REPORT OF THE
JOINT COMMISSION

STUDY OF THE INDIGENT/UNINSURED PURSUANT TO SJR 298 OF 1997

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 43

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RICHMOND
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Preface

Senate Joint Resolution (SJR) 298 of the 1997 Session of the General Assembly directed the Joint Commission on Health, in cooperation with the Department of Health, the Department of Medical Assistance Services, the Commonwealth's academic health centers and other public and private entities, to study the provision of health care for the indigent and uninsured. A copy of SJR 298 is provided at Appendix A.

Our work on this study began with a detailed analysis of the 1996 Health Access Survey on the Insurance Status of Virginians. This survey, which was sponsored by the Virginia Health Care Foundation, generated useful information regarding the insurance status of Virginians and provided an important base of knowledge regarding Virginia's indigent and uninsured population. An analysis of the survey data is presented in Appendix B.

Chapter One of this document includes an analysis of the various programs undertaken in Virginia and other states to serve the indigent and uninsured, and identifies additional initiatives that Virginia should consider as a means of assisting the indigent and uninsured population. Based on our research and analysis, we concluded the following:

- The 1996 survey on the insurance status of Virginians indicates that approximately 858,000 Virginians (13% of state population) are uninsured. The cost of health insurance was the most frequently cited reason for being uninsured. As expected, lower income persons make up a greater percentage of the uninsured population than higher income persons. Fifty-one percent of the uninsured are in families whose annual income is less than $20,000 per year. Thirty-seven percent of Virginia's uninsured population have family incomes that are at or below the federal poverty level. Nineteen percent of children, ages 0-19, are uninsured. Of this number, approximately 82,300 are eligible for Medicaid, but are not enrolled in the program.

- In comparing the 1996 survey results with a similar survey conducted in 1993, we found that while the total number of uninsured persons has remained relatively constant, the demographics of the uninsured population have changed in several ways. Specifically, our analysis of the 1993 and 1996 survey data showed that there was: (i) a substantial increase in the percentage of the uninsured who earn more than $50,000 per year; (ii) a significant decrease in the percentage of the uninsured who are African-Americans; and (iii) a significant increase in the percentage of the uninsured who are employed full-time.

- Programs that seek to improve access to care for the indigent and uninsured include public sector programs, private sector programs, and public-private partnerships. These programs typically involve strategies which either: (i) subsidize or improve access to health insurance; or (ii) provide or improve access to health care services.

- Virginia has enacted various laws and implemented a number of programs and other initiatives geared toward improving access to insurance and health care services for the indigent and uninsured, including: (i) small group and individual health insurance market reforms; (ii) Medicaid expansions for children and pregnant women; (iii) subsidies to offset uncompensated care losses in private acute care hospitals; (iv) collaborative health care projects sponsored by local health departments; and (v) the creation of the Virginia Health Care Foundation.

- The Commonwealth should consider implementing the following as additional strategies for further improving access to insurance and health care: (i) outreach programs to enroll the estimated 82,300 children eligible for, but not enrolled in Medicaid; (ii) pooled purchasing arrangements for health insurance for small employers and individuals; (iii) a Medicaid expansion to cover additional children and/or pregnant women; (iv) further health insurance market reforms; and (v) additional funding or other support to various programs (e.g., the Virginia Health Care Foundation, Free Clinics and Community Health Centers) providing care to the indigent and uninsured.

A number of policy options were offered for consideration by the Joint Commission in addressing the above issues. These policy options are discussed on pages I-35 through I-37 and II-29 through II-31.

Chapter Two of this report addresses a number of issues regarding the indigent and uninsured; however, the most significant issue is the State Children's Health Insurance Program (SCHIP). The SCHIP, which was established in the federal Balanced Budget Act of 1997, provides funding to states to provide health insurance coverage to uninsured children in families with incomes up to 200% of the federal poverty level (FPL). States must provide matching funds to receive the federal dollars. Virginia can receive up to $68.7 million in federal funds per year provided $35.4 million in state matching funds is appropriated.

Much of the analysis regarding this program occurred after the body of this report was written. Also, this program was the focus of considerable debate during the 1998 Session of the General Assembly. The following paragraphs summarize the actions taken by the General Assembly and the Governor to implement the SCHIP.

Following detailed staff analysis of the SCHIP, two public comment periods, and a public hearing, the Joint Commission introduced legislation (Senate Bill 433/House Bill 1074) which authorizes the implementation of SCHIP for children in families with incomes up to 200% of the FPL in accordance with conditions set forth in the Appropriation Act. While the General Assembly passed SB 433 and HB 1074, the Governor vetoed both bills.

However, the Governor has committed to implementing Virginia's children's health insurance program in accordance with language included in the Appropriation Act. The budget language requires a Medicaid expansion for children in families with incomes up to 150% of the FPL and a separate program, using Medicaid benefits and income methodologies, for children in families with incomes between 150% and 185% of the FPL. Families with children in the separate program would be required to pay premiums and co-payments on a sliding fee scale.

Virginia's child health initiative is expected to provide health insurance to a total of 83,360 children by fiscal year 2000. Of this total, an estimated 50,560 children will be enrolled in the new SCHIP component. The remaining 32,800 are children who currently are eligible for but not enrolled in Medicaid. These children are expected to be enrolled in Medicaid as a result of the outreach efforts associated with SCHIP. Implementation of this program will have a major impact in reducing the number of uninsured Virginians.

In conducting this study on Virginia's uninsured and indigent population, our review process included three separate staff briefings, which are incorporated in the body of this report, followed by a public comment period. In many cases, the public comments, which are summarized at the end of this report, provided additional insight into the various topics covered in this study. Another integral part of our review process for this study was the establishment of a Joint Commission Subcommittee. The Subcommittee, which met three times, reviewed the study findings, conclusions and policy options and made recommendations to the full Commission.

Jane N. Kusiak
Executive Director

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CHAPTER ONE
I.
Authority for Study

Senate Joint Resolution (SJR) 298 of the 1997 Session of the General Assembly directs the Joint Commission on Health Care, in cooperation with the Board of Health, the Department of Health, the Board of Medical Assistance Services, the Department of Medical Assistance Services, the Commonwealth's academic health centers, and various governmental entities to study the provisions of health care for the indigent and uninsured. The resolution also directs the Joint Commission to confer with local governments, the Virginia Health Care Foundation, the Virginia Indigent Health Care Trust Fund Technical Advisory Panel, the Virginia Primary Care Association, and other appropriate public and private entities regarding various issues related to the provision of health care for the indigent and uninsured.

Specifically, SJR 298 directs the Joint Commission to:

(i) analyze the recently completed survey on the insurance status of Virginians;
(ii) evaluate the underlying reasons for persons being uninsured;
(iii) assess the impact of not-for-profit to for-profit hospital conversions may be having on the indigent and uninsured;
(iv) analyze the impact that the provision of care for these populations has on individual providers and hospitals, particularly the academic health centers;
(v) assess the role that projects supported by the Virginia Health Care Foundation and the Virginia Indigent Health Care Trust Fund play in meeting the needs of the uninsured;
(vi) evaluate the appropriateness of expanding Medicaid coverage to certain segments of the uninsured population;
(vii) analyze the accessibility to child health preventive services;
(viii) analyze the cause, prevalence and impact of the inability of indigents to purchase prescribed medications; and
(ix) analyze whether subsidies to purchase private health insurance should be implemented.

A copy of SJR 298 is provided at Appendix A.

II.
Background and Organization of Report

The SJR 298 Study Was Conducted In Three Phases

This study was conducted and presented to the Joint Commission in three phases. The Phase I report was presented at the June 3rd Joint Commission meeting, and included an analysis of the results of a survey of the insurance status of Virginians, which was conducted in the Fall of 1996. The Phase I report is provided in Appendix B.

The Phase II report was presented at the July 2nd Joint Commission meeting. The Phase II report identifies: (i) the various actions and programs that other states have implemented to reduce the number of uninsured persons; (ii) the steps Virginia has taken to address its indigent and uninsured populations; and (iii) additional actions that the Commonwealth should consider as it continues its efforts to expand coverage to the uninsured and ensure access to appropriate health care services. These issues are addressed in this Chapter.

The Phase III report was presented at the August 5th Joint Commission meeting and addresses the following issues: (i) the key health-related provisions of the Federal Balanced Budget Act of 1997, including the State Children's Health Insurance Program; (ii) the Virginia Children's Medical Security Insurance Plan (House Bill 2682, 1997) as enacted by the 1997 Session of the General Assembly; (iii) the Indigent Health Care Trust Fund and the State and Local Hospitalization Program; (iv) the impact that not-for-profit to for-profit hospital conversions may be having on the indigent and uninsured; (v) the cause, prevalence and impact of the inability of indigents to purchase prescribed medications; and (vi) an analysis of whether certain graduate students in Virginia colleges and universities should be permitted to purchase health insurance coverage through the state employees' health benefits program. These issues are addressed in Chapter Two.

III.
Strategies/Programs To Reduce The Number Of Uninsured Persons And Provide Access To Care

Approximately 858,000 Virginians Are Uninsured

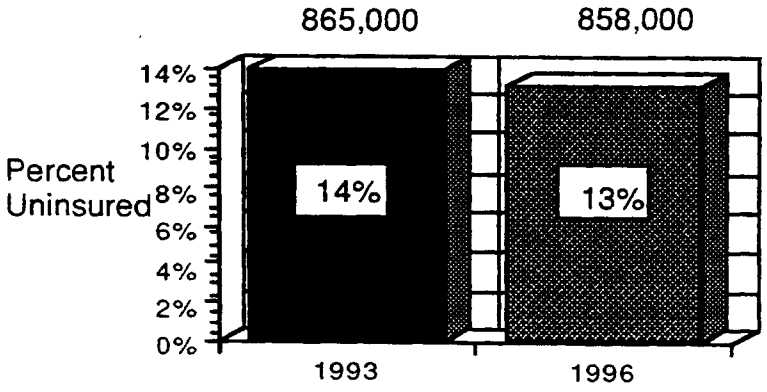
As previously noted, a comprehensive survey of the insurance status of Virginians was completed in the Fall of 1996. The survey was sponsored by the Virginia Health Care Foundation and conducted by Virginia Commonwealth University's Survey Research Laboratory.

As seen in Figure 1, the survey found that approximately 858,000 Virginians, or 13% of the total population, are uninsured. The total number of uninsured persons has remained relatively constant since 1993 (865,000, 14% of total population) when the last statewide survey was conducted. However, the 1996 survey uncovered some significant changes in the composition of the uninsured population. Also, for the first time, the survey identified the main reasons why persons are uninsured. Appendix B includes a detailed analysis of the survey results.

Figure 1

Virginia's Uninsured Population:

1993 and 1996



Source: JCHC Staff Analysis, 1993 and 1996 Health Care Access Surveys

Improving The Availability and Affordability Of Health Insurance For The Uninsured Continues To Be A Perplexing Public Policy Issue

During the past decade, finding ways to improve the availability and affordability of health insurance coverage for the uninsured has been a perplexing public policy issue at the national, state, and local government level. At the national level, major expansions of Medicaid eligibility have provided insurance coverage for greater numbers of pregnant women and children, as well as the elderly and disabled. President Clinton's national health reform proposal brought the issue of providing health insurance to all Americans to the forefront of national debate. However, the President's plan, as well as several other Congressional proposals, were not adopted.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, often referred to as the Kassebaum-Kennedy health care reforms, included a number of insurance reforms aimed at making coverage more available to individuals purchasing coverage for themselves and for small groups. Congress also passed the State Children's Health Insurance Program which will expand insurance coverage to millions of uninsured children in low-income families across the country.

While there has been increasing attention on the uninsured at the federal level, it has been the individual states which have taken the lead in trying to reduce the number of uninsured persons and provide access to appropriate health care services. It has been at the state level where the most extensive and innovative programs have been developed and implemented. As will be discussed in the following sections of this report, there has been varying success among the state programs in reducing their respective uninsured populations. Other programs have not been successful, and have been abandoned. Reviewing the types of programs implemented in other states and assessing their respective success or failure is instructive for Virginia as it moves forward in addressing this critical public policy issue.

Programs For The Uninsured Are Implemented As Public-Only Programs, Private Sector Programs, or Public-Private Partnerships

A wide range of state programs has been implemented across the country to address the uninsured issue, and can be classified or categorized in various ways. One fundamental way of categorizing these programs is by who sponsors the program in terms of financing, administration, and operation of the program. Within this context, there

are essentially three models: (i) public-only programs; (ii) private sector programs; and (iii) public/private partnerships.

Public-Only Programs: In the "public-only" model, the program/initiative is sponsored entirely by a governmental entity, either federal, state, or local, or a coordinated effort among two or more governmental levels. An example of a "public-only" model is the Medicaid program and the expansions that many states have implemented.

Private Sector Programs: In the private-sector model, a private entity sponsors the program and provides either funding, in-kind services (e.g., administrative services), direct health care services or a combination of services/support. A successful example of this type of program is the Caring Program for Children begun in the late 1980s by Blue Cross of Western Pennsylvania. This program, which has been replicated in 23 other states, subsidizes coverage for low-income children who are not eligible for Medicaid and do not have employer-based coverage. In most cases, Blue Cross Blue Shield plans donate administrative services and provide some matching funds. Remaining funds usually are raised from donations by charities, businesses, and community organizations.

Public-Private Partnerships: A number of the programs addressing the uninsured fall within the "public-private partnership" model where government (usually state or local government) and the private sector collaborate on the program. In many of these programs, the financing, administration and operation of the program are shared among the governmental entity and one or more private sector entities. Examples of this model can be found in many states, including Virginia. The Virginia Health Care Foundation (VHCF), which is supported financially by the Commonwealth and which obtains matching private funds, is an excellent example. The VHCF provides grants to different programs across the state and works with a variety of public and private entities to improve access to care for the indigent and uninsured.

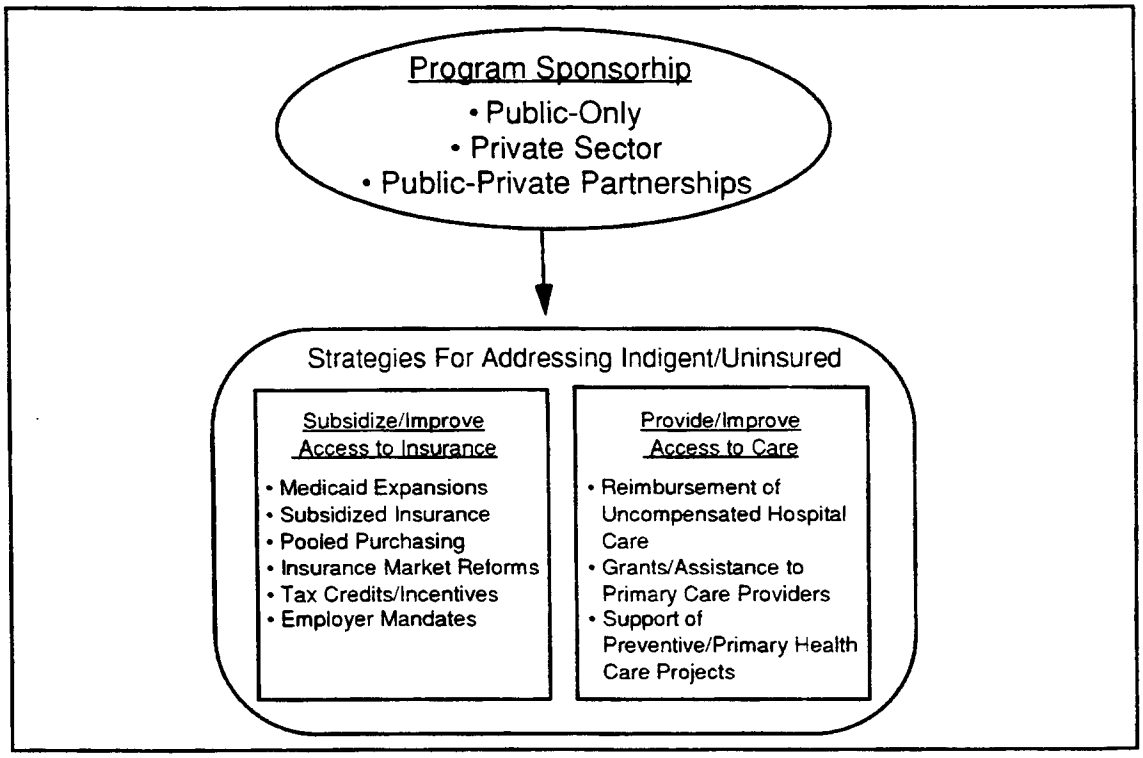
Strategies/Programs For The Uninsured Can Be Categorized Broadly As Efforts To: (I) Subsidize Or Improve Access To Insurance Coverage; Or (II) Provide Health Care

Within the conceptual framework of whether a program is "public-only," "private sector," or a "public-private partnership," efforts to address the uninsured issue can be broadly categorized as either: (i) subsidizing or improving access to insurance coverage for the uninsured;

or (ii) providing care to the indigent/uninsured. Within these two broad categorizations, there are a number of different strategies/programs that have been tried by various states, including Virginia. Figure 2 illustrates the conceptual framework of states' efforts to address the uninsured.

Figure 2

Conceptual Framework Of Programs To Address The Indigent/Uninsured



The following paragraphs describe the specific types of strategies/programs employed by the states; identify which states have adopted the various approaches; and assess the relative successes/failures of the programs.

Programs Designed To Subsidize Or Improve Access To Health Insurance Include Medicaid Expansions, Premium Subsidy Programs, Pooled Purchasing, Insurance Market Reforms, And Tax Incentives/Credits. Medicaid Expansions Have Been Implemented By Numerous States

Medicaid Expansions; Pregnant Women and Infants: Expanding Medicaid coverage to persons beyond federal requirements has been one of the more popular strategies employed by the states for reducing the number of persons who are uninsured. Currently, federal law requires states to provide Medicaid benefits to all pregnant women and infants in families with income below 133% of the federal poverty level (FPL) (maximum level is 185%). As of 1996, 34 states had expanded Medicaid for pregnant women and infants beyond the federal minimum level. Specifically, one state expanded its Medicaid coverage to include pregnant women and infants in families with income up to 140% of the FPL; in five states, coverage was expanded up to 150% of the FPL; 22 states expanded coverage up to 185% of the FPL; and five states expanded coverage up to incomes ranging from 200 to 300% of the FPL. (These states receive a waiver to apply different income disregards.) In Virginia, Medicaid coverage for pregnant women and infants is at the federal minimum level of 133% of the FPL.

Medicaid Expansions; Children Under Age 6: For children under age 6, 11 states have expanded their income eligibility beyond the minimum 133% of the FPL. One state increased its income eligibility to 150% of the FPL; six states raised their income limit to 185% of the FPL; and four states expanded their income eligibility to amounts between 200 and 300% of the FPL. (In Virginia, Medicaid coverage for children under age 6 is at the federal minimum level of 133% of the FPL.)

Medicaid Expansions; Children Ages 6-13: Current federal law requires states to provide Medicaid coverage to children ages six to 13 in families with incomes below 100% of the FPL. Each year, a new group of children is phased in so that all children below age 19 in families with incomes below 100% of the FPL will be eligible for Medicaid. As of 1996, Virginia was one of 19 states which had expanded its age eligibility beyond the federally required age 13. (Rather than phase-in a new age group each year, Virginia expanded its eligibility to age 19 all at once.)

In addition to expanding the age eligibility, 11 states increased the income eligibility for children ages 6-13. One state increased its income eligibility to 125% of the FPL; another state expanded up to 150% of the FPL; five states raised their income limit to 185% of the FPL; and three states expanded their income eligibility to amounts between 200% and 300% of the FPL. One state expanded its income eligibility only for children ages 6 and 7 to 250% of the FPL. (In terms of income eligibility, Virginia's Medicaid eligibility is set at the federally required minimum of 100% of the FPL.)

Appendix C provides a state-by-state listing of the current Medicaid expansions that have been implemented across the country.

Broad Medicaid Expansions For Other Low-Income Adults and Children: Within the past several years, seven states have implemented programs to expand coverage to other low-income children and adults after having received approval from the federal government to waive federal Medicaid rules under Section 1115 of the Social Security Act. Oregon and Tennessee were the first states to be granted Section 1115 waivers. Additionally, Delaware, Hawaii, Minnesota, Rhode Island, and Vermont have implemented waiver programs. Other states (Florida, Kentucky, Massachusetts, and South Carolina) have received Section 1115 waivers, but have not implemented the programs yet. Another four states, Illinois, Maryland, Ohio and Oklahoma, have received waiver approvals, but their programs do not expand coverage.

While the Medicaid expansion programs implemented in the seven states are diverse in many respects, most expand coverage to low-income adults and children. Delaware, Oregon, and Vermont limit their programs to those with incomes below 100% of the FPL; however, Hawaii, Minnesota, and Tennessee permit much higher incomes (300%, 275% and 400%, respectively). For the most part, premium subsidies are paid on behalf of enrollees depending on their income. Persons with higher income levels receive lower subsidies, and pay a greater portion of the premium.

Enrollment statistics collected in 1996 for six of the seven programs indicate varying degrees of success in terms of reaching their intended target populations. In 1996, Oregon had the highest "penetration rate," and covered 64% of those eligible for the program. Oregon's uninsured population has decreased from 18% in 1990 to 11% in 1996. MinnesotaCare covered about one-half of its intended population, while Hawaii covered around 40%. Delaware (34%), Tennessee (26%), and Vermont (22%) covered less of their target populations. (Lipson and Schrodel, 1996).

While these states received federal funds to support their broad Medicaid expansions, such expansions are very costly to the states. Some states have had to impose enrollment freezes and restrictions on eligibility to maintain the program. In addition, Massachusetts, Oregon and Vermont recently enacted major tobacco tax increases to fund their waiver programs.

Potential for "Crowd-Out": As eligibility for Medicaid increases and persons with higher incomes become eligible for benefits, the potential for "crowd-out" increases. "Crowd-out" occurs when persons covered under private insurance drop their private coverage to take advantage of free or lower cost coverage under Medicaid. Another type of "crowd-out" is when employers discontinue offering coverage because employees become eligible for Medicaid. Some researchers point to recent declines in the availability of employer-based coverage as evidence that "crowd-out" is occurring. Estimates of the degree to which "crowd-out" actually is occurring vary and there is little agreement on the true impact of this phenomenon.

