State Reform Efforts in the Small Group Market: Past, Present, and Future

by Shelly Ten Napel, Donald Cohn, and Enrique Martinez-Vidal

July 2009

ENGELBERG CENTER for Health Care Reform at BROOKINGS

State Coverage Initiatives
Robert Wood Johnson Foundation

About the Authors

Shelly Ten Napel is a senior associate at AcademyHealth, working primarily with the Robert Wood Johnson Foundation's State Coverage Initiatives (SCI) program, which collaborates with state policy leaders to develop strategies to improve insurance coverage and foster broad health care reform. She also works with states in the State Quality Improvement Institute, which helps states improve their health care delivery systems. Before joining AcademyHealth in November 2007, Ms. Ten Napel was development director for Columbia Road Health Services, a community health center that serves low-income and uninsured residents of Washington, D.C. Before her work in local health care, she served as a policy and program manager for the National Rural Health Association. Ms. Ten Napel spent the first four years of her career working for U.S. Senate Minority Leader Tom Daschle, becoming a legislative assistant on health care issues. Ms. Ten Napel holds master's degrees in social work and public policy from the University of Michigan.

Donald Cohn joined the Bipartisan Policy Center (BPC) in 2008 as senior policy analyst working primarily on the Leaders' Project on the State of American Health Care. In June 2009, the BPC and Sens. Baker, Daschle, and Dole released the project's final report titled *Crossing Our Lines: Working Together to Reform the U.S. Health System*, which presents key findings from the Leaders' sustained effort to develop consensus on bipartisan policy recommendations for health care reform. Formerly, Mr. Cohn was a policy advisor for the District of Columbia Council, Committee on Health, Chair David A. Catania (I-At Large). Before his work on the Council, he worked as an associate at the State Coverage Initiatives program.

Enrique Martinez-Vidal is a vice president at AcademyHealth and director of the State Coverage Initiatives program. He is currently also the project director for the State Quality Improvement Institute, a project of the Commonwealth Fund that facilitates ongoing contact between high-level state participants and expert faculty to support state efforts to improve care in three priority areas: delivery and financing systems reform, chronic care/population health improvement, and data integration/transparency.

Previously Mr. Martinez-Vidal was the deputy director for performance and benefits at the Maryland Health Care Commission, an independent state agency. Mr. Martinez-Vidal was formerly a policy analyst with the Maryland Department of Legislative Services for five years. During that time he staffed the House Economic Matters Committee and was involved with a number of health-care related issues. He holds a bachelor's degree in political science and international studies from Dickinson College and a master's degree in public policy from Georgetown University.

Acknowledgements

The authors would like to thank Scott Leitz, assistant commissioner of the Minnesota Department of Health, and Janet Ennis, chief, small group market at the Maryland Health Care Commission, for their thoughtful comments. They also appreciate the insight and data provided by the state officials implementing the programs described. They value the collaboration with Aaron McKethan and Nadia Nguyen of the Brookings Institution, who have written a paper jointly published with this paper.

A companion piece to this paper, "Evolving State Approaches to Expand Coverage in the Current Wave of State Access Reform," written by Aaron McKethan, Jennifer King, Nadia Nguyen, Amy Lischko, can be found at www.statecoverage.org/node/1928.

Executive Summary

The small group market has become a focus for reforms at both the state and national level. This is due to low and falling coverage rates in this market, dramatically increasing prices, premium instability due to risk rating and other factors, high overhead costs, and the falling value of coverage being purchased. State policymakers, especially, have focused on this market because it is the one over which they have substantial oversight responsibility; most small employers do not self-insure and therefore that oversight is not pre-empted by the Employee Retirement Income Security Act of 1974 (ERISA). As a result, many models for expanding and improving coverage in this market have been tried, some with more success than others. This paper will explore the impact of various reform strategies and attempt to identify the interventions that have the most promise moving forward.

In reviewing the reform strategies that have been implemented, several best practices can be identified. First, if state reformers are seeking to expand coverage rates among employees of small businesses, subsidies are a critical component. Affordability is the key problem in this market. Benefit design changes can impact price, but subsidies provide an added incentive for non-participating employers to enter the market. Subsidies can also counteract the potential for adverse selection in a new small group product that might otherwise attract only less healthy consumers.

"Wellness plans," like those being offered in Rhode Island, may offer another innovative strategy for reducing costs. For many years, the main method for reducing premiums was increasing deductibles and co-payments. In the last few years, states have begun to design benefit packages that engage the patient in becoming healthier over time, hoping to counteract long-term cost increases and make their population healthier. States are also attempting to steer patients toward more cost-effective primary care and away from emergency rooms and the need for hospital visits. For states that are already working throughout their health care system to reduce costs and improve value, these strategies can be brought into their small market reforms.

First-dollar coverage, as with the plan offered in Tennessee, is another new strategy that merits consideration. Advocates argue that low-income individuals are less worried about protecting their assets in the case of a catastrophic event and more worried about paying for routine care. First-dollar coverage helps ensure that patients receive the primary and preventive care that might help them avoid the need for expensive specialty or hospital care in the future.

Both the Tennessee and Rhode Island reforms set a target price and asked insurers to bid on what services they could provide for that premium within given parameters. Both states believe that they can use the state's negotiating power to craft a better deal for enrollees.

