REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

Review of Health Care Cost

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT NO. 162

COMMONWEALTH OF VIRGINIA
RICHMOND
2008

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care.

For the purposes of this chapter, "health care" shall include behavioral health care.

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Preface

Senate Joint Resolution 4 of the 2006 General Assembly Session directed the Joint Commission on Health Care (JCHC) 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 report was presented to JCHC in 2006; however, specific findings were delayed until 2007.

The rising cost of health care is a significant concern in the United States. According to a report by the Kaiser Family Foundation and Health Research and Educational Trust, health care spending has increased at an average annual rate of 9.8 percent since 1970, thereby increasing national health care expenditures from $75 billion in 1970 to $2.0 trillion in 2005. In Virginia, an estimated $35.8 billion was spent on health care in 2004.

Many states have taken steps to make health care more affordable. Virginia has undertaken such strategies as allowing for pooled purchasing of health insurance by small employers, advancing the provision of consumer-directed health plans, and improving the collection and publishing of health-related information.

Although no legislation was introduced related to this study in 2008, JCHC members voted to continue the examination of health care costs within the 2008 JCHC work plan. The 2008 study will examine the advisability of: i) establishing a Virginia health insurance exchange targeted for small businesses, ii) assisting employer adoption of Section 125 (cafeteria) plans, and iii) examining any other health insurance issues as deemed appropriate.

On behalf of the Joint Commission and staff, I would like to thank representatives of the Connecticut Business and Industry Association, National Conference of State Legislatures, Office of the Secretary for Health and Human Resources, and Virginia Association of Health Plans who assisted in this study.

Kim Snead
Executive Director

June 2008

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Review of Health Care Costs

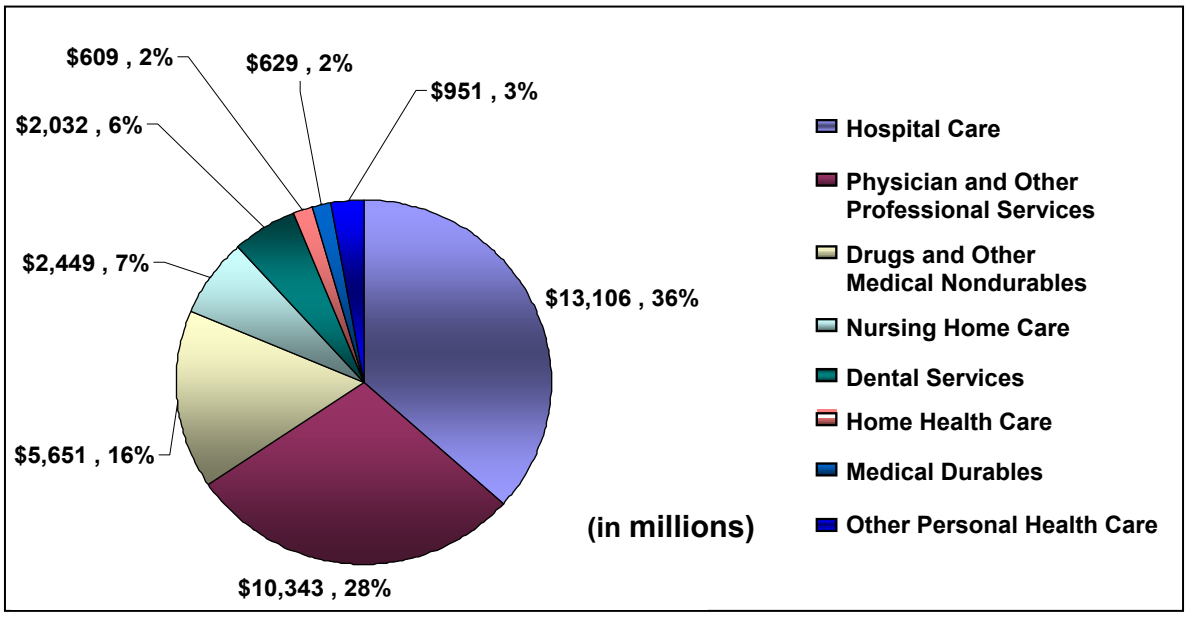
Background

Senate Joint Resolution 4 (2006), introduced by Senator Roscoe W. Reynolds, directed JCHC 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 report was presented to JCHC in 2006; however, specific findings and recommendations were delayed until 2007.

Health Care Costs

Health care is a significant area of concern as costs continue to rise. Spending has increased at an average annual rate of 9.8 percent since 1970. [1] In the U.S., health care expenditures were $75 billion in 1970, $2.0 trillion in 2005 and are estimated to reach $4.0 trillion in 2015.[2] In Virginia, $35.8 billion was spent on health care in 2004. As shown in Figure 1, spending related to hospital and physician/other professional services accounted for almost two-thirds of Virginia's 2004 health care spending.