Eight States Have Implemented Premium Subsidy Programs Outside Of Their Medicaid Programs To Assist Uninsured Persons Purchase Private Coverage

In addition to the seven states which have implemented broad Medicaid expansions under Section 1115 waivers, eight states have implemented "state-only" subsidized insurance programs for the uninsured. The eight states are: California, Colorado, Florida, Massachusetts, New Jersey, New York, Pennsylvania, and Washington. A total of 10 programs have been implemented as Massachusetts and New York each have implemented two programs: a children only program and a program for adults. The two key differences between these states' programs and the Medicaid expansions are that: (i) no federal/Medicaid funds are involved; and (ii) there is no entitlement to the benefits offered through the program.

While the specifics of each state's program vary in many respects, there are some common characteristics: (i) subsidies are targeted to low-income persons not eligible for Medicaid; (ii) premiums are subsidized according to the enrollee's income; and (iii) enrollment is either capped or subject to available funds.

Eligibility: In some states, eligibility is limited to low-income persons. In other states, higher income persons can enroll, but are not provided a premium subsidy. Six programs are designed only for children (one of which also includes infants and mothers). Examples of children only programs include Florida's "Healthy Kids" program, Massachusetts' "Children's Medical Security Plan," and New York's "Child Health Plus" program. The remaining four include both children and adults.

Benefits: The benefits in seven of the ten programs provide comprehensive coverage, while the remaining three programs provide limited coverage. The three "limited" benefits plans are children-only programs which provide primary and preventive care, and do not include inpatient care.

Subsidies: There is substantial variation in the subsidies provided by the programs. Of the 10 programs, four provide full subsidies (i.e., no enrollee contribution) for persons in the lowest income brackets. All 10 provide partial subsidies for some or all enrollees; and three of the 10 programs allow higher income persons to enroll, but do not provide a premium subsidy. It is clear from the experience of all ten programs that the level of subsidy is critical to the success of the program. Without a substantial subsidy, particularly among lower-income persons, enrollment is quite limited. One recent study concluded that "as premiums consume an increasing share of income, participation declines." When enrollees' premiums are low (1-3% of income), participation rates range from a third to nearly 60% of all those eligible. At 5% of income, participation rates drop below 20%. (Ku and Coughlin, 1997).

Financing: It comes as no surprise that the biggest challenge for states in developing and maintaining a state-subsidized insurance program is raising the revenue necessary to sustain the program. While nearly all of the programs require enrollees to share in the financing through premium contributions, the states assume the majority of the financing burden. States have raised funds from a variety of sources. In Washington, the majority of funds come from taxes on alcohol and tobacco. Minnesota and, to a lesser degree, Washington, use provider taxes.

Estimated Penetration Rates: Gauging the impact that these state-subsidized insurance programs have on the uninsured population is difficult to measure. Administrative factors such as available financing, marketing and enrollment play an important role in determining the success of the program. However, one method of measuring a program's impact is to estimate the percentage of the target population that the program has enrolled (i.e., a penetration rate). Based on 1995 data, the penetration rates ranged from 3% for New Jersey's Health Access Program to 48% for the New York Child Health Plus Program. The other programs' penetration rates generally fell within the 10-20% range. (Lipson and Schrodel, 1996.)

While these programs have had varying success in enrolling uninsured persons, each state still has a significant uninsured population.

Limiting The Potential For Crowd-Out: As with Medicaid program expansions, the potential for "crowd-out" exists for state-only premium subsidy programs as well. To minimize the impact of this phenomenon, states often: (i) require that enrollees in subsidized programs be ineligible for other coverage; and/or (ii) require that they be uninsured for a given period of time prior to enrollment.

Pooled Purchasing Or "Purchasing Cooperatives" Have Been Implemented To Improve The Availability And Affordability Of Coverage For Small Businesses And Individuals

At least 20 states have enacted laws to establish state-sponsored health insurance purchasing pools or to encourage the development of private pools. (Lipson, 1997.) Typically, small employers and individuals: (i) pay higher administrative costs, (ii) are considered a higher risk by carriers because of the small number of persons to "spread" the cost of a large claim, and (iii) are in a much weaker negotiating position with carriers than large groups who represent a larger portion of the carrier's book of business. As a result, small groups and individuals typically pay higher rates than larger groups for the same level of coverage. For some, the higher rates result in a decision not to purchase coverage at all.

Purchasing pools seek to "pool" the purchasing power of small groups and individuals such that they can enjoy many of the purchasing advantages of larger groups. In a purchasing pool or cooperative, many of the administrative functions are centralized which reduces overhead costs; claims are spread over a larger group which reduces the burden that any one group has to absorb; and the task of researching and selecting a health insurance plan is simplified by virtue of the cooperative making the purchasing decisions.

State pooling strategies vary widely according to a number of key factors, including: (i) the pool's market area, (ii) the number of cooperatives in each state, (iii) financing, (iv) existing state insurance market reforms, (v) administrative functions performed by the cooperative vs. participating groups, (vi) whether the choice of plans is at the employer or employee level, (vii) the role of insurance agents and brokers, and (viii) whether individuals are eligible to participate. Most of the purchasing cooperatives include only small groups up to 50 employees; however, some allow any sized group to participate.

California and Florida Are Examples of Successful Purchasing Cooperatives: The Health Insurance Plan of California (HIPC) has been one of the most successful purchasing cooperatives. The HIPC provides coverage to groups between 2 and 50 employees. As of March, 1997, the HIPC provided coverage to over 6,600 groups and a total of 124,200 covered lives. For the purposes of this study, perhaps the most significant statistic regarding the HIPC is that 20% of its existing groups were uninsured prior to joining the cooperative.

In Florida, 11 regional Community Health Purchasing Alliances (CHPAs) have been formed that enroll small businesses, state employees and some Medicaid enrollees. The 11 CHPAs have enrolled over 16,600 groups and a total of 74,400 covered lives across the state.

The Kentucky Health Purchasing Alliance: The Kentucky Health Purchasing Alliance combines both public and private employees in its cooperative. The public employees include state (mandatory participation), local government (voluntary), and university employees (voluntary). Private small employers (2-50 employees) and individuals also may participate. The vast majority of the 317,000 enrollees are state and local government employees (280,000). Approximately 21,000 enrollees are in small employer groups and the remaining 16,500 are individuals. Kentucky has used the financial stability and size of its state and local government health insurance program to allow private employers and individuals into the group. These persons realize substantially enhanced purchasing power by participating in the alliance.

Some Purchasing Cooperatives Have Not Been Successful

While there have been successful cooperatives, there also have been programs which have been discontinued due primarily to adverse selection of high risks into the cooperative. One of the greatest risks to a successful purchasing cooperative is that a disproportionately large number of high risk groups and individuals will enroll in the cooperative because it is the least costly or only place to obtain health insurance. When this occurs, the cooperative must raise its rates, often higher than the rates that the better risk groups could get in the market on their own. The result is that the better risk groups disenroll leaving behind a higher percentage of poor risks, which begins a spiral of higher and higher premium rates.

While some design features can limit the amount of adverse risk selection to the cooperative, the best way to protect a purchasing

cooperative from adverse selection is to apply the same underwriting reforms and other rating requirements to small group policies sold both inside and outside of the cooperative. In short, the rule is "don't require the cooperative to meet requirements or rules that do not apply to the rest of the health insurance market."

Most States, Including Virginia, Have Enacted Health Insurance Market Reforms To Improve The Availability And Affordability Of Coverage For Small Groups And Individuals

Nearly all states have enacted some degree of health insurance market reforms aimed at improving the availability and affordability of coverage for those persons who traditionally have had the most difficulty obtaining insurance, namely small groups and individuals. The reforms are designed to prevent health insurers from selecting healthy groups and individuals which segments the market, and leaves out the higher risk groups and individuals who become too expensive to insure.

The major reforms enacted across the country include the following.

- **Rating Restrictions** limit the variation in premiums that insurers can charge for the same coverage. These restrictions often set limits on the premiums that can be charged higher risk groups. A common rating restriction is "community rating" either in a pure or modified form. Community rating takes the insurance risk of a given individual or small group and spreads it across a larger number of persons or groups to moderate the premiums paid by persons with higher claims experience.
- **Guaranteed Issue** requires carriers to issue a policy to a group or individual regardless of the health status of the individual or group members.
- **Guaranteed Renewal** requires carriers to renew a policy to a group or individual regardless of the individual's or group's past claims or health status.
- **Pre-Existing Condition Restrictions** require carriers to limit the period of time that coverage can be excluded for a pre-existing condition. Many state laws limit the period of time to 12 months. Most states also require that carriers provide credit for waiting periods served by persons in previous coverage so that persons who maintain continuous coverage need only serve a total of 12 months, rather than multiple 12 month periods.

Health Insurance Portability and Accountability Act (HIPAA) of 1996: The passage of HIPAA requires that states enact a minimum set of insurance reforms similar to those outlined above, except rating restrictions. While HIPAA includes a number of important reforms, the absence of any rating reforms significantly limits the impact of the act.

Impact of Insurance Reforms Is Unclear: While the insurance reforms enacted across the country have improved the affordability and availability of coverage for some, it is difficult to identify any clear impact that these laws have had on reducing the number of uninsured persons.

A Handful Of States Have Implemented Tax Incentives/Credit Programs To Encourage Persons To Purchase Coverage; Most States Have Discontinued These Programs

Providing tax incentives or credits to small employers or individuals as a means of encouraging them to purchase health insurance benefits has been tried in at least five states (Iowa, Oregon, Kentucky, Massachusetts, and California). Beginning in 1987, Oregon provided tax credits to small employers (25 or fewer employees) which had not offered health benefits for the previous two years. The program was discontinued in 1995 due to low enrollment levels.

Massachusetts authorized tax incentives to small employers from 1990 to 1992 to encourage them to provide coverage voluntarily (prior to the "play or pay" mandate that was scheduled to become effective in 1992 but was never implemented). The tax incentive program was discontinued in favor of a different employer tax credit program implemented in 1996.

California passed legislation in 1989 to authorize tax credits beginning in 1993 for employers with fewer than 25 employees. However, due to cost concerns, the law never became effective and was repealed in 1993. Kentucky enacted a tax credit law in 1990 for employers who previously did not provide coverage. The tax credit, which is available to firms of any size, is worth up to 20% of the employer's contributions to premiums in the first year, decreasing 5% each year until expiring at the end of the fourth year.

Only Iowa allows individuals to deduct health insurance premiums on their state income tax returns (beginning in calendar year 1996).

Only A Few States Have Attempted To Mandate That Employers Provide Health Insurance Coverage; For The Most Part, These Efforts Have Failed

Generally, states cannot require employers to provide health insurance coverage due to the Employee Retirement Income Security Act (ERISA). ERISA strictly limits states' ability to impose certain requirements on employee health benefits plans. However, Hawaii implemented an employer mandate after obtaining a Congressional exemption from ERISA. Hawaii requires employers to provide coverage for full-time employees (not dependents), and also requires employees to accept insurance from their employers, unless they receive coverage from another source. Hawaii provides funding support to small employers adversely affected by the mandate.

Massachusetts' "Play or Pay" Law: Massachusetts passed legislation in 1988 that required employers with six or more employees (working at least 30 hours per week) who did not provide health insurance coverage by 1992 to pay into a fund that would help subsidize coverage of uninsured workers. However, after delaying implementation of this law for several years, the law was repealed in 1996.

Oregon's "Play or Pay" Law: Oregon passed a similar "play or pay" law in 1989 requiring all employers to provide coverage to all permanent employees working more than 17.5 hours per week or pay into a state fund that would help pay for their coverage. The law was scheduled to go into effect in 1994; however, the 1993 legislature made the law contingent upon obtaining an ERISA waiver. The waiver was not received and the law sunset without having gone into effect.

Washington's Employer Mandate: In Washington, a state law required employers to pay at least 50% of the premium for full-time workers and their dependents on a phased-in schedule starting with large employers and phasing in smaller employers. The law provided subsidies for small employers of 25 or fewer employees. However, like Oregon, when an ERISA waiver was not received, the law was repealed.

Florida: In 1996, Florida passed legislation requiring small employers (fewer than 20) to allow former employees to purchase group coverage for 18 months similar to the federal COBRA provisions that applies to firms with greater than 20 employees.

Providing Subsidies Or Other Support To Health Care Providers Who Serve The Indigent/Uninsured Is Another Broad Category Of State Programs

As previously discussed, a second broad category of programs to improve access to care for the indigent and uninsured are those programs which provide subsidies or other support directly to the providers who deliver health care services to these populations. While much of what has been written about other states pertains to programs designed to increase the number of persons with health insurance, there are programs in every state that also provide assistance, financial or otherwise, to the providers who deliver care to the indigent/uninsured. Some programs provide state and/or local government support, while others are sponsored and funded by the private sector.

There are a number of different programs that fall within this broad category; however, the two most common types of programs are those which provide reimbursement to hospitals for uncompensated care and those which provide grants or other funding to primary care providers such as clinics, local health departments, etc.

Reimbursement of Hospitals' Uncompensated Care: The majority of states, including Virginia, have implemented some type of program to provide reimbursement to hospitals to help offset the amount of uncompensated care provided to indigent and uninsured persons. Most programs distribute funds to hospitals in proportion to the amount of uncompensated care that is provided. While hospitals do not receive enough reimbursement to offset fully their uncompensated care burden, these programs do provide an important revenue source for many hospitals who serve large indigent/uninsured populations.

Grants/Assistance To Primary Care Providers: In every state, there are programs which provide grants or other funding directly to providers who treat the indigent and uninsured. These programs typically include providing funds to community health clinics, school-based clinics, local health departments, mobile medical or dental clinics, primary care initiatives, immunization initiatives, and many other similar entities/functions. The overall goal of these programs is to increase the availability of primary care and preventive services for the indigent and uninsured and reduce the expensive and improper use of hospital emergency rooms.

Determining Which Approach (Enhancing Affordability And Availability Of Health Insurance Coverage, Or Providing Direct Support To Providers) Is Most Effective Is Difficult; A Combination Of Both Approaches Provides The Best Chance Of Addressing The Indigent/Uninsured Problem

It is difficult to know which broad category of approaches ensures the most effective use of a state's limited financial and other resources. Most experts agree that one strategy alone likely will not make significant in-roads into the problem of the uninsured. Rather, a combination of approaches, including making insurance more affordable and available to uninsured persons, and providing financial support to providers who deliver health care services to the uninsured, is needed.

It must be recognized that even those states which have implemented a multitude of approaches still have uninsured persons, some with significant numbers of uninsured persons. Nonetheless, a comprehensive and coordinated state effort can increase the number of persons with insurance and ensure the availability of health care services.

IV.
Strategies/Programs In Virginia To Address The Indigent/Uninsured

A Number Of Programs Have Been Implemented In Virginia To Address The Indigent/Uninsured Problem

In Virginia, a number of programs have been implemented to assist the Commonwealth's indigent/uninsured populations. Within the conceptual framework discussed earlier, there are both public-only programs as well as public-private partnerships. Virginia's efforts include initiatives to improve the affordability and availability of insurance coverage, and provide support to providers of care.

Virginia's Efforts To Improve Affordability And Availability Of Insurance Coverage Include A Medicaid Expansion, Pooled Purchasing, and Insurance Reforms

Medicaid Expansion: In addition to the Medicaid expansions required by the federal government, Virginia expanded eligibility for children under age 19 more quickly than required by federal law. The Omnibus Budget Reconciliation Act (OBRA) of 1990 required states to phase in coverage for children ages 6-18 in families with incomes at or below 100% of the FPL. Rather than phase-in additional children one age group at a time as allowed under OBRA '90, Virginia expanded up to age 18 in one program expansion.

Pooled Purchasing: Virginia has not implemented a broad based purchasing cooperative for small employers as described earlier. However, pursuant to §2.1-20.1:02 of the Code of Virginia, the Department of Personnel and Training (DPT) administers an optional health insurance program for local governments, constitutional officers, school divisions and other governmental entities which can elect to purchase their employee health benefits through the state employee program. The program is called THE LOCAL CHOICE (TLC).

TLC functions in many respects like a pooled purchasing arrangement in that the groups which join the program: (i) enjoy the purchasing power of a very large group; (ii) pay lower administrative expenses; (iii) experience greater stability in their premiums as the rates are calculated on a modified community rating basis (depending on the size of the group) which spreads the risk across a larger pool; (iv) are

relieved of the cost and time involved in procuring health plans; (v) have a greater selection of plans than that which could be purchased on their own; and (vi) receive administrative support from DPT and the participating health plans.

The program has been successful since its implementation in 1990 and is financially strong. Currently, there are 182 groups participating in TLC representing a total of 21,461 eligible employees. Participation in TLC has remained stable over the years, with many groups having participated since its inception.

Health Insurance Market Reforms: Like many states, Virginia has enacted a series of insurance market reforms aimed at improving the affordability and availability of coverage for small groups and individuals. Virginia had enacted a number of reforms over the past several years prior to the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. The 1997 Session of the General Assembly passed House Bill 2887 and Senate Bill 1112 to implement the federal reforms in Virginia. As a result of Virginia's earlier reform efforts and the implementation of HIPAA (effective July 1, 1997), Virginia's market reforms include the following:

- guaranteed renewability of all policies for all groups and individuals;
- limits on pre-existing condition waiting periods and credits for waiting periods served in previous coverage for all groups and individuals;
- no exclusions from any size group;
- guaranteed issue of all products, including the state-established Essential and Standard Plans for groups of 2-50 employees;
- modified community rating on the Essential and Standard Plans for groups with 2-25 employees; and
- guaranteed issue of all policies and no pre-existing condition exclusions for "eligible" individuals who have left group coverage, are not eligible for other coverage, and have exhausted any COBRA eligibility (effective January 1, 1998).

A Number Of Programs/Initiatives Have Been Implemented In Virginia To Subsidize Or Provide/Coordinate Care For The Indigent And Uninsured

Numerous statewide and local programs/initiatives have been implemented in Virginia to subsidize or provide care to the indigent and uninsured. To identify and describe every program would be too

voluminous for this report. However, the following represent the major programs/initiatives designed to help provide care to the indigent/uninsured: the Virginia Health Care Foundation, the Indigent Health Care Trust Fund and the State/Local Hospitalization Program, the Academic Health Centers, Community Health Centers, Free Clinics, the Comprehensive Health Investment Project (CHIP) programs, and collaborative projects sponsored by the Department of Health and local health departments.

The Virginia Health Care Foundation: The Virginia Health Care Foundation (VHCF) was established in 1992 to encourage public/private partnerships that provide access to primary care for underserved Virginians. The VHCF receives financial support from the Commonwealth ($2.23 million in each year of the 1996-98 biennium) and secures additional revenues from private and local government sources ($5.6 million in FY 95). In 1996, the VHCF funded 49 projects across the Commonwealth including primary and preventive care clinics, pre- and post-natal care for at-risk women and their infants, dental clinics, community health centers, the CHIP program (primary care and case management for children), and many others. In 1996, nearly 40,000 uninsured or medically underserved persons received care through VHCF projects.

The current VHCF funding policy is to provide support for up to three years and have the program eventually become self-sufficient.

Indigent Health Care Trust Fund: The Indigent Health Care Trust Fund (IHCTF) was established in 1989 as a public/private partnership to address uncompensated charity care provided by private acute care hospitals. The fund is comprised of both state general funds and hospital contributions. Hospitals which provide charity care above a certain level receive payments from the fund to help offset their losses, while hospitals which provide charity care below a specified level pay into the fund. A total of $12 million ($6 million in state general funds and $6 million in special funds (hospital revenues)) was appropriated for the IHCTF in both FY 1997 and FY 1998. (Chapter Two includes a detailed analysis of the IHCTF.)

A Pilot Program To Subsidize Insurance Premiums For The Working Uninsured Is Being Implemented: In 1993, legislation was passed directing the Technical Advisory Panel (TAP) of the IHCTF to develop a pilot project to reconfigure the trust fund to support strategies for increasing access to health insurance. Since that time, the TAP has been working with the Department of Medical Assistance Services (DMAS) to

develop a program to offer a subsidized insurance product for the working uninsured. The TAP has received a commitment of $1.3 million from INOVA Health Systems in Northern Virginia for the first pilot site. The actual implementation date of the pilot will depend, in part, on when INOVA is able to obtain a license to operate a health plan to provide coverage to the enrollees.

Sentara Health System also has expressed a desire to pilot a similar program in their service area in Tidewater.

State/Local Hospitalization (SLH) Program: The SLH program provides funding to pay for certain hospital inpatient and outpatient health care costs incurred by indigent persons. The fund consists of both state and local government monies. The total amount of funding for FY 1997 was $13.8 million (state share: $11 million; local share: $2.8 million). Funding for FY 1998 is $14 million (state share: $11.1 million; local share: $2.8 million; federal trust monies: $121,000). Each year, the number of claims submitted for reimbursement far exceeds the amount of available funds.

Academic Health Centers: The Academic Health Centers (AHCs) deliver a substantial portion of the care provided to indigent and uninsured persons. An analysis of the AHCs was not included in this report due to the fact that the Federal Balanced Budget Act of 1997 will effect a number of significant financial changes at the institutions. A full and accurate assessment of these changes was not possible within the time frame of this study. Accordingly, the AHCs' role in providing for the indigent and uninsured will be addressed by the Joint Commission outside of this report.

Community Health Centers: In Virginia, 42 Community Health Centers (CHCs), including 37 primary care practice sites, are operated by 23 not-for-profit community corporations. These CHCs are located across the Commonwealth in more than 40 counties and municipalities, and provide services to insured as well as uninsured persons. All CHCs are located in medically underserved areas or care for underserved populations.

The CHCs provide access to primary care, and employ over 100 physicians. The CHCs charge for their services through a sliding fee scale that is based on patient income. To help offset the cost of reduced fees for qualifying patients, most CHCs receive some federal funds. The Virginia Health Care Foundation also provides financial assistance to some CHCs.

In 1996, the CHCs provided care to approximately 140,000 patients through 430,000 patient visits. According to statistics provided by the Virginia Primary Care Association, 21% of the CHCs' patients in 1996 were in families with income below the federal poverty level. In 1996, one-third of the CHCs' patients were uninsured.

Free Clinics: There are 30 Free Clinics located across the Commonwealth which are staffed with a large contingent of volunteers providing free medical care to the uninsured. Some of the clinics provide dental services in addition to medical care. With very limited staff, the Free Clinics reported approximately 117,000 patient visits in 1996. A recent survey by one of the Free Clinics estimated that volunteer physicians donate more than $8 million of free care at these clinics each year.