In 2006, Massachusetts implemented a series of reforms that led to rising coverage rates in the state's individual and small group insurance markets.[1] The increasing number of insured individuals in Massachusetts is mostly due to the "individual mandate" (a requirement that individuals who can afford it purchase health coverage or face a penalty) and increased subsidies to help individuals purchase insurance. Still, even for states that are not able to enact an individual mandate or dramatically increase funding for public coverage, there were a few new ideas introduced in the Massachusetts legislation that have gotten the attention of state small group reformers. These include implementation of a Connector, a requirement that employers offer a Section 125 plan (an administrative mechanism that allows the pre-tax withholding of premiums paid by employees), and a penalty for employers who do not offer coverage to employees.

Even the most well-conceived policy intervention can fail to achieve expected results if not effectively implemented and evaluated. Implementers should work closely with business groups to ensure that programs meet the needs of local businesses and that participation is simple. An effective marketing campaign requires using many outlets for communication; a program will not succeed if the state does not get the word out. Careful consideration should be given to the role of brokers in the program, as they are the traditional way small businesses select and purchase insurance products. Finally, states will not know if their programs are a success if they do not include a strong evaluation component. Evaluation enables policymakers to adapt programs midstream to address barriers and become more effective.

A word of caution is in order about coverage expansion programs that target small businesses. Even the "successful" programs highlighted in this report have attracted only a small segment of the insurance market. Engaging small and often low-wage employers is difficult expensive work. A given small employer may have only one or two uninsured workers, and those workers may or may not be interested in paying part of the premium for coverage. States have had greater success in enrolling large numbers of uninsured workers by targeting individuals, often with initiatives funded through Medicaid. However, if, for political or other reasons, state policymakers decide to focus on achieving increased affordability, choice, and fairness for employers and employees in small firms, they are well advised to consider many of the policy options discussed in this paper. The small group market is certainly costly, unstable, and eroding and there are many tools states can use to help those employers who are committed to offering health insurance to their employees.

Background

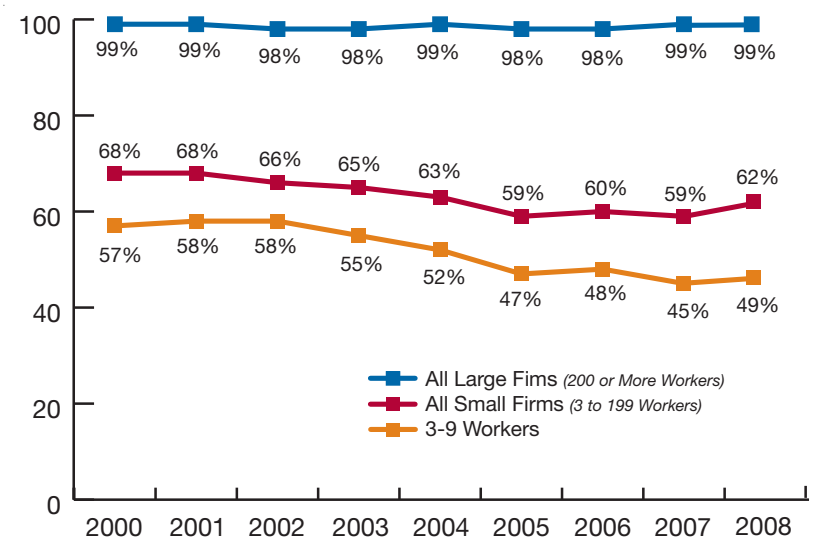
The erosion of employer-sponsored insurance (ESI) and related increase in the number of the nation's uninsured explains much of the interest in reforming the small group market. While the percentage of large firms offering coverage has remained fairly constant at 98 or 99 percent, the percent of employers with fewer than 200 workers offering insurance fell from 68 percent in 2000 to 62 percent in 2008. Even fewer very small employers (3 to 9 employees) offer coverage; their coverage rate fell from 57 to 49 percent over the same period.[2] The loss of ESI, which is primarily driven by a drop in coverage among small firms, has been a major cause of falling coverage rates in the United States since 2000.[3] Nearly 63 percent of uninsured adults work for small firms (100 or fewer employees) or are self-employed.[4]

Even among small businesses that do maintain coverage, there is a trend toward greater employee cost sharing. Average deductibles for those insured by small businesses tripled between 2000 and 2007.[5]

In addition to market-wide trends of rising costs and falling coverage rates, small businesses may be impacted by unusually high or volatile premium prices due to the relative health care costs of their employees. Depending on how much premium variation a state allows in the small group market, a sick employee could suddenly make coverage unaffordable for a given small business, even if that small business has been purchasing insurance for years.

For that reason, many states enacted some form of community rating during the 1990s. Their goal was to increase access to insurance for higher-risk groups and to prevent the large premium increases associated with a change in health status. States were also hoping that administrative costs would be lowered as a result of insurers spending less on risk rating and the churn that results from dramatically changing premiums.

Exhibit 1 Percentage of All Firms Offering Health Benefits, 2000–2008*



*Test found no statistical differences from estimate for the previous year shown (p<.05).
Note: Estimates presented in this exhibit are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.
Source: KFF/HRET Survey of Employer-Sponsored Health Benefits, 2000-2008.

States vary considerably in how they regulate the small group market, allowing different premiums based on health status, industry type, group size, gender, and age.[6] In addition, states vary in their treatment of "groups of one." Some states permit the self-employed to purchase insurance through the small group market; other states do not. Typically, "groups of one" have relatively higher health risk, which prevents them from purchasing in the individual market and effectively drives up costs in the small group market.

