Evolving State Approaches to Expand Coverage in the Current Wave of State Access Reform

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Overview

One of the most challenging hurdles that policymakers confront in their efforts to reduce the number of uninsured is how to cover those without access to employer-sponsored health insurance. This group of uninsured, which consists primarily of part-time workers, the self-employed, and many workers in small firms, now accounts for one of the largest and fastest-growing segments of the uninsured population. For example, between 2000 and 2006, the number of uninsured workers in the United States increased by six million, over half of whom (3.4 million) were self-employed or employed by small firms.[1] While individuals working for firms with fewer than 25 employees and their dependents account for 22 percent of the U.S. population, they make up 37 percent of the nation's uninsured population.[2]

Accordingly, in the latest wave of state access reform,[3] states are undertaking a range of initiatives to improve the availability and affordability of health insurance in the small and non-group markets. Some of the approaches implemented today—including health insurance purchasing exchanges and limited-benefit plans—are variations on approaches attempted by states in earlier waves of health reform. While these past efforts were helpful to the individuals who enrolled, they generally did not result in broad-based coverage expansions. To the extent that today's initiatives are evolving to address lessons from past efforts, current efforts could advance our understanding of the types of policies that will likely succeed in expanding coverage in the small and non-group markets and inform future state and national health reform efforts.

In this paper, we address three main questions:

- What common challenges characterized earlier state efforts targeting small firms and individuals?
- How are state initiatives in today's "new wave" of access reforms adapting and improving on past models?
- What are the implications of these models for other state or national proposals for expanding access in the small and non-group markets?

Drawing from an examination of the peer-reviewed literature as well as on reports published by health policy research and technical assistance organizations, we begin by broadly characterizing past state efforts to expand coverage among workers in small firms. We then present findings from interviews with leaders of expansion initiatives in four states—limited-benefit products in Arkansas and Tennessee and health insurance exchanges in Massachusetts and Washington. We selected these states because they represent a range of environments for health access reform and their small and non-group initiatives highlight how programs targeting similar populations may be tailored to address state-specific circumstances and goals. Given that the approaches we highlight are new or under development, limited evidence is available on their impacts on cost and coverage. However, we assess whether and how state leaders are explicitly seeking to avoid some of the problems that characterized earlier efforts and then conclude with a summary of possible implications for state and federal reform efforts.

What Obstacles Hindered Past State Efforts?

Researchers and health policy experts familiar with the experience of limited-benefit plans and purchasing pools have identified several overlapping challenges that prevented these initiatives from enrolling substantial numbers of previously uninsured workers.[4] Most notably, the challenges include limited health plan participation owing to concerns about adverse selection, resistance from insurance brokers, lack of pricing advantages, and insufficient marketing and outreach. For example, of the approximately 20 state health purchasing cooperatives established in the early 1990s that targeted small firms, only one or two captured as much as 5 percent of the small group market.[5] And, in the several states that allow insurance carriers to sell limited-benefit plans in the small group market, enrollment generally has been low.[6]

Rating Rules and Adverse Selection

A major difficulty facing both small business purchasing pools and limited-benefit plans lies in attracting and sustaining the participation of insurers. In the past, some health plans have been wary of purchasing pool participation because they believed that the purchasing pools could attract higher-risk and higher-cost populations. This concern stemmed in part from two policy design issues. First, a goal of many past purchasing pools was to allow employees to select one plan from a menu of many plan choices. Under such a consumer choice arrangement, health plans have been challenged to price their products or establish benefit designs that prevent adverse selection in the absence of robust risk-adjustment methods. Second, in some states, rating rules inside health insurance purchasing pools have differed from those outside the small group market; these differences led to adverse selection in some pools.[7] For example, if rating based on health status was *not* allowed inside a state's purchasing pool, but *was* allowed in the state's small group market outside of the pool, the pool was likely to attract a higher risk population.

Similar concerns about adverse selection have also affected the success of limited-benefit products. While several states have relaxed benefit mandates to allow insurance carriers to offer limited-benefit policies in the small group market, carriers have been concerned that doing so would create adverse selection in the market for more comprehensive products. Given that all small group coverage is guaranteed issue, carriers have feared that employers

with healthier workers would purchase the limited-benefit plan and obtain more comprehensive coverage only when their employees need it.[8]

Limited Cooperation by Insurance Brokers

Some state purchasing pools have encountered strong resistance from the insurance brokers who traditionally sell policies to small businesses. Pool administrators in some states either sought to cut out the "middleman" (broker) to save money or adopted policies that were poorly received by the broker community.[9] These policy choices may have initially overlooked the important role that brokers would need to play in marketing and selling products in the purchasing pools to small firms and individuals.

