REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

Report on the Effects of Health Care Cost Increases on Health Insurance Premiums

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 26

COMMONWEALTH OF VIRGINIA
RICHMOND
2006

JOINT COMMISSION ON HEALTH CARE: 2006

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COMMONWEALTH of VIRGINIA

Joint Commission on Health Care

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December 20, 2006

TO: The Honorable Timothy M. Kaine, Governor of Virginia

And

Members of the Virginia General Assembly

The 2006 General Assembly, in Senate Joint Resolution 4, directed the Joint Commission on Health Care to "study the derivative effects of increases in health care costs on health insurance premiums." The Joint Commission on Health Care approved the staff recommendation to continue to address health care cost issues as part of a 2007 study based on HB 1324 (to expand health insurance into rural areas of the Commonwealth). This continuance will allow for consideration of data and findings from other ongoing studies and reports in making recommendations prior to the 2008 General Assembly Session.

Enclosed for your review and consideration is the report, consisting of a preface, executive summary, and study presentation.

Respectfully submitted,

Phillip A. Hamilton
Chairman

PREFACE

Senate Joint Resolution 4 (2006) directed the Joint Commission on Health Care (JCHC) to "study the derivative effects of increases in health care costs on health insurance premiums."

Employer-sponsored health insurance is the primary source of health insurance for the non-elderly in the United States. More than 150 million Americans currently receive their health insurance through employers. However, the percentage of employers, particularly small employers, offering health insurance is decreasing. In addition, while the increasing cost of premiums for employer-sponsored health insurance has slowed in recent years, the 2006 increase of 7.7 percent exceeded the increase in overall inflation (3.5 percent) and in worker earnings (3.8 percent). (Source: Kaiser Family Foundation/Health Research and Educational Trust *2006 Employer Health Benefits Survey.*)

In response to rising health insurance costs, some employers have increased employee cost-sharing requirements, reduced retiree health benefits, or discontinued providing health insurance as a benefit. As employers reduce or eliminate health insurance benefits, some employees move to the more expensive individual health insurance market, while others access government programs or become uninsured. Employers, health insurers, and health care providers have undertaken a number of cost containment and quality improvement efforts in an attempt to reduce the cost of health insurance. However, these cost containment efforts are expected to be marginally effective in containing rising health insurance costs.

This report includes a preface, executive summary, and presentation of study findings. The Joint Commission on Health Care approved the staff recommendation to continue addressing the issue of health insurance costs as part of a 2007 JCHC study based on HB 1324 (to expand health insurance into rural areas of the Commonwealth). This continuance will allow for consideration of data and findings from other ongoing studies and reports in making recommendations prior to the 2008 General Assembly Session.

December 2006

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Staff Report: Effects of Health Care Cost Increases on Health Insurance Premiums – SJR 4 (2006)

Executive Summary

Background

Senate Joint Resolution 4 of the 2006 General Assembly Session directed the Joint Commission on Health Care (JCHC) to "study the derivative effects of increases in health care costs on health insurance premiums" and to examine "factors leading to rising health care costs in the Commonwealth; derivative effects of rising health care costs including increases in health insurance premiums and denial of coverage; and, ways to reduce health care costs in the Commonwealth and alleviate the burdens associated with the rising cost of health care."

A second health insurance study will be conducted next year and presented prior to the 2008 General Assembly Session.

- House Bill 1324 directed the "Commissioner of Insurance to develop, by July 1, 2008, a plan to double health insurance provider competition in rural areas in the Commonwealth."
    - This bill was passed by in the House Commerce and Labor Committee and a letter was sent requesting a JCHC study of the issues included in the bill.

The United States has the most expensive health care system in the world, with per capita health expenditures far above any other nation.

- The Centers for Medicare and Medicaid Services (CMS) recently released projected health care expenditures that were expected to be $2.1 trillion in 2006 and were projected to increase to over $4 trillion in 2015.
- Studies indicate that having the most expensive health care system in the world has not resulted in a longer life expectancy or a lower infant mortality rate than comparable countries.

Trends in Employer-Sponsored Health Benefits

Employer-sponsored health insurance is the primary source of health insurance for the non-elderly. More than 150 million Americans currently receive their health insurance through their employers.

The Kaiser Family Foundation (KFF) in conjunction with the Health Research and Educational Trust (HRET) conducts an annual survey of employer-sponsored health benefits.

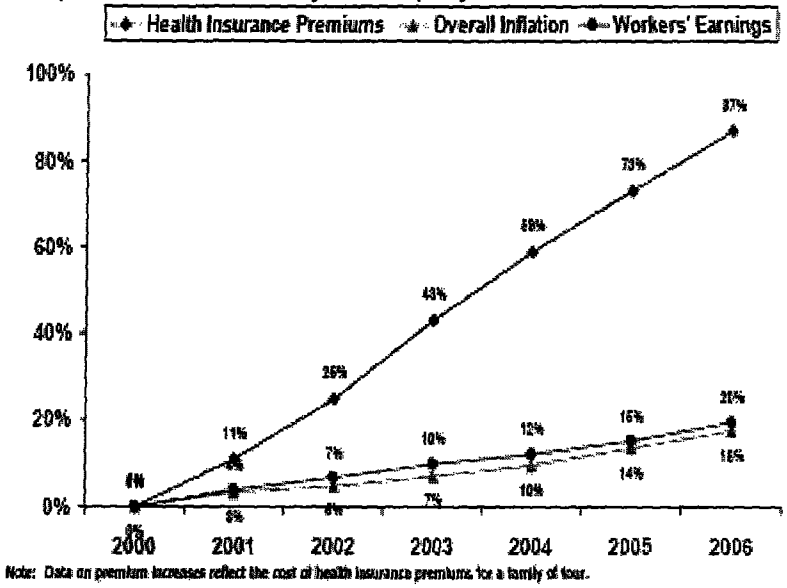
- KFF/HRET *2006 Employer Health Benefits Survey* found:
    - In 2006, within <u>all firms, including those that do not offer</u> insurance to their employees:

- 59% of employees were covered by their employers' health insurance (4% fewer than in 2000).

- In 2006, within the firms that offered their employees health insurance:
  - 65% of all employees were covered by their employer's health insurance (3% fewer than in 2000).
  - Only 78% of employees were offered health insurance and 82% of those employees chose to be covered.

