to more than $1.1 billion.[*xvii*]

Factors Affecting Insurance Coverage Decisions

Review of trends and research on insurance coverage among low income populations 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% of take-home pay. A Virginia SPG project analysis of family decision making indicates the cost of insurance predicts individual/family decisions to "take" insurance, considering perceived need and availability of insurance through the employer. The Virginia SPG prototype product is designed with low price tolerances as the primary driver for take-up decisions, while ensuring the proposed product meets Virginia Bureau of Insurance health insurance regulatory requirements.

3.2 What is the variation in benefits among non-group, small group, large group and self-insured plans?

According to the Bureau of Insurance regulations in the Commonwealth of Virginia, standard benefits are prescribed that must be available across all groups.

3.3 How prevalent are self-insured firms in your State? What impact does that have in the State's marketplace?

According to MEPS-IC Survey data from 2003, 33% of the firms in Virginia self insure and of these 86.4% are firms with more than 500 employees (*2003 AHRQ, MEPS-IC).*

3.4 What impact does your State have as a purchaser of health care (e.g., for Medicaid, SCHIP and State employees)?

Table 15: Percent of Virginia Insured by Age and Purchaser

Coverage	Children (0-18 years)	Adults (19-64 years)
Public	18.3%	9.5%
Private	75.2%	79.1%

Source: 2004 Virginia Health Care Insurance and Access Survey.

Availability of Publicly Funded Health Coverage

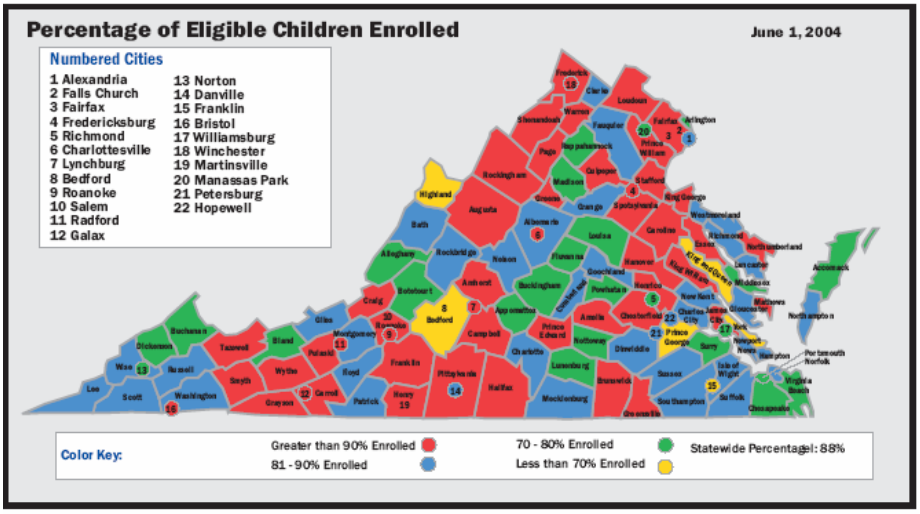
The Commonwealth's public insurance programs consist of Medicaid and FAMIS (SCHIP). In 2004, Medicaid paid for medical care for 760,246 Virginians[xviii]. The Medicaid program has been one of the largest and fastest-growing programs in Virginia in recent years. Because Virginia has very strict eligibility criteria for its Medicaid program, recipients represent the poorest of the poor. In order to be eligible for Medicaid, the annual income of a family of four may not exceed $24,472. With such stringent income requirements, recent estimates indicate that an additional 300,000 Virginians at or below the FPL are ineligible for Medicaid.

Virginia is ranked 44th when considering Medicaid recipients as a percent of the population, yet is ranked 39th when considering state spending per Medicaid recipient. In 2004, 50% of all Medicaid recipients were children. Only 10% of the program's recipients were low-income adults who were not elderly or disabled. Although the elderly, blind and disabled represent only 34% of the Medicaid population, they account for more than 76% of total program costs.

Despite a slow start, Virginia has made noteworthy recent success with enrollment in its FAMIS program. 42,210 children were enrolled in FAMIS and more than 419,904 children were enrolled

in FAMIS, FAMIS Plus or Medicaid expansion projects as of September 1, 2005 (approximately 97% of eligible children). However, just under 13,000 additional children are estimated to be eligible for these programs but remain uninsured.