Concerns about consumer education have also diminished the willingness of brokers and insurance carriers to sell limited-benefit products to small businesses. In many cases, brokers and carriers have worried that consumers would not fully understand the limited nature of their benefits.[10]

Lack of a Significant Pricing Advantage

Previous purchasing pool models sought to obtain competitive premium rates from insurers by pooling risk and using purchasing power to negotiate better prices for pool members.[11] However, in numerous small group purchasing pools, premiums inside the pools have not been substantially lower than those for policies outside the program and, in some cases, have been even higher.[12] In the case of pools that have achieved pricing advantages, the advantages have generally not been sufficient to induce considerable take-up of products inside the purchasing pools. This phenomenon has been both the result and cause of low plan participation in the pools. First, low plan participation has hindered the ability of purchasing pool programs to realize the administrative savings expected to lead to lower premiums. Second, with little price advantage to induce employers to purchase insurance through the pools, health plans have been hesitant to participate. In purchasing pools that suffered from adverse selection, premiums within the pools rose over time.[13]

Anecdotal evidence suggests that concerns over value also hindered enrollment in earlier limited-benefit programs. In some states, employers and employees have shown little interest in the limited-benefit policies despite their price advantage because they did not see the covered benefits as worth the cost.[14]

New State Initiatives

The programs in our study states fall into two categories: limited-benefit products in Arkansas and Tennessee and health insurance exchanges in Massachusetts and Washington. Exhibit 1 summarizes the design features of the initiatives. In each study state, decisions about which type of program to implement and its specific program features reflect a combination of available evidence about reform options and the political and fiscal circumstances unique to the state.

ARHealthNetworks

Arkansas's limited-benefit program grew out of recommendations from the Arkansas Health Insurance Roundtable, a process convened through a State Planning Grant from the Health Resources and Services Administration (HRSA). After the roundtable identified affordable coverage options for workers at small firms as a priority, several factors led to the decision to develop a subsidized limited-benefit program through a Health Insurance Flexibility and Accountability (HIFA) waiver. A limited-benefit model satisfied many of the roundtable's priorities, including an emphasis on preventive care and maintaining the link between health benefits and employment. Input from small employers seemed to support such a program. Further, state leaders saw an opportunity to claim unspent State Children's Health Insurance Program (SCHIP) funds through the HIFA waiver. Finally, although the roundtable examined a range of program options, as one interviewee put it, Arkansas is relatively "small, rural and poor" and viewed a limited-benefit program as the most feasible policy option in an uncertain fiscal environment.

The resulting program, ARHealthNetworks, was designed to provide access to a limited set of medical care services that meet most of the health care needs of a majority of working-age adults in a given year based on actuarial analysis. Program leaders emphasize that ARHealthNetworks is a limited-benefit program rather than comprehensive health insurance. However, unlike previous iterations of limited-benefit plans, which emphasized "mandate-free" plans and high deductibles, ARHealthNetworks offers plans designed to cover primary and preventive care. This first-dollar coverage may be of higher value to low-income workers than the catastrophic coverage offered in other types of "limited-benefit" plans. Exhibit 2 summarizes the specifics of the program's benefit limits and cost-sharing requirements.

The program is available to businesses with two to 500 employees, though early enrollment has been concentrated in small firms. As of June 2009, the average firm size in ARHealthNetworks was 4.25 employees. Recognizing that the net sum of employers would be minimal, the state plans to extend the ARHealthNetworks program beyond small employers; however, at the time of publication, the expansion had not yet occurred. Employers and employees contribute to the cost of premiums, and state and federal dollars subsidize premiums for individuals with annual incomes at or below 200 percent of the federal poverty level. Enrollment began in December 2006; as of June 2009, approximately 7,090 people had enrolled in ARHealthNetworks, up from 4,500 in October 2008.

Exhibit 1. Design Features of State Programs to Expand Access among Workers at Small Firms