In 2006, 61% of employers offered health insurance benefits; this was a decrease of 8% since 2000. As explained in the KFF/HRET survey: "While the year-to-year changes have not been statistically significant, the cumulative effect has been a large and statistically significant change over this six-year period. This change is driven largely by a decrease in the percentage of small firms (3-199 workers) offering coverage."

"Cumulative Changes in Health Insurance Premiums, Overall Inflation, and Workers' Earnings 2000 – 2006"
(KFF/HRET Survey of Employer Health Benefits 2006)



Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

Source: KFF/HRET Survey of Employer-Sponsored Health Benefits, 2001-2006; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2001-2006; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April), 2001-2006.

In response to the rising health care costs, more employers are offering Consumer-Directed Health Plans (CDHPs), the pairing of a high deductible health plan with an HRA or HSA.

- CDHPs are expected to lower the cost of health premiums paid by employers, as insured employees have more responsibility and incentive for restraining health care costs.
    - Employee out-of-pocket expenditures can be significant.
- A recent Government Accountability Office (GAO) report noted that as of January 2006, between 5 and 6 million Americans were enrolled in a either a HRA or HSA. (Source: Bureau of National Affairs' *Health Policy Report* Vol. 14 No. 23, June 5, 2006)
- Doug Gray of the Virginia Association of Health Plans reported that High Deductible Health Plans (HDHPs) and HSAs are becoming more popular in Virginia.
    - 62% pay $100 or less per month for their plans and some were previously uninsured.
        - It is clear that as HSAs and HDHPs grow there will be more consumers paying more out of pocket for health care, and the creation of HDHPs and HSAs are beginning to promote consumer directed care in Virginia. (Source: *High Deductible Health Plans Study in Virginia: HJ 818*, presentation by Doug Gray, Executive Director of Virginia Association of Health Plans, to JCHC on October 19, 2006)

Factors Contributing to the Cost of Rising Health Insurance Premiums

PricewaterhouseCoopers reported in January 2006 regarding the reasons for the increase in the overall cost of health care services and the corresponding increase in the cost of health insurance premiums between 2004 and 2005.

- The overall increase in premiums was estimated during that one-year period to be 8.8%. PricewaterhouseCoopers indicated that the increase was due to:
    - General Inflation (27%)
    - Increases in excess of inflation (30%)
        - Including "movement among purchasers toward broader-access health plans, provider consolidation, increased costs of labor, and higher priced technologies."
    - Increased Utilization (43%)
        - Including increased consumer demand, new medical treatments, more intensive diagnostic testing due partially to the practice of defensive medicine, [an] aging population and increasingly unhealthy lifestyles."

(Source: PricewaterhouseCoopers, *The Factors Fueling Rising Healthcare Costs 2006*, January 2006.)

Derivative Effects of Rising Health Care Costs

The KFF/HRET *2003 Employer Health Benefits Survey* found an increasing number of companies are reducing retiree health benefits as a way of lowering overall heath care costs.

- 10% of firms eliminated coverage for future retirees and 71% increased retirees' contributions for their coverage.
- A survey of 408 large companies found that one-fifth said they were likely to terminate health coverage for future retirees in the next 3 years.
    - 86% said they would require increases in contributions from retirees for health insurance coverage.

In addition to reducing retiree benefits, employers are dealing with the increase in health care costs by:

- Requiring employees to pay higher premiums and/or co-payments
- Reducing wage increases
- Hiring fewer permanent employees.

(Source: "Survey of Executives Finds Health Costs Up, with Effects on Hiring. Pay" *Health Care Policy,* Vol. 13, No. 30, July 25, 2005)

Increasing health insurance costs increase the number of uninsured people as employers "stop offering insurance to their employees, employees decline employer-offered health insurance because they cannot afford the employee share of the premium," and state governments react to increased costs by changing eligibility for Medicaid and other state programs.
(Source: Thomas Bodenheimer, MD, "High and Rising Health Care Costs. Part 1: Seeking an Explanation" *Annuals of Internal Medicine* Vol. 142, Issue 10, May 17, 2005)

A 2006 study funded by The Commonwealth Fund reported on Census data which indicated the "number of uninsured Americans climbed to 46.6 million in 2005...an increase of 7 million since 2000. Nearly all of the growth in the number of uninsured Americans is attributable to a decline in employer-based coverage." In addition, the Commonwealth Fund reported that as the availability of employer-based coverage diminishes, before becoming one of the uninsured, many workers turn to the individual insurance market.

- 8% of adults (8.5 million people between 19 and 64 years of age) have an individual health insurance policy.
    - "Compared with adults with employer coverage, adults with individual insurance give their plans lower ratings, pay more out-of-pocket for their premiums, face much higher deductibles, and spend a greater percentage of their income on insurance premiums and health care expenses."

- All 50 states have an individual insurance market, but many adults find the coverage either unaffordable or unavailable, especially older adults or people with health problems.
    - Nearly 90% of adults who considered purchasing individual health insurance never purchased a plan.
    - The employer-sponsored insurance mechanism functions effectively because, unlike the private insurance market, it allows risk to be pooled and people gain insurance as part of employment not as a last resort when the person has already become sick.

(Source: The Commonwealth Fund, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-being of American Families*, September 2006)

Ways to Reduce Health Care Costs

The Kaiser Family Foundation reports that health care providers are making efforts to reduce costs:

- By "investing in medical technology (such as electronic medical records), developing systems to reduce medical errors, and participating in programs that reward efficiency and quality."
- Furthermore, many states "have enacted laws to reduce medical malpractice judgments in order to reduce premium burdens on providers and lower overall costs."
    - Virginia currently has one of the most restrictive medical malpractice liability statutes in the country, limiting the total amount of recovery to $1,850,000. (*Code of Virginia* § 8.01-581.15).
- However, even when taken together these measures are not likely to reduce health care costs enough to ensure continued sustainability.