Figure 6: Percent Eligible Virginia Children Enrolled in FAMIS, 2004



Source: www. signupnowva.org

Virginia has also 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 Rising Cost of Expanding Public Coverage

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

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

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

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

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

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

3.5 What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?

The option for universal coverage was not pursued through this project (see Principles for Model Option Selection).

3.7 How did the planning process take safety net providers into account?

Input from safety net providers was obtained through participation in workgroup activities. Most notably, a there was a significant representation of community health and safety net providers among the Leadership and Community Outreach workgroups.

3.9 Did you consider the experience of other States?

Approaches from other states were examined in depth by the Model Development Workgroup. *A report summarizing state approaches examined is included in Appendix C.*

SECTION 4. OPTIONS FOR EXPANDING COVERAGE

The purpose of this section is to provide information about the policy options considered under the Virginia SPG.

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.)?

After considering current conditions in Virginia and the feasibility and impact of all available options, *four options were examined in depth* by the Model Development 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 State Planning Grant Model Development Work Group recommended 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 prototype insurance model was designed to be issued in the small group market as defined by the Virginia Board of Insurance and preferably offered under the state's standard insurance underwriting rules and regulations. A recommendation is being made for extensive education and outreach (marketing) to businesses, brokers and individuals. In addition, there is the option of offering tax incentives for small businesses for a portion of the individual premium. A group model was selected in order to reach a large number of uninsured, spread insurance risks, and keep costs low.

Employer contribution requirements are modest, defined, and predictable over time. Small employers typically cannot afford the cost of traditional insurance coverage. Nationwide, private-sector employer contributions for health insurance represent, on average about 7.4 percent of wages and salaries.[xxii] The cost of the proposed prototype is within the affordability range for small businesses expenses. An analysis of the stability of the product over time is being analyzed by an actuary from William F. Mercer and the results will be posted on the SPG website: http://www.InsureMoreVirginians.org .

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

4.2 What is the target eligibility group under the expansion?

Guided by the project's goals, and based upon the best available state and national data, the priority target population for the proposed health insurance expansion includes working uninsured citizens (and their families) who are uninsured , work for small businesses (<50 employees) and are between the ages of 19 and 64.

Target Population Characteristics:

Employed in small Virginia businesses (businesses employing between 2 and 50 employees). Rationale: Currently in Virginia, over half (51.7%) of all workers aged 19-34 years and eighty percent of all workers 35 to 64 years employed in Virginia businesses with 50 or fewer employees are uninsured. Just under a third of very small employers (those with fewer than 11 employees) in Virginia offer health insurance to their workers. Individuals working in companies with fewer than 50 employees are twice as likely to be uninsured as individuals working in companies with more than 50 employees. [xxiii] More tenuous profit margins and market characteristics make insuring small groups expensive and difficult for both insurers and small businesses. Additionally, small businesses are more susceptible to failure; even as they are the backbone of economic growth in their communities.

In households with incomes between 100% to 300% of the Federal Poverty Level (FPL). Rationale: The proportion of Virginia families without health insurance living at or below 150% FPL equals or exceeds 20 percent. The proportion is highest for households living at 134-150% FPL (nearly 29%). Rates at which employers offer health insurance in Virginia for workers at or below 150% Federal Poverty Level (FPL) are significantly lower (under 50%) than offer rates for workers above 150% FPL (over 60%).[xxiv] Employment and family income are the two most important factors for health insurance coverage. Working low-income households have difficulty accessing and affording health insurance coverage.

4.3 How will the program be administered?

Given that the specific administration of the program is dependent on a number of factors, including review and recommendations of the proposal from the Governor, the Virginia SPG has outlined the general aspects to be considered for adoption of the proposed model. Most proposals to assist low-income workers and families have not attempted to work with or through employers.[xxv]

4.4 How will outreach and enrollment be conducted?

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

4.5 What will the enrollee (and/or employer) premium-sharing requirements be?

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

The average total premium cost of the prototype product has been developed to be sold for approximately $100-$120 per individual per month—an amount perceived as affordable based on nationwide studies and household incomes among many of Virginia's uninsured. As with other private sector products, the new small group product is priced according to existing carrier pricing practices for premiums for adults aged 19 to 64 years. The product also includes premium cost sharing between the employer and employee, with the employer paying 60-80% of the premium cost.