	Arkansas	Tennessee	Massachusetts	Washington
Program type	**Limited benefit**	**Limited benefit**	**Exchange**	**Exchange**
Employer eligibility				
Size	2 to 500 full time employees	1 to 50 full time equivalent employees	Individuals and small groups to 50 full time employees. Part-time workers for firms greater than 50	2 to 50 full time employees
Income	At least one employee with annual income ≤200% FPL	At least 50% of employees earn ≤$43,000 per year[a]	None (for non-subsidized group coverage)	At least 50% of employees earn ≤$10 per hour
Take-up requirement	100% of subsidy-eligible employees; 50% of non-subsidy employees	None	75% of all employees	75% of all employees
Crowd-out provision	Not offered ESI in past 12 months	Not offered ESI or not paid ≥ 50% of premium in last 6 months	None	Not currently offering ESI
Employee eligibility				
Qualified employer	Full time employees at qualified employers	Employees who work ≥20 hours/week at qualified employers[a,b]	No income or work hours requirement	Full time employees at qualified employers
Non-participating employer	None	Employees who work ≥20 hours/week at non-participating employers and earn ≤$43,000 per year[a,b]	None	None
Individual (non-group) eligibility	Not eligible in first phase	Self employed individuals who work ≥20 hours/week and earn ≤$43,000 per year[a,b]	Yes	Not eligible in first phase
Individual (between jobs) eligibility	None	Individuals who have worked at least one 20 hour week in the last six months and earned ≤ $43,000 per year[a,d]	None	None
Financing				
Premium rating	Vary by gender and age up through 9/1/08; 9/1/08 transition to $25/month for subsidy employees and $200/month for non-subsidy employees	Vary by age, tobacco use, and BMI; one third of premiums averages $54/month[c]	Same as in merged non-group/small group market	Same as in small group market
Subsidies	Available for those with annual income ≤200% FPL	TN pays one-third of all enrollees' premiums (In the case of individual enrollment [non-group and between jobs], TN pays one-third of premiums and the individual is responsible for the remaining two-thirds)	None offered to groups	Available for those with annual income ≤200% FPL
Subsidy source	State tobacco settlement and Federal Medicaid and SCHIP funds	State funds	None	State funds (health plan assessment)
Employer contribution	None required	Employer pays one third of employees' premiums	Required contribution (amount not specified)	Employer must pay ≥ 40% of employees' premiums
Risk is borne by	State	Plans	Plans	Plans
Plan choice	One plan is offered	Plan choice at individual level (two plans from one carrier)	Participating employees can select a range of health plan options in one of three different tiers	Plan choice at firm level (12 plans from three carriers)
Key dates	Coverage began January 2007	Coverage began April 2007	Enrollment began November 2008	Coverage will begin September 2010

[a] Beginning January 1, 2009, CoverTN will raise their income limit from $43,000 to $55,000. CoverTN will also use adjusted gross income, instead of gross income, in determining eligibility of self-employed individuals.
[b] CoverTN will now count the hours from each job an individual works to determine if the applicant meets the 20 hour-per week requirement needed to enroll in the program. Previously, the program counted only the hours from an individual's primary job.
[c] CoverTN will not have a rate increase in 2009; premiums for the program will remain at 2008 levels.
[d] Individuals who have had their work hours reduced to below 20 per week in the last six months are still qualified for coverage under the new Tennesseans Between Jobs coverage category within CoverTN.

CoverTN

As in Arkansas, efforts to expand coverage among workers at small firms in Tennessee were spurred by an HRSA State Planning Grant process and motivated by the fact that most of the state's uninsured were self-employed or worked for small businesses. The planning grant team evaluated several options and initially recommended a reinsurance model. However, the priorities of state leaders—to design a small, manageable, and affordable program; leverage limited funds to assist as many people as possible; and provide access to primary care—made a limited-benefit program a more attractive option.

During the development of CoverTN, the state decided against pursuing federal funding or other federal involvement. The decision was heavily influenced by the state's recent challenges with TennCare, including a lawsuit brought against the state by TennCare beneficiaries, which operated under a waiver agreement with the Centers for Medicare and Medicaid Services (CMS). Leading up to the disenrollment of 170,000 individuals from the fully capitated managed care and coverage expansion program, the state felt that the Medicaid framework did not provide adequate flexibility to make changes that would have made the program more sustainable. Further, after the TennCare cutbacks, state leaders sought rapid implementation of new health access programs and did not perceive the political climate as conducive to the lengthy federal waiver process. CoverTN leaders commented that the federal-state partnership might succeed if CMS allowed for ongoing evaluation of a program's experience and rapid policy adjustments as needed.

CoverTN emerged from the planning process as a defined contribution benefit program that used a modified —or as one interviewee put it—"upside down" procurement process to solicit plan designs from insurers based on a fixed cost rather than on a prescribed benefit design. Specifically, based on feedback from employers and workers, the state established an average total premium price of $150 per individual per month to be split evenly among employer, employee, and the state. Using this price point, the state then solicited benefit designs from insurers through a competitive bid process and selected the two plans (both administered

Exhibit 2. Benefits and Cost Sharing for Limited Benefit Packages in Arkansas and Tennessee