Research to date demonstrates that states did partially stabilize premium rate increases and increased access for sicker groups by using their regulatory powers through tighter community rating bands. However, the states achieved such gains at the expense of younger, healthier members who dropped coverage as premiums increased. As a result, the regulatory reforms did not significantly affect the number of uninsured.[7]

State Strategies to Improve Availability of Coverage for Workers

States are focusing on several approaches or combinations of approaches to improve access to insurance in the small group market: (1) allowing flexible benefit designs; (2) subsidizing coverage; (3) combining strategies that address both benefit design and subsidies; and (4) strengthening the purchasing power of small employers.

Flexible Benefit Designs

When states have sought to expand coverage in the small group market without investing additional resources, they have experimented with changing (primarily reducing) benefit packages. Between 2001 and 2004, interest peaked in mandate-free or limited-benefit plans as more than 15 states passed legislation to permit the sale of mandate-free plans. Several years following implementation of such plans, observers still do not agree on the impact of the initiatives on coverage rates in the affected states. More

recently, states such as Rhode Island and New Hampshire enacted laws to promote "wellness plans," which set a price for coverage, define some of the benefits, and let insurers bid to provide an insurance product at the specified rate.

Mandate-Free Plans. For more than three decades, states have required private carriers to cover certain benefits or the services of specific types of providers. Mandated benefits vary from state to state; the most common mandated benefits are mammography and diabetes supplies. A Government Accountability Office (GAO) report disclosed that seven states had 30 or more benefit mandates while 15 states each had fewer than 10 mandates.[8] Given that most large employers are self-insured and therefore not subject to state mandates, the mandates principally affect the small group and individual markets.

The value of limited-benefit plans as a strategy to reduce the number of uninsured is a matter of debate. Primarily, there is a question of whether limited-benefit plans create a new coverage alternative for uninsured individuals or simply crowd out those who previously had comprehensive health insurance. A closely related issue is whether limited-benefit products are sufficient to ensure access to timely medical care and to protect individuals from personal bankruptcy. Moreover, if a state allows limited benefits, does it merely shift costs to providers in the form of uncompensated care? Finally, are the cost savings achieved by the plans sufficient to lower premiums and expand access to coverage for those with low to moderate incomes?

To date, limited-benefit products have not sold well in the private market. First, carriers may be reluctant to spend resources to develop and market the product out of belief that only a few consumers will purchase the limited-benefits option. In addition, carriers prefer not to compete with their existing full-benefit commercial products, particularly given the likely result of risk segmentation between products. At the same time, uninsured individuals have been reluctant to purchase limited-benefit products. The savings are marginal (5 to 9 percent[9]) and, given the reduced benefits, may not be seen as a good value.[10]

Texas is one of the few states that has seen substantial enrollment in its limited-benefit plan called the Consumer Choice Benefit Plan. According to a recent audit of the program, over 250,000 individuals had coverage through the plan at the end of 2007.[11] Of those covered lives, approximately 7,500 were previously uninsured. However, although carriers were exempted from covering certain *benefit mandates* in the plan, they were allowed to *increase cost sharing*. According to carrier disclosure statements filed with the Texas Department of Insurance, the increased affordability of the Consumer Choice Benefit Plan is largely attributable to increased cost sharing.[12]

Wellness Plans. Rhode Island has been experimenting with a new approach to containing costs. State policymakers are seeking to slow or reverse declining coverage rates in the small group market by adopting innovative strategies that go beyond cutting benefits and increasing deductibles. They believe that they can harness the state's regulatory power to encourage enrollees to become healthier, thus reducing underlying costs. This strategy has already found some successful application among large employers and in state employee programs.

Rhode Island issued a request for proposals to carriers for a "wellness" product called HEALTHpact. The state noted that the benefit package should emphasize preventive care and that the average premium could not exceed 10 percent of average wages in Rhode Island, or $314 for single coverage (in 2007).[13] Carriers responded with benefit package proposals. Meeting the legislatively defined price point is expected to reduce premiums for all small businesses to approximately 25 percent below market rate.

The goal of the Rhode Island program is to slow the erosion of coverage in the small group market, although policymakers recognize that the cost still will not be sufficiently low to bring in large numbers of uninsured. The program achieves cost savings through patient cost sharing that is designed to motivate healthy behaviors, selection of a primary care physician, required completion of a health risk assessment, and chronic condition management. The plan offers basic and advantage levels. Enrollees may enroll in the advantage program—which includes lower deductibles and copayments—by completing a health risk assessment in the first year and then beginning to meet health goals in the second year. New Hampshire and Florida passed similar plans in 2008.

Enrollment in HEALTHpact has been disappointing; as of April 2009, 1,100 people had enrolled. State officials note that the state has not invested any marketing dollars in the program and that insurance companies and brokers—who currently dominate the marketing of health insurance—have little incentive to promote the program. They also note that the offering was initially designed to include a state subsidy. When the state was unable to contribute the subsidy, the product became less attractive and private sector partners had less reason for enthusiasm about the program. Nevertheless, Rhode Island has shown that a state can influence the design and cost of health insurance products. Other states can build on Rhode Island's innovations and lessons to promote access to higher-value health insurance products in the individual and small group markets.

