Overview of the Joint Commission on Health Care

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Presentation to VCU
Introduction to Public Health
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Kim Snead
Executive Director

Background

The Joint Commission on Health Care (JCHC) was created by the 1992 session of the General Assembly to continue the work of the Commission on Health Care for all Virginians, established in 1990.

"The purpose of the Joint Commission on Health Care is to study, report, and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services." JCHC seeks to ensure that the greatest number of Virginians receives quality cost-effective health care and long-term care services.

Mission of the JCHC

- JCHC focuses on five main policy areas:
  - health insurance and access to care for the uninsured
  - health care cost and quality
  - health workforce issues
  - behavioral health care and
  - long-term care.

Membership of the JCHC

- Ten members of the House of Delegates, appointed by the Speaker of the House.
- Eight members of the Virginia Senate, appointed by the Senate Committee on Rules.
- The Secretary of Health and Human Resources is an *ex officio* member.

Current JCHC Members

Del. Phillip A. Hamilton Chair
Sen. Stephen H. Martin, Vice-Chair

Del. Clifford L. Athey, Jr.
Del. Benjamin L. Cline
Del. Kenneth R. Melvin
Del. David A. Nutter
Del. John J. Welch, III
Del. Robert H. Brink
Del. Franklin P. Hall
Del. Harvey B. Morgan
Del. John M. O'Bannon, III

Sen. Harry B. Blevins
Sen. R. Edward Houck
Sen. Linda T. Puller
Sen. William C. Wampler, Jr.
Sen. J. Brandon Bell, II
Sen. Benjamin J. Lambert, III
Sen. Nick Rerras

The Honorable Marilyn B. Tavenner
Secretary of Health and Human Resources

Role of JCHC Staff

- JCHC has a full-time staff of six: an executive director, 2 senior staff attorneys, 2 health policy analysts and an office manager
  - Provide impartial, apolitical analysis of issues involving health care, behavioral health care, and long-term care
  - Identify a range of policy options for consideration by the Joint Commission
  - Assist in supporting legislation and budget amendments that the members introduce on behalf of JCHC.

Study Process

- Staff research and presentation of Studies (May-October)
  - Public comments received (after issue brief)
  - Public comments summarized (next meeting after issue brief)
- Subcommittee meetings conducted (May-October)
- JCHC consideration of decision matrix (Nov.)
- JCHC vote on legislative package (Nov.)
- General Assembly session

7

Summary of JCHC Study of Health Insurance Issues (SJR 4 of 2006)

8

JCHC Health Insurance Study

- Senate Joint Resolution 4 (Senator Reynolds) directed JCHC to "study the derivative effects of increases in health care costs on health insurance premiums" and to examine:
  - "Factors leading to rising health care costs in the Commonwealth"
  - "Ways to reduce health care costs in the Commonwealth and alleviate the burdens associated with the rising cost of health care."
- Specific health insurance recommendations will not be made until next year as staff will address health care cost issues as part of a 2007 study (based on HB 1324) to examine ways to expand health insurance into rural areas of the Commonwealth
  - This will allow for consideration of data and findings from other ongoing studies and reports in making recommendations including
    - Virginia Health Care Foundation's Health Access in Virginia Report
    - JLARC report *Options for Extending Health Insurance to Uninsured Virginians* (HJR 158)
    - Report of the Governor's Health Care Reform Commission.

9

Types of Insurance to Be Discussed

- Conventional insurance (often referred to as a fee-for-service plan)
  - No restrictions on the physician or hospital used, insured individual may be required to file claims for reimbursement
  - The health care provider may require insured individuals to make co-payments
- Health Maintenance Organizations (HMOs)
  - Type of managed care plan with the most restrictions
  - HMO members must choose a primary care physician who will manage medical care that is received; referrals are usually required in order to have the care provided by specialists paid
- Preferred Provider Organizations (PPOs)
  - Type of managed care plan that also includes provisions of a fee-for-service plan
    - Members may go to physician or hospital of choice; however, there is an established network of "preferred providers" who provide services at a discounted rate to the plan's members.