As reported by the Kaiser Family Foundation: "Although many of these efforts may lead to efficiency and quality gains, none would appear to be of a scale to have any meaningful impact on the overall cost picture....If we began next year trying to hold health care cost growth to the current projected growth rate for GDP [gross domestic product] (i.e. slowing growth in health care costs to 4.9% annually starting in 2007) we would need to lower health spending by over $3 trillion over the 2007 to 2015 [time period]....These savings would represent about 10.8% of projected total health spending over the period, or an average annual reduction of about $340 billion relative to the projected level of spending."
(Source: Kaiser Family Foundation, *Comparing Projected Growth in Health Care Expenditures and the Economy*, May 2006)

Staff Recommendation

Given the complexity and magnitude of the problems surrounding health care costs, the staff recommendation is to continue to address health care cost issues as part of the 2007 study (based on HB 1324) which will examine ways to expand

health insurance into rural areas of the Commonwealth. This will allow for consideration of data and findings from other ongoing studies and reports in making recommendations including: Virginia Health Care Foundation's Health Access in Virginia Report, JLARC report on Options for Extending Health Insurance to Uninsured Virginians (HJR 158), and the report of the Governor's Health Care Reform Commission.

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Effects of Health Care Cost Increases on Health Insurance Premiums (SJR 4-2006)

Joint Commission on Health Care

Kim Snead
Executive Director

October 19, 2006

Authority for Study

- Senate Joint Resolution 4 (Senator Reynolds) directed JCHC to "study the derivative effects of increases in health care costs on health insurance premiums" and to examine:
  - "Factors leading to rising health care costs in the Commonwealth"
  - "Derivative effects of rising health care costs including increases in health insurance premiums and denial of coverage"
  - "Ways to reduce health care costs in the Commonwealth and alleviate the burdens associated with the rising cost of health care."
- A second health insurance study will be conducted next year and presented prior to the 2008 General Assembly Session.
  - House Bill 1324 (Delegate Nutter) directed the "Commissioner of Insurance to develop, by July 1, 2008, a plan to double health insurance provider competition in rural areas in the Commonwealth"
  - HB 1324 was passed by in the House Commerce and Labor Committee and a letter was sent requesting a JCHC study of the issues included in the bill.

Presentation Outline

- ■ *Background*
- ❑ Factors Leading to Rising Health Care Costs
- ❑ Trends in Employer-Sponsored Health Benefits
- ❑ Derivative Effects of Rising Health Care Costs
- ❑ Ways to Reduce Health Care Costs
- ❑ Attachments

Background

- "The United States has the most expensive health care system in the world, with per capita health expenditures far above any other nation."
  - —"U.S. health care expenditures have been growing above the overall rate of inflation in the economy."
- The Centers for Medicare and Medicaid Services (CMS) recently released projected health care expenditures
  - —Total health expenditures were estimated to be $2.1 trillion in 2006, and were projected to increase to over $4 trillion in 2015.
- As a share of the economy, health care has risen from 7.2% of GDP in 1965 to over 16% of GDP today, and it is projected to be 20% of GDP in 10 years, with total health spending in that period of about $30.3 trillion.
- Having the most expensive health care system in the world has not resulted in a longer life expectancy or a lower infant mortality rate than comparable countries.

Source: "High and Rising Health Care Costs Part 1: *Seeking an Explanation*" by Thomas Bodenheimer, MD, *Annals of Internal Medicine*, 17 May 2005, Volume 142, Issue 10, Pages 847-854 and "U.S. Health System Performance: A National Scorecard" by Cathy Schoen, Karen Davis, Sabrina K. H. How, and Stephen C. Schoenbaum, *Health Affairs* September 2006.

Presentation Outline

- ❑ Background
- ■ *Factors Leading to Rising Health Care Costs*
- ❑ Trends in Employer-Sponsored Health Benefits
- ❑ Derivative Effects of Rising Health Care Costs
- ❑ Ways to Reduce Health Care Costs
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Factors Contributing to Cost of Health Insurance Premiums

- PricewaterhouseCoopers reported in January 2006 regarding an increase in the overall cost of health care services and a corresponding increase in the cost of health insurance premiums.
- PricewaterhouseCoopers which estimated an overall increase in premiums between 2004 and 2005 of 8.8% indicated that the increase was due to:
  - General Inflation (27%)
  - Increases in excess of inflation (30%)
    - Including "movement among purchasers toward broader-access health plans, provider consolidation, increased costs of labor, and higher priced technologies."
  - Increased Utilization (43%)
    - Including "increased consumer demand, new medical treatments, more intensive diagnostic testing due partially to the practice of defensive medicine, [an] aging population and increasingly unhealthy lifestyles."

Source: PricewaterhouseCoopers, *The Factors Fueling Rising Healthcare Costs 2006*, January 2006.

Factors Contributing to Cost of Health Insurance Premiums

- The majority of the health insurance premium paid for the cost of actual health services including for:
  - Physician services – 24%
  - Outpatient costs – 22%
  - Inpatient hospital costs – 18%
  - Prescription drugs – 16%
  - Other medical services (medical equipment, home health, etc.) – 6%
  - Consumer services, provider support and marketing (including disease management programs, care coordination, health promotion, wellness and prevention programs, and investments in health information technologies) – 5%
  - Government payments, compliance, claims processing and other administration – 6%
  - Health plan profits – 3%
- While existing state and federal mandates continued to add to the cost of health benefits, the number of additional new mandates had showed and consequently did not appear to be a major contributor to 2005 increases.

Source: PricewaterhouseCoopers, *The Factors Fueling Rising Healthcare Costs 2006,* January 2006.

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Types of Insurance to Be Discussed

- Conventional insurance
  - No restrictions on the physician or hospital used
  - Insured individual may be required to file claims for reimbursement
  - The health care provider may require insured individuals to make co-payments
  - Often referred to as a fee-for-service plan.
- Health Maintenance Organizations (HMOs)
  - Type of managed care plan with the most restrictions
  - HMO members must choose a primary care physician who will manage medical care that is received; referrals are usually required in order to have the care provided by specialists paid
  - "HMO members pay a pre-determined fee or co-payment for hospital and doctors' visits, emergency room visits, and prescription drugs." (Bureau of Insurance Presentation to JCHC's LTCMedR Subcommittee, August 22, 2006)
- Preferred Provider Organizations (PPOs)
  - Type of managed care plan that also includes provisions of a fee-for-service plan
    - Members may go to physician or hospital of choice
      - However, there is an established network of "preferred providers" who provide services at a discounted rate to the plan's members.

