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RESEARCH CENTER

Implementing Small Group Insurance Market Reforms: Lessons From the States

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About the Paper and the Intended Audience

The paper provides an overview of the strategies all 50 states have used to increase insurance coverage in the small group market including what is known about the effectiveness of these strategies. It examines in more depth the experiences of three states with different types of health reforms, focusing on two states' efforts to reform the small group market and one state's experience with improving coverage in the individual market. Lessons are gleaned from these states about the processes they used to reform insurance coverage, and how their programs are structured, administrated, financed, and implemented so that other states that are considering reform options, such as New York, can learn from these experiences. The scan of 50 states' small group insurance market policies and the state case studies may be obtained by contacting the Rockefeller Institute of Government or visiting www.rockinst.org/HPRC.

About the Rockefeller Institute and the New York Health Policy Research Center

The Nelson A. Rockefeller Institute of Government is the public policy research arm of the State University of New York. The Institute focuses on the role of state and local government in the American federal system. The New York State Health Policy Research Center (HPRC), a program of the Rockefeller Institute, provides relevant, nonpartisan research and analysis of state health policy issues for New York State and national policymakers. With funding support from the New York State Health Foundation and other foundations, HPRC uses its in-house staff of health policy experts, as well as national experts, to build on the Rockefeller Institute's strength in analyzing the role of state and local governments in financing, administering, and regulating state health care systems.

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Executive Summary

State governments have been attempting to reform their health care systems to ensure that more people have or can obtain health insurance. Particularly challenging for states is the fact that small employers, in this case defined as businesses with 50 or fewer employees, are less likely and able to provide affordable health insurance to their employees. In this market, referred to as "the small group market," the risks and costs of health insurance often are higher for both employers and employees. Fixing problems in the small group market is important for insurance coverage because only 53 percent of firms with fewer than 25 employees have employment based health insurance.[1]

There are a range of strategies that states use to improve coverage in the small group market. Such strategies include regulations, pooling of risk, and subsidies for the purchase of insurance. This paper briefly summarizes methods states have used in an attempt to improve insurance coverage in the small group market, reviews the literature regarding the success of different policies, and provides in-depth information and lessons from three states' experiences with health coverage reform efforts.

A review of state small group insurance coverage strategies shows:

- Regulatory actions applicable to the small group market are more widespread, largely due to federal requirements passed in 1996 under the Health Insurance Portability and Accountability Act.
- Pooling and the use of subsidies for small groups for the purchase of insurance are less common. The use of these strategies also tends to be limited in scale and program funding can be tenuous.
- In terms of the effectiveness of different strategies, the literature indicates that states' regulatory actions such as guaranteed issue and community rating likely helped ensure access to insurance for high risk/high cost groups, but that such regulations have not been highly effective at decreasing the overall rate of uninsured in the small group market.
- The literature also indicates that other strategies to increase coverage in the small group market such as tax credits, premium subsidies, and group purchasing arrangements (GPAs) probably have helped select groups maintain coverage, but most such initiatives are administratively complex, with low take-up, and have been too small to make a significant impact on the number of uninsured. There is also evidence that take-up of premium assistance and tax credits can be improved through administrative simplification and that reinsurance, a form of indirect subsidy, could hold promise for improving purchase of insurance, but it is not widely used or assessed.

Through our field research we also find:

- The processes that are used to develop health coverage reforms have been important to successful implementation.
- Small details in reform programs' design have large impacts on take-up of insurance by eligible individuals.
- Collaborative governance of reforms has been important to sustainability.
- Financing for larger scale initiatives that address coverage in the small group market is not readily available to states and some financing mechanisms appear to be more politically sustainable than others.

[1] Figure is from Table 1 in Paul Fronstin's paper, "Workers' Health Insurance: Trends, Issues, and Options to Expand Coverage," The Commonwealth Fund, March 2006. The figures are taken from an analysis of the March 2005 Current Population Survey. Figures are national and may vary by state.