Figure 1
2004 Health Care Spending in Virginia [3]

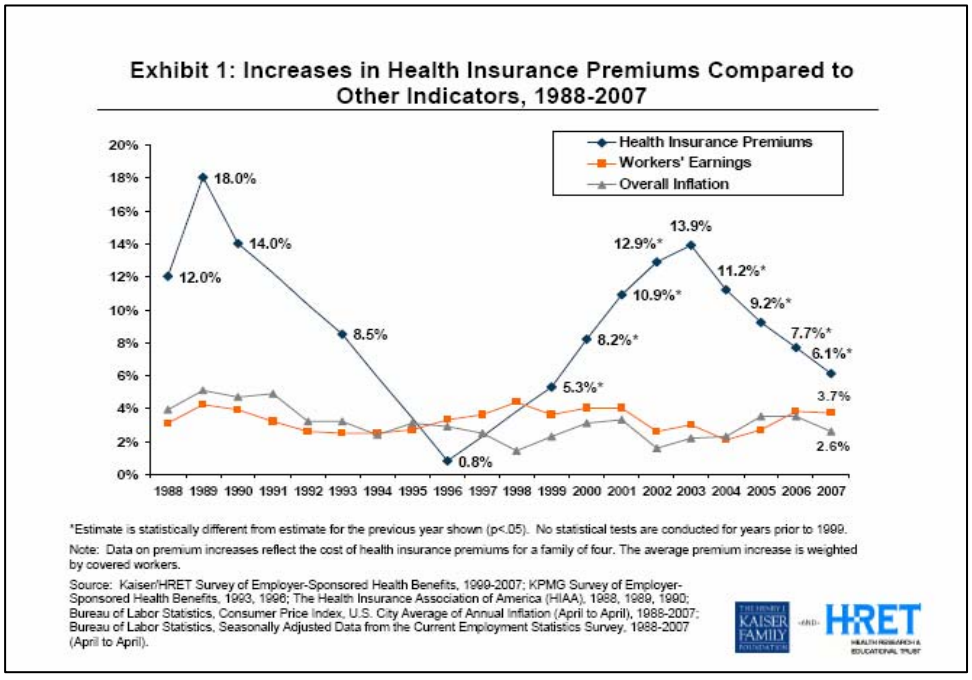


[1] Kaiser Family Foundation, *How Changes in Medical Technology Affect Health Care Costs*, March 2007
[2] *Id.*
[3] Kaiser - Statehealthfacts.org, *Virginia Expenditures*, last accessed April 9, 2007

Health care costs were not distributed evenly across the population, but rather 10 percent of the population accounted for 70 percent of the costs. Conversely, 50 percent of the population accounted for only three percent of the costs.[4] Common conditions among the highest-cost 10 percent of the population included ischemic heart disease, cancer, diabetes, hypertension, pulmonary conditions, mental health disorders, and trauma, as well as repeated hospitalizations for same illness.[5]

Health Insurance Premiums

Exhibit 1 compares increases in health insurance premiums, workers' earnings and overall inflation rates as reported in *Employer Health Benefits 2007 Annual Survey* (conducted by the Kaiser Family Foundation and Health Research and Educational Trust). Exhibit 1 shows an average increase in health insurance premiums of 6.1 percent in 2007, which was the lowest percentage increase in seven years and less than half the size of the 13.9 percent increase in 2003. Nonetheless, consumer-buying power still decreased since workers' earnings



only increased by an average of 3.7 percent in 2007. The primary types of health insurance plans offered in the United States are described in Figure 2.

[4] Bodenheimer and Fernandez, *High and Rising Health Care Cost - Part 4: Can Costs be Controlled While Preserving Quality*, Annals of Internal Medicine Vol. 143:1, July 2005.
[5] *Id.*

Figure 2
Description of Primary Health Insurance Plans

Health Maintenance Organization (HMO)

Type of managed care plan that typically includes the most restrictions.

Insured members must choose a primary care physician who will manage medical care that is received; referrals are usually required 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 Long-Term Care/Medicaid Reform Subcommittee on August 22, 2006)

Point of Service Plan (POS)

Type of managed care plan that is similar to the PPO except that the care received outside the plan's network typically will require the member to pay a deductible or coinsurance fee.

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 Long-Term Care/Medicaid Reform Subcommittee on August 22, 2006)

Preferred Provider Organization (PPO)

Type of managed care plan that also includes provisions of a fee-for-services plan.

Insured members may to go a physician or hospital of choice, although there is an established network of "preferred providers" who provide services at a discounted rate to the plan's members.

Consumer-Directed Health Plan (CDHP)

Relatively new type of health insurance plan which generally involves pairing a tax-sheltered health savings account with a health insurance plan that has a high deductible.

High-Deductible Health Plans with Savings Options (HDHP/SOs) as described in the *Employer Health Benefits 2007 Annual Survey* include:

- "(1) health plans with a deductible of at least $1,000 for single coverage and $2,000 for family coverage offered with an Health Reimbursement Arrangement (HRA)" and
- "(2) high-deductible health plans that meet the federal legal requirements to permit an enrollee to establish and contribute to a Health Savings Account (HSA)…."