10

Types of Insurance to Be Discussed

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

11

High Deductible Health Plans

- **HDHPs are health insurance plans that include a minimum deductible (in 2006) of:**
  - **$1,050 (self-only coverage)**
  - **$2,100 (family coverage)**
- **Annual out-of-pocket expenditures cannot exceed in 2006 (including deductibles and co-pays):**
  - **$5,250 (self-only coverage)**
  - **$10,500 (family coverage)**
- **HDHPs are not allowed to have first dollar coverage except for preventive care but may "be an HMO, PPO or indemnity plan, as long as it meets the requirements" for HDHPs.**

12

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

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

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

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

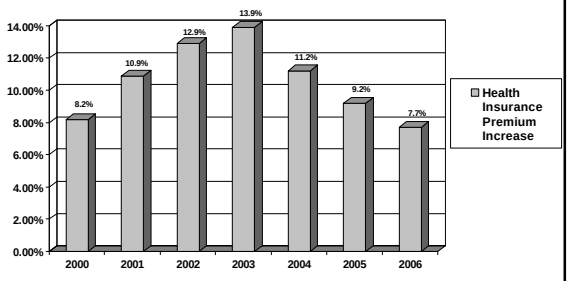
13

Data from KFF/HRET on Employer-Sponsored Health Plans

- The Kaiser Family Foundation (KFF) in conjunction with the Health Research and Educational Trust (HRET) conducts an annual survey of employer-sponsored health benefits.
  - The Kaiser/HRET *2006 Employer Health Benefits Survey,* completed between January and May of 2006 included responses from "3,159 randomly selected non-federal public and private firms with three or more employees…."
- More than 150 million non-elderly Americans receive their health insurance through their employers.
- In 2006, within all firms, including those that do not offer insurance to their employees, 59% of employees were covered by their employers' health insurance
  - This was 4% fewer than the 63% who had employer-sponsored health insurance in 2000.
- In 2006, within the firms that offered their employees health insurance:
  - 65% of all employees were covered by their employer's health insurance
    - This was 3% fewer than the 68% who had employer-sponsored health insurance in 2000
  - It should be noted that within the firms that offered health insurance, only 78% of the employees were offered health insurance and 82% of those employees chose to be covered.

14

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

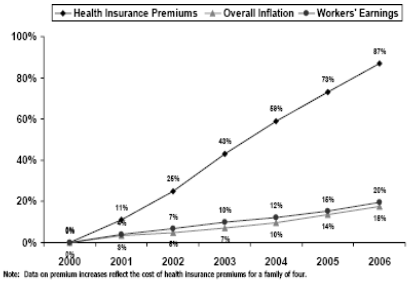


Source: KFF/HRET *2006 Employer Health Benefits Survey*.

15

"Cumulative Changes in Health Insurance Premiums, Overall Inflation, and Workers' Earnings 2000 – 2006"

(KFF/HRET Survey of Employer Health Benefits 2006)



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

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

16

Fewer Employers Are Offering Health Insurance to Their Employees

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

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

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

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

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

17

Health Insurance Market Share Has Changed Since 2000

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

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

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

18

Consumer-Directed Health Plans Are Being Offered by More Employers

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

19

Derivative Effects: Changes Being Undertaken by Some Employers

- An increasing number of companies are reducing retiree health benefits as a way of lowering overall heath care costs.
- In 2003, 10% of firms eliminated coverage for future retirees and 71% increased retirees' contributions for their coverage. A survey of 408 large companies found 1/5th said they were likely to terminate health coverage for future retirees in the next 3 years.
- Other ways that employers are dealing with health care costs include:
  - Requiring employees to pay higher premiums and/or co-payments
  - Reducing wage increases
  - Hiring fewer permanent employees.
- Shifting more costs onto employees may lead employees to:
  - Reduce their spending on discretionary health care
  - Defer needed care and risk long-term (more expensive) health problems or
  - Opt out of employee health care programs.
- A noted previously, the percentage of firms offering health benefits has fallen from 69 percent to 61 percent since 2000
  - The Kaiser Family Foundation indicates that the long-term trend points to the slow unraveling of coverage in the employment-based system, especially among smaller employers.

Source: KFF/HRT *2003 Health Benefits Survey and* "Survey of Executives Finds Health Costs Up, With Effects on Hiring, Pay" *Health Care Policy*, Volume 13, Number 30, July 25, 2005; and KFF/HRET *2006 Employer Health Benefits Survey*.

20

Derivative Effects: Increasing Number of Uninsured

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

Source: Annals of Internal Medicine, Medicine and Public Issues, Thomas Bodenheimer, MD, 17 May 2005, Volume 142, Issue 10, Pages 847-854 and The Commonwealth Fund, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-being of American Families*, September 2006.