	ARHealthNetworks	CoverTN	
		Plan A	Plan B
Physician visits per year	6	5[a]	6[a]
Inpatient hospital stays	7 days per year	$10,000 annual maximum	$15,000 annual maximum
Outpatient services per year	2 major services	1 surgery visit 2 diagnostic visits	1 surgery visit 2 diagnostic visits
Emergency services	Included in outpatient services limit	2 visits per year	2 visits per year
Prescription drugs	2 per month	$250 quarterly limit[b]	$75 quarterly limit[b]
Durable Medical Equipment	Included as part of inpatient, outpatient, or physician services	$500 annual maximum	Not covered
Maximum annual benefit	$100,000	$25,000	$25,000
Annual deductible	$100 (does not apply to physician visits and Rx)	None	None
Coinsurance after deductible	15%	None	None
Co-payments	For Rx only $5 generic $15 brand formulary $30 brand non-formulary	$15 physician visit $0 preventive visit $10 generic Rx $25 brand Rx insulin[c] $100 inpatient $25 outpatient surgery and diagnostic	$20 physician visit $0 preventive visit $8 generic Rx $25 brand Rx insulin[c] $100 inpatient $25 outpatient surgery and diagnostic

[a] Beginning January 1, 2009, both plans will increase physician visits from 5 (Plan A) and 6 (Plan B) to 12 per year. In addition, Plan A and Plan B will cover 5 and 6 specialist visits respectively. Previously, primary care and specialist visits were both subject to a 5/6 cap per year.
[b] Beginning January 1, 2009, diabetic medications and supplies are not subject to the quarterly pharmacy limit.
[c] Beginning January 1, 2009, copays on diabetic medications and supplies is reduced from $25 to $10.

by BlueCross BlueShield of Tennessee) with the richest benefit package for the price. Like ARHealthNetwork, CoverTN is intended as a prevention-focused limited-benefit plan with an annual benefit cap (for more plan details, see Exhibit 2).

CoverTN also recently added a new eligibility category, Tennesseans Between Jobs, which allows recently unemployed individuals to qualify for the program without first remaining insured for six months. Although portability has always been a feature of CoverTN, since implementation of the new eligibility category in October 2008, 1,166 individuals have enrolled under the category. As of May 2009, 6,861 small firms and self-employed individuals were participating in CoverTN, covering 20,242 individuals.

Commonwealth Connector

The Commonwealth Health Insurance Connector Authority is a major component of system-wide reform in Massachusetts. While earlier pooling efforts often operated as stand-alone reforms, the Connector builds on important changes to the insurance market achieved under the state's 2006 reform effort. Under the reform law—which, among other things, established the Connector and mandates that all residents age 18 and older have creditable health coverage if an affordable plan is available—the state is restructuring how private insurance is purchased, sold, and administered and how public subsidies are delivered. By integrating these reforms in the Connector, Massachusetts has been able to cover most of its uninsured residents within several years. As of March 2009, fewer than 3 percent of the state's residents were uninsured.[15]

The state has continued to build on its reforms by using the Connector—an independent, quasi-governmental entity designed to facilitate the purchase of health care insurance—as a mechanism for providing coverage to eligible individuals and small groups at affordable prices. The state began by offering subsidized products to uninsured individuals through the Connector in October 2006, adding unsubsidized products administered by private insurers in May 2007. In December 2008, the state once again expanded its coverage efforts on a pilot basis by allowing small employers to offer their employees a choice of insurance products through the Connector. The state hoped that, by opening the Connector to small employers, it could simplify the process of purchasing insurance for employers and provide employees with plan choice.

Under this new option, employers who elect to offer insurance through the Connector will select a benchmark plan in one of three health plan tiers—gold, silver, or bronze—and agree to contribute 50 percent of the benchmark plan premium. Employees will then select from a broad range of health plan options within the selected tier. Employees who choose a more expensive plan from the selected tier will pay the cost beyond the employer's premium contribution to the benchmark plan. As the rating rules inside the Connector are equal to those in the outside merged small and non-group market, when an employer offers coverage through the Connector, the employer is list-rated in accordance with age of employees, geography, group size, and SIC (Standard Industrial Classification) codes.

Employer and employee premium payments are to be made on a pre-tax basis; however, no direct public subsidies are available for small employers and employees who purchase insurance through the Connector. Although the Connector administers subsidized insurance for low-income individuals, workers with access to employer-sponsored insurance are ineligible for subsidized coverage regardless of the cost of their employer-based coverage. Massachusetts operates a separate program called the Insurance Partnership that provides subsidies for health insurance premiums to qualified small employers and their low-income employees. The Insurance Partnership is a distinct program that is not currently available through the Connector, although state officials have discussed integration of the two programs. The Connector reports, as of May 2009, 73 people enrolled in the small and non-group option.

Washington Health Insurance Partnership (HIP)

The HIP evolved out of previous attempts by the legislature to make insurance premiums more affordable for workers at small firms, including a premium assistance voucher program created in 2000 that was never funded. In 2006, the state launched the Blue Ribbon Commission on Health Care Costs and Access and charged it with working toward large-scale health reform. The commission's recommendations, including "[providing] affordable health insurance options for individuals and small businesses," afforded lawmakers a platform to revisit the issue. Largely because of the influence of a powerful legislator, the 2007 Blue Ribbon Commission bill created the HIP and provided the Washington Health Care Authority with the legal and legislative framework to implement it. State law then authorized the Health Care Authority to establish an advisory board of brokers, small employers, health plans, and other stakeholders and to solicit technical assistance from several experts previously responsible for designing or running purchasing pools in other states (e.g., California and Massachusetts). Based on feedback from these stakeholders, the board developed a list of proposed changes to the program design, and the legislature amended the HIP to reflect these changes in 2008.