Department of Health Programs and Collaborative Projects: The Department of Health (DOH) administers a number of grant programs aimed at providing public health and preventive health services to persons across the Commonwealth. The primary focus of DOH has been and continues to be in the area of prevention such as immunizations, control of communicable diseases, teen pregnancy prevention, and health screenings. The local departments of health across the state also have established partnerships or collaborative projects with various other local government agencies and private entities to address specific health care issues. DOH reports more than 150 such partnerships in the areas of child health, communicable diseases, dental health, environmental health, heart disease and cancer prevention, home health, immunizations, perinatal health, pharmacy support, primary care, teen pregnancy prevention, and women's health.

Funding for the various partnerships comes from a number of sources, including state appropriations, grant funds, local governments, and private entities.

V.
Additional Strategies/Actions Virginia Could Pursue To Increase Insurance Coverage And Improve The Level Of Care Provided For The Indigent/Uninsured

It is difficult to prioritize the actions or strategies that Virginia should pursue to address the problem of the indigent and uninsured. Determining whether the most appropriate course of action is to take steps to increase insurance coverage for the uninsured, or to increase the level of financial and other support to programs which provide care to the indigent and uninsured is a difficult public policy issue. As noted previously, there is no one all-encompassing action that will resolve the problem. Rather, a combination of actions likely holds the most promise for making improvements.

Moreover, for some populations, simply providing an "insurance card" often does not ensure that the person will receive necessary health care services. Often, case management services are needed in concert with insurance coverage to have any meaningful impact.

There are numerous actions Virginia could take to address the problem of the indigent and uninsured. Unfortunately, those actions which have the greatest potential impact also require a substantial financial commitment by the Commonwealth. The following paragraphs do not provide an all-inclusive list, but do summarize various actions Virginia could pursue in this regard.

The State Children's Health Insurance Program, the Virginia Children's Medical Security Insurance Plan, and the Indigent Health Care Trust Fund are discussed in Chapter Two.

Virginia Could Increase Its Medicaid Outreach Programs To Enroll Children Who Appear To Be Eligible For Medicaid But Are Not Enrolled In The Program

The results of the 1996 Survey of the Insurance Status of Virginians indicate there is a substantial number of children who appear to be eligible for Medicaid, but are not enrolled.

Children 0-5: Based on the survey results, approximately 60,000 children between the ages of 0 and 5 are uninsured. Of these 60,000 uninsured children, approximately 32% or 19,200 are in families with

income levels (<$20,000) which, when factoring in the various income disregards, would make them eligible for Medicaid.

Children 6-19: The survey found that approximately 154,000 children between the ages of 6 and 19 are uninsured. When taking into account the various income disregards, all of the uninsured children (approximately 32,300) in the lowest income bracket (<$10,000) would be eligible for Medicaid. In addition, another 30,800 children in the lower half of the $10,000-$20,000 income bracket would likely be eligible for Medicaid.

In total, it appears that approximately 82,300 children are eligible for Medicaid, but are not enrolled. This estimate is within the range of eligible but not enrolled children (under age 11) published by the Center on Budget and Policy Priorities which used data from the Census Bureau's 1993 through 1996 March Current Population Surveys. The Center calculated a range for each state using a low and high estimate. Virginia's low estimate was 56,800, while the high estimate was 163,800. Had the Center's analysis included children up to age 19, their estimate of the number of eligible children would have been substantially higher.

Outreach Programs: The Department of Medical Assistance (DMAS), in cooperation with the Department of Social Services, has instituted some administrative outreach programs such as stationing eligibility workers in hospitals, providing a shortened application for certain recipients, expediting eligibility determinations, and permitting some mail-in applications. However, for the most part, these programs focus on enrolling persons who already have received medical services. Few, if any, outreach programs have been implemented to inform the general public about Medicaid eligibility.

A number of states have developed statewide outreach programs in which the appropriate state agencies: produced public service announcements on television and radio; distributed program brochures and other literature; and established toll-free hot lines to provide information to potential enrollees. By implementing a similar type of broad outreach program, the Commonwealth could enroll some portion of the 82,300 children who appear to be eligible for Medicaid but who currently are uninsured.

Virginia Could Increase The Income Eligibility For Certain Medicaid Populations To Cover More Of The Uninsured

As reported earlier, a number of states have expanded the income eligibility for certain Medicaid populations as a way of reducing the number of uninsured persons. Thirty-four states have increased the income eligibility beyond the federal minimum of 133% of the FPL for pregnant women and infants. Eleven states have increased income eligibility for children below age 6 above the minimum 133% of FPL; and 11 states also have increased the income eligibility for children over age 6 above the minimum 100% of FPL. Virginia could expand its Medicaid program to cover additional uninsured persons in a similar fashion.

Figure 3

Estimated Impact of Potential Medicaid Expansions

		POSSIBLE EXPANSIONS					
		To 133% of FPL		To 150% of FPL		To 185% of FPL	
AGE GROUPING	CURRENT ELIGIBILITY (% OF FPL)	Add'l Recip.	Cost (millions)	Add'l Recip.	Cost (millions)	Add'l Recip.	Cost (millions)
Under 1	133%	n/a	n/a	2,023	$3.2	5,395	$8.5
Ages 1-5	133%	n/a	n/a	9,994	$3.4	26,650	$9.0
Ages 6-19	100%	54,487	$14.9	79,544	$21.6	98,263	$26.8
Pregnant Women	133%	n/a	n/a	2,023	$2.6	5,395	$7.0
TOTAL		**54,487**	**$14.9**	**93,584**	**$30.8**	**135,703**	**$51.3**

NOTES:

- Income disregards are assumed to be the same as current.
- Estimates of additional recipients does not include those currently eligible, but not enrolled in Medicaid.
- Cost estimates are state-only costs and are calculated at .48 of the total cost.
- Cost estimates assume 85% of those enrolling would be uninsured and 15% would have other coverage.
- Estimates of new recipients and cost assume 65% of newly eligible would enroll in Medicaid.

Source: Department of Medical Assistance Services

Figure 3 presents various scenarios for expanding Medicaid coverage. Included in Figure 3 are estimates of the number of persons who could be

covered under each level of expansion, and the approximate cost to the Commonwealth for each scenario.

As illustrated in Figure 3, the Commonwealth could decide to expand Medicaid eligibility to varying degrees, depending on the target population and available funds.

Virginia Could Pursue A Premium Subsidy Program For Low-Income Persons; However, This Approach Would Require Significant State Funding And Likely Would Require A New Revenue Source To Sustain The Program

Premium subsidy programs without federal financial participation usually provide coverage to fewer people than Medicaid expansions. To implement and sustain a successful program, a significant amount of funding is necessary. Without substantial subsidies, the experiences of other states indicate participation will be low. Moreover, most states have dedicated certain tax revenues to fund their plans. To support such a program in Virginia, a new and sizable source of revenue likely would be needed.

THE LOCAL CHOICE Program Could Be Analyzed To Determine Whether It Could Be Expanded To Include Private Employers; Or, Virginia Could Enact Legislation Which Either Establishes A Health Insurance Purchasing Cooperative Or Provides Certain Incentives For Private Cooperatives To Be Formed

In roundtable discussions held across the Commonwealth, small employers indicated a keen interest in being able to participate in a pooled purchasing arrangement as a means of offering coverage to their employees. Many small employers cannot afford coverage at all, while many others are barely able to continue paying a share of their employees' health insurance benefits.

Health insurance purchasing cooperatives provide a means of pooling small employers and providing many of the purchasing advantages currently enjoyed only by large employers. The pooled purchasing arrangements in California, Florida and other states have shown that these programs do have the potential for providing coverage to previously uninsured groups.

THE LOCAL CHOICE program could be analyzed to determine whether it could be expanded to include private employers. In examining

this issue, it would be essential to ensure that both the state employee and the existing LOCAL CHOICE programs are not adversely affected by including private employers. It would be especially important to financially insulate both state employees and participating localities from the claims experience of any private employers. Nonetheless, if such an expansion of THE LOCAL CHOICE program is workable, this may be the most effective way of providing pooled purchasing for private employers.

While there is nothing in the *Code of Virginia* which prevents a pooled purchasing arrangement from forming today, another alternative would be to enact legislation which either establishes a purchasing cooperative or provides incentives for other private pools to form.

Further Insurance Market Reforms Could Make Coverage More Available For Small Groups And Individuals

While Virginia has enacted several small group and individual insurance market reforms, some "fine-tuning" of existing reforms and some additional reforms could make coverage more available to small groups and individuals.

Market Reforms Have Had Minimal Impact: Information collected by the Bureau of Insurance regarding the impact of the guaranteed issue and modified community rating reforms in the primary small group market (2-25 employees) indicate that, thus far, these reforms have had very little impact in the market. The most recent reports (March, 1997) filed with the Bureau by primary small employer carriers show that only 14 of the 70 carriers authorized to sell Essential and Standard plans have actually sold any of the plans. In other words, 56 carriers have not sold <u>any</u> Essential or Standard plans to primary small employers. Statewide, only 96 employers, covering 565 employees, have purchased either the Essential or Standard Plans.

There likely are several reasons why so few employers have purchased the Essential and Standard Plans. One reason identified last year was the limited inpatient hospital benefit of 21 days. This benefit was increased to 365 days pursuant to House Bill 2786 of the 1997 Session of the General Assembly. It also has been noted by agents and some carriers that the benefit design of the plans needs to be revised to make the plans more affordable. HB 2786 also expands the authority of the Special Advisory Commission on Mandated Benefits to review the plans and recommend to the Bureau of Insurance any changes necessary to keep the products competitive and marketable.

Marketing of Essential & Standard Plans: Another reason why the plans are not selling is that few employers are aware that the plans are available. Despite the fact that §38.2-3431(D)(7) of the Code of Virginia requires small employer carriers to "fairly market" the plans, in roundtable discussions with primary small employers across the state, very few had ever heard of the plans. Based on this information, the very small number of employers who have purchased the plans, and the fact that 56 carriers have not sold either plan to any primary small employer, it seems evident that the plans are not being actively marketed by most of the carriers.

Virginia could strengthen the marketing requirements contained in the small group reform statutes, such as requiring carriers to periodically advertise the availability of the products in newspapers as is required of open enrollment carriers in §38.2-4214(D). Another option would be to have employers sign a form that indicates they were offered the plans by the agent or carrier representative. In addition, business organizations such as the Virginia Chamber of Commerce, the Retail Merchants Association and others should advise their members of the availability of the plans.

"Groups of 1": Another possible "fine-tuning" of the small employer reforms would be to include self-employed or sole proprietors among those eligible for the guaranteed issue and modified community rating reforms. This issue also was mentioned by some of the employers at the roundtable discussions after learning of the availability of the Essential and Standard Plans. While most states' small group reforms do not include "groups of 1," Maryland recently extended its small group reforms to sole proprietors.

Broader Insurance Reforms: As reported last year in a study of the Commonwealth's insurance reforms pursuant to House Bill 1026, a number of states have enacted broader insurance reforms than Virginia. While the provisions of the Health Insurance Portability and Accountability Act (HIPAA) extend the guaranteed issue provisions to <u>all</u> plans sold to small employers (2-50), guaranteed issue applies only to a very limited number of individuals. Also, in Virginia, the rating reforms apply only to primary small groups (2-25) and only to the Essential and Standard Plans. Broadening the guaranteed issue and rating reforms to other types of coverage and to more groups and individuals could increase the number of persons with private coverage.

Extraterritorial Jurisdiction: In today's insurance market, there are many instances in which insurance companies issue policies to a group or organization in one state, but also have policy "certificate holders" in other states. Typically, only the insurance regulations of the state in which the policy is issued apply to the coverage. However, a number of states have extended their regulatory authority to have extraterritorial jurisdiction over policies which are issued in another state but cover persons in their home state. Such authority ensures that all carriers and insurance policies must adhere to the state's insurance regulations. One positive effect of this authority is that it helps ensure all carriers and plans play by the same rules, which prevents the market from being segmented in a way that makes it more difficult or more expensive for higher risk persons to obtain coverage.

Virginia currently exercises very limited extraterritorial authority over accident and sickness policies only with respect to prohibiting subrogation of insurance benefits. The issue of extraterritorial authority is analyzed in a separate Joint Commission study published in 1998 Senate Document No. 25.

Virginia Could Provide Additional Funding Or Other Support To Various Programs Providing Care To The Indigent/Uninsured

While the Commonwealth currently provides financial assistance to various programs that provide care to the indigent/uninsured, additional funding or other support could be approved to enhance further these efforts. One alternative would be to increase the funding provided to the Virginia Health Care Foundation which, in turn, would raise other sources of revenue and provide additional grant monies to various worthy programs across the Commonwealth. To provide long-term funding for the various programs, the VHCF would have to change its current policy of providing support for up to three years, or the Commonwealth would have to provide funds through a different mechanism.

Another strategy would be to provide financial support directly to various programs across the Commonwealth, including CHIP programs, local primary care programs, children's' health programs, local health department programs, Free Clinics and Community Health Centers (CHCs).

Nearly all CHCs receive federal dollars and some receive financial support from the Virginia Health Care Foundation for a period of up to three years. However, several states provide direct financial support to

their CHCs. Nineteen states provide operational funds for existing primary care practices to provide care for the medically underserved populations. Fourteen states have established funds for the development of these practices. The George Washington University Center for Health Policy Research reported that the level of funding for these states ranged from $110,000 to as much as $31 million during the most recent fiscal year for the various states.

The Virginia Primary Care Association also has developed a draft outline of other strategies to enhance the CHCs' ability to provide primary care services, including establishing a process to define and qualify primary care practices as Virginia Qualified Health Centers; reducing barriers to fundraising and solicitation of contributions; and assisting CHCs provide health insurance to their employees.

Each of the types of programs listed above, and many others, provide valuable services and care to the indigent/uninsured. Additional resources for these programs would enhance their ability to serve these populations.

VI.
Policy Options

The following policy options are offered for consideration by the Joint Commission. They do not represent the entire range of actions that the Joint Commission may wish to pursue. Also, these policy options are not meant to be mutually exclusive of one another; combinations of various options can be implemented.

Chapter Two includes Policy Options regarding the State Children's Health Insurance Program, the Virginia Children's Medical Security Insurance Plan, the Indigent Health Care Trust Fund, and other issues.

Option I: Introduce Legislation Directing The Department Of Medical Assistance Services, In Cooperation With The Department Of Social Services, To Implement A Comprehensive Outreach Program To Enroll Children Eligible, But Not Enrolled In Medicaid.

As part of this Option, consideration should be given to approving an additional position(s) and funding to coordinate DMAS' outreach program.

Option II: Introduce Legislation To Expand Medicaid Eligibility For Certain Populations

Within this option, several alternatives could be pursued:

A. Expand eligibility for pregnant women and infants to either 150% or 185% of the Federal Poverty Level (FPL).
B. Expand eligibility for children ages 1-6 to either 150% or 185% of the FPL.
C. Expand eligibility for children ages 6-19 to either 133%, 150%, or 185% of the FPL.

Option III: Introduce Legislation To Establish A Purchasing Cooperative For Small Employers And Individuals

Option IV: Introduce Legislation Which Encourages And Provides Incentives For The Formation of Private Purchasing Cooperatives For Small Employers And Individuals

Option V: Introduce A Study Resolution And Appropriate Budget Amendment Directing The Department of Personnel And Training (DPT), In Cooperation With the Joint Commission On Health Care, The Bureau Of Insurance, And Other Appropriate Entities To Analyze Whether THE LOCAL CHOICE Program Could Be Expanded To Include Private Employers And/Or Individuals

Option VI: Introduce A Budget Amendment To Provide Funding To The Bureau Of Insurance For Consulting/Actuarial Assistance To Expedite The Special Advisory Commission on Mandated Benefits' Review Of The Essential And Standard Plans

There is growing concern and evidence that the current design of the Essential and Standard Benefits Plans needs to be revised. The Special Advisory Commission on Mandated Health Benefits has been given authority to review and update the plans. In order to expedite the review and update of the plans, Option VI would provide funding to the Bureau of Insurance which provides staff support to the Commission in order to expedite this process. The funds would be used to hire a consultant and/or actuary to complete the review and make recommendations to the Commission. The Commission then would recommend changes to the Bureau to amend the current regulations.

Option VII: Introduce Legislation To Expand The Guaranteed Issue And Modified Community Rating Reforms To The Self-Employed And Sole Proprietors

Option VIII: Introduce Legislation To Amend §38.2-3431(D)(7) To Require That Small Employer Carriers Advertise The Availability Of The Essential And Standard Plans

This option would require each small employer carrier authorized to sell the Essential and Standard Plans to advertise the availability of the plans at least 12 times annually in a newspaper(s) of general circulation throughout its service area. This provision would be similar to the advertising requirements for open enrollment carriers.

Option IX: Introduce Legislation To Extend The Modified Community Rating Reforms, Which Currently Apply Only To Essential And Standard Plans Issued To Primary Small Groups (2-25), To Other Types Of Coverage And/Or To Groups Up To 50 Employees

Option X: Introduce Legislation To Extend The Guaranteed Issue And Modified Community Rating Reforms To The Individual Market

Option XI: Increase The Amount Of Funds Appropriated For The Virginia Health Care Foundation To Provide Additional Support To "Test Models" Across The Commonwealth Providing Care To Indigent/Uninsured Persons

Option XII : Provide Direct Funding To Programs Across The Commonwealth Providing Care To Indigent/Uninsured Persons Such As Community Health Centers, Free Clinics, Etc.

In addition to providing financial support to these and other types of programs, this Option also could include taking other actions to improve the ability of these programs to serve their targeted populations. For instance, the Virginia Primary Health Care Association has indicated that revisions to the Virginia Solicitation of Contributions Law to include CHCs as exempted organizations would be beneficial to the centers in their fundraising efforts. Also, the VPHCA suggested other actions, such as establishing a process for defining and qualifying primary care practices as Virginia Qualified Health Centers. There may be similar types of actions that could be taken to assist other programs.

Option XIII: Increase Funding To The Department of Health And/Or Local Health Departments To Enhance Their Ability To Provide Primary And Preventive Health Care Services To The Indigent/Uninsured

(A summary of the public comments received by the Joint Commission regarding the above Policy Options is provided in Appendix D.)

CHAPTER TWO
I.
Key Health-Related Provisions Of The Federal Balanced Budget Act Of 1997

The Balanced Budget Act of 1997 Contains Several Significant Health-Related Provisions

The Balanced Budget Act of 1997 was passed by Congress in August, 1997. The Act includes a number of significant health-related provisions which will have major implications for the Commonwealth. The Act impacts Medicare, Medicaid, and creates a new children's health initiative, called the State Children's Health Insurance Program.

Figure 4 includes a brief overview of the Medicare and Medicaid-related provisions of the Act based on the information available at the time of this report. A more detailed assessment of the State Children's Health Insurance Program is provided later in this report.

As previously noted, these reforms will have a major impact on the provision and financing of health care for Virginia's Medicare and Medicaid populations. Moreover, many health care providers, particularly the academic health centers, will be affected. The full impact of these reforms will be determined over the coming months as details of the Act become available and are analyzed.

State Children's Health Insurance Program Represents $24 Billion Investment In Children's Health

The most significant provision of the Balanced Budget Act of 1997 regarding indigent and uninsured persons is the children's health initiative, entitled the State Children's Health Insurance Program (SCHIP). The Act includes a total of $24 billion in federal spending over a five year period to provide health insurance coverage to uninsured children. The following paragraphs summarize the major provisions of the SCHIP based on information available at the time of this report.

Figure 4

Medicare and Medicaid-Related Provisions of the Balanced Budget Act of 1997

Medicare Reform

- Extends life of Medicare Part A Trust Fund for 10 Years
- Contains structural reform and expands enrollee choice of plans
  - Provider Sponsored Organizations (PSOs)
  - Preferred Provider Organizations (PPOs)
  - Private fee-for-service plans
  - Medical Savings Accounts demonstration project
  - Private contracting for health services
- Expands preventive health care benefits for mammography, pap smears, and others
- Increases accountability through fraud and abuse penalties
- Creates a new prospective payment system for skilled nursing facilities, home health agencies, hospital outpatient departments, rehabilitation facilities and hospitals and ambulance services
- Creates a commission to address Medicare's long-term solvency

Medicaid Reform

- Provides approximately $13 billion in net Medicaid savings over 5 years
- Lowers the cost of Medicare for low-income beneficiaries by providing $1.5 billion over 5 years for low-income Medicare Part B premium protections
- Reforms disproportionate share hospital (DSH) payments through a revised formula
- Increases state flexibility in establishing provider payment levels by repealing the Boren amendment
- Allows states to provide Medicaid services through managed care without a waiver
- Requires states to restore Medicaid for children who lost eligibility due to the more strict definition of childhood eligibility for Supplemental Security Income in last year's welfare reform act
- Gives states the option of providing 12-month continuous coverage for children
- Eliminates over a multi-year period the requirement that states pay Federally Qualified Health Centers on a cost basis

Source: Summary of Provisions prepared by Majority Staffs, House and Senate Committees on the Budget

Program Description: The SCHIP provides $24 billion to the states in federal grants over a five-year period to expand health insurance access for low-income, uninsured children. States are given flexibility in the types of insurance coverage made available to eligible children.

Funding/Allocation to States: A total of $24 billion in federal dollars will be available to the states over a five year period beginning in fiscal year (FY) 1998. States will receive allocations from the federal government according to a formula contained in the Act. A minimum allotment of $2 million will be made to each state. Virginia's allotment is $68.7 million per year. States are eligible for payments under the SCHIP beginning October 1, 1997. The SCHIP limits the amount of funds that states can spend for non-coverage purposes to 10% of total expenditures.

States' Matching Funds: States will be required to match the federal allotments through a specified formula. A state's match rate is the Federal Medical Assistance Percentage (FMAP) plus 30% of the state's portion of the Medicaid rate. This formula will give Virginia's children's health program a FMAP of approximately 66%. In order to receive the maximum allotment of federal funds, Virginia would have to provide $35.4 million per year in matching funds.

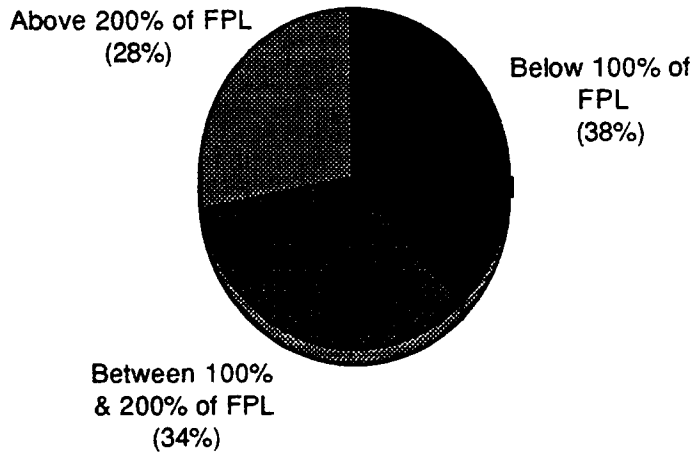
Eligibility: Uninsured children under age 19 and living in families with income at or below 200% of the federal poverty level (FPL) will be eligible to receive coverage through the SCHIP. (In states where existing Medicaid eligibility is at or above 200% of the FPL, the SCHIP eligibility is set at 50% above the Medicaid income eligibility ceiling.)