Types of Insurance to Be Discussed

- Point of Service (POS) Plans
  - Type of managed care plan that is similar to the PPO except that care received outside the plan's network typically will require a deductible or coinsurance to be paid
  - Insurers "licensed to sell HMOs in Virginia are required to offer a POS plan in conjunction with an HMO." (Bureau of Insurance Presentation to JCHC's LTCMedR Subcommittee, August 22, 2006)
- Consumer-Directed Health Plans (CDHPs)
  - Relatively new type of plan that "combines a high-deductible health plan (HDHP) with a tax-advantaged health reimbursement arrangement (HRA) or a health savings account (HSA) that enrollees can use to pay for a portion of their health expenses." (*Consumer-Directed Health Plans: Small but Growing Enrollment Fueled by Rising Cost of Health Care Coverage*, April 2006 General Accountability Office)

High Deductible Health Plans

- HDHPs are health insurance plans that include a minimum deductible (in 2006) of:
  - $1,050 (self-only coverage)
  - $2,100 (family coverage)
- Annual out-of-pocket expenditures cannot exceed in 2006 (including deductibles and co-pays):
  - $5,250 (self-only coverage)
  - $10,500 (family coverage)
  - Reasonable benefit designs not counted toward the out of pocket maximum include:
    - Lifetime limits on benefits
    - Limits to usual, customary and reasonable (UCR) amounts
    - Limits on specific benefits
      - Maximum number of days or visits covered
      - Maximum dollar reimbursements
    - Pre-certification requirements.
- HDHPs are not allowed to have first dollar coverage except for preventive care but may "be an HMO, PPO or indemnity plan, as long as it meets the requirements" for HDHPs.

Source: *The Basics of HSAs*, U.S. Treasury Department, November 28, 2005.

Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs)

- HRAs are accounts funded by an employer for an individual for his/her medical expenses
  - Accounts are owned by employers
  - Most employers do not allow employees to access the funds once they leave employment
  - Funds are tax-exempt for the employer as long as the funds are used only for medical expenses
  - Unspent balances can accumulate from year-to-year.
- HSAs are accounts in which money is placed to pay for medical expenses; each HSA must be paired with a high deductible health plan (HDHP)
  - Money placed in the HSA is tax deductible
  - The HSA is owned by an individual and is portable
  - Contributions can be made by either or both employers and employees
  - The health plan cannot have first dollar coverage except for expenses associated with prevention.

Source: *HSAs, HRAs, or FSAs: Which Consumer-Driven Health Care Option Should You Choose?*; The Council for Affordable Health Insurance, May 2004; *Issues: HSAs, MSAs, FSAs, and HRAs*, National Association of Health Underwriters, 2003; and *All About HSAs*, U.S. Treasury Department, November 28, 2005.

Data from Kaiser Family Foundation/Health Research and Educational Trust on Employer-Sponsored Health Plans

- The Kaiser Family Foundation (KFF) in conjunction with the Health Research and Educational Trust (HRET) conducts an annual survey of employer-sponsored health benefits. (KFF a "non-profit private operating foundation dedicated to providing information and analysis in health care issues.... is not associated with Kaiser Permanette or Kaiser Industries." HRET, "a non-profit research organization, is an affiliate of the American Hospital Association.")
- The Kaiser/HRET *2006 Employer Health Benefits Survey*
  - Was completed between January and May of 2006
  - Included responses from "3,159 randomly selected non-federal public and private firms with three or more employees (2,122 of which responded to the full survey and 1,037 of which responded to an additional question about offering coverage)."

Source: Kaiser Family Foundation News Release dated September 26, 2006.

Employer-Sponsored Health Insurance Is the Primary Insurer for Non-Elderly Americans

- More than 150 million non-elderly Americans receive their health insurance through their employers.
- In 2006, within all firms, including those that do not offer insurance to their employees:
  - 59% of employees were covered by their employers' health insurance
    - This was 4% fewer than the 63% who had employer-sponsored health insurance in 2000.
- In 2006, within the firms that offered their employees health insurance:
  - 65% of all employees were covered by their employer's health insurance
    - This was 3% fewer than the 68% who had employer-sponsored health insurance in 2000
  - It should be noted that within the firms that offered health insurance, only 78% of the employees were offered health insurance and 82% of those employees chose to be covered.

Source: KFF/HRET *2006 Employer Health Benefits Survey.*

Since 2003, Percentage Increases in Employer-Sponsored Health Insurance Premiums Have Slowed

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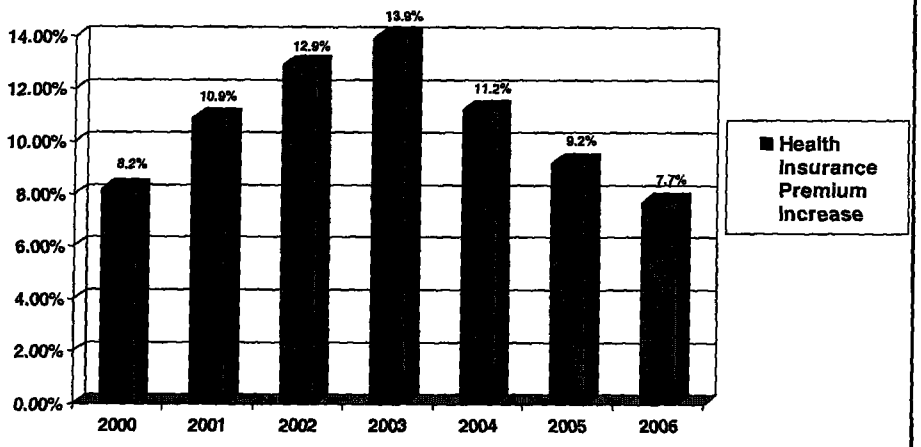

Source: KFF/HRET *2006 Employer Health Benefits Survey.*

Health Insurance Premium Increases Continue to Exceed Increases in Inflation and Worker Earnings