In its most current structure, the HIP was to offer benefits administration to qualifying small employers who agreed to establish a Section 125 "cafeteria" plan[16] and offer health insurance to their employees through the exchange. In addition, low-income individuals would be eligible for state-funded sliding-scale premium subsidies. While the state legislature has directed the HIP to investigate ways to obtain federal funding to finance part of the subsidies, program leaders believe that funding for

these subsidies will not be secured in the foreseeable future.

Coverage through the HIP was slated to begin in January 2009; however, at the time of publication, program implementation had been delayed by state budget constraints. The state has since applied for an HRSA State Health Access Program grant. If funded, a large component of the grant will support HIP implementation, for which the state projects an implementation date of September 2010.

State Efforts to Address Past Obstacles

While the state efforts profiled above exhibit similarities with earlier reform efforts, we identified several adaptations made by current policy designers based on the lessons of previous state reform efforts.

Health Plan Participation

Each of the four states reported taking a number of different approaches to ensure participation from insurance carriers, with varying degrees of success. While carriers have not derailed efforts in any of the study states, they remain skeptical about the effects of fundamental design changes. In Arkansas, carriers represented at the Health Insurance Roundtable were perceived by interviewees as generally supportive of the development of a limited-benefit program, although interest in participation did not materialize. Though the program's initial priority was to offer enrollees a choice of plan options, the competitive bid process culminated in the identification of only one carrier (NovaSys) to serve as third-party administrator, with the state holding the risk for the enrollees.

In Tennessee, the administration worked closely with insurance carriers to draft the CoverTN legislation. One of the resulting compromises was a June 2010 sunset provision that would allow for modifications if the program is to continue. The procurement drew bids from four carriers—Blue Cross Blue Shield of Tennessee, CIGNA, United Healthcare, and Aetna.

Similarly, in Washington, leaders worked with carriers to develop the HIP and have made some adaptations based on carriers' concerns. For example, one goal of the original HIP legislation was to provide employees with product choice. However, as in past state purchasing pool experiences, carriers feared that product choice would lead to adverse selection within firms. The Health Care Authority and state legislature responded by revising the HIP structure to allow employers to choose only one plan for their employees. Further, while the HIP is authorized to require plan participation, program leaders deliberately avoided mandates in favor of working collaboratively with plans. The program is also actively involving carriers in selecting plans for inclusion in the HIP. Washington leaders believe that the carriers want to help but are concerned about the performance of the HIP once implemented.

In Massachusetts, a statute required carriers with 5,000 lives in the small group market to bid on the business in the Connector.

Adverse Selection

To gain carrier participation and achieve program sustainability, the study states have attempted to address concerns about adverse selection. With regard to limited-benefit products, concern has historically focused on the possibility that limited-benefit plans would draw healthier groups out of the market for more comprehensive products, leaving only sicker patients in the comprehensive market and thus eventually driving up premiums. ARHealthNetworks has attempted to avoid such an outcome by requiring individuals and employer groups not to have been offered coverage in the previous 12 months before becoming eligible to enroll in the limited-benefit plan. CoverTN has a similar six month requirement. Thus, program leaders believe that these programs have mostly attracted employers that did not previously offer health insurance. In Tennessee, survey results show that 75 percent of CoverTN employers have never before offered health insurance.

Program leaders in Arkansas and Tennessee also acknowledged the concern that limited-benefit products themselves may attract adverse risk pools. To maintain a more favorable risk pool for ARHealthNetworks, 100 percent of subsidy-eligible uninsured workers and at least 50 percent of non-subsidized uninsured workers at a qualified employer must enroll in the program if a business is to participate. (Originally, the threshold was 100 percent of all workers, but the state recently relaxed the requirement for non-subsidy workers in an effort to increase enrollment.) Interviewees also commented that "the healthy worker effect" may mitigate some adverse selection risk, reasoning that, because only workers and their dependents are eligible for the program, enrollees would be relatively healthy.

For CoverTN, some factors could increase the risk of adverse selection: enrollment is open to individuals ("groups of one"), and other limited-benefit plans offered in the private market use more rigorous underwriting and rating procedures. However, given that CoverTN used a defined contribution approach to procure benefit designs, state leaders assumed that the bidding carriers would account for these factors in their benefit design, including the $25,000 benefits cap. Early data from the state show that the program is attracting older individuals with a higher propensity to smoke compared to the state average; however, relatively few people (specifically, eight people as of October 2008) have exhausted their benefits thus far.