Approximately 72,000 Virginia Children Appear Eligible For SCHIP: Based on an analysis of the results of the Health Access 1996 Survey, approximately 214,000 children in Virginia, ages 0-19, are uninsured. As shown in Figure 5, approximately 28% or 59,900 children are in families with incomes above 200% of FPL; an estimated 154,100 are in families with incomes at or below 200% of the FPL. As reported in Chapter One, approximately 82,300 children are eligible, but not enrolled in Medicaid. The federal SCHIP law stipulates that children found through the screening process to be eligible for Medicaid shall be enrolled in the Medicaid program. Thus, any of the 82,300 children eligible but not enrolled in Medicaid who apply for participation in SCHIP would be enrolled instead in Medicaid. Accordingly, the total number of children in Virginia who appear eligible for SCHIP (but not Medicaid) is approximately 72,000.

Figure 5

Estimates Of Uninsured Children In Virginia Eligible For The State Child Health Insurance Program

Total Uninsured Children (0-19): 214,000



• Total Uninsured Children (0-19):	214,000
• Uninsured Children (0-19) >200% FPL:	(59,900)
• Uninsured Children (0-19) Eligible/Not Enrolled in Medicaid:	(82,300)
• **Uninsured Children (0-19) Eligible For SCHIP**	**71,800**

Source: 1996 Health Access Survey; DMAS and JCHC Staff Analysis

Benefits/Coverages: States are given flexibility in determining the benefits and types of coverage to provide to eligible children. States can use federal funds to: (i) expand Medicaid coverage, (ii) enroll children in health plans administered by private health plans; or (iii) provide health services directly to children. If a state chooses the Medicaid option, enrollment in the program cannot be capped even if the allotment is exhausted. The SCHIP limits the amount of funds that states can spend for

non-coverage purposes (direct services, administration, and outreach) to 10% of total expenditures.

States which choose to provide coverage to eligible children through private health plans have flexibility in the benefits that are offered. However, the coverage must be either one of several "benchmark" plans or the "actuarial equivalent" of a "benchmark" plan. The "benchmark" plans that states can offer include:

- a state-administered program in effect on the date of enactment that covers at least inpatient and outpatient hospital services, physicians' services, laboratory and radiological services and well-baby and well-child care;

- the Standard Blue Cross/Blue Shield preferred provider option service benefit plan offered under the Federal Employees Health Benefits Program;

- the health coverage that is offered and generally available to state employees (in Virginia, Key Advantage is the statewide employee plan); and

- the health coverage offered by an HMO with the largest commercial enrollment.

Coverage that is offered as the "actuarial equivalent" of one of the "benchmark" plans must include inpatient and outpatient hospital services, physicians' surgical and medical services, laboratory and radiology services and well-baby and well-child care.

Within certain guidelines and limitations, states can require premiums, deductibles, coinsurance and other cost-sharing based on a sliding scale. Such cost sharing cannot favor children from families with higher income over targeted low-income children. No cost sharing is permitted on benefits for preventive services.

State Child Health Plan: To receive payments under the SCHIP, states must develop a State Child Health Plan for expanding coverage to eligible children. State plans must be submitted to and approved by the Secretary of Health and Human Services. The state plan must outline how the funds are to be used, and must include certain information (e.g., strategic objectives, performance goals, and performance measures) required in the Act. State plans can become effective in the calendar

quarter as stated in the plan, but in no case earlier than October 1, 1997. A state plan is considered approved unless the Secretary notifies the state within 90 days after receipt of the plan that it is denied. Annual reports and state evaluations also are required.

In Developing Virginia's State Child Health Plan, A Number Of Key Issues Must Be Addressed

To ensure that the most appropriate and cost-effective plan is developed to implement the federal children's health initiative in Virginia, a number of critical issues must be addressed and included in Virginia's State Child Health Plan. Among these issues are:

- the benefits and types of coverage to be offered;
- the amount of funds to be used for outreach activities, administration and direct services;
- funding sources to generate Virginia's required match amount, including whether funding allocated to other existing programs such as the Virginia Children's Medical Security Insurance Plan, the Indigent Health Care Trust Fund and the State and Local Hospitalization program should be re-directed and used as part of Virginia's match amount; and
- the degree to which existing local children's health programs can be incorporated into Virginia's plan.

A Process For Developing Virginia's State Child Health Plan Should Be Established As Soon As Possible

As noted above, to receive the federal grant funds available through the SCHIP, states must submit a State Child Health Plan to be approved by the Secretary of Health and Human Services. As required in the Balanced Budget Act of 1997, the plan must provide comprehensive information as to how a state plans to implement the SCHIP.

In order to take advantage of the federal funds at the earliest possible date, the Commonwealth needs to begin to develop its State Child Health Plan as soon as possible. A process for developing the plan should be established immediately. To ensure that Virginia's plan is comprehensive, a coordinated process is needed that involves several state agencies, including the Department of Medical Assistance Services, the Department of Health, the Bureau of Insurance, and perhaps the Department of Personnel and Training. Additionally, various other health care providers, organizations and entities need to be included in the

process to ensure that Virginia's State Child Health Plan presents the best possible approach to providing insurance coverage and health care services to Virginia's uninsured children.

The Joint Commission on Health Care staff and Indigent/Uninsured Subcommittee will work in cooperation with appropriate state agencies and other public and private entities to coordinate Virginia's response. The Joint Commission's role in developing Virginia's plan would be similar to the role it played in coordinating the Commonwealth's response to the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

II.
Virginia Children's Medical Security Insurance Plan

The Virginia Children's Medical Security Insurance Plan Was Established To Provide Insurance Coverage For Low Income, Uninsured Or Under-Insured Children

The 1997 Session of the General Assembly passed House Bill 2682 which established the Virginia Children's Medical Security Insurance Plan (VCMSIP). The plan was established to provide coverage for uninsured or under-insured children up to age 18 who live in families with incomes at or below 200% of the federal poverty level (FPL). The key provisions of the VCMSIP are outlined below:

- The Department of Medical Assistance Services (DMAS) must develop a proposal for the plan by December 1, 1997. In developing the plan, DMAS shall consider:
    - services recommended by the American Academy of Pediatrics in its Child Health Insurance Reform Plan;
    - the provision of services through a network of participating providers;
    - the development of public/private partnerships;
    - a schedule of providing universal coverage for uninsured and under-insured children in families with incomes at or below 200% of the FPL to be phased in over a period of five years; and
    - alternatives for soliciting or requiring contributions from employers.
- The Virginia Children's Medical Security Insurance Plan Trust Fund was established pursuant to HB 2682 to provide funding for the program. Approximately $3.3 million is anticipated to be available in FY 1998. An estimated $7.5 million is anticipated to be available in each succeeding fiscal year. The legislation limits the amount of the fund to be used for administrative purposes to 5% each year. The funding is generated through an increase in the premium taxes levied on "open enrollment" health insurance carriers (SB 1112/HB 2887).

- DMAS is required to report annually on the status of the VCMSIP and the trust fund.

The Provisions Of The Virginia Children's Medical Security Insurance Plan Are Very Similar To The Federal Children's Health Initiative Recently Passed By Congress

The provisions of the VCMSIP are very similar to many aspects of the State Children's Health Insurance Plan passed by Congress as part of the Balanced Budget Act of 1997, including the age and eligibility requirements. Approximately the same number of Virginia children (71,800) appear to be eligible for both programs.

There are, however, benefit differences between the VCMSIP and the federal initiative. The federal children's health initiative places tighter restrictions on the level and types of benefits that must be offered to eligible children than that required under the VCMSIP.

There Are Several Possible Approaches To Implementing The VCMSIP

Prior to the passage of the federal initiative, there were several possible approaches to implementing the VCMSIP. The following benefit designs had been identified as potential coverage options for children eligible for the VCMSIP. The estimated number of children who could be covered under each option is calculated on the assumption that $7.1 million of the $7.5 million would be available to pay for services. (The remaining $375,000 represents five percent of the total which is the maximum amount that could be spent on administrative expenses.)

- Enroll eligible children in a benefits package similar to current **Medicaid** benefits.

- Enroll eligible children in the **Essential or Standard Plans** that were developed as part of Virginia's small group insurance reforms and are planned to be offered through the Indigent Health Care Trust Fund Pilot Project (to be discussed later in this report).

- Enroll eligible children in an insurance product that covers **primary care and preventive health services** only.

In addition to the above options for enrolling children in various *insurance products*, the Northern Virginia Access to Health Care Consortium (NVAHCC) has proposed an alternative approach. The NVAHCC recommended approach would:

- allocate money from the trust fund by jurisdiction to the district health departments according to a specified formula;

- direct the district health department to work with the local government and local health care providers to select programs that provide a minimum level of specified services in which to enroll children; and

- have the local government or the district health department establish the criteria and priorities for which children would be enrolled.

The NVAHCC identifies a number of advantages of such an approach, including: (i) maximizing the number of children served with the available funds; (ii) allowing for local flexibility to meet the most critical needs in each area; and (iii) supporting existing local programs rather than undercutting existing cooperative efforts.

The approach recommended by the NVAHCC also could be implemented as part of the program to be established pursuant to the federal initiative.

Another Use Of The Virginia Children's Medical Security Insurance Plan Trust Fund Dollars Would Be To Use The Money As Part Of Virginia's Matching Funds Required Under The Federal Children's Health Initiative

As discussed previously, the federal children's health initiative requires states to provide matching funds in order to receive the federal allotments available under the program. Given the similarities in the target populations and objectives of each program, perhaps the most prudent use of the funds available through the Virginia Children's Medical Security Insurance Plan Trust Fund would be to use these funds as part of Virginia's required match amount of $35.4 million.

III.
Virginia Indigent Health Care Trust Fund/ State And Local Hospitalization Program

The Indigent Health Care Trust Fund and the State and Local Hospitalization Program represent major initiatives by the Commonwealth, in cooperation with private acute care hospitals and local governments, to address the burden of uncompensated hospital care associated with indigent persons. In total, the Commonwealth invests approximately $17 million each year as one means of addressing the problem of the indigent and uninsured.

The Virginia Indigent Health Care Trust Fund Was Established To Help Offset The Cost Of Uncompensated Care In Virginia's Private Acute Care Hospitals

The Indigent Health Care Trust Fund (IHCTF) was established in 1989 as a public/private partnership to help offset some of the charity care provided by Virginia's private acute care hospitals. The IHCTF program is codified in Chapter 11 of Title 32.1 of the Code of Virginia (§32.1-332, et. al). The IHCTF is the responsibility of the Board and Department of Medical Assistance Services. The Board annually appoints a Technical Advisory Panel which recommends to the Board: (i) policies and procedures for administering the fund; (ii) the methodology relating to creation of charity care standards; and (iii) contribution rates and distribution of payments.

IHCTF Is Comprised Of General Funds And Hospital Contributions: The IHCTF is a funding mechanism which receives contributions from the Commonwealth and individual hospitals, and annually distributes the funds to hospitals with high charity care loads. The fund also can receive voluntary contributions from hospitals and other entities, including local governments.

Item 323 of the 1997 Appropriation Act specifies that the Commonwealth will contribute $6 million to the fund. Hospitals contribute approximately $4 million. A total of approximately $10 million has been distributed to hospitals from the fund each year since the program's inception.

Hospital Contributions/Distribution Of Funds: Some, but not all hospitals make contributions to the fund based on the amount of charity

care they provide. Contributions are made according to a formula specified in the Code. A hospital's contribution is based on the amount of charity care (defined as persons at or below 100% of the FPL) it provides in relation to its operating margin and the median amount of charity care provided by all participating hospitals. Proprietary hospitals receive a credit for the amount of state corporate taxes they pay. Hospitals which provide charity care below the median amount contribute dollars to the fund. Hospitals' contributions are limited to 6.25% of a positive operating margin.

Payments from the fund are made to hospitals based on the amount of charity care the hospital provides in excess of the median amount of such care for all hospitals, adjusted by each hospital's cost-to-charge ratio. The IHCTF pays up to 60% of these charity care costs. In FY 1997, the median charity care amount equated to 1.7756% of the hospital's gross hospital revenue. Accordingly, hospitals whose charity care amount exceeded 1.7756% of their gross patient revenue received payments from the fund.

Figure 6 provides various information regarding the operation of the IHCTF since FY 1991 when the first funds were distributed to the hospitals. According to officials at the Department of Medical Assistance Services who manage the fund, the significant variations in the data for the first two years of operation (FY 1991 and FY 1992) as compared to the succeeding years are partially due to a "learning curve" by the hospitals with regard to how the program operated, and how to submit the necessary documentation regarding the provision of charity care.

The IHCTF Is Able To Compensate Hospitals For Approximately Thirty-Eight Percent Of The Cost Of Charity Care Above The Median

Figure 6 illustrates that the cost of charity care above the median as reported by the hospitals has varied somewhat over the past several years ranging from $21.7 million in FY 1994 to $27.6 million in FY 1996; the amount above the median in FY 1997 was $26.8 million. The $10 million that was distributed through the IHCTF for FY 1997 compensated hospitals for approximately 38% of charity care above the median. As seen in Figure 6, the percentage of charity care costs above the median that the IHCTF has been able to offset has remained relatively constant since FY 1993, except in FY 1994 when the percentage rose to 46%.

FIGURE 6

INDIGENT HEALTH CARE TRUST FUND:

Program Operating Statistics: FY 1991 - FY 1997

For Trust Fund Fiscal Years	FY 1991	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
Hospital FY Between These Dates	7/1/89 to 6/30/90	7/1/90 to 6/30/91	7/1/91 to 6/30/92	7/1/92 to 6/30/93	7/1/93 to 6/30/94	7/1/94 to 6/30/95	7/1/95 to 6/30/96
Number of Hospitals (groups) Participating	87	87	86	86	85	85	85
Gross Hospital Revenue	$4,806,453,524	$5,634,917,358	$6,496,457,168	$7,233,272,775	$7,776,860,967	$8,208,355,696	$8,610,929,050
Qualifying Charity Care Charges	$74,342,668	$77,297,616	$103,332,379	$132,183,818	$145,843,042	$148,333,806	$152,899,333
Median Charity Care % of Gross Hospital. Rev.	1.2879%	1.2798%	1.2194%	1.6310%	1.6340%	1.4857%	1.7756%
Amount of Charity Care Above The Median	$24,968,716	$20,417,020	$40,348,165	$36,072,337	$43,937,451	$48,687,705	$48,911,752
Cost to Charge Ratio	x 66.57%	x 63.08%	x 61.59%	x 60.36%	x 59.15%	x 55.33%	x 51.99%
Cost of Charity Care Above The median	$16,622,492	$12,879,256	$24,848,919	$21,773,779	$25,987,084	$27,650,215	$26,860,706
(1) State DSA Payment Percentage	x 60.00%	x 60.00%	x 39.00%	x 46.40%	x 39.06%	x 36.76%	x 37.98%
Gross Amount Compensated	$9,973,495	$7,727,554	$9,691,078	$10,103,033	$10,150,555	$10,164,219	$10,201,696

(1) The DSA percentage may be set between 0% and 60% in order to distribute the funds available in proportion to charity care above the median.

SOURCE: Department of Medical Assistance Services

The IHCTF Has Become An Important Source Of Revenue For Certain Hospitals, While Some Pay Significant Amounts Into The Fund

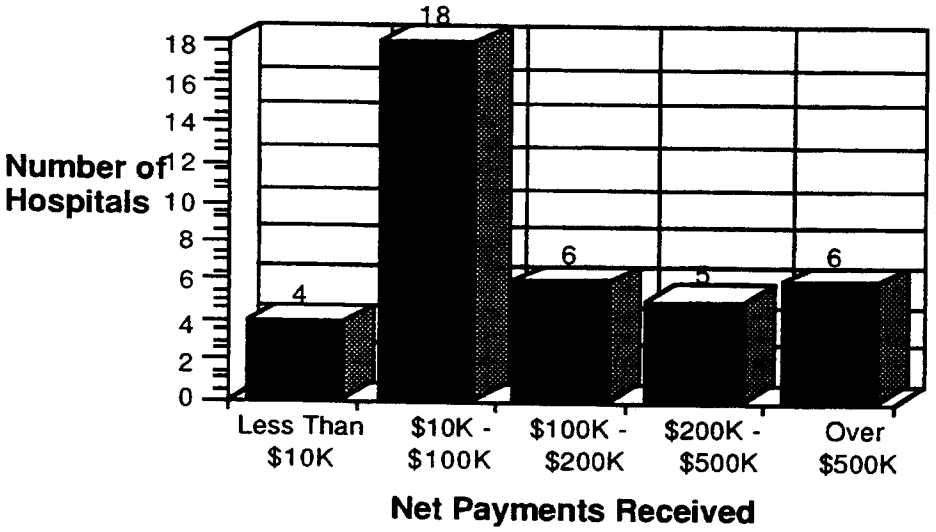
In FY 1997, 84 hospitals/hospital groups participated in the IHCTF. Of this amount, 36 hospitals made "net payments" into the fund ranging from $304 (Children's Hospital of the Kings Daughters) to $295,223 (Henrico Doctor's Hospital). For the most part, the same three hospitals/hospital groups (Henrico Doctor's, St. Mary's, and Columbia [Chippenham and Johnston-Willis]), all located in Richmond, have paid the greatest net amount into the IHCTF over the past few years. Each of these hospitals/hospital groups made net payments in excess of $225,000 in FY 1997. A total of 10 hospitals/hospital groups (Henrico Doctor's, St. Mary's [Richmond], Columbia, Winchester Medical Center, Prince William Hospital, Russell County Medical Center, Chesapeake General Hospital, Sentara Leigh Hospital, Rockingham Memorial Hospital, and Lewis-Gale Hospital) had net payments in excess of $100,000 in FY 1997.

In FY 1997, nine hospitals had a "zero" net payment. Thirty-nine hospitals received net payments from the IHCTF. The net payments ranged from $145 (Dickenson County Medical Center) to $1.36 million (Sentara Norfolk General). Figure 7 illustrates the net payment amounts received by the 39 hospitals.

For the most part, the following five hospitals have received the greatest net payments from the IHCTF over the past several years: Fairfax Hospital, Carilion Hospital Systems, Alexandria Hospital, Arlington Hospital, and Sentara Norfolk General Hospital.

While there are differing opinions as to the appropriateness of the IHCTF results in terms of some hospitals paying substantial amounts into the fund and others receiving significant payments from the fund, the program is helping to balance the burden of uncompensated care at the private acute care hospitals.

Figure 7
Indigent Health Care Trust Fund
Net Payments To Hospitals: FY 1997



Source: Department of Medical Assistance Services, "Virginia Indigent Health Care Trust Fund Results for FY 1997"

The IHCTF Technical Advisory Panel Has Been Working For Several Years To Implement A Pilot Program To Convert The Fund Into A Subsidized Insurance Program For The Working Uninsured

While the IHCTF has been successful in re-distributing some of the burden of uncompensated care at private acute care hospitals, it was recognized several years ago that if these monies could be used to subsidize the cost of health insurance for the working uninsured, even greater benefits could be realized. Providing subsidized health insurance for the working uninsured would not only provide coverage for a broad range of health services, including primary/preventive care, but also would leverage additional dollars through employee and employer contributions toward the cost of the coverage.

In 1993, the General Assembly adopted Senate Joint Resolution 315 directing the Technical Advisory Panel (TAP) to develop a proposal to convert the IHCTF to increase the number of Virginians with insurance. Also in 1993, legislation was passed to expand the TAP to include representatives from the insurance industry, the Commissioner of Insurance, the Virginia Health Care Foundation and physicians. In 1994,

legislation was passed to authorize the use of voluntary donations to the IHCTF to support a pilot program to offer subsidized insurance to the working uninsured.

The TAP has been working since 1993 to implement a pilot program to test the feasibility of using IHCTF monies to subsidize the cost of insurance for the working uninsured. During the time since 1993, progress toward implementation of the pilot program has been slow as the TAP has had to work through a number of administrative and regulatory issues.

INOVA Health Systems has committed $1.3 million toward a pilot project in Northern Virginia and has been working with the TAP and staff of DMAS to implement the project.

Pilot Project Now Expected To Be Implemented In Early 1998: The pilot project is scheduled to be implemented in Northern Virginia sometime after January 1, 1998. INOVA recently purchased an HMO (Principal Health Plan) to function as the insurance component for the pilot project enrollees. The pilot program is expected to be operational by early 1998.

Sentara Health Systems Has Expressed Interest In Piloting A Program Within Their Service Area

Sentara Health Systems in Norfolk has expressed interest in piloting a program within their service area in Tidewater. If implemented, their pilot would not become operational until sometime after the Northern Virginia project. However, Sentara's interest indicates a willingness and desire by another of Virginia's major health care systems to move toward converting the IHCTF into a subsidized health insurance program.

Despite The Slow Progress In Converting The IHCTF, The Pilot Program Should Be Implemented And Evaluated Prior To Making Any Other Substantive Changes To The IHCTF

While progress to convert the trust fund into an insurance product for the working uninsured has been quite slow over the past four years, the pilot project is expected to be implemented within the next several months. Moreover, the key stakeholders agree that the IHCTF could reap far greater benefits if the program is converted into subsidized health insurance coverage for the working uninsured. Given the commitment of the principals involved, and the projected start date for the pilot, it seems prudent to implement the pilot project as quickly as possible and evaluate

the results for possible replication in other areas of the state prior to making any substantive changes to the program.

The State And Local Hospitalization (SLH) Program Provides Funding To Pay For Certain Hospital Inpatient And Outpatient Costs Incurred By Indigent Persons

Similar to the Indigent Health Care Trust Fund (IHCTF), the SLH program provides funding for hospital costs incurred by indigent persons. However, whereas the IHCTF reimburses hospitals based an overall amount of charity care provided by each hospital, the SLH program is "claims based" in that specific claims incurred by eligible indigent persons are approved for payment.

Program Administration and Funding: The SLH program was established in 1946 as an optional program for local governments. In 1989, the program became statewide with all counties and cities being required to participate. Chapter 12 of Title 32.1 of the Code of Virginia establishes the program. The Department of Medical Assistance Services (DMAS) administers the program.