Table 16: Target Worker Contributions (Pre-Tax)*

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

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

4.6 What will the benefits structure be (including co-payments and other cost-sharing)?

The prototype product includes the following benefit features:

- Preventative and primary care services for individual employee with household coverage available for family members (adults and children),
- Maternity care and emergency room visits,
- Limited or generic prescription drug coverage,
- An option or rider to cover some basic level of dental care and dependent coverage,
- Basic hospitalization coverage (inpatient services and outpatient surgery) associated with catastrophic-related care.

To sustain its attractiveness, the product would:

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

4.7 What is the projected cost of the coverage expansion? How was this estimate reached? (Include the estimated public and private cost of providing coverage.)

An actuarial analysis of the prototype product was pending (by William F. Mercer Co.) at the time of this report. Results will be posted on the Virginia SPG website: http://www.InsureMoreVirginians.org

4.8 How will the program be financed?

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

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

Table 17: Business Current and Target Estimates

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

*Source: Based on data from MEPS 2003 data for Virginia **VA Insurance regulations include limits on premium increase rates for small business plans; hence a built in limit on increases of burdens to the State from tax revenue off-set.

Future Issues/Options

A hybrid approach to public subsidies for employment-based coverage (explored by IHPS) may be of interest if the President's proposed tax-credit proposals allow parents working for qualified

small firms to use the tax credits for employment–based coverage. [xxvii] Virginia may be able to combine tax credits for adults purchasing employment based coverage with premium assistance for children under Medicaid or FAMIS to make employment-based family coverage affordable for low-wage, uninsured, small-business workers and their families.

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

4.9 What strategies to contain costs will be used?

The proposed product will utilize current private sector market strategies to contain costs. In addition, there is a statutory requirement within the Commonwealth limiting the amount by which premiums in the small group market may rise in a given year. Given the low price tolerances for health insurance among the targeted population, cost shifting rather than containing costs are of greater concern. Therefore the Virginia SPG proposed model includes a stipulation that only though employers who have not offered health insurance for the prior year will be eligible to purchase the new insurance product.

4.10 How will services be delivered under the expansion?

As the proposed product is an insurance product, services will be delivered through existing health systems utilizing insurance reimbursement mechanisms, with provider networks to be determined by individual carriers offering the product.

4.11 What methods for ensuring quality will be used?

The new product will be issued through already established carriers and will be determined using current quality/performance parameters.

4.12 How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?

Virginia's mission and goal for this grant was to develop a health insurance product that did not already exist through the private market, but would utilize current health insurance private sector market structures and systems.

4.13 How will crowd-out will be avoided and monitored?

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

4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?

Currently, there is no mechanism available through the Board of Insurance or other state agency to collect information on the product. However, enrollment data will be collected and audited through existing health insurance carrier mechanisms.

4.15 How (and how often) will the program be evaluated?

Design of the evaluation and reporting mechanisms on the proposed product will occur outside the scope of this phase of the project, and will be done pending any decision to implement the model option.

4.16 For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the State to consensus on each of these approaches?

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

More recent developments include a 2004 law allowing insurers to extend coverage to dependent children of group insured individuals, regardless of the child's age, and a 2003 law that allows cost sharing arrangements with essential and standard health service benefit plans. Recent legislation not enacted include bills that allow self-employed individuals to buy in to the state employee health plan, direct the Secretary of Health and Human Resources to establish a plan for unemployed residents in Virginia, and create consumer choice benefit plans that would not be subject to mandated benefits.