- Flexibility and adaptability of state coverage initiatives after implementation are important to sustainability.
- Larger contextual factors can affect the success of health coverage initiatives and must be considered when reform is undertaken.
- Affordability of health insurance premiums remains a challenge for states but strategies exist to address affordability.

Overall, we conclude that states have tried many different strategies and may have had some success with improving and maintaining access to insurance for small groups although we did not uncover any clear evidence of a comprehensive or highly successful solution to the small group problem.

Instead we found that most strategies to address small group coverage have been too small in scale to make a major impact on the rate of uninsured persons in small groups and that each strategy appears to have benefits and drawbacks. Newer administrative simplification strategies such as insurance exchanges and larger pooling mechanisms such as merging the small group and individual markets are promising. However, little is known yet about how effective such measures are under different circumstances, or how they can be effectively implemented on a large scale.

We also learned that affordability of insurance for persons in small groups remains one of the biggest challenges facing that market. But most affordability strategies such as providing subsidies for purchasing insurance have been limited in scope.

Field research in New Jersey, Minnesota, and Maine revealed that certain administrative and implementation methods such as inclusive reform and governance, flexibility in modifying reform approaches, attention to program design details, and sustainable funding were essential to the success of major health reforms. These case studies show that after initiating reforms it is important for states to re-evaluate and make timely adjustments to changing circumstances, including growing health care costs.

I. Overview and Background

Report Structure

The first section of this report provides an overview of the issue and background on states' approaches to increasing insurance coverage in the small group market. The second section provides lessons and findings learned from examining all 50 states' strategies for increasing coverage in the small group market, including what is known from the literature about the effectiveness of different approaches. The third section provides an overview of three states where more in-depth field research was conducted on administration, financing, and implementation of health coverage initiatives. The fourth section discusses the common findings among the three field research states. The final section summarizes the overall lessons and conclusions from both the scan of 50 states' policies and the field research.

Problem of Insurance Coverage in the Small Group Market

Maintaining coverage has proved especially challenging in the small group market — generally defined as businesses ranging in size from 2-50 employees.[2] Providing coverage for individuals in the small group market is more difficult in part because the small group market is subject to different regulatory rules compared to the large group market. In addition, smaller employers are less likely to provide health insurance and employees are less likely to buy insurance because the cost of premiums is often too high for workers who are self employed or work for firms with fewer than 50 employees. It is also harder for insurers to spread the risk of adverse events among small groups and so the price of health insurance products is higher. In addition, the administrative cost of selling and administering health insurance is higher for small firms that have smaller economies of scale, making it less likely that firms can offer insurance coverage or that individuals will buy insurance. The result is that 73.4 percent of workers in firms with 25-499 employees have employment based insurance coverage while only 52.9 percent of workers employed by firms with under 25 employees have employment based coverage.[3]

[2] According to the Kaiser Commission on Medicaid and the Uninsured, there are 13 states that include "groups of one" in their definition of small group.

[4] A quick scan of state websites indicated that Minnesota, Utah, Mississippi, Missouri, and Oregon were among the states considering implementing an insurance exchange. There may be other states in the process of establishing insurance exchanges.

Overview of State Strategies to Increase Insurance Coverage

Three major sets of coverage strategies in the small group market have emerged. They include: regulating the supply of insurance products, pooling and managing risk (while at times simultaneously simplifying administration), and subsidizing groups or insurers to make insurance more affordable. The first set of strategies, **regulations that affect the supply of insurance products** in the small group market include: requiring that insurers provide coverage to employees in small groups (guaranteed issue), allowing people to keep their insurance coverage if they switch from one job to another (portability), or preventing insurers from creating large differences in the price of insurance by enrollee demographic characteristics or health status (rating bands and modified or pure community rating).

Most states have what is known as modified community rating in their small group. Modified community rating is a rating process that allows premiums to vary by some predetermined amount for selected rating dimensions (typically defined by age, industry, gender, and/or geography, but not health status or utilization experience). When states use health status for determining premium rates in the small group market, they typically set bands (i.e., limits) regarding how much the premiums can vary. One state, New York, has pure community rating, which does not allow for differences in rating for any factors.