As provided in Item 325 of the 1997 Appropriation Act, the total amount of funding for FY 1997 was $13.8 million (state share: $11 million; local share: $2.8 million). Funding for FY 1998 is $14 million (state share: $11.1 million; local share: $2.8 million; federal trust monies: $121,000).

Eligibility and Covered Services: SLH assistance is available to persons who are not enrolled in Medicaid and have incomes at or below 100% of the federal poverty level (FPL). Covered services are limited to hospital inpatient and outpatient services including services received in approved ambulatory surgical centers and local health department clinics.

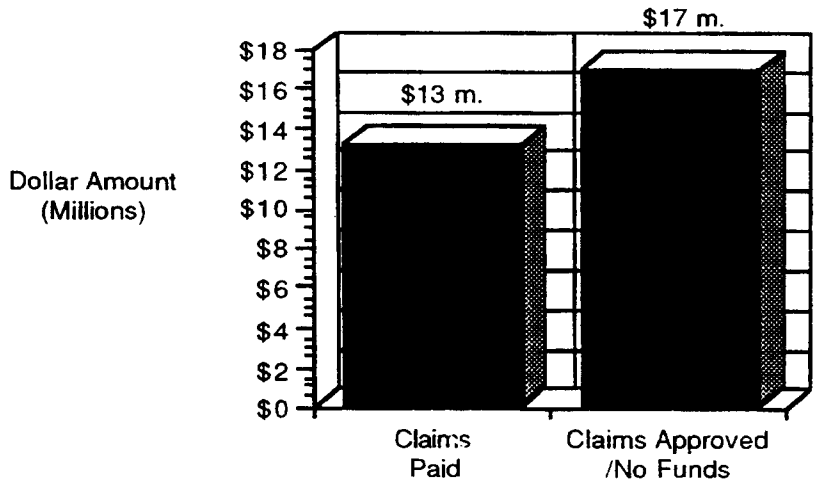
Each Year, The Amount Of Claims Eligible For Payment Through The SLH Program Far Exceeds The Amount Of Available Funds

Each year, there is a significant number of claims eligible for payment through the SLH program that are not paid due to a lack of funds. As seen in Figure 8, in FY 1996, a total of $13.2 million (8,721 claims) was paid through the SLH program. However, there also was an additional $17 million in claims (9,349) which was approved for payment but could not be paid due to the fund being depleted.

This problem of the SLH program running out of funds was identified during a site visit by the Joint Commission's Indigent/Uninsured Subcommittee to Northern Virginia where staff from a local health care program for indigent persons indicated that one of the more serious problems they face is finding inpatient hospital care for their clients. The health care programs can assist clients in securing SLH assistance when funding is available; however, when the funds are exhausted, arranging inpatient care for clients often becomes quite difficult. The local program administrator indicated that additional SLH funds would make a significant difference in the program's ability to serve indigent persons.

Figure 8
State and Local Hospitalization Program:
Claims Administration: FY 1996

(In Millions)



Source: Department of Medical Assistance Services

IV.
The Impact That Not-For-Profit To For-Profit Hospital Conversions May Be Having On The Indigent And Uninsured

Nationally, The Number Of Hospital Conversions Has Increased Significantly In Recent Years

After a decade in which only about nine hospitals converted to for-profit status each year, 34 hospitals converted in 1994 alone. In 1995, 59 hospitals converted to for-profit status. (Needleman, Chollet and Lamphere, 1997.) Interestingly, nearly half of the recent conversions have occurred in a handful of states, Florida, Texas, California, Georgia, and Alabama.

Despite the recent conversion activity that has occurred, an overwhelming majority of hospitals (3,092) were operating as not-for-profits in 1995 compared to 752 for-profit hospitals. (Stauffer, 1997.) In Virginia, there currently are 75 not-for-profit acute care hospitals and 14 for-profits.

In Many Hospital Conversions, Foundations Are Formed To Continue The Non-Profit's Mission

One of the trends that has accompanied the increase in hospital conversions has been the establishment of foundations to continue the mission of the not-for-profit. More than $9.3 billion has been placed in 79 foundations created by the conversion of hospitals, Blue Cross/Blue Shield plans and health maintenance organizations across the nation.

The foundations are formed because, under federal law, organizations which convert to for-profit status must follow strict rules about what to do with their assets. To compensate the public for years of tax-exempt status, and, in many cases, to pay back the public for years of donations, converting organizations must find a way to make sure their assets continue to be used for charitable purposes and do not end up as additional profits for the for-profit company. (Marchetti, 1997.)

Most of the new foundations have been created through hospital conversions. Some non-profit leaders and state regulators believe the hospital "conversion foundations" should continue to use their assets to

provide care for indigent and uninsured persons in their communities. In some cases, hospital executives negotiating a sale have required the for-profit buyer to make a commitment through the foundation to maintain the same level of charity care that was provided by the non-profit institution.

In Virginia, Five Hospitals Have Converted From Not-For-Profit To For-Profit Status And Established Foundations To Continue Charitable Activities In Their Respective Communities

Five hospitals in Virginia have converted from not-for-profit to for-profit status and have created foundations to continue the charitable/non-profit mission of the institution. Figure 9 identifies the five hospitals which have converted. One of the most recent conversions in Virginia was Arlington Hospital which converted in 1996 and established a foundation with assets of $140 million.

Figure 9

Foundations Established In Virginia As A Result Of Hospitals Converting from Not-for-Profit to For-Profit Status

Hospital	Foundation	Year Created	1996 Assets
John Randolph Hospital	John Randolph Foundation	1995	$25 million
Arlington Hospital	Arlington Health Foundation	1996	$140 million
Retreat Hospital	Annabella R. Jenkins Foundation	1995	$25.5 million
Bedford Community Hospital	Bedford Community Health Foundation	1984	$4 million
Alleghany Hospital	Alleghany Foundation	1995	$40 million

Source: The Chronicle of Philanthropy, July, 1997

In addition to the five hospitals listed in Figure 9, three additional hospitals (Williamsburg Community, Portsmouth General Hospital and Mary Immaculate Hospital) have created foundations as a result of disposition of their assets to another not-for-profit organization.

Because Most Hospital Conversions Have Occurred Very Recently, There Is Little Information Available Regarding The Impact Of These Conversions On The Indigent And Uninsured

As previously noted, the recent increase in the number of hospital conversions across the nation has occurred within the past few years. As such, there is little available information on the impact that these conversions are having on the provision of care to indigent and uninsured persons and to their respective communities as a whole. Figure 9 illustrates that the majority of conversions in Virginia have occurred within the past two years; some of the foundations created as a result of the conversions are just forming.

Perhaps the most crucial issue being debated regarding hospital conversions is the valuation of the entity's assets, and the amount that should be channeled back to the community through a foundation or other process to ensure that the full measure of the public's investment in the nonprofit is protected.

Much is being written about hospital conversions in the health care literature. While there is little *empirical* evidence on the impact of these conversions, some researchers believe that for-profit companies are getting bargain prices for assets built by taxpayer support and philanthropic contributions. Others believe the foundations that have been created to continue the not-for-profit institution's charitable mission, along with the new tax revenues, will result in the community obtaining a net overall improvement. (Pomeranz, 1997.)

The debate regarding the impact of these conversions on communities is best summarized by Needleman, et al, who, in 1997, wrote: *"[D]espite the large number of conversions that have occurred, we cannot yet answer the most fundamental question that should drive community decisions about public and not-for-profit hospital conversions: In a dynamic marketplace, are communities better or worse off when their hospitals change ownership?"*

Conversions Of Hospitals And Health Plans Pose Major Issues For State Health Policymakers; Some States, Including Virginia, Have Enacted Laws To Provide Oversight Of Hospital Conversions

In response to the growing trend and concerns of hospital conversions, at least 19 states are examining some type of legislation to regulate these conversions. Along with Georgia and Arizona, legislation

was passed during the 1997 Session of the Virginia General Assembly regarding hospital conversions.

Virginia's law, pursuant to House Bill 2335, specifies that a nonprofit hospital, health services plan or health maintenance organization must notify the Office of the Attorney General in writing at least 60 days before a proposed transaction takes place so that the OAG can exercise its common law and statutory authority over the activities of these organizations. Within 10 days of receipt of the notice, the OAG is required to place a public notice of the transaction in a newspaper within the entity's jurisdiction. Through the OAG's review of these transactions, there is a process in Virginia to monitor the conversion of hospitals and other health care entities.

V.
Purchase of Prescription Drugs By Indigent Persons; Health Insurance Coverage For Graduate Students

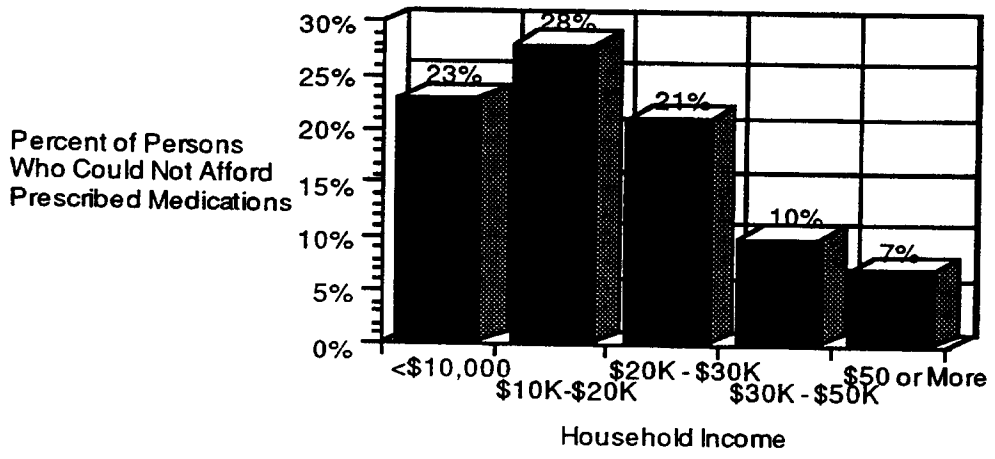
Indigent Persons Often Cannot Afford To Purchase Prescription Drugs Prescribed By Their Physician

Senate Joint Resolution 298 directs the Joint Commission on Health Care to assess the cause, prevalence, and impact of the inability of indigent persons to purchase prescription drugs. Based on the results of the Health Access '96 Survey, 23% of those persons in households making $10,000 or less reported that, in the past 12 months, they have received a prescription from their doctor, but did not purchase the medication because it cost too much. Twenty-eight percent of those in families with incomes between $10,000 and $20,000 reported not purchasing prescribed medicine because it costs too much.

As seen in Figure 10, the percentage of persons in the lower income brackets who did not purchase prescribed medications is more than double the percentage of persons in the $30,000 - $40,000 income bracket, and more than three times greater than those persons in the $50,000 or more bracket.

Figure 10

Percentage Of Persons Who Could Not Afford To Purchase Prescribed Medications By Income Bracket



Source: JCHC Staff Analysis of Health Access '96 Survey

The results of the Health Access '96 Survey also show that lower income persons are far more likely than those in higher income brackets to take a smaller than prescribed dose of a prescription drug due to the cost of the medication. The survey showed that 18% of those making less than $10,000, and 12% of those making between $10,000 and $20,000 took a smaller than prescribed dosage during the past 12 months. This is compared to only 7% of persons making between $30,000 and $50,000 and 2% of persons making $50,000 or more having the same difficulty.

Preliminary Research Findings From Carilion Health Systems Confirm Survey Results

Carilion Health Systems recently released some interim findings of a research project it has undertaken to assess the cause, prevalence and impact of indigents' inability to purchase prescription drugs. Their interim findings indicate that 13% of indigent persons surveyed stated that they were unable to get their last prescription filled. Thirty-one percent of those surveyed stated they had had a problem within the past three years getting a prescription filled. The vast majority of these persons cited a "lack of money" as the main reason for not getting their prescriptions filled.

With regard to the impact of persons not purchasing their medications, the Carilion research found that one-third of the persons who did not have their prescriptions filled had to return to a doctor for additional services.

Additional Research Is Being Conducted: Carilion officials indicate that additional research and analysis regarding the impact of indigents not purchasing prescribed medications is ongoing and should be completed within the next few months. Specifically, their research will focus on the related costs that are incurred when persons who do not purchase their medication: (i) have to access emergency room care and other hospital and physician services; (ii) miss time from work; and (iii) develop other medical conditions.

Legislation To Allow Graduate Students To Purchase Health Insurance Coverage Through The State Employees' Health Benefits Program Was Vetoed By Governor Allen

House Bill (HB) 2793, patroned by Delegate Shuler, would have permitted full-time, in-state graduate students attending a public institution of higher education in the Commonwealth and receiving a

stipend, to purchase health insurance coverage for themselves and their dependents through the state employees' health benefits program. The 1997 Session of the General Assembly passed HB 2793; however, Governor Allen vetoed the bill. Following Governor Allen's veto of the legislation, Delegate Shuler requested that the Joint Commission review this matter as well as whether temporary employees also could be included in the state employees' program.

The legislation was intended to provide graduate students with a means of purchasing better coverage than what typically is available in the market for such students. Participation in the state employees' benefits program would provide access to several high quality benefit plans.

According to the director of the state employee program, having graduate students participate in the plan would not have an adverse impact on the state employee pool or employee premiums because these students generally are younger and incur fewer claims than the state employee population as a whole. Also, as drafted, the schools would be responsible for the administrative tasks associated with the students. There is, however, some question as to the number of graduate students who actually would purchase benefits through the state program. Because the state employee benefits generally are much richer than that currently available to students, the cost likely will be significantly higher.

In vetoing the legislation, Governor Allen cited two reasons for his action: (i) the legislation provides benefits reserved for full-time employees to graduate students which would be unfair to part-time and wage employees who do not have the coverage; and (ii) the legislation does not stipulate that the graduate students bear the full cost of the premiums. The Governor also noted that "[I]n an effort to assist a relatively small number of persons, this legislation creates more problems than it solves."

A 1995 Study By The Secretaries Of Education And Administration Concluded That Each University Should Procure The Best Plan Available To Meet Their Students' Needs

In response to House Joint Resolution 232 of the 1994 Session of the General Assembly, the Secretaries of Education and Administration examined alternatives in coverage, financing and administration of health insurance for graduate students and their dependents. Their study found that the marketplace offers many types of coverage suitable to the needs of graduate students and that the cost of such coverage is reasonable. The

Secretaries concluded that each university has needs which can more readily be accommodated by the variety of plans in the market than by any single benefits plan. Accordingly, they concluded that each university should procure the best plan available which meets its needs.

A 1990 Study By The Department Of Personnel And Training Found That Most Part-Time Employees Have Coverage; And That, If Included In The State Program, A State Contribution To The Premium Would Be Needed To Protect The Program From Adverse Selection

In 1990, the Department of Personnel and Training (DPT) studied the feasibility of providing coverage to part-time employees in response to Senate Joint Resolution 212 of the 1989 Session of the General Assembly. The DPT study found that while there was interest among part-time workers to obtain coverage, 71% of part-time employees already had insurance through other means. DPT also concluded that to avoid the cost of adverse selection (i.e., attracting a disproportionate number of poor risks) a state contribution to the cost of the coverage would be necessary. (This finding is different from the issue regarding graduate students' impact on the state program because graduate students, as a group, generally are younger and healthier than part-time employees.) While this study was conducted in 1990, many of the same issues apply today, particularly the need for a state subsidy.

In the time available to study these issues, no compelling information was found to suggest that graduate students should or should not participate in the state employee program. With respect to the ambiguity in HB 2793 regarding whether the state would make a contribution to the cost of coverage, this issue easily could be addressed by stating that the Commonwealth will not make a contribution to the cost of graduate students' coverage. However, the question as to the number of students who would enroll in the state program remains. In order to answer this question, additional study, such as a survey of students, would be needed.

Regarding temporary employees, the major issue here is the cost to the state to provide a reasonable premium subsidy so that the program would attract good risks as well as the poor risks. Without a subsidy and a good "mix" of enrollees, the program would become increasingly expensive for the participants, and eventually would be priced beyond most persons' means.

VI.
Policy Options

The following policy options are offered for consideration by the Joint Commission on Health Care on the issues presented in this chapter. They do not represent the entire range of actions that the Joint Commission may wish to pursue. Also, these policy options are not necessarily mutually exclusive of one another; combinations of various options can be implemented.

Options Related To Children's Health Issues

Option I: The Joint Commission on Health Care Staff And Indigent/Uninsured Subcommittee Would Work With The Appropriate State Agencies And Other Public/Private Health Care Entities To Develop Virginia's State Child Health Plan As Required By The Federal Children' s Health Initiative

To receive the federal funds that will be allotted to Virginia for the children's health initiative, the Commonwealth must submit a State Child Health Plan to the Secretary of Health and Human Services. This Option would have the Joint Commission work with the appropriate state agencies including the Department of Medical Assistance Services, the Department of Health, the Bureau of Insurance, and the Department of Personnel and Training, and other public and private health care organizations to develop Virginia's State Child Health Plan.

In developing the plan, consideration must be given to a number of critical issues, including:

- the benefits and types of coverage to be offered;
- the amount of funds to be used for outreach activities, administration and direct services;
- funding sources (in addition to the funds ($7.5 million) available in the Virginia Children's Medical Security Insurance Plan Trust Fund, additional funding sources will need to be identified including potential offsets that may be available from the Indigent Health Care Trust Fund, the State and Local Hospitalization program and the academic health science centers' indigent care appropriations); and

- the degree to which existing local children's health programs can be incorporated into Virginia's plan.

Options Related To Not-For-Profit Hospital Conversions

Option II: Take No Action

Minimal information currently is available regarding the impact of hospital conversions on the indigent and uninsured. Moreover, Virginia has passed legislation requiring such transactions to be reviewed by the Office of the Attorney General. Accordingly, under Option II, the Joint Commission would take no action on this issue at this time.

Option III: Invite The Foundations That Have Been Created As The Result Of Hospital Conversions In Virginia To Periodically Update The Joint Commission On The Charitable Activities Of Their Organizations

Option IV: Introduce A Study Resolution Directing The Joint Commission To Monitor The Issue Of Hospital Conversions And Their Impact On The Provision Of Care For Indigent And Uninsured Persons

Options Related To The Indigent Health Care Trust Fund And The State And Local Hospitalization Program

Option V: Monitor The Indigent Health Care Trust Fund Pilot Project And Evaluate Results

Under this Option, the Joint Commission would not take any specific action at this time regarding the Indigent Health Care Trust Fund but would monitor the conversion pilot project in Northern Virginia and any other additional sites. At the appropriate time, an evaluation of the pilot(s) would be conducted to determine the feasibility of converting the entire fund into a subsidized health insurance program. Included in the evaluation should be an assessment of whether additional funds should be appropriated for the program and whether health care entities and/or providers other than hospitals should participate in the program.

Option VI: Take No Action Regarding The State And Local Hospitalization Program

Option VII: Increase The Amount Of Funding Appropriated For The State And Local Hospitalization Program

As noted in this report, there were approximately $17 million in eligible claims submitted to the SLH program that were denied due to a lack of funds. Because this fund is used to pay specific claims of indigent persons, additional funding would result in more indigent persons having their hospital claims paid. If the amount of state funding is increased, the local match (currently 25%) could remain the same which also would result in additional dollars from local governments. Conversely, the match rate could be lowered so that the amount of funding from localities would remain the same.

Options Related To The Purchase of Prescription Drugs By Indigent Persons And Health Insurance Coverage For Graduate Students

Option VIII: Request Carilion Health Systems To Present The Final Results And Findings Of Its Research Regarding The Impact Of Indigents' Inability To Purchase Prescribed Medications

Option IX: Take No Action Regarding Graduate Students Purchasing Health Insurance Coverage Through The State Employees' Benefits Program

Option X: Request The Institutions Of Higher Education To Survey Their Graduate Students To Determine How Many Would Purchase Health Insurance Through The State Program, And Report Their Findings To The Joint Commission

(A summary of the public comments received by the Joint Commission regarding the above Policy Options is provided at Appendix E.)

APPENDIX A

Senate Joint Resolution 298

SENATE JOINT RESOLUTION NO. 298

ecting the Joint Commission on Health Care, in cooperation with the Board and Department of Health, the Board and artment of Medical Assistance Services, the Commonwealth's academic health centers, and various governmental, public ...d private entities, to study the provision of health care for the indigent and uninsured.

Agreed to by the Senate, February 22, 1997
Agreed to by the House of Delegates, February 22, 1997

WHEREAS, indigent and uninsured Virginians are among the most vulnerable populations in terms of access to affordable, quality health care services; and

WHEREAS, research has found that persons without health insurance are less likely than those with insurance to receive needed medical services such as immunizations and routine check-ups, and, as a result, are more likely to develop conditions which could have been prevented or more successfully treated with early intervention and primary care; and

WHEREAS, within the health care marketplace, the indigent and uninsured often pay higher health care costs than persons with insurance because providers have negotiated contracts with insurers to provide services to their enrollees at a discounted price; and

WHEREAS, the provision and financing of health care services for the indigent and uninsured pose important and complex policy issues for state and local governments, the Commonwealth's academic health centers, and for businesses and health care providers; and

WHEREAS, the Virginia Indigent Health Care Trust Fund was established to help offset the expenses incurred by Virginia hospitals in providing care to the Commonwealth's indigent populations; and

WHEREAS, the limited funding available through the Indigent Health Care Trust Fund does not fully reimburse Virginia's hospitals for the total amount of indigent care provided; and

WHEREAS, the Indigent Health Care Trust Fund Technical Advisory Panel has been working for some time to establish a program for subsidizing private health insurance for the working poor, but has not yet been successful in implementing rogram; and

WHEREAS, the Commissioner of Health has announced that the Department of Health will sponsor a primary health care summit meeting in cooperation with public and private sector organizations to highlight innovative approaches which are expanding access to primary health care and to identify gaps that still need to be addressed; and

WHEREAS, a recent survey commissioned by the Virginia Health Care Foundation found that approximately 13 percent of Virginians, or 855,500 persons, have no health insurance of any kind; and

WHEREAS, an analysis of the survey data indicates that the percentage of the uninsured who are employed full time has increased 16 percent since 1993; and

WHEREAS, one of the founding purposes of the Joint Commission on Health Care was to ensure that the greatest number of Virginians receive quality, cost-effective health care services, including the indigent and uninsured populations; and

WHEREAS, during the past several years, there has been: (i) no analysis of the underlying reasons why persons are uninsured, (ii) no evaluation of current efforts and programs to reduce the number of uninsured Virginians and to provide services to the indigent, and (iii) no comprehensive analysis of new programs or policies to reduce the number of indigent and uninsured persons; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care, in cooperation with the Board of Health, the Department of Health, the Board of Medical Assistance Services, the Department of Medical Assistance Services, the Commonwealth's academic health centers, various governmental entities study the provision of health care for the indigent and uninsured. The joint commission shall also confer with local governments, the Virginia Health Care Foundation, the Virginia Indigent Health Care Trust Fund Technical Advisory Panel, the Virginia Primary Care Association, and other appropriate public and private entities, regarding various issues related to the provision of health care for the indigent and uninsured.

tudy shall include, but not be limited to: (i) an analysis of the recently completed survey on the insurance status of

Virginians; (ii) an evaluation of the underlying reasons for persons being uninsured; (iii) an assessment of the impact that not-for-profit to for-profit hospital conversions may be having on the indigent and uninsured; (iv) an assessment of the impact that the provision of care for these populations has on individual providers and hospitals, particularly the academic health centers; (v) an assessment of the role that projects supported by the Virginia Health Care Foundation and the Virginia Indigent Health Care Trust Fund play in meeting the needs of the uninsured; (vi) an evaluation of the appropriateness of expanding Medicaid coverage to certain segments of the uninsured population; (vii) an analysis of accessibility to child health preventive services; (viii) the analysis of the cause, prevalence, and impact of the inability of indigents to purchase prescribed medications, and (ix) an analysis of whether subsidies to purchase private health insurance should be implemented. As part of the study, the joint commission shall develop a program to be presented to the 1998 Session of the General Assembly and, if approved by the General Assembly, implemented by April 1, 1998, which will provide basic health insurance coverage for low-income, uninsured Virginians.