The *Employer Health Benefits 2007 Annual Survey* found that premiums vary by type of plan. As shown in Figure 3, on average the PPO is the most expensive and the HDHP/SO is the least expensive. When all types of health insurance plans were considered, the average annual cost was $4,479 for individual coverage and $12,106 for family coverage. The *2007 Annual Survey* reported that

Figure 3
Average Annual Premiums (Paid by Employer and Worker)[6]

Plan Type	Single Coverage	Family Coverage
HMO	$4,299	$11,879
PPO	$4,638	$12.443
POS	$4,337	$11,588
HDHP/SO	$3,869	$10,693
ALL PLANS	$4,479	$12,106

on average employees were responsible for paying 16 percent of the health insurance cost for single coverage and 28 percent for family coverage.[7]

In 2006, Virginia's small group health plans were ranked as the third lowest-cost plans in the U.S. by America's Health Insurance Plans (AHIP) in its Center for Policy and Research report *Small Group Health Insurance in 2006.* Figure 4 shows the average cost of health insurance in Virginia and the United States as reported in the 2006 AHIP report.[8]

Figure 4
Average Monthly and Annual Premiums in 2006

	Virginia		United States	
	Monthly	Annual	Monthly	Annual
Individual Plan	$246	$2,952	$311	$3,732
Family Plan	$645	$7,740	$814	$9,768

[6] KFF/HRET *2007 Employer Health Benefits Survey*.
[7] KFF/HRET *2007 Employer Health Benefits Survey*.
[8] American Health Insurance Plans' Center for Policy and Research, *Small Group Health Insurance in 2006*, September 2006.

Health Insurance Offerings

Not all firms offer health insurance to its employees. In fact, the likelihood of a firm offering health insurance to its employees is highly correlated with the size of the firm. Only 45 percent of the smallest firms offered health insurance in 2007, whereas 99 percent of firms with 200 or more employees offered health insurance. Figure 5 highlights the percentage of firms that offer health insurance by the firm size.

Figure 5
Percentage of Firms Offering Health Benefits in 2007[9]

Number of Employees	% Offering Health Benefits
3 to 9	45%
10 to 24	76%
25 to 49	83%
50 to 199	94%
200 or more	99%
All Firms	60%

Increases in health care costs have encouraged the development of new health insurance products such as consumer-directed health plans (CDHPs). These increasingly popular products are being offered by more employers each year. AHIP, a national trade organization, reports that 31 percent of new individual HDHP/HSA policies and 33 percent of small firm policies are for people or companies that were previously uninsured.[10] CDHPs are expected to result in lower health premium costs for employers (over time) as employees limit their health-related expenditures in response to paying higher deductibles. There are some drawbacks; however, as studies have found that lower-income CDHP enrollees choose to forgo some necessary acute or preventive health care.[11]

Cost Strategies Undertaken by States to Address Affordability

Many states have developed strategies to help make health care more affordable for their residents. Similar strategies undertaken in Virginia are shown in Figure 6 and in the written descriptions that follow.

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[9] KFF/HRET *2007 Employer Health Benefits Survey*.
[10] America's Health Insurance Plans, *HSAs and Account Based Health Plans*, June 2006.
[11] Thomas H. Lee, M.D., and Kinga Zapert, Ph.D. , *Do High-Deductible Health Plans Threaten Quality of Care?*, New England Journal of Medicine, 353:12 September 22, 2005

Pooled Purchasing. Pooled purchasing allows a group of public and/or private entities, usually small employers, to form a coalition in order to purchase health insurance. These purchasing coalitions typically "leverage greater market share and wield more influence" over insurers.[12]

In 2006, the *Code of Virginia* was amended (House Bill 761) to allow for the establishment of "small employer health group cooperatives." The legislative change allowed each cooperative to be deemed a single entity for the purpose of negotiating the terms of health insurance coverage (including premium rates) for

Figure 6
State's Health Cost Containment Strategies

Cost Strategies[13]	Virginia Initiative
Allowing pooled purchasing	HB 761 (2006) Health Group Cooperatives
Authorizing consumer-driven health plans	HB 1492 (2005) Virginia Health Savings Account Plan
Examining insurance mandates	SB 478/HB 1106 (1990) Special Advisory Commission on Mandated Health Insurance Benefits Virginia Improving Patient Care and Safety (VIPCS); and
Decreasing medical errors	HB 1570 (2005) hospitals will report certain types of infections beginning July 1, 2008
Providing for cost transparency and disclosure	HB 1307 (1996) State Health Commissioner and Board of Health to contract with nonprofit organization for health care data projects

its members. Membership was limited to employers with an average of between two and 50 employees during the previous year.

Consumer-Directed Health Plans. Virginia took steps in 2005 to allow for and encourage the use of health savings accounts. House Bill 1492, as enacted, required the Department of Taxation and the State Corporation Commission to develop and present the "Virginia Health Savings Account Plan" for legislative approval. The Plan was required to be "consistent with federal law authorizing the establishment and use of health savings accounts, [to] identify measures…that will increase the utilization and efficacy of health savings accounts…and [to] include recommendations for legislation that would increase the attractiveness of health savings accounts, or eliminate barriers for to their use…." In addition, the Department of Taxation and the State Corporation

[12] Slide 20, *Health Care Costs & Spending: Latest State Strategies*, Richard Cauchi, NCSL, September 19, 2007
[13] Slide 15, *Health Care Costs & Spending: Latest State Strategies*, Richard Cauchi, NCSL, September 19, 2007

Commission were required to report annually on updates made to the Virginia Health Savings Account Plan.