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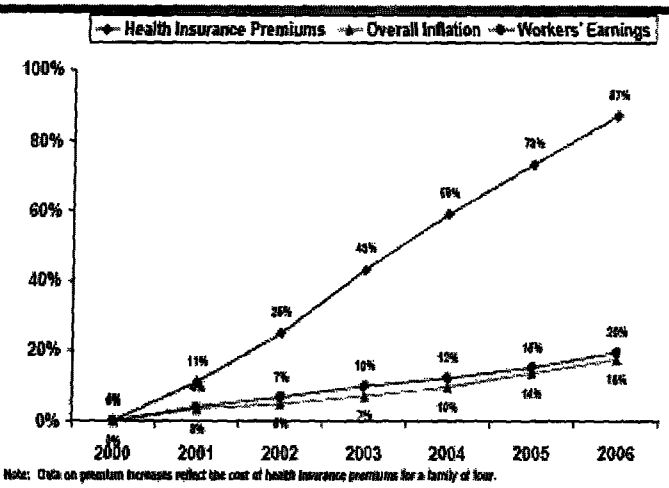
- The increase of **7.7%** was the lowest percentage increase **in premiums** since 1999; however, it exceeded the increase in **overall inflation (3.5%)** and in **worker earnings (3.8%) for 2006.**
- In 2006, the average annual premium for all types of health insurance plans for single coverage was $4,242 and for family coverage was $11,480
  - These premiums differed by type of plan as shown in the Table to the right >>>
  - **54%** of firms offered at least 1 **PPO**
    17% offered at least 1 **HMO**
    28% offered at least 1 **POS**
    7% offered at least 1 **HDHP/SO**
    7% offered at least 1 **conventional plan.**

Average Annual Premium (as Paid by Employer and Worker)		
Plan Type	Single Coverage	Family Coverage
PPO	$4,385	$11,765
HMO	$4,049	$11,278
POS	$4,168	$11,107
HDHP/SO	$3,405	$9,484

Source: KFF/HRET *2006 Employer Health Benefits Survey.*

"Cumulative Changes in Health Insurance Premiums, Overall Inflation, and Workers' Earnings 2000 – 2006" (KFF/HRET Survey of Employer Health Benefits 2006)



Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

Source: KFF/HRET Survey of Employer-Sponsored Health Benefits, 2001-2006; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2001-2006; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April), 2001-2006.

Fewer Employers Are Offering Health Insurance to Their Employees

- In 2006, 61% of employers offered health insurance benefits, this was a decrease of 8% since 2000. As explained in the KFF/HRET survey:

"While the year-to-year changes have not been statistically significant, the cumulative effect has been a large and statistically significant change over this six-year period. This change is driven largely by a decrease in the percentage of small firms (3-199 workers) offering coverage."

- Of the employers offering health insurance plans in 2006
  - — 31% offered coverage to part-time and 3% to temporary employees
  - — 88% only offered one type of plan.

Number of Employees	Percentage Offering Health Benefits in 2006
3 to 9	48%
10 to 24	73%
25 to 49	87%
50 to 199	92%
200 or more	98%
All Firms	**61%**

Source: KFF/HRET *2006 Employer Health Benefits Survey.*

Health Insurance Market Share Has Changed Since 2000

- Market share as measured by the number of workers covered by each type of health insurance plan has changed since 2000 as follows:
  - **PPOs** ↑ from **42%** to **60%**
  - **HMOs** ↓ from **29%** to **20%**
  - **POS plans** ↓ from **21%** to **13%**
  - **Conventional plans** ↓ from **8%** to **3%**
    - HDHP/SOs were first reported in 2006 so no comparison could be made, **4%** of workers **had a HDHP/SO in 2006.**
- In 2006, workers paid "on average 16% of the premium for single coverage and 27% of premiums for family coverage" or $627/year for single and $2,973/year for family coverage
  - These premiums differed by type of plan as shown in the Table to the right >>>

Annual Premiums Paid by Workers		
Plan Type	**Single Coverage**	**Family Coverage**
PPO	$637	$2,915
HMO	$590	$3,079
POS	$634	$3,226
HDHP/SO	$569	$2,247
All Plans	**$627**	**$2,973**

Source: KFF/HRET *2006 Employer Health Benefits Survey.*

Consumer-Directed Health Plans Are Being Offered by More Employers

- CDHPs (the pairing of a high deductible health plan with an HRA or HSA) are described by the Kaiser Family Foundation as:
  - Seeking to "increase consumer awareness of health care costs and provide incentives for consumers to consider costs when making health care decisions." (*Consumer-Directed Health Plans*, Kaiser Family Foundation June 2006)
- Use of CDHPs are expected to lower the cost of health premiums paid by employers as insured employees have more responsibility and incentive for restraining health care costs
  - However, employee out-of-pocket expenditures can be significant.
- A recent Government Accountability Office (GAO) report noted that as of January 2006, between 5 and 6 million Americans were enrolled in a either a HRA or HSA
  - The GAO report stated "[c]oncern about the rising cost of health care is the main reason some employers are offering CDHP options to their workers." (Bureau of National Affairs' *Health Care Policy Report* Vol. 14 No. 23 dated Monday, June 5, 2006)

Presentation Outline

- ❑ Background
- ❑ Factors Leading to Rising Health Care Costs
- ❑ Trends in Employer-Sponsored Health Benefits
- ■ Derivative Effects of Rising Health Care Costs
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Derivative Effects: Movement to Individual Health Insurance

- A study funded by the Commonwealth Fund (CF) examined the effect of increasing health care costs on "the health and financial well-being of American families."
- The study reports that as the availability of employer-based coverage diminishes, before becoming one of the uninsured, many workers turn to the individual insurance market
  - Eight percent of adults (8.5 million people between 19 and 64 years of age) have an individual health insurance policy
  - More than half of adults with individual insurance have premium costs greater than $3,000, compared with one in five covered by employer plans
  - 43% of adults with individual insurance spent more than 10% of their incomes on premiums and out-of-pocket medical expenses, compared with 24% of those with employer plans
  - "Compared with adults with employer coverage, adults with individual insurance give their plans lower ratings, pay more out-of-pocket for their premiums, face much higher deductibles, and spend a greater percentage of their income on insurance premiums and health care expenses."

Source: The Commonwealth Fund, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-being of American Families*, September 2006.