Another strategy, offering limited benefit insurance plans to small groups, is designed to affect the supply of insurance products by making them more affordable or financially accessible. Limited benefit plans are allowed in most states unless explicitly banned. If a state has many mandated benefits, employers can offer limited benefit plans as long as they offer a plan with the mandated benefits. In general the more benefits, the more expensive an insurance policy. States are also encouraging insurers to offer products with wellness incentives or insurance riders. Riders may either exclude specific pre-existing conditions from a policy or allow additional benefits to be covered under a policy. Wellness incentives reward healthy behaviors in an attempt to reduce premiums. The regulatory strategies governing the supply of insurance product offerings are outlined in the first section of Table 1.

The second set of strategies outlined in Table 1 that states or employers use to improve insurance coverage in the small group market are **pooling mechanisms that may also simplify administration** of purchasing insurance. Pooling is the idea of bringing together groups or individuals to make a larger group, which helps spread risk. The four pooling strategies outlined in Table 1 include group purchasing arrangements (GPAs), merging of the individual and small group markets, insurance exchanges (which may have more administrative simplification benefits than pooling benefits), and extending dependent coverage.

Group purchasing arrangements are designed primarily to increase access to insurance coverage for (mainly small) groups by reducing the administrative burden involved with purchasing and, possibly, enhancing purchasing power. Insurance exchanges work by serving as a marketplace or clearinghouse from which small employers or individuals can purchase insurance.[4] The one state that has a fully operational insurance exchange, Massachusetts, has an agency known as the Connector that serves as the exchange and connects people with insurance and, in doing so, simplifies the administration of purchasing insurance. Merging the small group and individual markets, creates a much broader pool for spreading risk than when the markets are separated. A fourth strategy in the "pooling category" is

[4] A quick scan of state websites indicated that Minnesota, Utah, Mississippi, Missouri, and Oregon were among the states considering implementing an insurance exchange. There may be other states in the process of establishing insurance exchanges.

requiring insurers to enroll dependents of people who have health insurance coverage. These individuals are allowed to remain on their parents' insurance policy after reaching adulthood (e.g., until age 25 or 26 as opposed to 18 or 21 years of age). It is assumed that allowing these individuals, who tend to be younger and healthier, into the market will help reduce average premium costs for other members in the pool.[5]

The third set of strategies in Table 1 includes initiatives that attempt to improve the affordability of insurance by providing **direct or indirect subsidies**. Direct premium subsidies include premium subsidies and tax credits. Eight states have a premium subsidy program while six have tax credit programs. Tax credits can be used toward the purchase of insurance. The premium subsidy programs outlined in this paper do not include those targeted at public health insurance program enrollees. Publicly funded reinsurance, another subsidy strategy designed to make insurance more affordable, differs from premium subsidies and tax credits in that it is an indirect subsidy that is targeted to help finance care of high cost individuals or groups. Under reinsurance, anyone within a defined group whose health insurance costs fall above or within a certain threshold is reinsured by the state or another entity. In reinsuring these higher risk populations, the cost of premiums for the remaining population is lowered because the high cost cases are removed from the calculation of the premium cost. If reinsurance is publicly financed it can help stabilize or even reduce premiums for the markets to which they apply. Reinsurance can, at least in theory, also encourage the entry of insurance carriers into individual and small group markets, by reducing risk liability held by the carriers.

[5] The Rutgers Center for State Health Policy is currently studying states' use of dependent coverage extensions.