Health Insurance Mandates. In an effort to contain health care costs, many states have examined the mandates placed on health insurance products. Although adding mandates has been shown to add to health insurance costs, the repealing of mandates has not assured lower premiums.[14] In general, states are no longer imposing new mandates on health insurance products.

In 1990, the Virginia General Assembly established a Special Advisory Commission on Mandated Health Insurance Benefits to examine legislation that would expand mandated benefits in health insurance products. In order for such legislation to be considered by the General Assembly, the legislation is first sent to the Special Advisory Commission for review. This process requires statutory mandates to be reviewed and their impact to be estimated prior to consideration by the General Assembly.

Medical Errors. The 1999 Institute of Medicine (IOM) report, *To Err is Human: Building a Safer Health System* brought nationwide attention to the critical problem of medical errors. The IOM report estimated that at "least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of [preventable] medical errors." The IOM report indicated that medical errors resulted in an estimated total cost "(including the expense of additional care necessitated by the errors, lost income and household productivity, and disability) of between $17 billion and $29 billion per year…."

In response to the IOM report, Virginians Improving Patient Care and Safety (VIPC&S) was formed in 2000. VIPC&S was recognized in 2002 by the National Academy for State Health Policy as "one of the seven most mature patient safety coalitions in the United States."[15] VIPC&S membership has increased significantly in its eight years of existence from its six founding members – Trigon (now Anthem) Blues Cross and Blue Shield, The Medical Society of Virginia, Virginia Association of Health Plans, Virginia Department of Health, Virginia Hospital & Healthcare Association, and Virginia Pharmacists Association – to more than 45 members. VIPC&S mission is "to identify and promote strategies to improve patient care and safety with the citizens of the Commonwealth of Virginia through building awareness, education, legislation, endorsement, support and advocacy."

Furthermore in Virginia, a number of bills have been enacted to address patient safety; a few examples are noted. Senate Bill 316 (2002) expanded Virginia's peer

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[14] Slide 19, *Health Care Costs & Spending: Latest State Strategies*, Richard Cauchi, NCSL, September 19, 2007

[15] Letter from Rebecca Snead, President, VIPC&S to Kim Snead, Executive Director, Joint Commission on Health Care (November 6, 2002) (on file with the Joint Commission on Health Care).

review statute to permit sharing of patient safety information among providers and patient safety organizations. SB 316 was introduced following JCHC and VIPC&S studies which highlighted the importance of allowing hospitals to share information concerning patient safety to encourage replication of best practice techniques and to reduce medical errors. House Bill 1570 (2005) will require hospitals to report nosocomial infections to the Centers for Disease Controls and Prevention (CDC) beginning July 1, 2008. Nosocomial infections are infections, acquired after admission to a hospital or other health care facility, that were not present in the patient upon admission. The CDC operates the National Healthcare Safety Network (NHSN) which collects information from a "sample of healthcare facilities in the United States to permit valid estimation of the magnitude of adverse events among patients and healthcare personnel…[and to determine] adherence to practices known to be associated with prevention of healthcare-associated infections…."[16]

Cost Transparency and Disclosure. Collecting data from providers and health plans,[17] and disseminating that information will assist in encouraging quality and efficiency while allowing consumers to make better "value" determinations.

Virginia recognized the need to improve the quality of the health care data collection in 1996 when House Bill 1307 was enacted. HB 1307 directed the State Health Commissioner and Board of Health to contract with a nonprofit organization "to develop and implement health data projects that provide useful information to consumers and purchasers of health care…." That nonprofit organization, Virginia Health Information (VHI) "collects and publishes information on all major providers of care including HMOs, hospitals, nursing facilities, other long term care providers and physicians.…"[18]

Use of Section 125 Plans Could Reduce Cost of Health Insurance

Section 125 plans, also known as "cafeteria" plans, allow an employee's health insurance premiums to be deducted from his salary before tax liability is determined. This pre-tax benefit helps reduce the actual cost of health insurance and can be provided even if the employer pays none of the employee's health insurance cost. Figure 7 illustrates the potential savings for the employee who participates in a Section 125 plan as compared to an employee

125 plans allow employees to use pretax dollars when paying their health insurance premiums

[16] Center for Disease Control and Prevention, National Healthcare Safety Network (NHSN) <http://www.cdc.gov/ncidod/dhqp/nhsn.html>.
[17] Slide 23, *Health Care Costs & Spending: Latest State Strategies*, Richard Cauchi, NCSL, September 19, 2007
[18] 2007 Virginia Health Information Annual Report.

who does not have such a plan. In the example, a total tax rate of 28 percent is used, which assumes tax rates of 15 percent for federal, 5 percent for State, and 8 percent for FICA/Medicare taxes.

In the example, the employee's health insurance premium of $3,000 is not subject to taxes increasing his annual take home pay by $840 and thereby reducing his actual health insurance cost to $2,160.