Defining a Benefit Package and Affordability

As states grapple with costs in the small group market, benefit design and its impact on affordability is a recurring issue. States seek to answer two underlying questions: What is affordable for whom? What services should be covered?

The individual mandate in Massachusetts has advanced the discussion of affordability of coverage because the law stipulates that the board of the Connector Authority should define an adequate, creditable benefit package and schedule of affordability. The board has the power to waive the individual mandate requirement for certain individuals based on hardship criteria. Following is the Massachusetts standard:[14]

Table 1: Massachusetts 2008 Affordability by Age and Income: Individuals

Age Band	Least Expensive Choice Plan	Individual Income Category and Maximum Monthly Premium			
		Income Range	$31,213	$37,501	$42,501
			$37,500	$42,500	$52,500
		Premium	$165	$220	$330
Up to age 26	$137.93		Yes	Yes	Yes
27-29	$192.13		No	Yes	Yes
30-39	$193.95		No	Yes	Yes
40-49	$243.96		No	No	Yes
50-54	$288.99		No	No	Yes
55 +	$384.24		No	No	No

Note: This chart was created by the Massachusetts Commonwealth Connector under the heading "2008 Affordability by Age and Income: Individuals." For more information about affordability standards in Massachusetts, visit their Web site at www.mahealthconnector.org.

Outside Massachusetts, states are only beginning the discussion of what is an affordable product given the income levels of the uninsured and the scope of the benefit package. In the absence of an individual mandate, many states are looking to craft a benefit package that is affordable for low- and middle-income families yet rich enough to be "better than nothing." In general, the market has made insurance more affordable by increasing copayments and deductibles.

Within public coverage programs, states rely on the federal standard outlined in the State Children's Health Insurance Program (SCHIP) and Deficit Reduction Act (DRA) of 2005 such that cost sharing for most families may not exceed 5 percent of a household's gross or net income.[15] A recent study in *Health Affairs* that attempted to measure underinsurance used the following standards that included both total out-of-pocket costs and deductibles compared to income: (1) out-of-pocket medical expenses for care amounting to 10 percent of income or more; (2) among low-income adults (below 200 percent of the federal poverty level), medical expenses amounting to at least 5 percent of income; or (3) deductibles equaling or exceeding 5 percent of income.[16]

Subsidized Products

For a number of years, states have used subsidies as a strategy to expand coverage to low-income individuals. The interest in subsidizing the small group market has ebbed and flowed with the state fiscal situation or willingness to raise new revenues. State policymakers have tried a number of different approaches to subsidized programs, both in terms of whom to cover and how to cover them.

The states that have enacted comprehensive reforms all have included subsidies targeted to small employers and the low-income working uninsured as part of the reform.

State experience with subsidies provides some important lessons. For example, it demonstrates that subsidies designed to encourage small businesses to offer insurance or to encourage low-income workers to purchase insurance need to be substantial (50 percent or more of premium) in order to stimulate significant enrollment in a voluntary system.[17]

Subsidies in the small group market may have one of two goals. First, subsidies may help low-income groups afford the purchase of insurance. Second, subsidies may improve the risk profile of a group by encouraging low-cost individuals to purchase insurance because it is perceived

as a good deal. In that case, subsidies are used in conjunction with reforms that narrow rating bands and restrict insurers' ability to reject or price out high-cost enrollees.

Who Receives the Subsidy? With limited resources and a desire to make the greatest impact on the uninsured rate, policymakers must carefully consider who will receive a subsidy and then determine crowd-out implications. The issue of crowd-out is important. If a firm currently offers insurance to its employees or its workers purchase insurance via the individual (non-group) market, can employees become eligible for the subsidized product? The question raises equity issues and has major implications for state budgets. States have answered the crowd-out question in different ways, but the majority of subsidized products have crowd-out provisions limiting eligibility to only those previously uninsured within certain income guidelines.

Making a subsidy available to all low-wage employers under a certain size would subsidize many employers already offering insurance. The subsidy would largely offset the premiums already being paid by those who currently offer insurance, thereby increasing the cost for each newly insured person. However, failure to offer the subsidy to all employers raises fairness concerns; it penalizes those who previously offered insurance to their employees. In addition, it limits the subsidy's effect on preventing the erosion of coverage by those already offering it. While most state subsidy programs do limit eligibility to small firms that have not offered insurance for six to 12 months, a few explicitly address the needs of those currently offering insurance.

Montana's small business initiative called Insure Montana uses two mechanisms to help very small firms (two to nine employees) afford the cost of health insurance. Qualifying small firms that currently offer insurance are eligible for a refundable tax credit. Forty percent of total Insure Montana funding serves firms that currently offer coverage. At the same time, qualifying uninsured small firms (two to nine employees) may purchase insurance via a purchasing pool with a state subsidy if they have not offered insurance for the past 24 months. Sixty percent of funding serves the previously uninsured. Under the purchasing pool program, an employer must pay at least 50 percent of an employee-only policy. Insure Montana covers the other 50 percent. In addition, each employee receives a monthly premium assistance payment with amounts ranging from 20 to 90 percent of his or her premium contribution based on a sliding scale tied to annual family income.[18]

As part of its comprehensive health reform, Maine entered into a partnership with Anthem Blue Cross Blue Shield to launch a coverage expansion called DirigoChoice. DirigoChoice is a state-sponsored, voluntary program designed to offer affordable health insurance coverage to small businesses, self-employed persons, and individuals. As a matter of equity, Maine officials felt it important to allow all employers to participate in DirigoChoice whether or not they offered insurance. Employers may not voluntarily drop coverage in order to enroll their employees into DirigoChoice as individuals.