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

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

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

The Rising Cost of Expanding Public Coverage

Virginia, like many other states, has experienced rising expenditures and growth in its public insurance programs. Nationwide, although the percentage of those without health insurance coverage was unchanged between 2003 and 2004, the proportion of people covered by government insurance programs rose (from 26.6% to 27.2%) while those covered by employment-based health plans declined (from 60.4% to 59.8%). Most of the increase in the proportion on public coverage was driven by Medicaid (up 0.5% to 12.9%) and military health care programs.[xxviii]

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

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

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

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

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

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

- Have the greatest impact on improving continuous coverage for the target population.
- Not duplicate existing coverage options for the target population or adversely impact the coverage of other populations with limited resources.
- Have a significant impact on reducing health care costs for the target population.
- Have a significant impact on improving the health status of the target population.
- Be implemented in an environment requiring that the cost of model coverage be shared by and be affordable and sustainable to target employees and employers as well as state government.
- Be implemented in an environment dictating that available public subsidies for model coverage be budget-neutral.
- Reduce target employee low productivity, absenteeism, turnover, and other employer costs associated with lack of health care coverage and disease prevention.
- Otherwise, be easily understood, economically attractive and politically feasible to target employers, health insurance brokers, and state government.

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

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

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

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

Compared to public coverage programs, employment based coverage may attract greater participation from previously uninsured employees because of the current enrollment structures available through employer sponsored coverage. Additionally, employer based coverage is less likely to have a perceived 'stigma' often associated with public assistance programs. Also, payroll deduction is the most easy and reliable method of collecting worker contributions toward the cost of coverage. The Virginia prototype also has the benefit of low administrative overhead, uses existing regulatory mechanisms to prevent refusal of coverage based on health status, and is designed to provide affordable coverage across workers of all ages and health risk levels.

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?

Virginia's report and recommendations will be submitted for approval to the Governor in the very near future. The challenges then, if the plan is approved, will be to develop a comprehensive plan for outreach and education to ensure enrollment/take-up rate targets are achieved.

4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)?

The following state approaches were considered by the Model Development Work Group (MDWG) that represent the best options for expanding private insurance coverage under the mission of the Virginia State Planning Grant—to improve access to health insurance for the working uninsured.

1) <u>Subsidizing or Reducing the Cost of Private Coverage</u>:

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

- Allow group purchasing arrangements for health insurance such as association health plans

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

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

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

Considering the feasibility and impact of all available options, four options were examined in depth and considered before a final recommendation was made:
- Small group reforms
- Consumer-driven health plans
- Tax incentives
- Sale of 'mandate-light' or no-mandate policies

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, and
- Minimization of administrative requirements for expansion program partners (i.e., insurers and employers)

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

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.

A significant part of the recommendations for promotion of the proposed insurance product include development of marketing and distribution strategies (especially to businesses and their employees, as well as the Virginia health insurance and broker community). Recommendations also include the importance of establishing an education program and incentives for insurance brokers. To increase brokers' incentives to sell the product, the model would provide: 1) Commission incentives for volume product sales in an 'under-tapped' market, and 2) New product information in broker bi-annual re-certification courses. Feedback, obtained from both the broker community and small business community, indicate that the option of an affordable health insurance product will be appealing to them.

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 Virginia SPG project is directed by the VDH OHPP in collaboration with subcontracted partners: the Center for Health Policy Research and Ethics at the George Mason University (CHPRE), SHADAC, the HRSA-sponsored Arkansas Center for Health Improvement, Multi-State Integrated Database (MSID), the Agency for Health Research and Quality (AHRQ) Medical Expenditure Panel Survey Insurance Component Division (2003 AHRQ, MEPS-IC Survey), the Healthcare Leadership Council and Project REACH at Virginia Commonwealth University. Mr. Robert A. Archer (Board of Directors, Virginia Chamber of Commerce) and the Small Business Advisory Board for Virginia have also played an integral role in the Virginia SPG project.

Detailed strategic planning, policy evaluation, and decision-support activities were specified in the Virginia SPG work plan. The work plan utilized an inclusive, participative process between stakeholders representing local, regional and state-level employers, community leaders, as well as agencies and offices of the Commonwealth. The Virginia SPG communication plan and participatory processes have included stakeholders, knowledgeable experts and key public agencies as well as outreach to the public through the Virginia SPG website: www.InsureMoreVirginians.org.

Key to the success of the overall Virginia SPG project is close collaboration with public and private sector entities also engaged in health care coverage expansion activities. The Virginia SPG staff and consultants worked closely with other agencies and entities to obtain the best available data, to conduct analyses on the costs of uninsurance, and to engage in strategies that complement yet do not duplicate other health coverage expansion activities. A closely related set of objectives includes the development and dissemination of the best available data and

information through regional work group meetings, the Virginia SPG website, and the resulting Virginia SPG strategic business plan.