The joint commission shall submit its findings and recommendations to the Governor and the 1998 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

Phase I Report: Analysis of 1996 Health Access Survey on Insurance Status of Virginians

INDIGENT/UNINSURED STUDY (SJR 298):

PHASE I REPORT

Indigent/Uninsured Study: Phase I Report

Presentation Outline

- *1993 and 1996 Health Access Surveys*
- Virginia's Uninsured Population: 1996
- Recent Medicaid Expansions/Program Issues
- Key Findings/Trends/Conclusions

1993 and 1996 Health Access Surveys

Methodology

1993 Survey

Method: Telephone

Households: 1,332

Individuals: 3,502

Weighted? YES

Sampling Error: + or - 3% at 95% Confidence Level

1996 Survey

Method: Telephone

Households: 1,861

Individuals: 4,694

Weighted? YES

Sampling Error: + or - 2.27% at 95% Confidence Level

1993 and 1996 Health Access Surveys

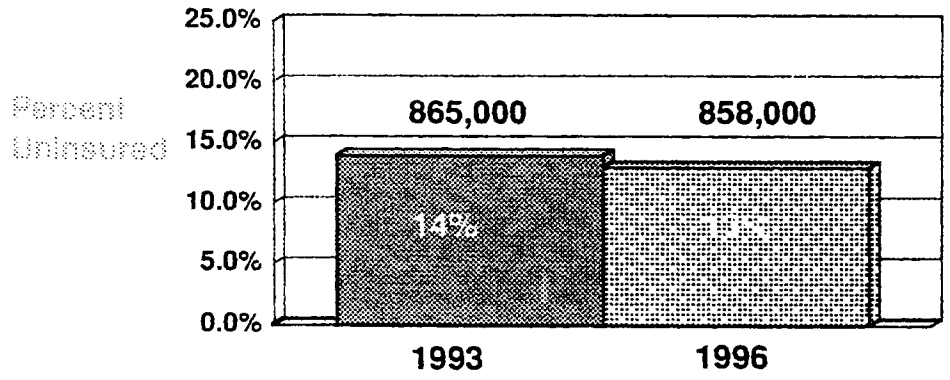
Data Limitations

- Survey findings are estimates only
- Despite weighting the data, some bias may still exist
- More detailed analyses limit the number of responses in a given category which can reduce the validity and/or reliability of the results
- More detailed analyses may be needed in certain areas

1993 and 1996 Health Access Surveys

5

Percentage of Uninsured Virginians Has Remained Relatively Constant



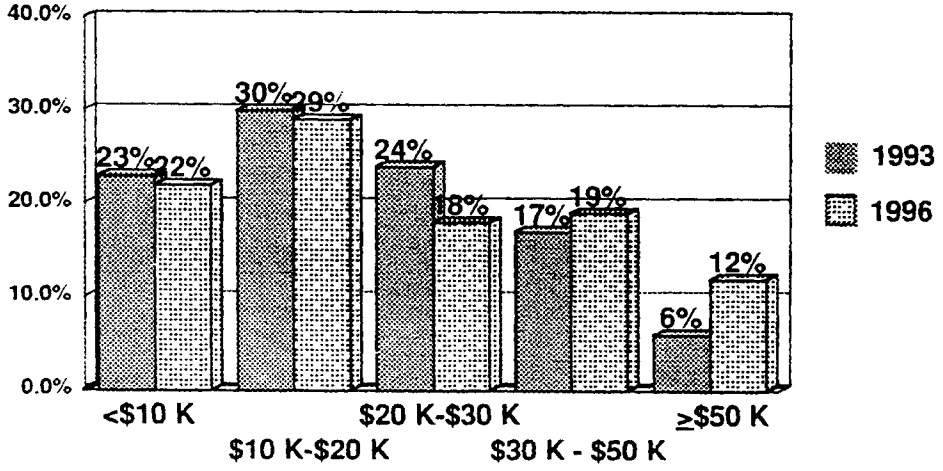
JCHC Staff Analysis: '93 & '96 Health Care Access Surveys

Joint Commission on Health Care

1993 and 1996 Health Access Surveys

6

Uninsured by Household Income

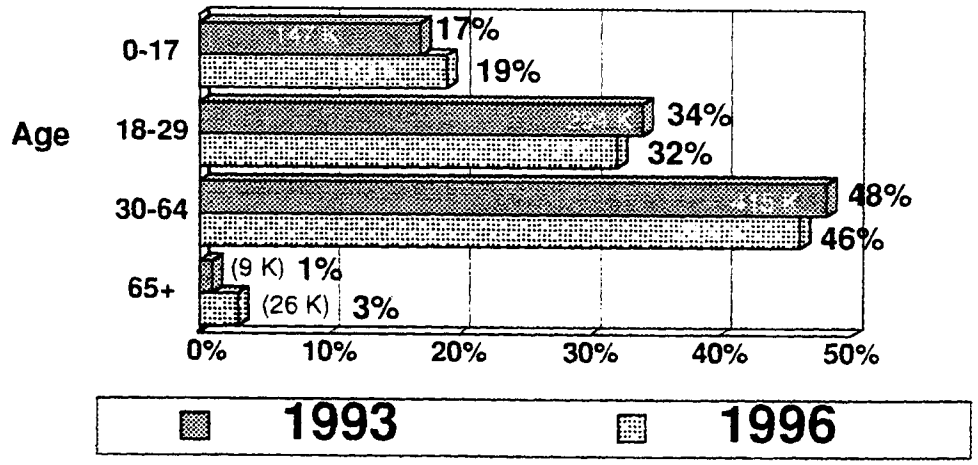


JCHC Staff Analysis: '93 & '96 Health Care Access Surveys

Joint Commission on Health Care

1993 and 1996 Health Access Surveys

Uninsured by Age

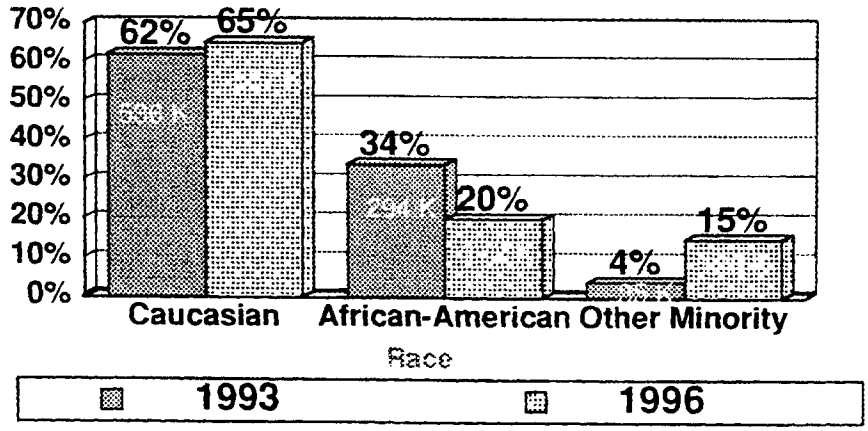


Source: JCHC Staff Analysis: '93 & '96 Health Care Access Surveys

Joint Commission on Health Care

1993 and 1996 Health Access Surveys

Uninsured by Race

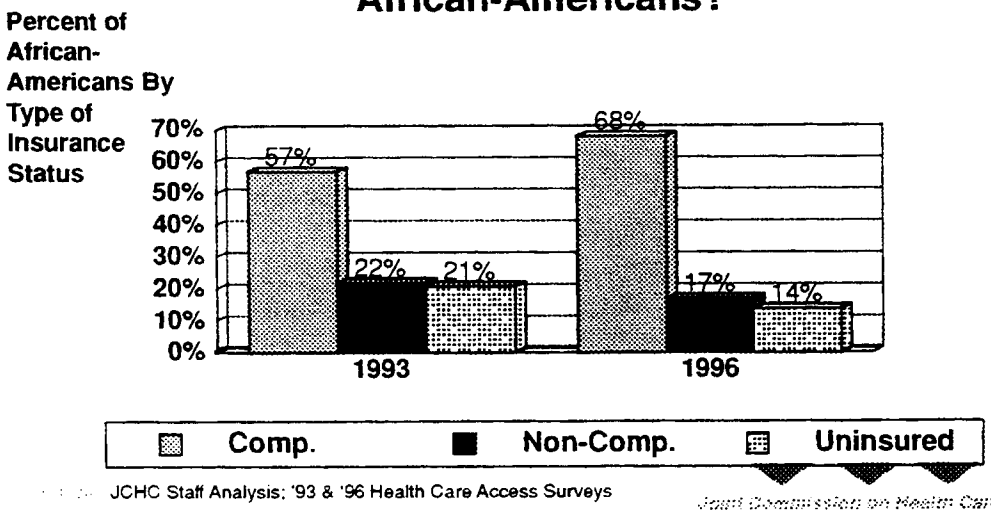


Source: JCHC Staff Analysis: '93 & '96 Health Care Access Surveys

Joint Commission on Health Care

1993 and 1996 Health Access Surveys

What Is The Insurance Status of African-Americans?

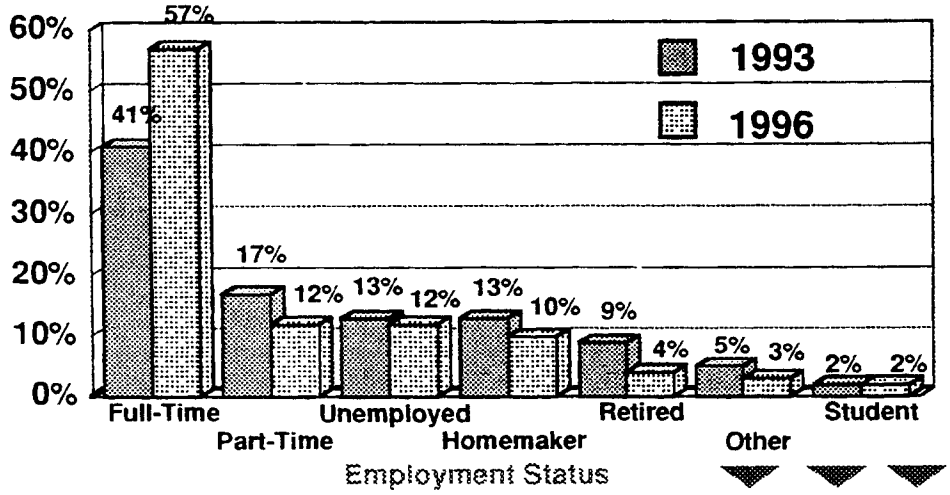


JCHC Staff Analysis: '93 & '96 Health Care Access Surveys

Joint Commission on Health Care

1993 and 1996 Health Access Surveys

Uninsured Adults By Employment Status

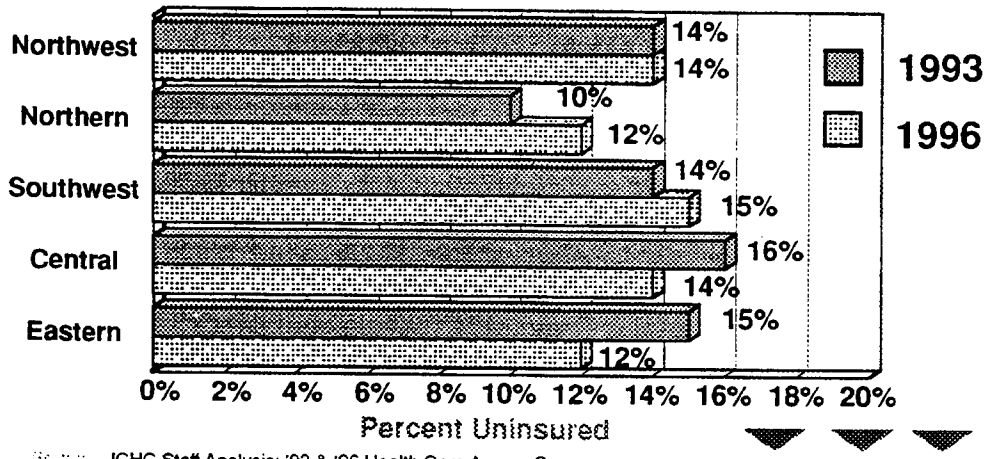


JCHC Staff Analysis: '93 & '96 Health Care Access Surveys

Joint Commission on Health Care

1993 and 1996 Health Access Surveys

Within Each Region, What Percent Are Uninsured?



JCHC Staff Analysis: '93 & '96 Health Care Access Surveys

Indigent/Uninsured Study: Phase I Report

Presentation Outline

- 1993 and 1996 Health Access Surveys
- *Virginia's Uninsured Population: 1996*
- Recent Medicaid Expansions/Program Issues
- Key Findings/Trends/Conclusions

Virginia's Uninsured Population: 1996

The Consequences of Being Uninsured

- Compared to persons with insurance, uninsured persons are less likely to:
  - have health problems or injuries treated
  - have a routine source of health care
  - receive necessary immunizations
  - receive necessary dental care

Virginia's Uninsured Population: 1996

Survey Data Confirm Adverse Impact of Being Uninsured

- When compared to persons with comprehensive coverage, uninsured persons:
  - visit clinics, hospitals, and doctors' offices less frequently;
  - have longer periods of time between medical care visits
  - are one-half as likely to regularly go to a dentist
  - are three times more likely to not get a prescription filled because it costs too much; and
  - are four times more likely to take a smaller than prescribed dose of prescription drug

Virginia's Uninsured Population: 1996

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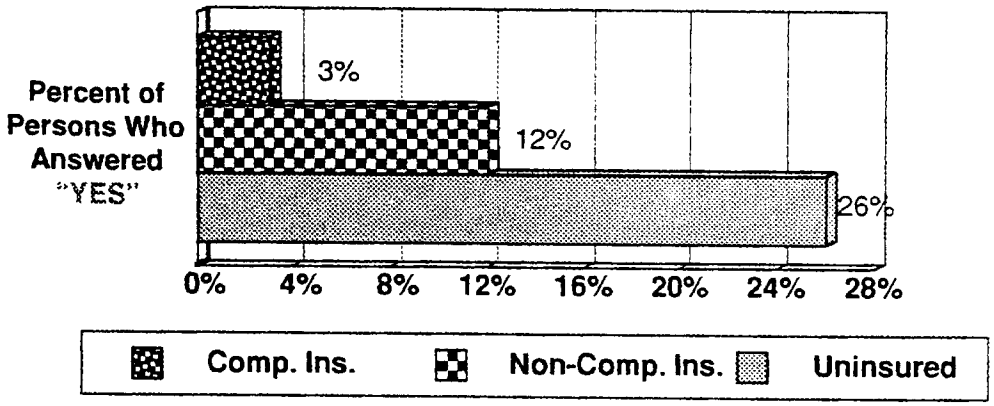
Was There A Time During The Past Year That You Were Unable To Get Needed Health Care?



Source: JCHC Staff Analysis; '96 Health Care Access Survey

Joint Commission on Health Care

Virginia's Uninsured Population: 1996

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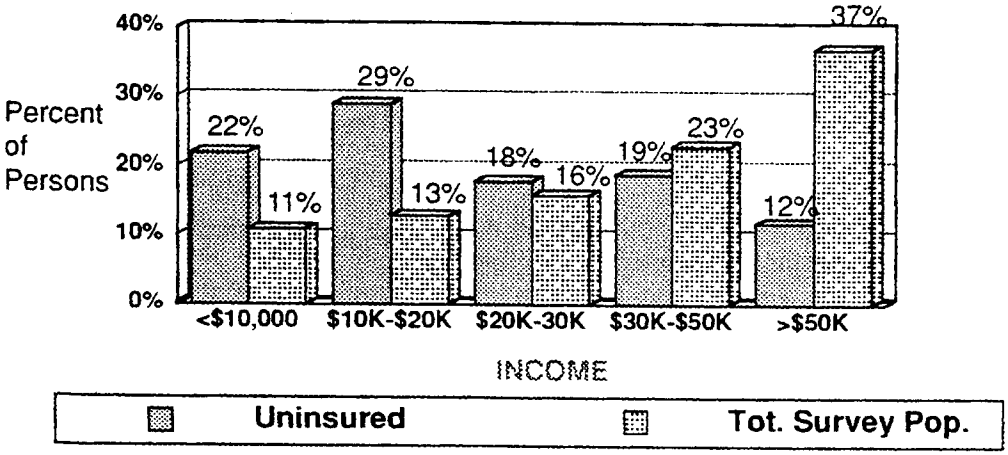
Uninsured vs. Population: Income

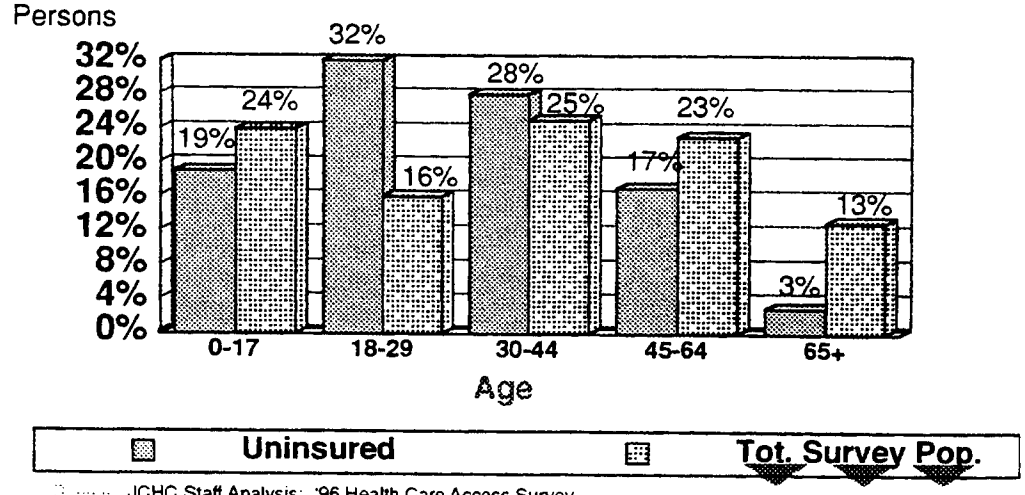


Source: JCHC Staff Analysis; '96 Health Care Access Survey

Joint Commission on Health Care

Virginia's Uninsured Population: 1996

Uninsured vs. Population: Age

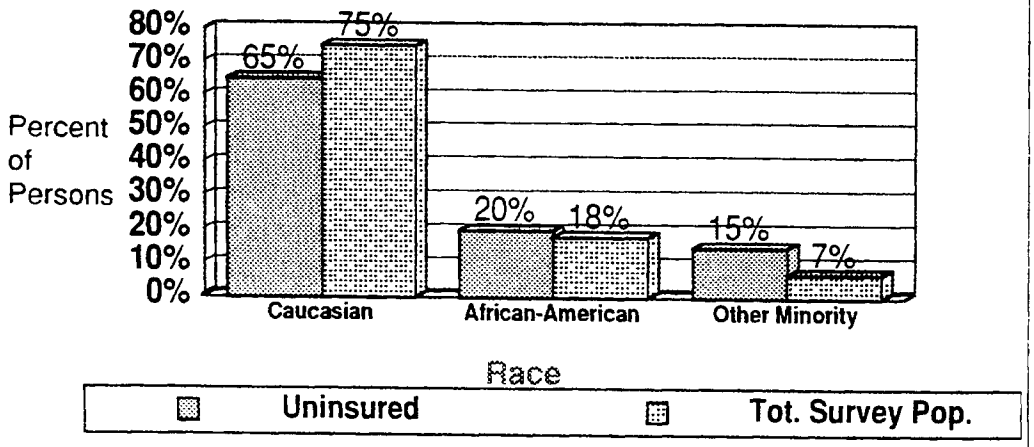


JCHC Staff Analysis; '96 Health Care Access Survey

Joint Commission on Health Care

Virginia's Uninsured Population: 1996

Uninsured vs. Population: Race



JCHC Staff Analysis; '96 Health Care Access Survey

Joint Commission on Health Care

Virginia's Uninsured Population: 1996

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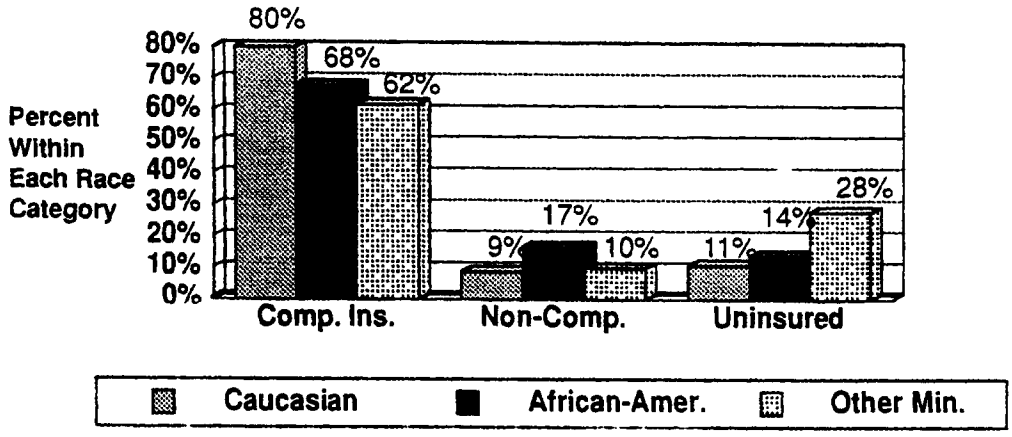
What Is The Insurance Status By Race?