An August 2008 report on DirigoChoice found that:

- Forty percent of DirigoChoice members were previously uninsured and another 22 percent were underinsured before enrolling.
- The program has enrolled 15,000 members (before the start of the program, the state estimated that 49,000 Maine residents were uninsured and employed by a small business). Of those, 23 percent are employed by small businesses, 28 percent were sole proprietors, and 49 percent were low-income individuals.[19]

The crowd-out choices made by Maine state officials maintain equity in the treatment of small employers. DirigoChoice competes against the commercial market for market share and assists the underinsured or those facing significant cost-sharing or benefit package limits. The majority of enrollees indicated that DirigoChoice was a better value than their previous commercial insurance. Unfortunately, the funding mechanism for DirigoChoice has not proven reliable such that the program is currently closed to new members who need a subsidy (it is only open to non-subsidized applicants). State officials are looking for an alternative funding mechanism.[20]

States face a second major question in determining who will be eligible for subsidized new products for small firms. Does the state limit enrollment to the employer only? Put another way, is the employee's participation capability dictated by the firm owner, or may the employee join the subsidized insurance program without the firm? If the employer cannot be motivated to offer insurance, the state may directly enroll low-income individuals into subsidized insurance programs. See Table 2 for a few examples of how states have dealt with the eligibility question.

States that have allowed individuals to join their programs have found that this significantly boosts enrollment. In the Healthy New York program as of October 2007, 31 percent of enrollment came from small businesses, 16 percent from sole proprietors, and 53 percent from individuals.[22] Insure Oklahoma has a higher percentage of enrollees whose employer pays a part of their premium, with 11,200 in the small group plan and 5,600 in the individual plan (which includes the self-employed).[23]

How Will the Subsidy Be Provided? A subsidy may take many forms such as tax credits, access to newly created products, or premium subsidies to buy in to public programs. Some states have provided state-funded reinsurance

Table 2: State Eligibility Requirements for Participation in Coverage Expansion Programs

	Arkansas	Oklahoma	New Mexico	Healthy NY	DirigoChoice	CoverTN
May workers without access to ESI join?	No	Yes	Yes	Yes	Yes	Yes, with limitations
Eligibility requirements	All must be uninsured and working for an employer who agrees to participate	Employees of small firms who do not have access to ESI and earn less than 200 percent of the federal poverty level	Low-income, uninsured, working adults with family income below 200 percent of the federal poverty level; individuals must pay the employer's portion of the premium	Workers who earn less than 250 percent of the federal poverty levels and are uninsured for 12 months or those who lost coverage because of a specified event	The unemployed and qualified individuals who work for small firms and do not have access to ESI	At the start of the program, individuals had to work for a small firm that had either: (1) not offered coverage in the last six months; or (2) not paid 50 percent or more of the premiums. As of January 2009, the program added a "Tennesseans Between Jobs" component that would include anyone who had worked at least 20 hours in one week in the last six months or who has had their hours reduced below 20 hours per week[21]

support rather than a subsidy of the premium. Many states structure subsidy mechanisms through a federal waiver to allow them the possibility of drawing federal financial participation for their respective programs.[24] If states choose to forgo federal funds, they have considerable latitude in designing subsidy programs. The majority of subsidized products rely on commercial carriers or Medicaid managed care organizations to deliver the product. Decisions about subsidy form and delivery system may affect how the market perceives new products and the extent to which the subsidized product is selected.

Combining Subsidies with Benefit Redesign

Many of the latest innovations in small group market reform include both subsidies and a restructured benefit plan. Tennessee is one state that has adopted such a combined approach.

After Tennessee rolled back eligibility for its Medicaid program (TennCare), the state enacted several coverage programs targeted to some former TennCare enrollees. To create a portable and affordable product for the working uninsured, the state issued a request for proposals for an insurance plan administrator for CoverTN. The state set guidelines that require carriers to include a choice of two benefit packages. The benefit plans must emphasize preventive care, and premiums must average $150 per member per month. After the state and the employer each contributes one-third of the total premium, individuals pay between $35 and $99 per month depending on age, tobacco use, and body weight. To participate, the employee must work for a low-wage firm and not previously have been offered coverage. Alternatively, an individual who is self-employed or working for a non-offering firm and is willing to pay two-thirds of the premium must earn below $55,000 per year. Once purchased, the coverage is portable and can even cover the individual during short periods of unemployment. In addition, as of January 1, 2009, the plans are available to Tennesseans who are recently unemployed or have recently had their hours reduced. Of the five responses to the RFP, the state awarded both benefit packages to Blue Cross Blue Shield. Both plans provide first-dollar coverage, with a yearly limit of $25,000 per person along with limits on prescription drugs and physician visits. They emphasize preventive care and healthy lifestyles. As of February 2009, about 18,000 individuals had enrolled in the program.[25]

Healthy New York is another example of a program that added subsidies to other premium-reducing strategies. To reduce costs to small, low-wage firms that had not previously offered coverage, the state (1) reduced the benefit package and increased cost sharing; (2) provided care through limited-network plans that agreed to

Table 3: Selected State Small Group Programs that Combine Subsidies with Wellness Benefit Standards