Although Section 125 plans can reduce the actual cost of health insurance for employees, many small businesses in Virginia do not offer such plans. Two major impediments appear to be a general lack of understanding about the plans and a reluctance to take on the administrative responsibilities involved in adopting a plan. The administrative requirements and costs associated with establishing and managing a Section 125 plan include:

- Initial plan set-up
- Annual activities related to employee renewals, insurer contracts, and tax form submission procedures
- Ongoing responsibilities to comply with legal requirements related to the plan.

Figure 7
Example of Effect of Employer Enrollment in Section 125 Plan on Employee's Take Home Pay

	w/o Plan	**With Plan**
Annual Income	$50,000	$50,000
Pre-tax Employee Health Insurance Contribution	$ 0	$ 3,000
Taxable Income	$50,000	$47,000
Estimated Taxes 28%	$14,000	$13,161
After-Tax Employee Health Insurance Contribution	$ 3,000	$ 0
Net Take Home Pay	$33,000	$33,840
Annual Savings from Pre-Tax Contributions	**$ 0**	**$ 840**

The State may want to consider assisting in disseminating information about Section 125 plans and in the administration of such plans. One option would be to work with small business organizations to further adoption of these plans and the other is to support the establishment of a health insurance exchange.

State Assistance with Health Insurance Exchange. A health insurance exchange acts as a clearinghouse of insurers and insurance products; thereby allowing a

small business to designate the exchange as its health plan. As noted in the Joint Legislative Audit and Review Commission (JLARC) report, *Options for Extending Health Insurance to Uninsured Virginians*, the business "would then have the option of sending its employees to the exchange to select their preferred policy [and] still have the ability to contribute to the purchase of the policy with pre-tax dollars. In addition, employees would be considered to be insured under an employee plan and therefore could pay their share of the premium with pre-tax dollars as well. The JLARC report also discussed disadvantages associated with operating a health insurance exchange. The disadvantages include: "the administrative costs associated with the establishment and operation of the [health insurance exchange and the fact that establishing the exchange]…would limit or even eliminate the small group [health insurance] market and adversely impact insurers that sell those types of products."[19]

Virginia Reports Reviewed

During this study, many reports were reviewed including two Virginia-specific reports: the JLARC study *Options for Extending Health Insurance to Uninsured Virginians* and *Roadmap for Virginia's Health: A Report of the Governor's Health Reform Commission.*

Some of the health insurance options and findings discussed in *Options for Extending Health Insurance to Uninsured Virginians* included the following:[20]

- Allowing small employers to utilize State employee or Local Choice health plans, which
    - ♦ Makes providing insurance more affordable and attractive by reducing premium and administrative costs
    - ♦ Leads to higher premiums for State and Local Choice employees, increased administrative burden and costs for the State. [21]
- Establishing a market exchange that small employers could designate as their employer plan, which
    - ♦ Could encourage more small employers to offer health insurance by providing the opportunity to offer pre-tax employer contribution without any administrative responsibilities
    - ♦ However, eliminating the administrative burden may not provide sufficient incentive to offer health insurance. [22]
- Expanding Medicaid/FAMIS eligibility, which
    - ♦ Allows Virginia to cover more low-income individuals

[19] *Options to Extend Health Insurance Coverage to Virginia's Uninsured Population*, JLARC, House Document 19 (2007)
[20] *Id.*
[21] JLARC, *Options for Extending Health Insurance to Uninsured Virginians*, slide 41 (December 11, 2006).
[22] *Id. at* slide 42.

    - Expands the use of federal matching funds
    - Adds costs to the State. [23]
- Providing direct subsidies to low-income individuals to purchase health insurance, which
    - Fills gap between what some individuals can afford and the price of insurance
    - Requires substantial subsidy for individuals to engage
    - Adds costs to State. [24]
- Providing subsidies to small employers, which
    - Could be provided through tax incentive or direct payment
    - Could require that employers contribute to employees' health insurance
    - Would require substantial subsidy to be attractive for small employers
    - Would add costs to State. [25]

Roadmap for Virginia's Health: A Report of the Governor's Health Reform Commission also provided options that would affect health care costs.[26] One option was to create a private health insurance product for working uninsured Virginians and small businesses who have limited access to other health insurance options. The private health insurance product would be available for uninsured individuals who work for small employers that have not offered health insurance for at least the last six months. The product was expected to cost the Commonwealth of an estimated $20,000,000 per year and include:

- A health care insurance policy capped at $50,000 in claims per year.
- A monthly premium estimated to be $135.
- Premiums for individuals whose income is less than 200 percent of the Federal Poverty Level would be paid:
    - 1/3 by employer
    - 1/3 by employee
    - 1/3 by Commonwealth.
- Individuals whose income is more than 200 percent FPL could purchase health insurance without a State contribution.

The Governor's Health Reform Commission also recommended that the Health Information Technology Council assist Virginia Health Information in developing a consumer-friendly portal that would be a clearinghouse for information on health care quality, pricing and literacy.

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[23] *Id. at* slide 36.
[24] *Id. at* slide 37.
[25] *Id. at* slide 38.
[26] Governor's Health Reform Commission, *Roadmap for Virginia's Health*, September 2007.