The exchange programs in Washington and Massachusetts also have several features designed to avoid adverse selection, including the use of identical rating rules for plans outside and inside the exchanges. In addition, as noted earlier, the HIP eliminated employee plan choice in response to concerns about adverse selection. Washington also requires 75 percent of employees at a firm to participate in order for an employer

to purchase coverage through the HIP. In Massachusetts, the individual mandate is believed to improve the performance of health insurance markets by ensuring that younger, healthier workers participate in the market. In addition, unlike earlier purchasing pools, the Connector operates as an exchange and thus does not hold any risk for its commercial products. Instead, plan experience for carriers participating in the Connector is pooled with all of their other open-market small and non-group plan experience to mitigate risk-selection issues.[17]

Relationships with Insurance Brokers

In what has led to mixed results, Tennessee and Arkansas have relied on third-party administrators to establish relationships with brokers. With ARHealthNetworks, traditional brokers were not aggressively marketing the product because doing so required them to (1) devote significant resources to learn about a new product type; (2) market to businesses not currently offering coverage (which often required labor intensive cold-calling); and (3) deal with an increased administrative burden (e.g., brokers were responsible for fulfilling the federal requirement that individuals applying for federal subsidies must document citizenship). In addition, broker commissions for the limited-benefit plan were lower than those for their other products.

Exhibit 3. Program Design Responses to Past Obstacles

	ARHealth Networks	CoverTN	Commonwealth Connector (MA)	Health Insurance Partnership (WA)
Fear of adverse selection into small business program				
Minimum % of employees must participate	Y	N	Y	Y
Self-insured plan (state bears risk)	Y	N	N	N
Plan choice within firms	n/a	Y	Y	N
Rating rules same in outside small group market	n/a[a]	N	Y	Y
Groups of 1 are not eligible	Y	N	N	Y
Defined contribution benefit package	n/a	Y	Y	n/a
Not designed to negotiate better prices than outside market	n/a	n/a	Y	Y
Fear of adverse selection in comprehensive small group market				
Crowd out provision	Y	Y	n/a	n/a
Resistance from insurance carriers				
Inclusion of carriers in program development/ implementation	Y	Y	Y	Y
Provide guidance on legal issues related to exchanges (e.g., antitrust)	n/a	n/a	Y	Y
Resistance from brokers				
Inclusion of brokers in program development/ implementation	Y	Y	Y	Y
Pay same commission as outside market	N	N	N	Y
Dedicated brokers to sell limited benefit policy	Y	N	n/a	n/a
Lack of a price advantage				
Subsidies for low-income workers	Y	Y	N	Y
Require Section 125 plan to capture tax advantage for premium contributions	N[b]	N	Y	Y

[a] No other limited benefit plans are available in the private market in Arkansas.
[b] Technically the terms and conditions of the waiver are silent on this issue; however, the state assumes that many if not most employers will elect to use some type of pre-tax vehicle within this arrangement. They do not however require employers to set up Section 125 mechanisms.

After initial problems in generating enthusiasm for ARHealthNetworks among traditional brokers, NovaSys hired two dedicated brokers to sell only the limited-benefit product. Although ARHealthNetworks did not increase broker commissions for the limited-benefit plan, the state reports that NovaSys has had better results with the dedicated brokers. The brokers travel the state to market the program, often partnering with local opinion leaders who lend credibility to the program. More recently, the state phased out its system of setting premiums based on age and gender, thereby simplifying the enrollment process for the brokers.

Tennessee offers an enhanced enrollment bonus to carriers as an incentive to market its plan aggressively. CoverTN leaders assumed that the carrier would, in turn, use the bonus as an incentive for brokers. However, the state did not initially outline a formal agreement for brokers to earn commissions on the CoverTN product and does not know whether the transfer has occurred. Within the last six months, the state has implemented a formal broker incentive program that includes a traditional broker payment of 6 percent of total premium through BlueCross BlueShield, along with broker training on the product.

To foster good relationships with brokers, the exchange program in Washington collaborated with brokers on program design and selection of plans for inclusion in the HIP. If implemented, the commission for HIP products was to be the same as for products in the outside small group market. HIP leaders reasoned that, given the possibility that the subsidy option could induce more consumers to take up employer-sponsored coverage, brokers would benefit from working through the HIP without an additional commission payment.

In Massachusetts, the Connector has established a commission system for brokers who bring lives to the Connector. It remains to be seen how broker-Connector relations will develop; the Connector began selling to small groups in December 2008. Preliminary results indicate that only a few brokers are participating, in part because the program has not been widely advertised. The program has about 30 accounts, most of which are very small employers.