State	Target Group	Funding Source	Benefit Design Elements	Number of People Enrolled as of February 2009
Tennessee	Earn below $55,000 or employed by a firm with an average wage below $55,000; previously uninsured	1/3 individual, 1/3 employer, 1/3 state funds (on average; the individual contribution and state subsidy vary by the individuals income, weight, and tobacco use)	$25,000 limit; preventive and primary care; drug limits	18,000
Arkansas	Workers in firms with two to 500 employees; previously uninsured	State and federal funds (using Medicaid) cover a portion of premium on a sliding scale based on income; about 10 percent of enrollees cover entire cost with no subsidy	Seven inpatient days, two major outpatient services, six physician visits, and maximum $100,000 per year; two prescriptions per month; $1,000 out-of-pocket annual maximum; guarantee issue and no medical underwriting	5,000
Maryland	Firms with two to nine employees; low-wage; not previously offering	State covers up to 50 percent of premium	Must include a wellness rider; employer must offer a Section 125 plan	420[26]

reduced reimbursement; and (3) included a state-funded reinsurance program. Since enactment of the program, the state has offered additional benefit packages to make the program more attractive. It is estimated that Healthy New York's premium is about 40 percent lower than the average premium in the small group market and two-thirds less than premiums in the individual market.[27]

New York elected to implement its subsidy through a reinsurance program in which the state covers 90 percent of the costs for an individual between $5,000 and $75,000.[28] Some economists argue that reinsurance programs enable insurers to reduce premiums even more than subsidies because they do not have to cushion the premiums as much in order to cover the potential cost of adverse selection. New York retained the incentives for insurers to manage the costs of enrollees by requiring them to pay 10 percent of premiums between $5,000 and $75,000 and all additional costs above that threshold. Healthy New York has been operating since 2001 and counted more than 150,000 enrollees as of fall 2008.[29, 30]

The current trend in state reforms is more comprehensive than the stand-alone limited benefit strategies of earlier years. However, finding agreement on the appropriate benefit design still remains a challenge for state policymakers. Some have tackled the benefit debate by allowing commercial providers to design products that follow government-prescribed parameters. The CoverTN model is such an example. In Massachusetts, the legislature set up the Connector Board, which is a public/private entity that oversees both the affordability and scope of the benefit package. Reliance on an advisory group allows for more flexibility over time in the benefit package than if the law specified requirements. In the case of the Connector Board, the public/private group has generally earned a good reputation, bolstered in part by the public process of its meetings and the excellent qualifications of board members. If current trends hold, more states will continue to combine flexible benefit design strategies with subsidies to make new products affordable to lower-income populations.

Pooling and Purchasing

During the 1990s, several states attempted to help small employers offer insurance to their workers by creating voluntary, unsubsidized purchasing cooperatives that would pool risk and purchase insurance on behalf of employers. The cooperatives were developed to help the small group market look more like the large group market, with more choice, lower administrative

The Massachusetts Example: Individual Mandate, the Connector, and Section 125 Plans

The agreement reached as part of the 2006 Massachusetts coverage reform introduced new possibilities for expanding coverage into the individual and small group markets. By passing an individual mandate, the state was able to get around many of the trade-offs typically experienced by small group and individual market regulators. Given that an individual mandate forces everyone to buy coverage, it pulls healthy individuals into the risk pool and enables the state to require insurers to accept sicker individuals without the risk of spiraling premiums. The ultimate goal—as overtly expressed by policymakers and insurers during the 2007–2008 California health reform debate—is to create a market in which insurers compete on price and quality rather than on ability to avoid risk.

In conjunction with these market reforms, Massachusetts implemented the Commonwealth Health Insurance Connector Authority (the Connector). The Connector does not pool risk but instead acts as a purchasing mechanism to help individuals and small businesses navigate the insurance market.[33] It gives more plan choice to individuals and to employees of small businesses while enabling the purchase of portable coverage, thus achieving some of the goals of the early pools.[34]

Massachusetts has also required that employers make Section 125 plans available to their employees, regardless of whether they offer insurance or not. The state has worked to make this easier for employers through on-line guidance and assistance offered through the Connector.

Under Section 125 of the IRS tax code, employees may pay their health premium with pre-tax dollars whether or not their employer contributes to the premium. The tax benefits to individual employees vary but typically range between 20 and 40 percent of the premium. For an individual to be eligible for this benefit, the employer must set up a Section 125 plan with the IRS. States have begun to show interest in Section 125 by adopting a variety of approaches: (1) requiring employers to offer Section 125 plans to their employees; (2) offering assistance to employers who want to set up the plans; and (3) making enrollment in a Section 125 plan a condition of participation in a subsidized insurance plan in the small group market.[35]

costs, and—in some cases—less medical underwriting. For the most part, the efforts did not succeed in expanding coverage or reducing costs.[31] They always created "unnatural groups;" there was no natural reason for people to be in the same pool other than to obtain coverage. Thus, the same challenges related to adverse selection and administrative costs that affected the individual and small group markets plagued state-sponsored pools.

An example of a pooling plan was Florida's effort to create 11 Community Health Purchasing Alliances (CHPA) in 1993 as part of small group market reform. Enrollment peaked in 1998 with 92,000 covered lives and an average group size of two. Due to Florida's regulatory environment, the CHPAs enrolled a disproportionate number of groups of one as an alternative to the individual market. Participating health plans raised concerns about adverse selection and began to withdraw from CHPA. Subsequently, enrollment fell quickly, and premiums increased significantly, leading the CHPAs to disband in July 2000.[32] In the final analysis, the program did not reduce costs or increase coverage but did offer enrollees more choice than they otherwise would have had in the regular small group market.