Policy Options

Option 1: Take no action

Option 2: Request by letter of the Chairman that the Joint Commission convene a workgroup to develop a plan: i) establishing a Virginia health insurance exchange targeted for small businesses, ii) increasing employer adoption of Section 125 plans, and iii) any other health insurance issues as deemed appropriate. A report to JCHC would be due by November 2008. The workgroup will include representatives of:

- SCC's Bureau of Insurance
- Health insurance brokers
- Health insurers
- Small business employers.

☑ **Option 3:** Include in the 2008 JCHC work plan a study of the advisability of: i) establishing a Virginia health insurance exchange targeted for small businesses, ii) increasing employer adoption of Section 125 plans, and iii) any other health insurance issues as deemed appropriate. A report to JCHC would be due by November 2008.

No public comments were received regarding proposed policy options.

JCHC Staff for this Report
Stephen W. Bowman
Senior Staff Attorney/Methodologist

Health Care Costs

Presented to the:
Joint Commission on Health Care

October 26, 2007

Stephen W. Bowman
Senior Staff Attorney/Methodologist

Background: Health Care Costs Study

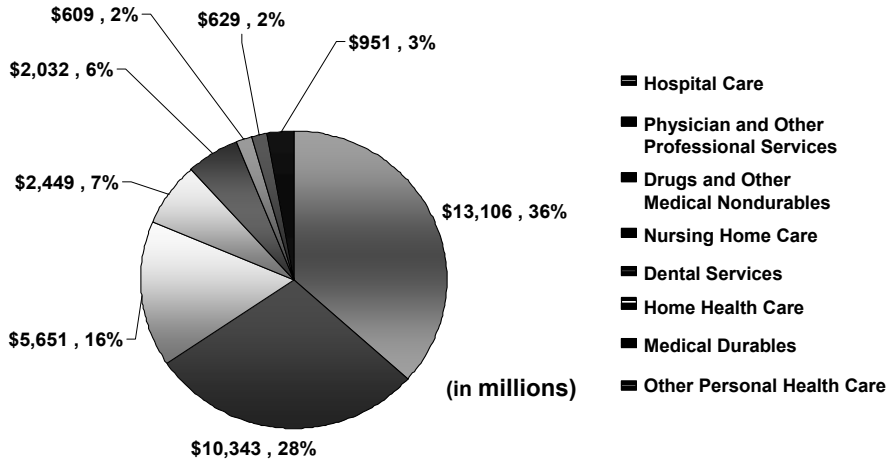
- Senate Joint Resolution 4 (Senator Reynolds) directed JCHC to ”study the derivative effects of increases in health care costs on health insurance premiums” and to examine:
  - “Factors leading to rising health care costs in the Commonwealth”
  - “Derivative effects of rising health care costs including 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 report was presented to JCHC on October 19, 2006 however specific findings were delayed until 2007

Health Care Costs Continue to Rise

- HC spending has increased at an average rate of 9.8% since 1970
  - Annual HC spending
    - 1970 - $75 billion
    - 2005 - $2.0 trillion
    - 2015 - $4.0 trillion

Source: Kaiser Family Foundation, *How Changes in Medical Technology Affect Health Care Costs*, March 2007

2004 Total Health Care Expenditures in Virginia $35.8 Billion



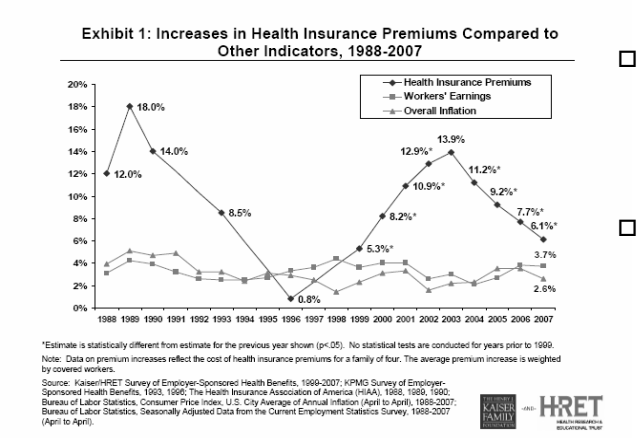
Source: Kaiser - Statehealthfacts.org, *Virginia Expenditures*, last accessed April 9, 2007

Health Care Costs Are Not Equally Distributed Across the Population

- Health Care Costs from 1970-96
  - 10% of the population accounts for 70% of the costs
  - 50% of population accounted for 3% of the costs
- Common conditions among the highest-cost 10% of the population
  - Ischemic heart disease, cancer, diabetes, hypertension, pulmonary conditions, mental disorders, and trauma
  - Repeated hospitalizations for same illness

Bodenheimer and Fernandez, *High and Rising Health Care Cost - Part 4: Can Costs be Controlled While Preserving Quality*, Annals of Internal Medicine Vol . 143:1, July 2005.