Achieving a Price Advantage

The study states have adopted a variety of approaches to make their small business access initiatives more affordable for employers and employees. To ensure that their limited-benefit products are a good value for employers and employees, both Tennessee and Arkansas offer public subsidies for the products. Tennessee contributes one-third of the premium cost to offset the cost for employers and employees and requires employers to contribute at least another one-third of the premium, ensuring that employees contribute only one-third of the cost. In addition, CoverTN did not institute a rate increase in 2009; premiums for the program remain at 2008 levels and continue to be divided equally among state, employer and employee. The stability in rates may be an early indicator of success, especially given the older average age of CoverTN enrollees.

Arkansas targets subsidies to low-income employees. Currently, employers are not required to make a premium contribution in order to participate in ARHealthNetworks. Program leaders expected employers to make voluntary contributions; however, fewer employers than expected have done so, and the state is considering implementation of a required employer contribution. Program leaders believe that the product is a good deal for subsidy-eligible enrollees but say that the same may not be true for higher-income workers who do not receive subsidies. Beginning in September 2008, subsidized employees had to pay only $25 per month for their premiums compared to the non-subsidy rate of $200 per month. Arkansas has not yet seen the effects of this change but hypothesizes that enrollment will increase in response to less price uncertainty.

The exchanges in Massachusetts and Washington, on the other hand, are designed to help small employers and individuals purchase affordable insurance by simplifying administrative processes, offering some degree of portability and pre-tax treatment of premiums, and providing choice of contributions from one or more sources (which, in Washington, was to include public subsidies for low-income workers).[18] These exchanges differ significantly from the earlier purchasing pools, which focused on pooling risk and negotiating favorable prices for members.

Discussion and Policy Implications

Innovations

Identifying effective strategies for expanding access to health care among employees in small firms and among individuals without access to employer-sponsored health insurance is critical to both incremental and comprehensive health reform efforts. The evolution of state initiatives targeted to these populations has implications for future state and federal efforts. Our study states highlight innovations designed to make health coverage products more affordable, reduce concerns about adverse selection, and support collaboration with important stakeholders such as insurance brokers.

Cost as Persistent Obstacle

Notwithstanding the innovations introduced by the study states, the programs in the four states are facing some of the same barriers confronted by similar programs introduced in earlier years. Perhaps most important, even with subsidies and measures to prevent adverse selection, it is unclear whether today's programs offer a price advantage sufficient to attract a significant number of previously uninsured enrollees, especially employees with incomes too high to qualify for subsidies. For example, ARHealthNetworks originally required all eligible employees of a given employer to enroll in the program as a condition of employer participation. In practice, it has been difficult to date to achieve full participation among employees not eligible

for subsidies and therefore responsible for the entire cost of the premium. Interviewees in Washington predict that they might encounter similar problems, and some have speculated that the lack of subsidies in the Massachusetts Connector may limit enrollment in small firms with low-income workers.

Need for Learning Between and Within States

It will be important to evaluate the longer-term experience of the above programs and others like them in order to understand whether they increase access to health care. With respect to state health policy, credible information about the impacts of reforms is often lacking, although there is considerable promise for creating a database with the emergence of organizations and projects that are dedicated to facilitating learning within and between states and amassing evidence from past and current state health policy innovations. However, such efforts must overcome substantial challenges, including technical issues such as limited data availability and issues such as which outcome measures should be evaluated and whether and how findings in one state might be generalizable to other states.[19]

These issues are integral to future decisions about health reform. For example, it is important to identify the desired outcomes of health access expansions. The limited-benefit programs in Arkansas and Tennessee are designed to increase access to primary and preventive care; they do not offer protections for major medical expenses. In contrast, the goals of the exchanges in Massachusetts and Washington are to increase access to comprehensive health insurance. Thus, the success of access expansions need to be evaluated not only in terms of enrollment trends and the number of people with any health benefit package but also in terms of whether the programs respond to the goals of access expansions, potentially including adequate financial protection for catastrophic expenses and coverage that allows individuals to meet all of their medical needs.

A related issue when generating evidence on program impact is the baseline against which progress is measured. Given the scarcity of funds at the state and federal levels, it will be important to develop the capacity to assess which type of intervention can achieve the greatest impact at a given time for a given investment.

Opportunities for Federal-State Partnerships

The experiences of the study states highlight several opportunities for enhanced federal-state partnerships with the common goal of expanding access in the small and non-group markets. Federal funding is often the first consideration in any discussion of these partnerships. Federal participation is an important component for many state initiatives, allowing states to achieve a scale that would not otherwise be possible. Further, federal funding is less vulnerable, albeit certainly not immune, to cyclical economic fluctuations and can help make state programs more stable over the long term. However, given the current federal fiscal climate, funding of broad coverage expansions may be limited absent complementary reforms designed to slow overall cost growth.