Source: JCHC Staff Analysis; '96 Health Care Access Survey

Joint Commission on Health Care

Virginia's Uninsured Population: 1996

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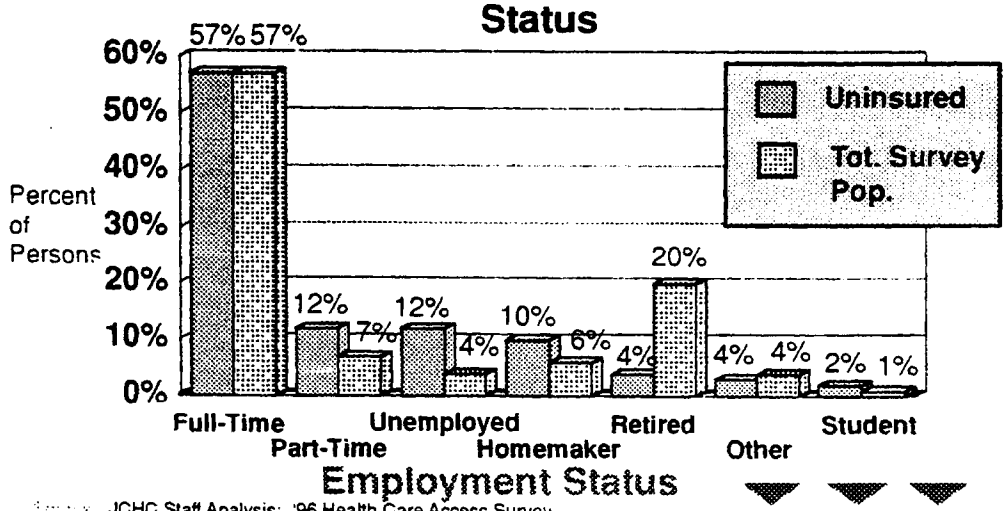
Uninsured vs. Population: Employment Status

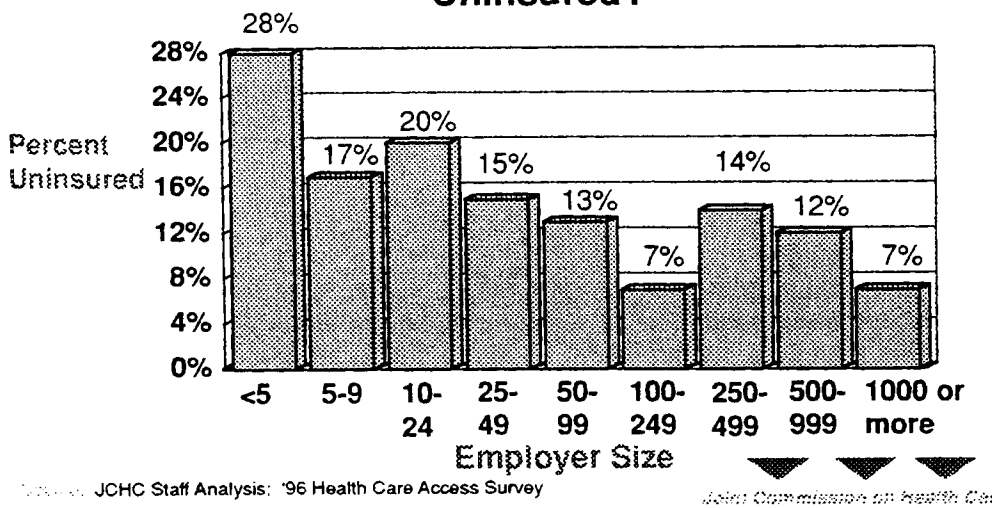


Source: JCHC Staff Analysis; '96 Health Care Access Survey

Joint Commission on Health Care

Virginia's Uninsured Population: 1996

By Size of Employer, What Percent Are Uninsured?

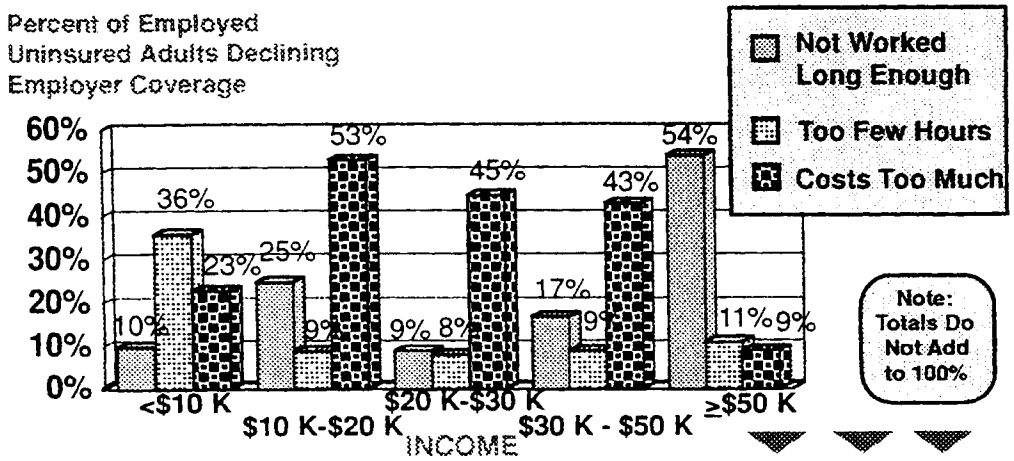


JCHC Staff Analysis: '96 Health Care Access Survey

Joint Commission on Health Care

Virginia's Uninsured Population: 1996

51% of Uninsured Adults Are Offered Coverage by Employer, Why Was Coverage Declined?

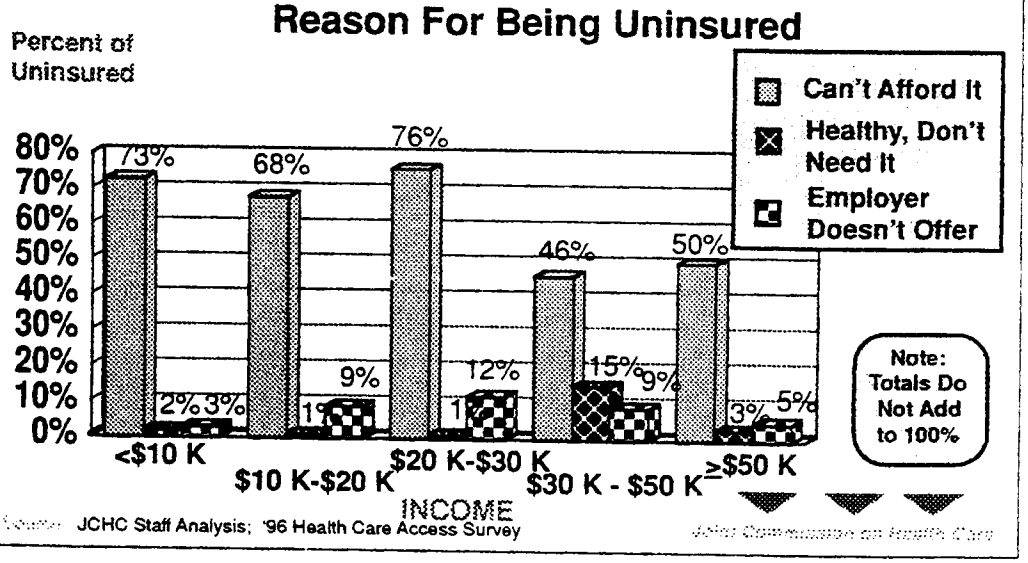


JCHC Staff Analysis: '96 Health Care Access Survey

Joint Commission on Health Care

Virginia's Uninsured Population: 1996

Cost Is Identified Most Often As The Main Reason For Being Uninsured



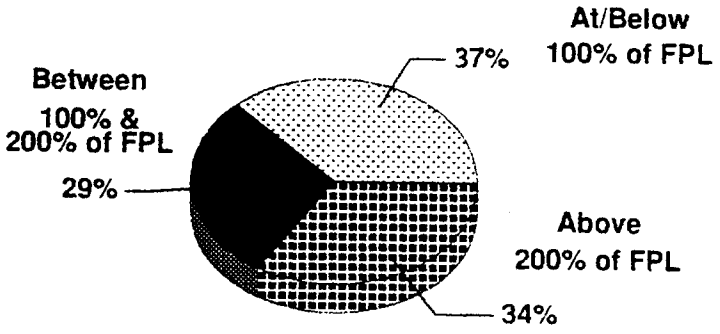
Note: Totals Do Not Add to 100%

Source: JCHC Staff Analysis; '96 Health Care Access Survey

Joint Commission on Health Care

Virginia's Uninsured Population: 1996

Many of Virginia's Uninsured Are At Or Near The Federal Poverty Level

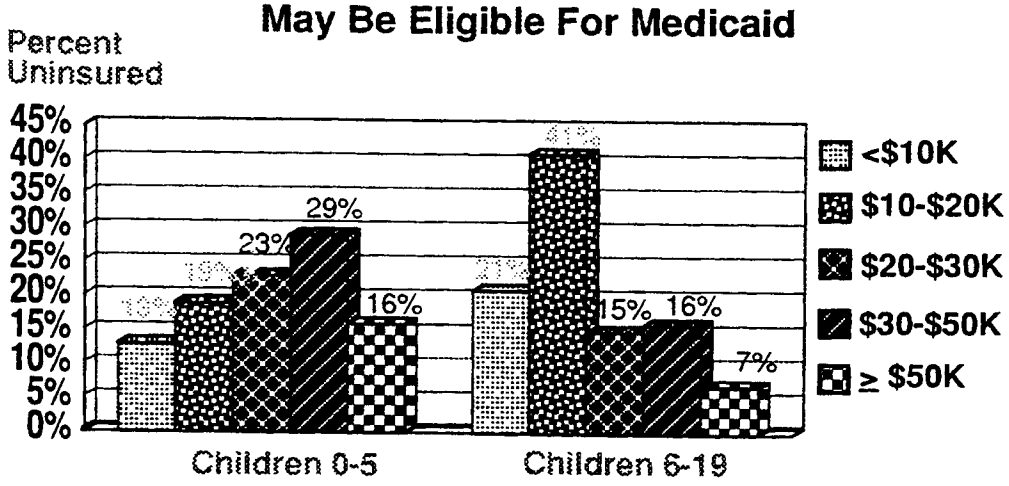


Source: JCHC Staff Analysis; '96 Health Care Access Survey

Joint Commission on Health Care

Virginia's Uninsured Population: 1996

A Portion of Virginia's Uninsured Children May Be Eligible For Medicaid



JCHC Staff Analysis; '96 Health Care Access Survey

Indigent/Uninsured Study: Phase I Report

Presentation Outline

- 1993 and 1996 Health Access Surveys
- Virginia's Uninsured Population: 1996
- *Recent Medicaid Expansions/Program Issues*
- Key Findings/Trends/Conclusions

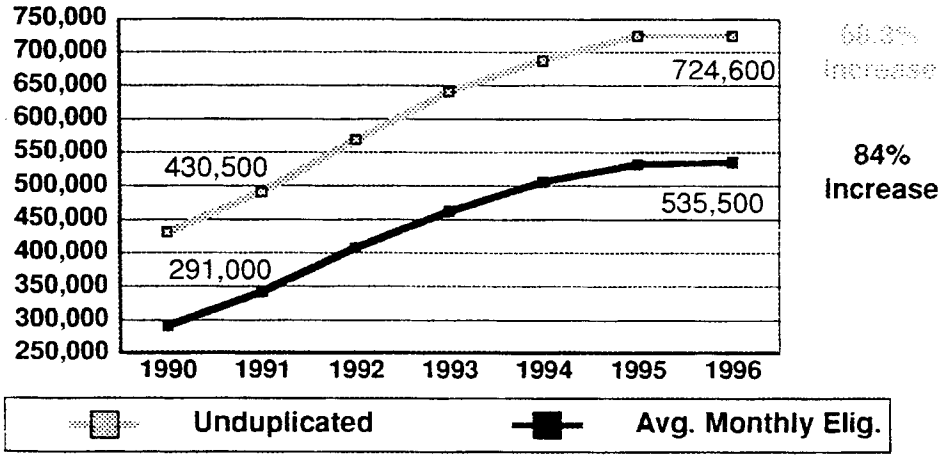
Recent Medicaid Expansions/Program Issues

Major Eligibility Categories

- Aged, Blind & Disabled
- Adults With Children (at or below 133% of FPL)
  - primarily pregnant women
  - other adults with children
- Children <21
  - children < 1 (133% of FPL)
  - children 1-5 (133% of FPL)
  - children 6-19 (100% of FPL)
  - foster care,corrections, subsidized adoptions, nursing facility resident (very few in these categories)

Recent Medicaid Expansions/Program Issues

Unduplicated vs. Average Monthly Eligibles



66.8% Increase

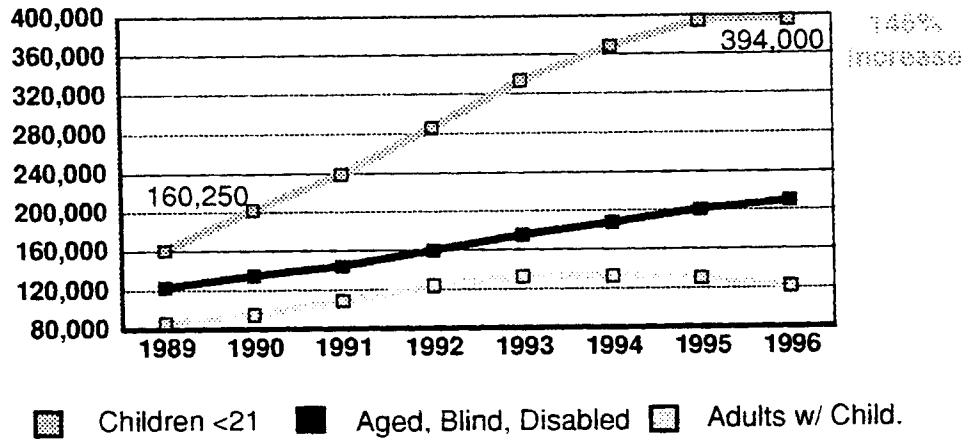
84% Increase

Source: DMAS, Statistical Record of Medicaid Program, 1996

Recent Medicaid Expansions/Program Issues

29

Largest Increase Has Been "Children Under 21"



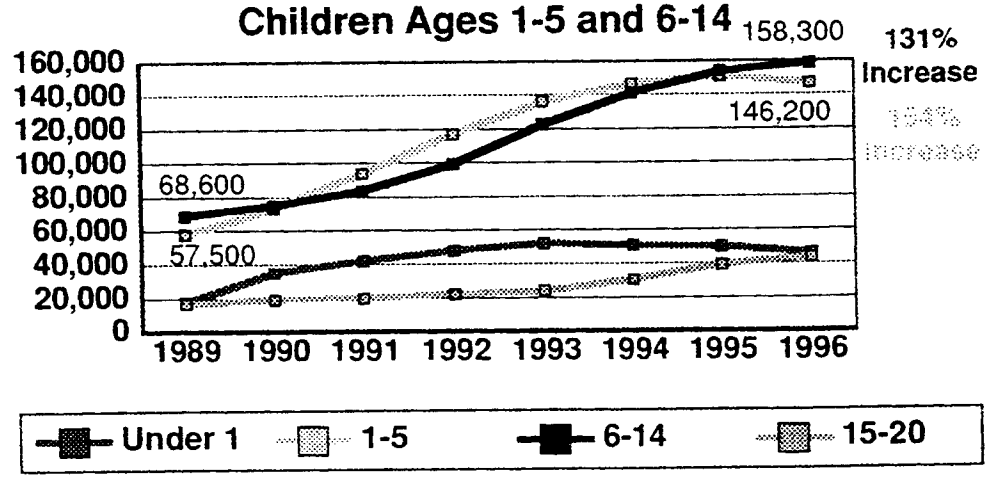
DMAS, Statistical Record of Medicaid Program, 1996

Joint Commission on Health Care

Recent Medicaid Expansions/Program Issues

30

Greatest Increases Have Occurred in Children Ages 1-5 and 6-14

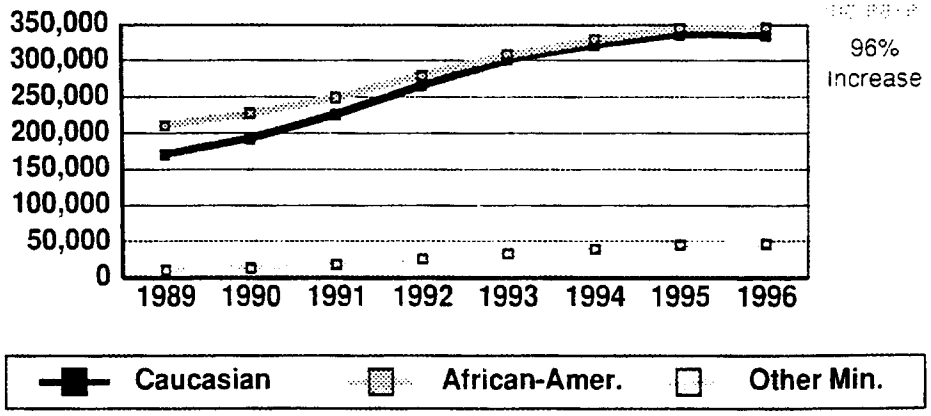


DMAS, Statistical Record of Medicaid Program, 1996

Joint Commission on Health Care

Recent Medicaid Expansions/Program Issues

Increases in Medicaid by Race



DMAS, Statistical Record of Medicaid Program, 1996

Recent Medicaid Expansions/Program Issues

Primary Reasons for Increased Medicaid Populations

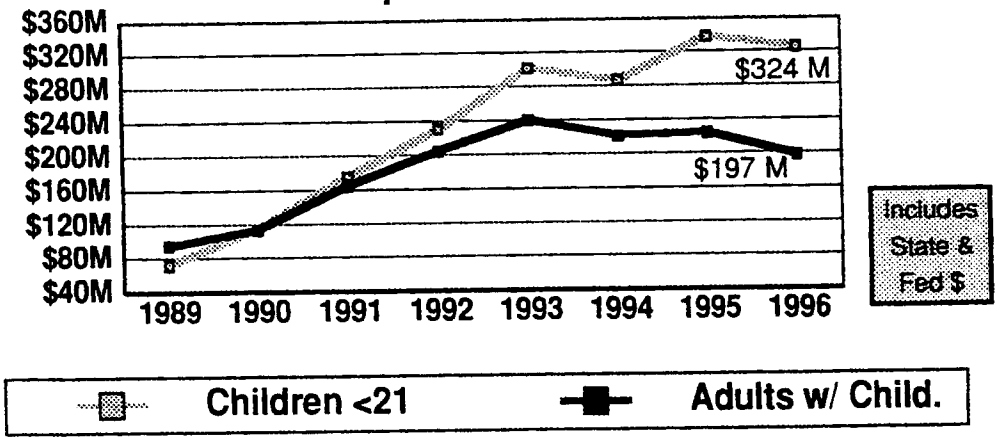
1988	1989	1990
Medicare Catastrophic Coverage Act Mandated Coverage of Pregnant Women and Infants ≤ 100% FPL	Omnibus Budget Reconciliation Act (OBRA) Mandated Coverage of Pregnant Women and Children <6 ≤ 133% FPL	OBRA '90 Mandated Phased-In Coverage of Children 6-18 ≤ 100% FPL (Va. Implemented Expansion Early) Mandated Coverage of Low-Income Medicare Beneficiaries

DMAS, Statistical Record of Medicaid Program, 1996

Recent Medicaid Expansions/Program Issues

33

Expansions Have Helped Fuel Medicaid Expenditure Growth



DMAS, Statistical Record of Medicaid Program, 1996

Indigent/Uninsured Study: Phase I Report

34

Presentation Outline

- 1993 and 1996 Health Access Surveys
- Virginia's Uninsured Population: 1996
- Recent Medicaid Expansions/Program Issues
- *Key Findings/Trends/Conclusions*

Key Findings/Trends/Conclusions

35

Consequences of Being Uninsured

- Survey data confirm that uninsured are less likely to:
  - receive needed health care;
  - have a routine source of health care; and
  - get needed prescriptions filled

Key Findings/Trends/Conclusions

36

1996 Compared to 1993

- The total number and percentage of the population who are uninsured has remained relatively stable
- Analysis of the uninsured by age and region shows little variation over time
- A substantial increase was seen in the percentage of the uninsured who earn $50,000 or more
- There was a substantial decrease in the percentage of the uninsured who are African-Americans

Key Findings/Trends/Conclusions

1996 Compared to 1993 (cont'd)

- There was a significant increase in the percentage of the uninsured who are employed, full-time
  - may reflect change in employer/employee premium contributions
  - cost increases also may have caused some employers to drop coverage
  - some health care experts estimate that 15-33% of the drop in employer coverage can be attributed to increased availability of Medicaid

Key Findings/Trends/Conclusions

Characteristics of 1996 Uninsured

- Lower income persons (<$20K), younger adults (18-29), and "other minorities" make up a significantly greater percentage of the uninsured than of the total population
- Small employers (<5) have the highest percentage of workers who are uninsured (28%)
- A substantial portion of Virginia's uninsured population is at or near the Federal Poverty Level
  - some may be eligible for Medicaid
- Cost/affordability of insurance remains a significant barrier to coverage

Key Findings/Trends/Conclusions

Medicaid Expansions

- Largest increase has been in "Children <21"
  - within this category, the number of children ages 1-5 and 6-14 have seen greatest growth
- Despite Medicaid expansions for children, the percentage of the uninsured who are age 0-17 has increased slightly since 1993 (1993: 17%; 1996: 19%)
- A sizable portion of uninsured children ages 0-5 and 6-19 may be eligible for Medicaid
- There is a sizable number of uninsured families at or below 200% of FPL; children <18 in these families would be eligible for services through the Virginia Children's Medical Security Insurance Plan