Outreach and Marketing

Even well-conceived policy ideas have failed in the implementation stage when adequate attention has not been paid to outreach and marketing. Particularly when working with business groups, outreach should be done during the policy design phase, throughout the drafting of regulations and then as programs are rolled out and marketed.

States should consider several factors in this area. The program should be as consumer-friendly as possible, with multiple ways to enter the program, and include enrollment assistance for those who need it. Marketing through multiple outlets–both paid and unpaid–will be critical. In addition, efforts should be made to work with brokers and other traditional retailers of insurance. Involving key stakeholders, like business groups, insurers and brokers, is critical to the success of a program.[36]

Evaluating Reform Programs

The success or failure of many small group business insurance initiatives remains unknown because states do not include an evaluation component in their programs. Particularly for programs administered through private carriers, state legislation should include benchmarks and data reporting requirements that permit policymakers to know whether initiatives are achieving their objectives. In addition, a strong evaluation component will enable states to alter a program midstream if needed. A key lesson learned by many states is that program administrators must be nimble and capable of addressing program challenges as they arise.[37]

Conclusion

Efforts to increase small employer offer rates pose several policy dilemmas for states. Past efforts have demonstrated that it is exceedingly difficult to change employer behavior and improve employer offer rates. Still, existing state programs point to a few lessons for policymakers.

Affordability remains that main barrier to coverage. States can add value in the small group market by bringing state and federal funds, whenever possible, to the table and negotiating with insurance plans to offer a product that meets the needs of low-wage workers. Innovative benefit designs can offer an alternative to the current trend of increased cost sharing and growth in the employee's share of the premium. If programs can be made available to employees without access to ESI or to groups of one, enrollment will be higher, though this eliminates one source of funds for coverage, the employer premium contribution.

Cheaper premiums are not sufficient to entice previously uninsured small groups. States have also learned that, to recruit new employers to the market, they must work closely with them to make sure that programs meet their needs. They must pay attention to outreach and marketing as well.

After many years of effort, states have seen that mandate-free plans and efforts to create larger purchasing pools have achieved only limited success. For states interested in spreading risk to provide more even coverage for the ill, they must ensure that program rules are consistent with rules outside the program—unless significant subsidies are made available.

Increasingly, states are struggling with benefit design. They are asking what a "basic" benefit package should include and whether there are ways to cut costs by providing higher-quality, more cost-effective care. In fact, states can turn to several strategies to cut costs without cutting benefits or increasing cost sharing. They may, for example, decrease administrative costs, offer a more restrictive panel or tiered levels of providers, encourage patients and doctors to choose generic drugs, make fundamental changes to payment policy, and redesign the delivery system to encourage primary and preventive care. As states experiment with these policy solutions, strategies will trickle into the small group market and find application there.

Finally, states will be watching reforms being implemented in Massachusetts, including the employer requirements, the individual mandate, the Connector, and the Section 125 plan requirement. Taken together, the innovations have the potential to create fundamental rather than incremental change. Early indications show that Massachusetts is covering more individuals while slowing the growth of per person spending. The full impact of these reforms remains to be seen.

Endnotes

1 Long, S. et al. "Health Insurance in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey," Urban Institute, December 18, 2008, www.urban.org/publications/411815.html.

2 "Employer Health Benefits Annual Survey, 2008," Kaiser Family Foundation and Health Research Education Trust, September 2008, http://ehbs.kff.org/.

3 Holahan, J. and A. Cook. "The U.S. Economy and Changes in Health Coverage, 2000-2006," *Health Affairs*: Vol. 27, No. 2 (2008):w135-w144.

4 Fronstin, P. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population Survey," Employee Benefit Research Institute, September, 2008, www.ebri.org/pdf/briefspdf/EBRI_IB_09a-2008.pdf.

5 Schoen, C. et al."How Many Are Underinsured? Trends among U.S. Adults, 2003 And 2007," *Health Affairs*, July/August 2008; Vol. 27, No. 4: 274: w298-w309.

6 Curtis, R. et al."Health Insurance Reform in the Small Group Market," *Health Affairs*, May/June 1999; Vol. 18, No. 3:151-160.

7 "Implementing Small Group Insurance Market Reforms: Lessons from the States," New York State Health Policy Research Center, September 2008, www.rockinst.org/pdf/health_care/2008-09-implementing_small_group_insurance_market_reforms_lessons_from_the_states.pdf.

8 General Accounting Office. *Federal and State Requirements Affecting Coverage Offered by Small Businesses*, September 2003, www.gao.gov/new.items/d031133.pdf.

9 The debate over the costs of benefit mandates is part of a charged political debate. The difficulty in assessing costs of a benefit mandate is to show the cost of the mandate itself above and beyond what would have existed absent the state mandate. For example, employers may have selected to cover a service without the mandate. If a self-insured firm selects to cover a service, does the mandate impose a cost? The state of Maryland conducts analyses of both the overall and marginal costs of a mandate. For a full review of the literature on the topic, see, State of New Jersey, Department of Human Services in collaboration with the Rutgers Center for State Health Policy, "Mandates Health Insurance Benefits: A Critical Review of the Literature," January 2007, www.cshp.rutgers.edu/downloads/7130.pdf.