Derivative Effects: Movement to Individual Health Insurance

- All 50 states have an individual insurance market, but many adults find the coverage either unaffordable or unavailable, especially older adults or people with health problems.
  - Nearly ninety percent of adults who considered purchasing individual health insurance never purchased a plan.
- Some states have "strong individual market regulations that require community rating, under which everyone is charged the same premium regardless of age or health status or impose 'age rating bands'....Still, while these reforms have improved access for older and less healthy people, they also have made coverage less affordable for younger, healthier people."
- The employer-sponsored insurance mechanism functions effectively because, unlike the private insurance market, it allows risk to be pooled and people gain insurance as part of employment not as a last resort when the person has already become sick.

Source: The Commonwealth Fund, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-being of American Families*, September 2006.

Derivative Effects: Reduction in Retiree Health Benefits

- An increasing number of companies are reducing retiree health benefits as a way of lowering overall heath care costs.
- In 2003, 10% of firms eliminated coverage for future retirees and 71% increased retirees' contributions for their coverage. A survey of 408 large companies found that one-fifth said they were likely to terminate health coverage for future retirees in the next 3 years.
  - 86% said they would require increases in contributions from retirees for health insurance coverage.

Source: KFF/HRT *2003 Health Benefits Survey.*

Derivative Effects: Changes Being Undertaken by Some Employers

- Besides reducing retiree benefits, employers are dealing with the rise in health care costs by:
  - Requiring employees to pay higher premiums and/or co-payments
  - Reducing wage increases
  - Hiring fewer permanent employees.
- Some fear that shifting more costs onto employees may lead employees to:
  - Reduce their spending on discretionary health care
  - Defer needed care and risk long-term (more expensive) health problems or
  - Opt out of employee health care programs.
- Moreover, (as previously noted) the percentage of firms offering health benefits has fallen from 69 percent to 61 percent since 2000
  - The Kaiser Family Foundation indicates that the long-term trend points to the slow unraveling of coverage in the employment-based system, especially among smaller employers.

Source: "Survey of Executives Finds Health Costs Up, with Effects on Hiring, Pay" *Health Care Policy*, Vol. 13, No. 30, July 25, 2005; and KFF/HRET *2006 Employer Health Benefits Survey.*

Derivative Effects: Increasing Number of Uninsured

- Rising health insurance costs increase the number of uninsured people as:
  - "Employers stop offering insurance to their employees, employees decline employer-offered health insurance because they cannot afford the employee share of the premium," and state governments react to increased costs by changing eligibility for Medicaid and other state programs.
- A 2006 study funded by The Commonwealth Fund reported that according to the Census data, the "number of uninsured Americans climbed to 46.6 million in 2005...an increase of 7 million since 2000. Nearly all of the growth in the number of uninsured Americans is attributable to a decline in employer-based coverage."

Source: Thomas Bodenheimer, MD, "High and Rising Health Care Costs. Part 1: Seeking an Explanation" *Annuals of Internal Medicine* Vol. 142, Issue 10, May 17, 2005 and The Commonwealth Fund, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-being of American Families*, September 2006.

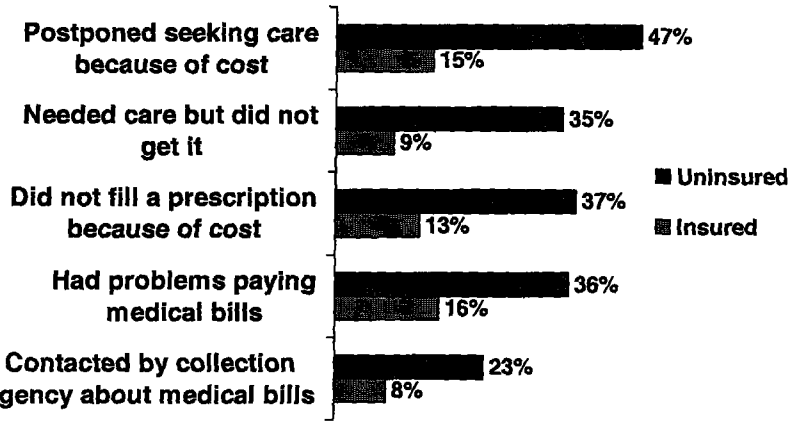
Derivative Effects: Increasing Number of Uninsured

- The Kaiser Family Foundation reported in 2006:
  - Adults are more likely to be uninsured than children.
  - Minorities are more likely to be uninsured than white Americans.
  - 79% of the uninsured are American citizens.
  - Lack of health coverage, even for short period of time, results in decreased access to care.
    - The uninsured are up to 3 times more likely than those with insurance to report problems getting needed medical care, even for serious conditions
    - Many uninsured are not able to follow recommended treatment
    - The uninsured are more likely to be hospitalized for avoidable health problems because they are less likely than the insured to have regular outpatient care
  - Having insurance improves health overall and could reduce mortality rates for the uninsured by 10-15%.

Source: Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer*, The Kaiser Family Foundation. January 2006.

Why Health Insurance Matters

Percent Reporting Barriers to Health Care, 2003



Notes: *Experienced by the respondent or a member of their family. Insured includes those covered by public or private health insurance.

Source: *Kaiser 2003 Health Insurance Survey.*

Derivative Effects: Uncompensated Care Costs

- Costs not paid by the uninsured themselves are referred to as uncompensated care costs
  - The cost of uncompensated care was estimated to be about $41 billion in 2004
  - Projected government spending available to pay for the care of the uninsured in 2004 was $34.6 billion or about 85% of the total uncompensated care bill.
- Most government dollars for uncompensated care goes for hospital care, although additional "safety net" providers receive some government funding.
- To some extent, insured patients help to pay the cost of providing care for the uninsured; thereby adding to health insurance costs.

Source: Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer,* The Kaiser Family Foundation. January 2006.

Presentation Outline

- ❑ Background
- ❑ Factors Leading to Rising Health Care Costs
- ❑ Trends in Employer-Sponsored Health Benefits
- ❑ Derivative Effects of Rising Health Care Costs
- ■ Ways to Reduce Health Care Costs
- ❑ Attachments

Ways to Reduce Health Care Costs

- A number of cost containment and quality improvement efforts have been undertaken by health insurers, including
  - Improvements in health information technology
  - Disease management and wellness programs
  - Identification and management of high cost and chronically ill patients
  - Incentives for providers for appropriate and high quality care"
  - Increased consumer responsibility (through such mechanisms as tiered co-payments to encourage the use of less expensive medications) in combination with information on health care alternatives to allow and encourage consumers to make better informed decisions about their health care.