The work of the Virginia SPG grant was conducted with stakeholder involvement through four project work groups. Specialized workgroups were charged with soliciting data and input from the businesses and communities across Virginia, including those in all geographic regions, inclusive of rural and urban areas. These workgroups include the Data Workgroup, Model Development Workgroup, Business Task Force, and the Community Outreach Workgroup. The data and information that was gathered served to inform and to guide the Virginia SPG Leadership Team and the Virginia SPG Workgroups in their deliberations and decision-making processes.

The SPG Leadership Team and Data Work Group comprised of key representatives from private sector, non-profit and state agencies were convened for purposes of reviewing data and information, and discussing gaps in available information to inform decision-making about options for expanding health insurance coverage in Virginia. The Data Work Group's efforts in the design, development and implementation of the 2004 Virginia Health Care Insurance and Access Survey prioritized data collection to support sub-state analyses and planning. The Leadership Team, which included members of the safety net community, provided feedback and input on the proposed model option. Members of the Business Task force also serve as a leadership group to the Governor on issues related to small businesses, and provided valuable feedback on the palatability of the proposed expansion option model.

Detailed information about the composition of the Virginia SPG Leadership Team, Work Groups, and collaborative partners may be accessed through the project web page (http://www.InsureMoreVirginians.org). The project web page was designed with grant funding and serves a broad range of information dissemination and communication purposes (internal and external to Virginia and the SPG grant).

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)?

Each of the Virginia SPG workgroups held a specific charge, linked and supported by various workgroup activities. Specific work group charges and activities can be found on the SPG website. For example, the Data workgroup analyzed extant national and state data to determine appropriate data sources to drive decision making and provided guidance for the development and implementation of the Virginia Household Survey. Their activities provided the data support for the model development groups' work. Throughout the development process of the proposed insurance model, the Model Development Workgroup actively solicited input from a variety of stakeholders within the Commonwealth, through the work of the Business Workgroup (BWG) and the Community Outreach Workgroup (COWG). The recommendation proposed was developed with feedback collected from the small business community, insurance brokers and carriers, and members of the community at large, which, including representatives from community leaders and health care providers across the Commonwealth.

Business Community Input

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

Additionally, an electronic mail survey of Virginia small employers about health insurance, conducted by the Virginia Department of Business Assistance as part of the BWG input process (July 2005), yielded 345 respondents. *(A summary of the latest survey findings are found on the SPG website: http://www.insuremorevirginians.org).* The following findings are noted:

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

Insurance Community Input

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

Input was solicited from both insurers and brokers about incentives that could be developed to encourage insurance brokers, which serve as the primary link between small businesses and

health insurance products, to sell the product. Recognizing that commissions for this product would not be large, most felt the opportunity to offer an affordable product to those not able to participate in the market now would serve as an incentive to brokers who focus on the small business market. Feedback from insurance carriers indicated there was no equivalent product available in the Commonwealth at this time. One carrier was considering a product that provides a 'basic health insurance' product with limited coverage for preventative services and medical services, but does not include a catastrophic coverage option. They were also considering an expanded, creative eligibility provision for employees with work hours that vary from week to week.

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

Community Input

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

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

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

Others wondered whether premiums for the lowest income workers (under 100% FPL) could be fully-subsidized. For uninsured adults with income under 100% FPL - the costs of the model may be too high to be attractive. While a $50 per month/person premium ($600/year) may be less than 10 percent of family income, concerns that the other out-of-pocket expenses (e.g.,

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

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

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

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

The activities of the Virginia SPG grant were meticulously documented through the program website at www.InsureMoreVirginians.org. All work products, meeting minutes, and background literature used by the grant is available on the SPG website. The HRSA funded Virginia SPG web page provides critical access and links to project activities and a broad range of resources on other related projects and a variety of audiences. For example:

- The website Virginia Uninsurance Facts provides an overview of uninsurance facts in Virginia.
- What is the Purpose of the SPG Workgroups? This second describes the four SPG Workgroups and how they were developed to solicit stakeholder input on the process of gathering information about the uninsured and determining the feasibility of various models and strategies for reducing the number of uninsured in the Commonwealth of Virginia.
- The SPG website Knowledge Center provides access to information of interest to specific stakeholders across the five VA- SPG Planning Regions for:

    1. **Individual or Family:** Features resources for individuals who are looking for affordable health care and/or health insurance coverage.
    2. **Business:** Features resources for employers looking for information and resources related to health care benefits and options.