Key Findings/Trends/Conclusions

Next Steps

- **Further survey analysis**
  - **estimate uninsured persons eligible for Medicaid**
  - **analyze number of elderly Virginians on Medicare who might also be eligible for Medicaid**
  - **others?**
- **Roundtable discussions with employers who do not offer coverage**
- **Assess impact of potential Medicaid expansions**

Key Findings/Trends/Conclusions

Next Steps (cont'd)

- Analyze Indigent Health Care Trust Fund/SLH Programs
- Review programs in other states to reduce the number of uninsured persons
- Analyze potential for purchasing cooperatives for small businesses
- Site visits (Staff/Subcommittee)

APPENDIX C

Medicaid Expansions in Other States

,pendix C

Expanded Medicaid Coverage of Pregnant Women, Infants, and Children, August 1996 and Federal Medicaid Matching Fund Rate for 1997

State	Pregnant Women and Infants	Children Below Age Six	Children Ages Six and Above[a]		Medicaid Match Rate (%)
	Greater than 133% of FPL	Greater than 133% of FPL	Greater than 100% of FPL	and/or Ages 14 and Above	
Alabama					69.54
Alaska					50.00
Arizona	140%			14	65.53
Arkansas					73.29
California	200%				50.23
Colorado					52.32
Connecticut	185%	185%	185%		50.00
Delaware	185%			19	50.00
Florida	185%				55.79
Georgia	185%			19	61.52
Hawaii[b]	300%	300%	300%	19	50.00
Idaho					67.97
Illinois					50.00
Indiana	150%				61.58
Iowa	185%				62.94
Kansas	150%			17	58.87
Kentucky	185%				70.09
Louisiana					71.36
Maine	185%		125%	19	63.72
Maryland[c]	185%	185%	185%		50.00
Massachusetts	185%				50.00
Michigan	185%	150%	150%	17[d]	55.20
Minnesota	275%				53.60
Mississippi	185%				77.22
Missouri	185%			19	60.04

State	Pregnant Women and Infants	Children Below Age Six	Children Ages Six and Above[a]		Medicaid Match Rate (%)
	Greater than 133% of FPL	Greater than 133% of FPL	Greater than 100% of FPL	and/or Ages 14 and Above	
Montana					69.01
Nebraska	150%			17	59.13
Nevada					50.00
New Hampshire	185%	185%	185%		50.00
New Jersey	185%			19	50.00
New Mexico	185%	185%	185%	19	72.66
New York	185%				50.00
North Carolina	185%			19	63.89
North Dakota				18	67.73
Ohio					59.28
Oklahoma	150%				70.01
Oregon				19	60.52
Pennsylvania	185%				52.85
Rhode Island[e]	250%	250%	[250%][100%][f]	[8][13][f]	53.90
South Carolina	185%				70.43
South Dakota				19	64.89
Tennessee	400%[g]	400%[g]	400%[g]		64.58
Texas	185%				62.56
Utah				18	72.33
Vermont	[200%][225%][h]	225%	225%	18	61.05
Virginia				19	51.45
Washington	[185%][200%][i]	200%	200%	19	50.52
West Virginia	150%			19	72.60
Wisconsin	185%	185%			59.00
Wyoming					59.88
TOTAL	**34 States**	**11 States**	**24 States**		

Notes for Appendix C

FPL = federal poverty level.

a. Under the Omnibus Reconciliation Act of 1990, states are required to provide Medicaid coverage to children ages six and older born after September 30, 1983--currently thirteen years old--living in families with income below 100 percent of the federal poverty level (FPL). This column indicates those states that cover (1) children ages 13 and under with incomes greater than 100% of poverty, (2) children greater than age 13 with incomes up to 100% of poverty, or (3) a combination of both.

b. Hawaii's coverage of pregnant women and children is through Hawaii QUEST, a Section 1115 waiver managed care program. Income eligibility is established if income does not exceed 300 percent of the FPL. However, fully subsidized coverage is provided if income does not exceed 185 percent of the FPL. For children ages one through five, fully subsidized coverage is provided if income does not exceed 133 percent of the FPL. For children ages six and above, fully subsidized coverage is provided if income does not exceed 100 percent of the FPL. When income exceeds the applicable income limits of 185 percent, 133 percent, or 100 percent of the FPL for the respective groups, the recipient is eligible to participate in Hawaii QUEST but must cover the full cost of the premium.

c. For children ages one through five, fully subsidized Medicaid coverage is provided in Maryland if income does not exceed 133 percent of the FPL. Children below age six receive a primary care benefits package if income is below 185 percent of poverty. For children ages six and above born after September 30, 1983, fully subsidized Medicaid coverage is provided if income does not exceed 100 percent of the FPL. Children ages six and above born after September 30, 1983, and whose income is below 185 percent of poverty receive a primary care benefits package.

Defined in Michigan as being born after June 30, 1979.

e. For individuals in family units with incomes between 185 percent and 250 percent of the FPL, cost sharing in Rhode Island is incorporated at the point of service or on a premium basis.

f. In Rhode Island, children ages six or seven are covered at 250 percent of the FPL and children ages eight through twelve are covered at 100 percent of the FPL.

g. Tennessee's coverage of pregnant women and children is through TennCare, a Section 1115 waiver program. Pregnant women and infants are automatically eligible if income is below 185 percent of the FPL. Children below age six are automatically eligible if income is below 133 percent of the FPL; children ages six and above born after September 30, 1983, are automatically eligible if income is below 100 percent of the FPL. Tennessee also covers individuals above the specified income thresholds who were uninsured as of March 1, 1993. When income exceeds the applicable income limits specified above, the TennCare recipient must pay premiums the subsidy for which is fully phased out at 400 percent of the FPL. Under certain conditions, Tennessee may suspend enrollment of expanded eligibility groups.

h. In Vermont, pregnant women are covered at 200 percent of the FPL and infants are covered at up to 225 percent of the FPL.

I. In Washington, pregnant women are covered at 185 percent of the FPL and infants are covered at up to 200 percent of the FPL.

Source: National Governors' Association, August 1996.

APPENDIX D

Summary of Public Comments on Phase II Report

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS: INDIGENT/UNINSURED PHASE II REPORT

Individuals/Organizations Submitting Comments

A total of 11 individuals and organizations submitted comments in response to the Phase II Issue Brief.

American Association of Retired Persons
Janet Eddy, M.D.
Kaiser Permanente
Trigon BlueCross BlueShield
Virginia Academy of Family Physicians
Virginia Association of Free Clinics
Virginia Association of HMOs
Virginia Association of Health Underwriters/Va. Association of Life Underwriters/Association of Health Insurance Agents
Virginia Hospital & Healthcare Association
Virginia Poverty Law Center
Virginia Primary Care Association

Policy Options Included in Phase II Issue Brief

The following policy options were included in the Phase II report for consideration by the Joint Commission. They do not represent the entire range of actions that the Joint Commission may wish to pursue. Also, these policy options are not meant to be mutually exclusive of one another; combinations of various options can be implemented.

Option I: Introduce Legislation Directing The Department Of Medical Assistance Services, In Cooperation With The Department Of Social Services, To Implement A Comprehensive Outreach Program To Enroll Children Eligible, But Not Enrolled In Medicaid.

As part of this Option, consideration should be given to approving an additional position(s) and funding to coordinate DMAS' outreach program.

Option II: Introduce Legislation To Expand Medicaid Eligibility For Certain Populations

Within this option, several alternatives could be pursued:

A. Expand eligibility for pregnant women and infants to either 150% or 185% of the Federal Poverty Level (FPL).
B. Expand eligibility for children ages 1-6 to either 150% or 185% of the FPL.
C. Expand eligibility for children ages 6-19 to either 133%, 150%, or 185% of the FPL.

Option III: Introduce Legislation To Establish A Purchasing Cooperative For Small Employers And Individuals

Option IV: Introduce Legislation Which Encourages And Provides Incentives For The Formation of Private Purchasing Cooperatives For Small Employers And Individuals

Option V: Introduce A Study Resolution And Appropriate Budget Amendment Directing The Department of Personnel And Training (DPT), In Cooperation With the Joint Commission On Health Care, The Bureau Of Insurance, And Other Appropriate Entities To Analyze Whether THE LOCAL CHOICE Program Could Be Expanded To Include Private Employers And/Or Individuals

Option VI: Introduce A Budget Amendment To Provide Funding To The Bureau Of Insurance For Consulting/Actuarial Assistance To Expedite The Special Advisory Commission on Mandated Benefits' Review Of The Essential And Standard Plans

There is growing concern and evidence that the current design of the Essential and Standard Benefits Plans needs to be revised. The Special Advisory Commission on Mandated Health Benefits has been given authority to review and update the plans. In order to expedite the review and update of the plans, Option VI would provide funding to the Bureau of Insurance which provides staff support to the Commission in order to expedite this process. The funds would be used to hire a consultant and/or actuary to complete the review and make recommendations to the Commission. The Commission then would recommend changes to the Bureau to amend the current regulations.

Option VII: Introduce Legislation To Expand The Guaranteed Issue And Modified Community Rating Reforms To The Self-Employed And Sole Proprietors

Option VIII: Introduce Legislation To Amend §38.2-3431(D)(7) To Require That Small Employer Carriers Advertise The Availability Of The Essential And Standard Plans

This option would require each small employer carrier authorized to sell the Essential and Standard Plans to advertise the availability of the plans at least 12 times annually in a newspaper(s) of general circulation throughout its service area. This provision would be similar to the advertising requirements for open enrollment carriers.

Option IX: Introduce Legislation To Extend The Modified Community Rating Reforms, Which Currently Apply Only To Essential And Standard Plans Issued To Primary Small Groups (2-25), To Other Types Of Coverage And/Or To Groups Up To 50 Employees

Option X: Introduce Legislation To Extend The Guaranteed Issue And Modified Community Rating Reforms To The Individual Market

Option XI: Increase The Amount Of Funds Appropriated For The Virginia Health Care Foundation To Provide Additional Support To "Test Models" Across The Commonwealth Providing Care To Indigent/Uninsured Persons

Option XII : Provide Direct Funding To Programs Across The Commonwealth Providing Care To Indigent/Uninsured Persons Such As Community Health Centers, Free Clinics, Etc.

In addition to providing financial support to these and other types of programs, this Option also could include taking other actions to improve the ability of these programs to serve their targeted populations. For instance, the Virginia Primary Health Care Association has indicated that revisions to the Virginia Solicitation of Contributions Law to include CHCs as exempted organizations would be beneficial to the centers in their fundraising efforts. Also, the VPHCA suggested other actions, such as establishing a process for defining and qualifying primary care practices as Virginia Qualified Health Centers. There may be similar types of actions that could be taken to assist other programs.

Option XIII: Increase Funding To The Department of Health And/Or Local health Departments To Enhance Their Ability To Provide Primary And Preventive Health Care Services To The Indigent/Uninsured

Overall Summary of Public Comments

American Association of Retired Persons

William L. Lukhard submitted comments on behalf of the Virginia State Legislative Committee of the American Association of Retired Persons (AARP). Mr. Lukhard stated that the AARP supports all thirteen options as potential positive actions which could lower the number of indigent/uninsured persons in Virginia and provide them with health care. Specifically, he expressed strong support for Options III through X which attempt to increase coverage for the uninsured through the private sector. Regarding Options I, II, XI, XII and XIII which involve state appropriations to cover costs of health care coverage, Mr. Lukhard stated that whereas children and young

adults make up the largest portion of the indigent/uninsured, this report is lacking in two major respects. First, he commented that there was no reference to the elderly indigent/uninsured who could benefit from a drug program due to the high costs of drugs. Second, he stated that the options requiring additional state appropriations did not include any cost estimates nor identify potential sources of funding.

Janet Eddy, M.D.

Dr. Eddy commented that the Joint Commission should consider ways to involve physicians more in programs that serve indigent persons and include them as part of a statewide plan. She also suggested that before Medicaid is expanded, efforts are needed to determine the number of providers who will accept Medicaid.

Kaiser Permanente

Todd R. House, Government Relations Representative, expressed support for extending modified community rating reforms to all other types of coverage for employers (2-50). He also recommended against advertising requirements for Essential and Standard plans. Mr. House also expressed support for implementation of a purchasing cooperative and stated that such a cooperative would require the enactment of strict rating requirements for the small group market.

Trigon BlueCross BlueShield

Leonard L. Hopkins, Jr. recommended that a study of THE LOCAL CHOICE program be conducted before considering legislation to establish or provide incentives for purchasing cooperatives. Additionally, he recommended that additional study is needed regarding further insurance reforms or "fine tuning" of existing reforms. He expressed support for providing extraterritorial jurisdiction over policies issued in other states that cover persons in Virginia to ensure all carriers and products adhere to Virginia regulations.

Virginia Academy of Family Physicians

James L. Ghaphery, M.D., Physician Representative, expressed support for incentives for employer-based coverage and purchasing cooperatives. He also expressed support for expanding Medicaid to 185% of poverty and providing state and/or private subsidies for those who cannot afford basic coverage. Additionally, the Academy favors increased taxes on tobacco and alcohol to fund these programs.

Virginia Association of Free Clinics

Rebecca F. Noftsinger, Chair, Resource Development Committee, submitted comments in support of Option XII to provide direct funding to programs providing care to indigent/uninsured persons, such as Community Health Centers and Free Clinics. She also recommended direct funding to the Association of Free Clinics. Ms. Noftsinger suggested that regulatory barriers be removed which prevent local health departments from donating used property to Free Clinics. She recommended upholding Virginia's current legislation which provides immunity to health care providers delivering services in Free Clinics and requested assistance in finding a means to provide employees with affordable health insurance coverage and other benefits, in order that they may retain quality, experienced staff.

Virginia Association of HMOs (VAHMO)

Mark C. Pratt, Director of Policy, stated that the VAHMO was not offering formal positions on the policy options at this time; however, the Association did suggest that perhaps the most important consideration in addressing the issue of the uninsured is recognizing what <u>not</u> to do and that policymakers should refrain from enacting laws that increase the cost of coverage or restrict affordable options for purchasers.

Virginia Association of Health Underwriters/Va. Association of Life Underwriters/ Association of Health Insurance Agents

Susan Maley Rash and Richard Herzberg commented in support of Options I and VI. The Associations also support expanding guaranteed issue and modified community rating to self-employed but only if all insurers much comply with the law. The Associations raised a number of questions regarding purchasing cooperatives, and do not support options to establish or provide incentives for HIPCs. Lastly, the Associations oppose individual market reforms until all insurers, including group trusts and associations, must comply with the law. The Associations would be very supportive of further reforms if group trusts and associations must comply with the reforms.

Virginia Hospital & Healthcare Association

Katharine M. Webb, Senior Vice President, expressed support for changes that use Medicaid resources most effectively and encourage employer-based insurance. She recommended that the General Assembly establish a long-term plan that phases in legislative and programmatic changes to expand coverage for the poor and working uninsured and that the plan be outlined in a joint resolution. Ms. Webb stated that the first year of the plan include: (i) outreach programs to enroll children eligible for Medicaid; (ii) expand THE LOCAL CHOICE program; and (iii) pilot-test subsidized health insurance products.

Virginia Poverty Law Center

Jill A. Hanken, Staff Attorney, expressed strong support for Options I, II, XI, XII and XIII. Ms. Hanken indicated that the Policy Options regarding insurance reforms will make coverage more available to the uninsured. She urged the Joint Commission to consider ways to assist low income elderly and disabled people.

Virginia Primary Care Association

John B. Cafazza, Jr., Executive Director, expressed support for Option XII to provide state funding to support existing Community Health Centers and supported development of a Virginia Qualified Health Center model. Mr. Cafazza believes an expanded partnership with the Virginia Health Care Foundation could improve care for Virginia's underserved persons.

APPENDIX E

Summary of Public Comments on Phase III Report

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS: INDIGENT/UNINSURED PHASE III REPORT

Individuals/Organizations Submitting Comments

A total of 10 individuals and organizations submitted comments in response to the Phase III Issue Brief.

Virginia Department of Health
Virginia Primary Care Assoc.
Va. Hospital & Healthcare Assoc.
N. Va. Access to Health Care Consort.
Va. Pediatric Soc./Va. Chapt. AAP
Sentara Health System
Betty L. Newell
Va. Poverty Law Center
INOVA Health System
James C. Turner, MD (UVA)

The Virginia Chamber of Commerce submitted "preliminary comments" on the insurance related options included in the Phase II Issue Brief.

Policy Options Included in Phase III Issue Brief

Policy Options on Children's Health Issue

Option I: **The Joint Commission on Health Care staff and Indigent/Uninsured Subcommittee would work with the appropriate state agencies and other public/private health care entities to develop Virginia's State Child Health Plan as required by the Federal children's health initiative.**

Policy Options on Not-for-Profit Hospital Conversions

Option II: Take No Action.

Option III: Invite the foundations that have been created as the result of hospital conversions in Virginia to periodically update the Joint Commission on the charitable activities of their organizations.

Option IV: Introduce a study resolution directing the Joint Commission to monitor the issue of hospital conversions and their impact on the provision of care for indigent and uninsured persons.

Policy Options on Indigent Health Care Trust Fund and the State/Local Hospitalization Program

Option V: Monitor the Indigent Health Care Trust Fund Pilot Project and evaluate results.

Option VI: Take no action regarding the State/Local Hospitalization Program.

Option VII: Increase the amount of funding appropriated for the State/Local Hospitalization Program.

Policy Options on Purchase of Prescription Drugs by Indigent Persons

Option VIII: Request Carilion Health Systems to present the final results and findings of its research regarding the impact of indigents' inability to purchase prescribed medications.

Policy Options On Health Insurance Coverage for Graduate Students

Option IX: Take no action regarding graduate students purchasing health insurance coverage through the state employees' benefits program.

Option X: **Request the institutions of higher education to survey their graduate students to determine how many would purchase health insurance through the state program, and report their findings to the Joint Commission.**

Overall Summary of Public Comments

Children's Health

Virtually all those submitting comments expressed support for Option 1 which calls for the Indigent/Uninsured Subcommittee and the Joint Commission staff to work with other appropriate entities in developing Virginia's response to the new children's health initiative. Commissioner of Health, Randolph L. Gordon, commented that the Department of Health has identified a potential role in implementing the new program, including measuring quality, identifying appropriate benefit packages, establishing eligibility requirements, developing strategic health objectives, using VDH's VISION system as an information management system, and supporting community-based activities.

The Virginia Primary Care Association (VPCA) recommended that, whenever possible, the state contract directly with community health centers to provide services to uninsured children. The VPCA also suggested transferring funding from other programs (i.e., Indigent Health Care Trust Fund, State/Local Hospitalization Program, and the Virginia Medical Security Insurance Plan) to finance the new program.

The Virginia Chapter of the American Academy of Pediatrics/Virginia Pediatric Society commented that the new children's program should be consistent with its principles and philosophies on access to health care (e.g., preventive health services, a medical home for each child, choice of provider, and adequate physician compensation).

The Northern Virginia Access to Health Care Consortium (NVAHCC) recommended the new program work with local jurisdictions to provide coverage and deliver services.

Betty L. Newell urged that the free clinics and community health centers be included in Virginia's response to the children's health initiative.

Hospital Conversions

Regarding not-for-profit hospital conversions, two commenters (Northern Virginia Access to Health Care Consortium and INOVA Health System) expressed support for Option III in which the hospital foundations would be invited to periodically update the Joint Commission on their charitable activities. The Virginia Hospital & Healthcare Association commented that it believes conversions have not affected access to care, but offered to help arrange presentations to the Joint Commission by the foundations on their charitable activities.

Four commenters (Virginia Primary Care Association, the Northern Virginia Access to Health Care Consortium, the Virginia Poverty Law Center, and INOVA Health System) commented in favor of Option IV which would call for a study resolution to direct the Joint Commission to monitor the issue of hospital conversions. Sentara commented that the Joint Commission and/or the legislature should continue to collect and analyze information on this issue.

Indigent Health Care Trust Fund and the State/Local Hospitalization Program

With respect to the Indigent Health Care Trust Fund and the State/Local Hospitalization (SLH) Program, five commenters (Sentara Health Systems, Virginia Primary Care Association, Virginia Hospital & Healthcare Association, Virginia Poverty Law Center, and INOVA Health System) supported Option V to evaluate the Indigent Health Care Trust Fund Pilot Project and evaluate the results. The Virginia Hospital & Healthcare Association also commented in support of Option VI (take no action regarding the SLH Program). Two commenters (Sentara Health System and INOVA Health System)

supported Option VII which would provide additional funding for the SLH program. Betty Newell commented that the Indigent Health Care Trust Fund be expanded to provide care to persons with income up to 200% of the federal poverty level.

Purchase of Prescription Drugs by Indigent Persons

Two commenters (the Virginia Poverty Law Center and the Virginia Hospital & Healthcare Association) supported Option VIII requesting Carilion Health Systems to present the final results of its research on the purchase of medications by indigent persons. The Virginia Poverty Law Center also commented that the Commonwealth should take more affirmative steps to address the medication needs of indigent persons. Betty Newell commented that one of the most pressing needs of indigent and uninsured persons is access to mental health medications.

Insurance Coverage for Graduate Students

Only two commenters addressed Options IX and X regarding the purchase of health insurance by graduate students. Dr. James Turner, who directs the Student Health Program at UVA, commented in support of the Governor's veto of legislation last year that would have permitted graduate students to participate in the state employee plan. He commented that any future legislation should direct the schools to make student health insurance available. The Virginia Hospital & Healthcare Association commented in support of Option X which would request the schools to survey their graduate students to determine how many would purchase coverage through the state program, if this coverage were made available.

Other

The Virginia Chamber of Commerce submitted "preliminary" comments on the insurance-related policy options included in the Phase II Issue Brief. The Chamber commented in support of purchasing cooperatives generally, and specifically expressed support of the study of THE LOCAL CHOICE program to determine if it could be expanded to small businesses. The Chamber also supported the revision of the Essential and Standard benefit plans. It

commented that requiring carriers to advertise the availability of the plans may not be feasible, but that it could support a statutory requirement that brokers and agents present the products to their clients. The Chamber commented that it supports extending the small group reforms to the self-employed and sole proprietors. Lastly, the Chamber indicated that it supports further examination of similar reforms in the individual market, but that the same market rules must apply to all carriers.

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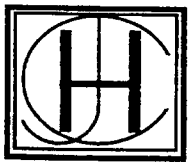

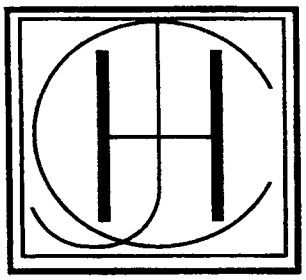

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