Source: Kaiser Family Foundation, *Comparing Projected Growth in Health Care Expenditures and the Economy*, May 2006.

Ways to Reduce Health Care Costs

- Employers are using incentives in an effort to reduce health care costs, including
  - Establishing financial incentives to encourage employees to live healthier lifestyles
  - Providing employees with better information about quality health care
  - Providing employees with information about generic drugs that can be used in place of more costly brand-name drugs
  - Requiring employees who exhibit unhealthy behavior, such as smoking or poor nutrition, to pay a larger share of their health costs.

Source: "Survey of Executives Finds Health Costs up 12 %, With Effects on Hiring, Pay" *Health Care Policy*, Volume 13, Number 30, July 25, 2005.

Ways to Reduce Health Care Costs

- Health care providers are making efforts to reduce costs by "investing in medical technology (such as electronic medical records), developing systems to reduce medical errors, and participating in programs that reward efficiency and quality."
- Many states "have enacted laws to reduce medical malpractice judgments in order to reduce premium burdens on providers and lower overall costs"
  - Virginia currently has one of the most restrictive medical malpractice liability statutes in the country, limiting the total amount of recovery to $1,850,000. (*Code of Virginia § 8.01-581.15).*
- However, even when taken together these measures are not likely to reduce health care costs enough to ensure continued sustainability. As reported by the Kaiser Family Foundation:

"Although many of these efforts may lead to efficiency and quality gains, none would appear to be of a scale to have any meaningful impact on the overall cost picture....If we began next year trying to hold health care cost growth to the current projected growth rate for GDP [gross domestic product] (i.e. slowing growth in health care costs to 4.9% annually starting in 2007) we would need to lower health spending by over $3 trillion over the 2007 to 2015 [time period]...These savings would represent about 10.8% of projected total health spending over the period, or an average annual reduction of about $340 billion relative to the projected level of spending."

Source: Kaiser Family Foundation, *Comparing Projected Growth in Health Care Expenditures and the Economy*, May 2006.

Staff Recommendation

- A number of the initiatives recommended as ways to reduce health care costs have been and will continue to be topics of review for JCHC including disease management and wellness programs, patient safety, electronic health records, quality incentive programs for health care providers, and the provision of data to allow for informed consumer choice.
- Given the complexity and magnitude of the problems surrounding health care costs, the staff recommendation is to defer making specific recommendations for one year and to
  - Address health care cost issues as part of the 2007 study (based on HB 1324) which will examine ways to expand health insurance into rural areas of the Commonwealth
    - This would allow for consideration of data and findings from other ongoing studies and reports in making recommendations including
      - Virginia Health Care Foundation's Health Access in Virginia Report
      - JLARC report *Options for Extending Health Insurance to Uninsured Virginians* (HJR 158)
      - Report of the Governor's Health Care Reform Commission.

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Consumer-Directed Health Plans (CHDPs)

- CDHPs, plans that typically involve pairing a high deductible health plan (HDHP) with either a health reimbursement arrangement (HRA) or a health savings account (HSA), are described by the Kaiser Family Foundation as:
  - Seeking to "increase consumer awareness of health care costs and provide incentives for consumers to consider costs when making health care decisions" (*Consumer-Directed Health Plans*, Kaiser Family Foundation June 2006)
- Use of CDHPs are expected to lower the cost of health premiums paid by employers as insured employees have more responsibility and incentive for restraining health care costs
  - Employee out-of-pocket expenditures can be significant.
- A recent Government Accountability Office (GAO) report noted that as of January 2006, between 5 and 6 million Americans were enrolled in a HRA or HSA.
  - The GAO report stated "[c]oncern about the rising cost of health care is the main reason some employers are offering CDHP options to their workers. (Bureau of National Affairs' *Health Care Policy Report* Vol. 14 No. 23 dated Monday, June 5, 2006)

High Deductible Health Plans

- HDHPs are health insurance plans that include a minimum deductible (in 2006) of:
  - $1,050 (self-only coverage)
  - $2,100 (family coverage)
- Annual out-of-pocket expenditures cannot exceed in 2006 (including deductibles and co-pays):
  - $5,250 (self-only coverage)
  - $10,500 (family coverage)
  - Reasonable benefit designs not counted toward the out of pocket maximum include:
    - Lifetime limits on benefits
    - Limits to usual, customary and reasonable (UCR) amounts
    - Limits on specific benefits
      - Maximum number of days or visits covered
      - Maximum dollar reimbursements
    - Pre-certification requirements
- HDHPs are not allowed to have first dollar coverage except for preventive care but may "be an HMO, PPO or indemnity plan, as long as it meets the requirements" for HDHPs.

Source: *The Basics of HSAs*, U.S. Treasury Department, November 28, 2005.

Health Reimbursement Arrangements (HRAs)

- HRAs are accounts funded by an employer for an individual for his/her medical expenses
  - Accounts are owned by employers
  - Most employers do not allow employees to access the funds once they leave employment
  - Funds are tax-exempt for the employer as long as the funds are used only for medical expenses
  - Unspent balances can accumulate from year-to-year.

Source: *HSAs, HRAs, or FSAs: Which Consumer-Driven Health Care Option Should You Choose?*, The Council for Affordable Health Insurance, May 2004 and *Issues: HSAs, MSAs, FSAs, and HRAs*, National Association of Health Underwriters, 2003.

Health Savings Accounts (HSAs)

- HSAs were established in 2003 Medicare legislation.
- HSAs are accounts in which money is placed to pay for medical expenses; each HSA must be paired with a high deductible health plan (HDHP).
  - Money placed in the HSA is tax deductible.
  - The HSA is owned by an individual and is portable.
  - Contributions can be made by either or both employers and employees.
  - The health plan cannot have first dollar coverage except for expenses associated with prevention.

Source: *All About HSAs*, U.S. Treasury Department, November 28, 2005.