3. **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.
4. **Researchers**: Features data resources and sources for researchers wanting to better understand issues related to health, health access, uninsurance, and underinsurance.

Additionally, **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.

Finally, in October 2005, a website entitled "A Guide to Health Insurance Options for Small Businesses in Virginia will be launched and corresponding hard copy guides for each of the five SPG Planning Regions will be made available.

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.

Virginia's current Governor as well as legislature will be newly elected in the fall of 2005. It is not known at this time what the likelihood of adoption/implementation of SPG recommendations will be. However, an SPG Continuation Grant has been funded which will provide a continued venue for discussing and analyzing the proposal put forth under the Virginia SPG.

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.

All discussions and decisions were informed by data acquired through qualitative and quantitative methods), much of which was collected or assembled and analyzed through grant funding. Information about data collected was explained earlier in this report. In particular, we note the decision making of the Model Development Workgroup whose decisions such as selection of the target market, feasibility analysis of options considered and selected were heavily influenced by data collected under the grant. In addition, the sub state analysis from the 2004 Virginia Health Care Insurance and Access Survey helped identify Central Virginia as having the highest rates of uninsurance.

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

All were important for different reasons; however, having household and business data on insurance coverage at the sub-state level (regions) through surveys conducted by nationally known entities (SHADAC and AHRQ respectively), access to multi-state data via the Arkansas MSID. Vetting and subsequent feedback through stakeholder surveys and focus groups on the model options considered was also useful.

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)?

None.

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

The household survey timetable was extended to allow for additional recruitment and more robust participation. The Data workgroup's advice and decisions helped ensure that data collection efforts were non-duplicative and relevant. Lynn Blewett and team at SHADAC were particularly 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. Jim Branscombe and his team at AHRQ were also helpful in setting up the sub-state/regional analyses of Virginia's MEPs-IC survey data.

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?

Market research on the take-up and impact (across the entire private insurance market) is needed. Some of these needs will be addressed during the SPG Continuation Grant.

6.6 Has the State proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?

As a result of its leadership and involvement with the issue of uninsurance with the HRSA planning effort, the VDH OHPP has reorganized to include uninsurance as a formal program focus. This will ensure the continuity of efforts to improve health insurance coverage beyond the period of available SPG funds from HRSA.

6.7 What key lessons about your insurance market and employer community resulted from the HRSA planning effort? How have 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?

Feedback from the small business community and insurance broker community indicated a great deal of interest in the availability of an affordable health insurance product option within the small group market. In addition, a number of insurance carriers have been helpful and interested in the development of the proposed product. Paramount to obtaining buy in from the small business community was the effort to tap in to the Small Business Advisory Board for Virginia, who provided consistent leadership in the small business community across the Commonwealth.

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

It is important that states pursing a state planning grant ensure a transparent and participative process across a large key stakeholder groups is essential. Good communication with the public, state agencies and technical experts through the same source (such as a project website) and integrating information on all matters 'insurance related' in the state was valuable.

Building awareness that different sources of data produce different results is important. Having knowledgeable technical consultants who help manage project process to keep decision-making on-track (while managing politics and different viewpoints) is important. Taking advantage of Academy Health and HRSA resources and consultants was also very valuable.

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

While the state's economy is improving, demands on public resources are increasing. In light of recent events in Louisiana and Texas, Virginia, as well as other states who are accepting evacuees from the hurricane region, are experiencing an increased demand on public resources, including public health insurance and social service programs. In addition, Virginia has a one term Governorship requiring extensive lead time in planning and support for programs that require legislative action which may span different administrations.