Health Insurance Premiums Continue to Rise



- Premiums are rising at a slowing rate
- Rate of increase is still greater than workers' earning increases

Sources: Kaiser Family Foundation and Health Research Educational Trust, *Employer Health Benefits* (2007)
Catlin, et al., *National Health Spending In 2005: The Slowdown Continues*, Health Affairs 26 (1): 142 (2007)

Premium Growth Continues to Exceed Increases in Inflation and Worker Earnings

2006

- Insurance premiums increased 6.1%
  - Lowest percentage increase in premiums since 1999
- Average annual premium for all types of health insurance plans
  - Single coverage was $4,479
  - Family coverage was $12,106
- Employee % of premium payment
  - 16% for Single coverage
  - 28% for Family coverage

Average Annual Premiums (Paid by Employer and Worker)		
Plan Type	Single Coverage	Family Coverage
PPO	$4,638	$12,443
HMO	$4,299	$11,879
POS	$4,337	$11,588
HDHP/SO	$3,869	$10,693

Source: KFF/HRET *2007 Employer Health Benefits Survey*.

Employers' Health Insurance Offerings

In 2006, 60% of firms offered Health insurance down from 69% in 2000

2006

- Approximately 77% of covered employees that pay 0% - 50% of premium costs
- 6% of covered workers are in firms that vary contribution based on worker wellness participation
  - 3% in 2005.

# Employees	% Offering Health Benefits in 2006
3 to 9	45%
10 to 24	76%
25 to 49	83%
50 to 199	94%
200 or more	99%
All Firms	**60%**

Source: KFF/HRET *2007 Employer Health Benefits Survey*.

Virginia Has Some of the Least Expensive Small Group Health Plans in the Nation

- Virginia premiums for all small groups
  - $246 for single monthly premium average
  - $645 for family monthly premium average
- United States premiums for all small groups
  - $311 for single monthly premium average
  - $814 for family monthly premium average
- Virginia's small group health plan premiums were ranked 3rd most inexpensive in the U.S.

Source: American Health Insurance Plans' Center for Policy and Research, *Small Group Health Insurance in 2006*, September 2006.

Effect of Rising Health Care Costs on the Market

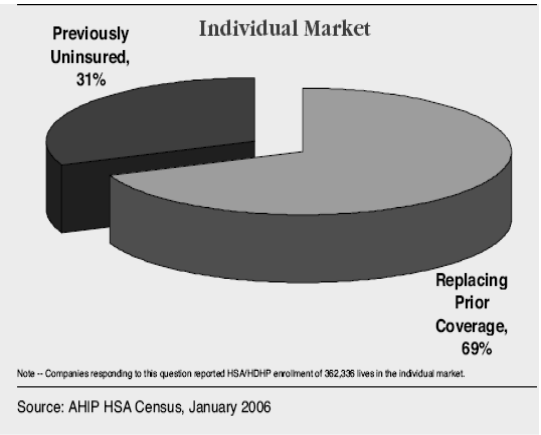
- Consumer-Directed Health Plans (CDHPs) are increasingly popular
  - Combines a high-deductible health plans (HDHP) with a tax-advantaged health reimbursement account or health savings account (HSA)
  - Offered more by employers
  - Expected to lower health care utilization
  - Have some drawbacks such as:
    - Reduced % of low-income adults who sought highly effective care for acute conditions
    - Associated with worse blood-pressure control and less preventative measures

Sources: United States Government Accounting Office, *Consumer-Directed Health Plans*, 514, April 2006. Thomas H. Lee, M.D., and Kinga Zapert, Ph.D. , *Do High-Deductible Health Plans Threaten Quality of Care?,* New England Journal of Medicine, 353:12 September 22, 2005

HSA/HDHP Encourage the Uninsured to Purchase Health Insurance Policies

HSA/HDHP policies that were for previously uninsured:

- 33% of small firms policies
- 31% for individual plans



Source: America's Health Insurance Plans, *HSAs and Account Based Health Plans*, June 2006.

Efforts to Reduce Costs

Health Insurers

- Disease management
- Wellness programs
- Information technology
- Identifying the chronically ill
- Increased consumer responsibility

Employers

- Encourage healthier lifestyles
- Provide information about quality health care to employees
- Provide information about generic drugs
- Employees with unhealthy behaviors pay more

Providers

- Electronic medical records
- Develop systems to reduce medical errors
- Participate in programs that reward efficiency and quality

Sources: Kaiser Family Foundation, *Comparing Projected Growth in Health Care Expenditures and the Economy*, May 2006 & *"Survey of Executives Finds Health Costs up 12 %, With Effects on Hiring, Pay" Health Care Policy, Volume 13, Number 30, July 25, 2005.*

State Affordable Cost Strategies

Virginia

- ✓ 1. Pooled purchasing
  - ❑ HB761(2006)- Health Group Cooperatives
- ✓ 2. Consumer-driven plans - HSAs
  - ❑ Established in 2005
- ✓ 3. Examining insurance mandates
  - ❑ Special Advisory Commission on Mandated Health Insurance Benefits established in 1990

Source: Slide 15, *Health Care Costs & Spending: Latest State Strategies*, Richard Cauchi, NCSL, September 19, 2007

State Affordable Cost Strategies

Virginia

- ✓ 4. Decrease health care acquired infections
  - ❑ Virginia Improving Patient Care and Safety (VIPCS) established in 2000
  - ❑ July 1, 2008 hospitals will report certain types of infections
- ✓ 5. Cost transparency & disclosure
  - ❑ Virginia Health Information (VHI) established in 1996