HSA Eligibility

- Stipulations regarding HSA eligibility:
  - Individual and/or family must be covered by a HDHP but not by other health insurance
    - However, this does not apply to "specific disease or illness insurance and accident, disability, dental care, vision care...long-term care insurance [and] drug discount cards"
  - Individual and/or family cannot be eligible for Medicare
  - Individual cannot be a dependent on another person's tax return, although a spouse may establish a separate HSA
  - Individual may be eligible for Veterans Administration (VA) benefits as long as no VA health benefits were accessed in the previous three months.
- There are no income limitations on who can establish an HSA.

Source: *All About HSAs*, U.S. Treasury Department, November 28, 2005.

HSA Distributions

- Distributions from a HSA are tax-free if used for qualified medical expenses.
  - Can be used for individual who is covered by the HDHP or the individual's spouse or dependents.
    - This is the rule even if the spouse and dependents are not covered by the HDHP.
- If the distribution is not a qualified medical expense, then the amount is included as income.
  - This results in a 10% additional tax unless the individual is eligible for Medicare, dies, or becomes disabled.
- An individual can use the distribution to pay for other health insurance in a limited number of circumstances.
  - Qualified long-term care insurance.
  - COBRA coverage.
  - Health coverage while on unemployment.
  - Medicare eligible individuals can pay for Medicare premiums, out-of-pocket expenses, and their share of premiums for employer-based coverage (does not include Medigap premiums).

Source: *The Basics of HSAs*, U.S. Treasury Department, May 15, 2004 and *All About HSAs*, U.S. Treasury Department, May 17, 2005.

Potential HSA Advantages

- The federal government and miscellaneous organizations have stated a number of advantages of HSAs.
  - By encouraging savings for future needs, HSAs can potentially provide a source of funding for:
    - non-covered services in the future,
    - health coverage during a period of unemployment,
    - long-term care expenditures,
    - medical expenses after retirement but before Medicare coverage, and
    - insurance coverage after becoming eligible for Medicare (excluding Medigap).
- HSAs are owned by an individual and are completely portable.

Source: *The Basics of HSAs*, U.S. Treasury Department, May 15, 2004.

Potential HSA Advantages (continued)

- HSAs allow unspent balances to remain in the account.
  - Potentially encourages consumers to spend funds wisely and to get the most value for their money.
- HSAs allow growth through the investment of funds.
- HSAs have tax advantages.
- HSAs are incorporated with HDHPs which should have more affordable premiums than traditional health plans.

Source: *The Basics of HSAs*, U.S. Treasury Department, May 15, 2004.

Potential HSA Disadvantages

- Previous studies have found that employees who have to pay for a large share of their medical care eliminated 1/4 of unnecessary doctors visits but also eliminated 1/3 of crucial visits.
  - This could lead to substantially higher costs for related problems down the road.
- Some groups have claimed that HSAs will pull the "healthy and the wealthy" making comprehensive insurance for those that remain more expensive.
  - Past research by several groups "found that premiums for comprehensive insurance could *more than double* if MSA use becomes widespread."
  - This research also predicts that "(t)he number of Americans who are uninsured or underinsured would likely increase as more employers and employees alike *dropped out of comprehensive* coverage because they could no longer afford it."
- Some groups argue that providing employees with a pool of money under consumer-directed care approaches will not "save money or improve the quality of care."
  - Argument that "the vast majority of consumers will always lack the knowledge about disease and appropriate care that is necessary to make cost-effective and quality choices."
- Employers that did not allow employees to have access to a pool of cash before may see increased utilization or more enrollment in HSAs than they had in traditional plans, potentially increasing their costs.

Source: *Cost Cure-All? Or Unhealthy Shift?*, U.S. News and World Reports, December 15, 2003; *Health Tax Provision Being Pushed in Medicare Conference Poses Threats to Long-Term Fiscal Policy and to the Employer-Based Health Insurance System*, Center on Budget and Policy Priorities, October 27, 2003; Consumer-Directed Health Care Won't Fly, Managed Care, January 2004; *Health Savings Accounts Ready to Enter the Market*, Managed Care, March 2004.

JCHC HSA Legislation

- **House Bill 1492 and Senate Bill 1097 of 2005** *(Chief Patrons: Delegate Hamilton and Senator Martin)*
  - **Purpose:** Repeal the provisions of the Virginia Medical Savings Account Act and establish the Virginia Health Savings Account Plan in compliance with Medicare legislation authorizing HSAs.
    - The legislation also included a provision that stated that no later than July 1, 2006, the health insurance plan for state employees is required to include, as one of the health coverage options offered in each planning district, a high deductible health plan that would qualify for a health savings account.
  - **Final Action:** HB 1492 and SB 1097 were passed unanimously by both chambers of the General Assembly and were approved by the Governor (*2005 Acts of Assembly*, Chapters 572 and 503 respectively).

APPENDIX A

SENATE JOINT RESOLUTION NO. 4

Directing the Joint Commission on Health Care to study the derivative effects of increases in health care costs on health insurance premiums. Report.

Agreed to by the Senate, February 8, 2006
Agreed to by the House of Delegates, March 6, 2006

WHEREAS, premiums for employee-sponsored health insurance in the United States have been rising on average five times faster than workers' earnings since 2000; and

WHEREAS, employee spending for health insurance coverage has increased by 126 percent between 2000 and 2004; and

WHEREAS, retail prescription prices have increased an average of 7.4 percent a year from 1993 to 2003; and

WHEREAS, health care spending is rising at the fastest rate in our country's history and is expected to continue rising in the near future; and

WHEREAS, dramatic increases in health care costs lead to higher insurance premiums that make health insurance unaffordable to many Virginians; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be directed to study the derivative effects of increases in health care costs on health insurance premiums.

In conducting its study, the Joint Commission on Health Care shall examine (i) the factors leading to rising health care costs in the Commonwealth, (ii) the derivative effects of rising health care costs including increases in health insurance premiums and denial of coverage, and (iii) ways to reduce health care costs in the Commonwealth and alleviate the burdens associated with the rising cost of health care.

Technical assistance shall be provided to the Joint Commission on Health Care by the Virginia State Corporation Commission's Bureau of Insurance. All agencies of the Commonwealth shall provide assistance to the Joint Commission on Health Care for this study, upon request.

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

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