21

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Derivative Effects: Increasing Number of Uninsured

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

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

22

Derivative Effects: Uncompensated Care Costs

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

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

23

Ways to Reduce Health Care Costs

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

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

24

Ways to Reduce Health Care Costs

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

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

25

Ways to Reduce Health Care Costs

- Health care providers are making efforts to reduce costs by "investing in medical technology, developing systems to reduce medical errors, and participating in programs that reward efficiency and quality."
- Many states "have enacted laws to reduce medical malpractice judgments in order to reduce premium burdens on providers and lower overall costs"
  - Virginia has one of the most restrictive medical malpractice liability statutes limiting the total amount of recovery to $1,850,000. (*Code of VA§ 8.01-581.15).*
- However, even when taken together these measures are not likely to reduce health care costs enough to ensure continued sustainability. As reported by the Kaiser Family Foundation:
- "Although many of these efforts may lead to efficiency and quality gains, none would appear to be of a scale to have any meaningful impact on the overall cost picture….If we began next year trying to hold health care cost growth to the current projected growth rate for GDP [gross domestic product] (i.e. slowing growth in health care costs to 4.9% annually starting in 2007) we would need to lower health spending by over $3 trillion over the 2007 to 2015 [time period]…These savings would represent about 10.8% of projected total health spending over the period, or an average annual reduction of about $340 billion relative to the projected level of spending."

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

26

Summary of Medicaid Reform Initiatives (HB 758 of 2006)

27

Medicaid Reform Initiatives

- Increasing Medicaid costs, which are placing a strain on federal and state budgets, has spurred many states to look for ways to contain costs. In addition, many states are working to improve access and the quality of care for Medicaid clients.
  - In Virginia, HB 758 (2006) directed the Department of Medical Assistance Services (DMAS) to establish a Medicaid Revitalization Committee to "prepare recommendations for any State Plan amendments or waiver authority…necessary to reform and revitalize Virginia's Medicaid program."
    - Report due by Dec. 1, 2006 to the Governor, and the legislative committees of House Appropriations, Health, Welfare & Institutions, Senate Finance, Senate Education and Health.
  - Five meetings of the Medicaid Revitalization Committee were held this summer and fall
    - DMAS presented 7 Committee recommendations during a presentation to JCHC in October.

28

Medicaid Reform Recommendations

1. DMAS should request funding and approval to **expand disease management programs** "to target high cost and/or high prevalence disease states for which nationally accepted evidence-based care guidelines exist."
2. DMAS should request funding and approval to "provide **access to enhanced benefit accounts**, or a similar mechanism, in which recipients are rewarded for compliance with aspects of their care plan through financial incentives that can be used to purchase healthcare related goods and services…."
3. DMAS should "require **electronic funds transfer for payment of healthcare services** to…Medicaid providers."
4. DMAS should request funding "to implement a **web-based claims submission system** available free of charge to all health care providers for use in the submission of Virginia Medicaid claims…."

29

Medicaid Reform Recommendations

5. DMAS should "continue working toward the goal of **expanding managed care** into new regions and across additional eligibility categories where feasible."
6. DMAS should consider the impact of "public subsidy of **employer-sponsored or other private health insurance coverage for Medicaid-eligible individuals**…to further encourage the use of available private insurance coverage options."
7. DMAS should "seek federal approval to **expand, where feasible, 'buy-in' programs** to allow for expanded participation in the Medicaid and FAMIS programs…to the extent such expanded participation can be shown to be cost effective/cost neutral to the Commonwealth."

30

Joint Commission on Health Care

JCHC Internet website:

http://legis.state.va.us/jchc/jchchome.htm

Includes meeting schedules, studies, reports, and legislation.

Joint Commission on Health Care
900 E. Main Street, 1st Floor West
P. O. Box 1322
Richmond, VA 23218
804-786-5445/(FAX) 804-786-5538
ksnead@leg.state.va.us

JCHC Staff

Kim Snead, Executive Director
Stephen W. Bowman, Sr. Staff Attorney/Methodologist
Catherine W. Harrison, Senior Health Policy Analyst
Mamie V. White Jones, Office Manager
Jaime H. Hoyle, Sr. Staff Attorney
Sylvia A. Reid, Health Policy Research Assistant

31