Source: Slide 15, *Health Care Costs & Spending: Latest State Strategies*, Richard Cauchi, NCSL, September 19, 2007

Other State Affordable Cost Strategies

Mandating employers offer 125 plan with state insurance connector (Massachusetts)

125 plans offer employees to use pretax dollars toward health insurance

	w/o Plan	With Plan
Annual Income	$50,000	$50,000
Annual pre-tax Employee Contribution	$ 0	$ 3,000
Taxable Income	$50,000	$47,000
Estimated Taxes 38%*	$19,000	$17,860
Annual After-Tax Employee Contribution	$ 3,000	$ 0
Net Take Home Pay	$28,000	$29,140
Annual Savings from Pre-Tax Contributions	**$0**	**$ 1,140**

*38% comprised of 25% Federal + 5% State + 8% FICA/Medicare

Other State Affordable Cost Strategies

- Increasing the number of insured
  - Uninsured health care costs are partially paid for by the insured
  - Significant decrease of the uninsured is expected to decrease insured health care costs due to less subsidization of the uninsured

Virginia Reports Reviewed

- JLARC's Options for Extending Health Insurance to Uninsured Virginians
- Governor's Health Reform Commission's Roadmap for Virginia's Health

JLARC Options

- Allow small employers to utilize State employee or Local Choice health plans
  - Could make providing insurance more affordable and attractive by reducing premium and administrative costs
  - Could lead to higher premiums for State and Local Choice employees, increased administrative burden and costs for the State
    - Small employers would still incur substantial premium costs

Source: JLARC slide 41 *Options for Extending Health Insurance to Uninsured Virginians*, December 11, 2006

JLARC Options

- Establish a market exchange that small employers could designate as employer plan
  - Could encourage more small employers to offer health insurance because provides opportunity to offer pre-tax employer contribution without any administrative responsibilities
  - Elimination of administrative burden may not provide sufficient incentive to offer health insurance

Source: JLARC slide 42 *Options for Extending Health Insurance to Uninsured Virginians*, December 11, 2006

JLARC Options

- Expand Medicaid/FAMIS eligibility
  - Medicaid and FAMIS covered over 800,000 Virginians (2006); Expansion would:
    - Allow Virginia to cover more low-income individuals
    - Expand the use of federal matching funds
    - Add costs to the State
- Provide direct subsidies to low-income individuals to purchase health insurance
  - Fills gap between what some individuals can afford and the price of insurance
  - Requires substantial subsidy for individuals to engage
  - Adds costs to State

Source: *Options to Extend Health Insurance Coverage to Virginia's Uninsured Population*, JLARC, House Document 19 (2007)

JLARC Options

- Provide subsidies to small employers
  - Could provide tax through tax incentive or direct payment
  - Could require that employers contribute to employees health insurance
  - Would require substantial subsidy for small employers to engage
  - Would add costs to State

36% of Virginia's uninsured adults are full-time employees of business with less than 100 people

Source: *Options to Extend Health Insurance Coverage to Virginia's Uninsured Population*, JLARC, House Document 19 (2007)

Governor's Health Reform Commission Recommendations

- Create a private health insurance product for working uninsured Virginians and small businesses who have limited access to other health insurance options
  - Available to uninsured individuals who work for small employers that have not offered health insurance for at least the last 6 months
    - $50,000 capped health care insurance policy
    - $135 estimated monthly premium
    - Those under 200% of the Federal Poverty Level
      - 1/3 paid by employer
      - 1/3 paid by employee
      - 1/3 paid by Commonwealth
    - Individuals over 200% FPL can purchase w/o VA contribution
    - Estimated cost $20,000,000

Source: Governor's Health Reform Commission, *Roadmap for Virginia's Health*, September 2007.

Governor's Health Reform Commission Recommendations

- Health IT Council to assist VHI in developing a consumer-friendly portal for all Virginians.
  - VHI would be a health care information clearinghouse that includes information on:
    - Quality
    - Pricing
    - Health Literacy
  - Estimated cost to create the portal is $454,750 over a 3 year period
    - Does not include marketing plan or insurer information

Source: Governor's Health Reform Commission, *Roadmap for Virginia's Health*, September 2007.

Policy Options

Policy Options

Option 1: Take no action

Option 2: Request by letter of the Chairman that the Joint Commission convene a workgroup to develop a plan i) for establishing a Virginia Health Insurance Exchange targeted for small businesses, ii) for increasing employer adoption of Section 125 plans, and iii) any other health insurance issues as deemed appropriate. A report to JCHC would be due by November 2008

- Workgroup will include:
  - Bureau of Insurance
  - Health insurance brokers
  - Health insurers
  - Small business employers

Public Comments

- Written public comments on the proposed options may be submitted to JCHC by close of business on November 5, 2007. However, to ensure comments are included in the preliminary matrix draft that will be distributed to JCHC members prior to the meeting, the comments must be received by close of business November 1st.

- Comments may be submitted via:
  - E-mail: sareid@leg.state.va.us
  - Fax: 804-786-5538
  - Mail: Joint Commission on Health Care
    P.O. Box 1322
    Richmond, Virginia 23218

- Comments will be summarized and presented to JCHC during its November 8th meeting.

Joint Commission on Health Care

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