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

The project goals did not change and were accomplished as planned. The drafting and successful completion of planning processes specified in the grant involved considerable stakeholder input. This was a particularly significant success for Virginia since it experienced a number of changes in key technical consultant personnel and collaborators in the early and middle stages of the project.

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

Virginia is funded for a continuation grant to continue planning activities in the region with the highest rate of uninsurance (Central region) and to develop a prototype web-based community decision support took kit.

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?

Increase the size of CPS survey samples to support sub-state analysis and/or extend funding support for additional standardized state survey activity that provides sub-state level data. Consideration should be given to moving up the release data on 2003 AHRQ, MEPS-IC surveys. The current 2 year lag means that current data is not available for state level planning use.

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?

Establishing standardized data collection to capture community challenges related to uninsurance (including those presented by immigrants and undocumented aliens) and documentation of the local safety-net and faith-based health care initiatives would be useful. Additionally, standardized documentation of employment status among Medicaid recipients would be especially useful for states pursuing employer sponsored insurance options.

APPENDICES

Appendix A: **Baseline Information**

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

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

APPENDIX A: BASELINE INFORMATION

State of Virginia Baseline Information:

Population:
7,386,330

Number and percentage of uninsured (current and trend):
13.0% (CPS, 2003) and 8.9% (Virginia Household Survey, 2004)

Average age of population:
35.7 years with 24.5% of Virginia's population under 18 years old, 6.5% under 5 years old and 11.2% over 65 years old (CPS, 2000).

Percent of population living in poverty (<100% FPL):
Families 7%; Families with related children under 18 years old- 10.2%; Families with related children under 5 years old- 12.3%; Families with female householder- 23.0%; Individuals- 18 years and older-8.7%; 65 years older-9.5% (CPS, 2000).

Primary industries:
Education, health and social services, retail, professional and manufacturing (CPS, 2000); Retail/other services and professional services (MEPS, 2003).

Number and percent of employers offering coverage:
159,466 establishments in VA with 59.4% offering health insurance (MEPS, 2003).

Number and percent of self-insured firms:
33.3% of firms self insure at least one plan. The largest % of self insured plans fall within companies with 500 and more employees who account for 86.4% of the plans (MEPS, 2003).

Payer mix:
Not Applicable

Provider competition:
Not Applicable

Insurance market reforms:
Not Applicable

Eligibility for existing coverage programs (Medicaid/SCHIP/other):

SCHIP:
In order for children to be eligible for SCHIP, the following criteria must be met:

- Live in Virginia
- Are under age 19

- Don't have health insurance now and haven't had it in the past 4 months (some exceptions apply)
- Are not eligible for the Virginia state employee health insurance plan
- Are not eligible for FAMIS Plus (also known as Medicaid)
- Live in families meeting FAMIS income guidelines
- Are United States citizens or qualified aliens (other children may be eligible, please call us to find out more

FAMIS Income Limits - 200% FPL (Gross Income) February 18, 2005		
Family Size	**Income Limits**	
	Year	**Month**
1	$19,140	$1,595
2	$25,660	$2,139
3	$32,180	$2,682
4	$38,700	$3,225
5	$45,220	$3,769
6	$51,740	$4,312
7	$58,260	$4,855
8	$64,780	$5,399
Each additional family member	$ 6,520	$ 544

SCHIP and Medicaid:

Program Name	Program Description
Children's Health Insurance (Medicaid, FAMIS Plus and FAMIS)	Children's Health Insurance in Virginia provides comprehensive medical services to children under age 19 with countable income within 200% of the federal poverty level. Children who receive a "may not be eligible" because their family income is higher than the income limits may be eligible because of deductions that are allowed for work and child care or because the income of a stepparent or brother or sister is not counted in determining a child's qualification for the program.
Medicaid for Pregnant Women	Medicaid for Pregnant Women provides comprehensive medical services for pregnant women who have countable income within 133% of the federal poverty level. Pregnant women who receive a "may not be eligible" result may be eligible when Medicaid income disregards and budget unit policy are used or when there are high medical bills.
Women, Infants & Children (WIC)	WIC is a special, supplemental nutrition program for Women, Infants and Children sponsored by the United States Department of Agriculture. WIC helps women and children get the nutrition services and foods that they need to stay healthy. WIC has also shown to help a baby develop better mentally.