10 Friedenzohn, I. "States' Experience with Benefit Design," State Coverage Initiatives Issue Brief, April 2003, www.statecoverage.org/node/185.

11 Longley, D. "Texas Health Insurance Market—Insuring the Uninsured," Presentation to Senate Finance Committee, August 19, 2008.

12 Data from Texas Department of Insurance. For a comprehensive list of carriers and their expected savings, see Texas Department of Insurance, www.tdi.state.tx.us/company/documents/lhccplst_73004.pdf.

13 Office of the Health Insurance Commissioner, "Health Insurance Bulletin Number 2007-1," www.dbr.state.ri.us/documents/divisions/healthinsurance/070306%20Bulletin%202007-1.pdf.

14 The legislature charged the Connector Authority with developing a standard for "affordable coverage." According to Massachusetts law, all individuals are required to purchase health insurance unless coverage is deemed unaffordable. For more information on the Massachusetts affordability standard, see www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/FindInsurance/Individual/Affordability%20Calculator/Connector%20Affordability%20Info%20Sheet.pdf.

15 "Coverage Requirements for Children's Health Insurance, Title 21 of Social Security Act," Social Security Administration, www.ssa.gov/OP_Home/ssact/title21/2103.htm

16 Schoen, C., et al. "How Many Are Underinsured? Trends among U.S. Adults, 2003 And 2007." *Health Affairs*, July/August 2008; Vol. 27, No. 4: w298-w309.

17 Helms, W.D., et al. "Mending the Flaws in the Small Group Market," *Health Affairs*, Summer 1992; Vol. 11, No. 2: 7-27.

18 For more information about Insure Montana, see www.insuremontana.org/.

19 Kilbreth, E. and K. Fox. "The Dirigo Health Reform Act: A Case Study of Small Group Market Reform in Maine" The Nelson A. Rockefeller Institute of Government Health Policy Research Center, August 2008, www.rockinst.org/WorkArea/showcontent.aspx?id=15272.

20 "State Strategies: Success Varies; Vision Remains," *State of the States*, January 2009, State Coverage Initiatives, www.statecoverage.org/node/1296.

21 "Governor Bredesen Announces CoverTN Benefit Improvement for 2009," Press Release by the Governor's Office, September, 2008, www.tennesseeanytime.org/governor/viewArticleContent.do?id=1283&page=2.

22 "2007 Annual Report on Healthy New York." Prepared by EP&P Consulting for the State of New York Insurance Department, January 2008, www.ins.state.ny.us/website2/hny/reports/hnyepp2007.pdf.

23 "Insure Oklahoma Fast Facts," February 2009, www.oepic.ok.gov/WorkArea/showcontent.aspx?id=3510.

24 Healthy NY and Insure Montana are funded by state dollars only. New Mexico, Oklahoma, Arkansas, Maine, and Massachusetts all draw federal funds.

25 For more information on the CoverTN program, see www.covertn.gov/web/brochure_covertn.pdf.

26 As of December 1, 2009, 420 individuals and 80 businesses were enrolled; the program began in October 2008.

27 Swartz, K. "Reinsurance: How States Can Make Health Coverage More Affordable for Employers and Workers," The Commonwealth Fund, July 2005, www.commonwealthfund.org/publications/publications_show.htm?doc_id=286904.

28 Ibid.

29 *State of the States,* State Coverage Initiatives, January 2009, www.statecoverage.org/node/1296.

30 For other examples of states that have used subsidies to expand coverage in the small group market, see "Enrollment Experience of Select State Small Business Subsidy Programs," *State of the States,* State Coverage Initiatives, January 2009, page 50, www.statecoverage.org/node/1296.

31 Long, S.H. and M.S. Marquis. "Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?" *Health Affairs* Jan/Feb 2001: 154–163.

32 Wicks, E., M.A. Hall and J.A. Meyer. "Barriers to Small Group Purchasing Cooperatives," Economic and Social Research Institute, March, 2000, www.esresearch.org/Documents/HPC.pdf.

33 Haislmaier, E., and N. Owcharenko. "The Massachusetts Approach: A New Way to Restructure State Health Insurance Markets and Public Programs," *Health Affairs* November/December 2006: 1580-1590.

34 For more information on the Massachusetts Connector and similar approaches, see the State Coverage Initiatives Issue Brief, "Health Insurance Connectors and Exchanges: A Primer for State Officials," www.statecoverage.org/node/165.

35 For more information about Section 125 plans, see "Section 125 Plans: Policy Implications for States," and "Overview of State Approaches to Section 125 Policies Designed to Expand Coverage" in *State of the States,* State Coverage Initiatives, January 2009, www.statecoverage.org/node/1296. Also see slides and background from the SCI meeting, Section 125 Policy and Implementation Issues, www.statecoverage.org/node/978F.

36 The arguments included in this section are taken from a State Coverage Initiatives Issue Brief by Ann Volpel, Asher Mikow, and Todd Eberly, called "Marketing State Coverage Programs: Experiences from Four States," www.statecoverage.org/node/164.

37 *Implementing Small Group Insurance Market Reforms: Lessons from the States.* The Nelson A. Rockefeller Institute of Government, September 2008, www.rockinst.org/WorkArea/showcontent.aspx?id=15288.