Yet, federal-state partnerships go far beyond a simple transfer of funds and could be mutually beneficial. A flexible framework for working together through a waiver or demonstration process that is timely and transparent with respect to acceptable conditions for approval may help both federal and state stakeholders better reach their goals.[20] The potential benefits of increased flexibility, however, must be balanced against the importance of federal oversight, budget predictability, and technical assurance that reforms accomplish their objectives within budget.

In addition, federal support (e.g., financial resources and technical assistance) could be used to perform rapid and rigorous evaluations of state efforts that combine coverage reform strategies with delivery system reforms designed to improve quality and lower costs. Such support could provide states with the information needed to make program adjustments that better achieve program goals, in addition to building a body of evidence that other states could draw on in the future. In turn, federal agencies and policymakers could benefit from accumulated state evidence when making national policy.

Overall, making and sustaining significant coverage gains in the small and non-group markets will remain highly challenging in the current health care and economic climate. Without significant new investment in coverage subsidies or the introduction of reforms in health care delivery that can achieve greater value in health care spending, state efforts to create more affordable coverage options for individuals or workers in small firms are likely to remain important but incremental near-term responses to needed reform. Nonetheless, the approaches highlighted here deserve research and political attention in the coming months and years as they may contain important innovations in policy design and implementation approaches that can inform other state and national policy efforts.

Endnotes

1 Holahan, J. and A. Cook. "The U.S. Economy and Changes in Health Insurance Coverage, 2000-2006," *Health Affairs,* Vol. 27, No. 2, published on-line February 20, 2008, pp. w135-w144.

2 ASPE Office of Health Policy, "Overview of the Uninsured in the United States: An Analysis of the 2005 Current Population Survey," September 22, 2005. Also see http://aspe.hhs.gov/health/reports/05/uninsured-cps/ib.pdf.

3 McDonough, J.E. et al. "A Progress Report on Health Access Reform," *Health Affairs*, Vol. 27, No. 2, published online January 29, 2008, pp. w105–w115.

4 New York State Health Policy Research Center, "Implementing Small Group Insurance Reforms: Lessons from States," September 2008. Also see www.nyshealthfoundation.org/userfiles/file/Final%20Phase%20I%20paper%209-10-08%20with%20Appendices.pdf.

5 Wicks, E.K. et al. "Barriers to Small-Group Purchasing Cooperatives," Economic and Social Research Institute, March 2000, Also see www.esresearch.org/Documents/HPC.pdf.

6 Friedenzohn, I. "Limited-Benefit Policies: Public and Private-Sector Experiences," State Coverage Initiatives Issue Brief, July 2004. Also see www.statecoverage.net/pdf/issuebrief704.pdf.

7 Wicks, E.K. et al., op. cit.

8 Friedenzohn, I., op. cit.

9 Wicks, E.K. et al., op. cit.; Long, S.H. and M.S. Marquis, "Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?" *Health Affairs*, Vol. 20, No. 1, January/February, 2001, pp. 154-63; Riley, T. and B. Yondorf, "The Flood Tide Forum—Access for the Uninsured: Lessons from 25 Years of State Initiatives," National Academy for State Health Policy, January 2002. Also see www.nashp.org/files/Flood_tide_forum.pdf.

10 Friedenzohn, I., op. cit.

11 Lischko, A. "Health Insurance Connectors & Exchanges: A Primer for State Officials," State Coverage Initiatives Issue Brief, September 2007. Also see www.statecoverage.net/pdf/healthinsurance0907.pdf.

12 Riley, T. and B. Yondorf, op. cit.; Friedenzohn, I., op. cit.

13 Wicks, E.K. et al., op. cit.

14 Friedenzohn, I., op. cit.

15 Long, S. H. et al. "Health Insurance Coverage in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey," March 2009. Also see www.mass.gov/Eeohhs2/docs/dhcfp/r/survey/08his_coverage_rev.ppt#448,1,Slide 1.

16 Section 125 or "cafeteria" plans refer to Section 125 of the U.S Internal Revenue Code, which established rules related to taxable and non-taxable benefits offered by employers. Providing Section 125 plans to small-firm workers allows workers to purchase their health care coverage on a pre-tax basis. For more information regarding Section 125 plans, see State Coverage Initiative, "State of the States," January 2009, p. 52. Also see www.statecoverage.org/files/State%20of%20the%20States-2009.pdf.

17 Lischko, A., op. cit.

18 Ibid.

19 Quinn, B.C. "The Need for Research and Evaluation of State Health Reforms," *Health Services Research*, Vol. 43, No. 1, February, 2008, pp. 341-343.

20 Rhode Island's pending global budget Medicaid waiver may offer an example of how expanding state flexibility within budget ceilings can offer the potential for states not only to reform delivery of care but also create shared savings opportunities to expand access.