(Downloaded: http://www.dss.state.va.us/benefit/medicaid_coverage.html on 13 September 2005)

Use of Federal waivers:

Virginia has utilized the following federal waivers:

- **Comprehensive State Health Reform Waivers Under 1115 Authority Family Planning** – Approved through September 30, 2007 7/22/02
- **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. 12/23/91
  - **Medallion II Program** - Approved through December 25, 2004. 9/28/98
- **Home and Community Based Services Waivers Under 1915(c) Authority:**
  - **Virginia HCBS Waiver: Aged and Disabled (0048)** - Approved through 7/1/93 4/01/01
  - **Virginia HCBS Waiver: Developmental Disorders (0358)** - Approved through 9/28/03 7/01/00
  - **Virginia HCBS Waiver: Mental Retardation and Developmental Disabilities (0372)** - Approved through 6/30/07 09/15/01
  - **Virginia HCBS Waiver: HIV/AIDS (4160)** 06/30/94

APPENDIX B: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

The SPG web site is located at http://InsureMoreVirginians.org. It includes the following useful components:

1. The Knowledge Center section provides access to information of interest to specific consumer groups, including links to a number of data resources for researchers related to health, health access, uninsurance and underinsurance. In addition, the Center contains a Library which links to reading materials on a number of topics relating to the uninsured.
2. The SPG Project Workgroups section contains various data reports and other work products pertinent to the work of these groups.
3. The Headlines section includes news and links on recently released studies.

APPENDIX C: SPG SUMMARY OF POLICY OPTIONS

This appendix includes the following reports*:*

a. *Insurance Coverage Expansion Options: Lessons Learned from Other States*
b. *Overview of Proposed Model Option to Expand Health Insurance Coverage Among Employed Virginians*
c. *2003 AHRQ, MEPS-IC Survey Report: Issue Brief, Data Tables and Additional Analyses*
d. *Virginia HRSA State Planning Grant Final Report and Additional Analyses: 2004 Virginia Health Care Insurance and Access Survey*
e. *2005 Virginia Business Health Insurance Survey, Virginia Department of Business Assistance*

END NOTES

[i] Ibid., 2004 VIRGINIA HEALTH CARE INSURANCE AND ACCESS SURVEY 2005.
[ii] Kaiser Commission on Medicaid and the Uninsured. Health Insurance Coverage in America: 2003 Data Update. November 2004.
[iii] Ibid., 2004 VIRGINIA HEALTH CARE INSURANCE AND ACCESS SURVEY.
[iv] Kaiser Family Foundation. The Uninsured: A Primer. November 2004. http://www.kff.org
[v] The Small Business Key Informant Survey is an employer based survey developed to ascertain small business leaders decision making processes in their determination on whether to offer health insurance to their employees. Local chambers of commerce throughout Virginia were contacted via mailed letter to ask their participation in identifying key small business leaders within their community who would be willing to participate in the survey. Upon receipt of businesses who indicated they would be interested, a follow up phone call or email message was sent to determine if the business was still interested and whether they currently offered health insurance. If the business stated they were interested, a survey was emailed to the participant. The goal was to obtain two to three surveys representing the five regions of the state. The results of the key informant survey then helped to inform the direction of the health insurance product development. In addition, the results also led to the development of a survey on small business to determine their thoughts on cost tolerances and available products; this survey was administered through the Small Business Advisory Group for Virginia. The results of this survey validated the direction that the model development work group had taken in their product development.
[vi] U.S. Agency for Healthcare Quality and Research. Medical Expenditure Panel Survey-Insurance Component (MEPS-IC), 2003 Virginia-Specific Data. July 2005.
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[viii] Ibid., MEPS-IC.
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[xxiii] Ibid., 2004 VIRGINIA HEALTH CARE INSURANCE AND ACCESS SURVEY.
[xxiv] Ibid.
[xxv] Neuschler E. & Curtis, R., "Applying Large-Scale Subsidies for Low-Income Populations to Health Insurance Coverage through Small Employers", IHPS Project Report, May 2003.
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[xxix] http://www.dmas.virginia.gov/downloads/Stats_04/Chapter_10/Title_XXI_Overview--04.pdf
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