Table 1. Overview of State Strategies to Improve Health Insurance Coverage in the Small Group* Market		
Strategy	**Brief Description**	**Estimated Number of States Using Strategy**
Regulation of Supply		
Guaranteed Issue	Requiring that insurers issue policies to all members of the small group market.	50
Portability	Requiring that employees of small businesses can access health insurance when they switch jobs.	50
Modified Community Rating	Requiring that premiums vary in selected rating dimensions (such as age, industry, or geography but not necessarily by health status or utilization experience) Pure community rating allows no variation.	46
Prohibit Medical Underwriting	Requiring the insurers not be allowed to set premiums based on medical history of groups of applicants.	39
Rating Bands	Method for constraining premium variation among demographic groups or by health status.	37
Limited Benefits Plans	Allowing employers to make available insurance plans with limited benefits, which presumably cost less.	13+
Pooling and Administrative Simplification		
Group Purchasing Arrangement	Public or private initiatives that allow more than one small or large employer and/or individuals to pool together to collectively purchase health insurance.	8+
Statewide Insurance Exchange	A single place where people can go to learn about health insurance options to purchase coverage.	1
Merged Markets	Pooling the risk of small groups and individuals in determining premium rates.	1
Dependent Coverage	State regulations or legislation that allow younger dependents to remain on their parents' insurance until later ages.	13+
Subsidies		
Premium Subsidy	Financial subsidy to help pay for private insurance.	6
Refundable Tax Credits to Employers	Benefit through the tax system, which offsets cost of health insurance.	8
Reinsurance (indirect)	An insurance product or program that protects against the risk of financial losses from high cost cases.	6

*Note: Most of these strategies can be used in both the small group and individual markets. The number of states using the strategies in the third column cannot always be determined with accuracy, hence the minimum is listed with "+" indicating that there may be more states than the number listed. Sources for this table include the Kaiser Commission on Medicaid and the Uninsured and the Robert Wood Johnson Foundation's State Coverage Initiatives. This chart highlights premium subsidies available to persons not enrolled in public insurance.

II. Major Findings From the 50 State Scan

The purpose of examining all 50 states' different strategies for improving coverage in the small group market was to learn which strategies are more common; which are less common, but might hold potential for decreasing the rate of uninsured; and what is known from the literature about which strategies are effective. The research found the following:

1. **No dominant or highly successful reform approach has emerged, although regulatory strategies are more common.** States use a variety of coverage strategies to increase health insurance coverage in the small group market, ranging from regulation and pooling of risk to administrative simplification and subsidies. Regulatory strategies are the most common in part because of federal legislation passed in 1996 that requires states to enact minimum standards for insurance products supply. Less common are subsidies and pooling mechanisms. Determining the impact of the various strategies is difficult. What studies have been done of different strategies show that some interventions have helped maintain coverage for certain targeted groups, but it is unclear whether such strategies have been effective at lowering the overall rate of the uninsured in the small group market. Several nonexperimental studies have been conducted on these policies, and though they cannot be definitive about impacts, they do provide insight regarding the challenges to increasing insurance coverage for small groups. Most research shows that any effects from the various strategies for increasing insurance coverage in the small group market have been modest. In perhaps one of the most comprehensive reviews of the literature on the effects of small group market regulatory reforms, Kosali Simon concludes that the regulatory efforts of states in the early and middle 1990s may have had minor impacts on who received coverage (with higher risk individuals receiving better coverage) but that the aggregate number of people with coverage remained relatively unchanged.[6] The experiences of states and the literature on the success of subsidy and pooling strategies are also mixed. Many efforts have been too small to create significant measurable impacts, and most programs are not rigorously evaluated.

2. **Sustainability of initiatives in the small group market is one of the biggest challenges for states.** In observing the small group coverage strategies that are used by states it is notable that funding for some strategies are more affected by state budgetary cycles making them tentative (i.e., requiring year to year authorization) and tenuous (i.e., unclear sustainability). This is especially true in the case of subsidies. A number of states have programs that subsidize insurance coverage costs so small employers or their employees can afford coverage. But because state funds are limited and state budgets are subject to economic cycles, funding for subsidies may not be stable. For example, Insure Montana determines the amount of the refundable tax credit on a yearly basis.[7] Even group purchasing arrangements, which don't always require ongoing operating funds, usually require financial assistance to begin operations (e.g., for marketing and administration). For instance, New York's HealthPASS, a purchasing alliance, used $2.7 million in funding to get up and running, most of which came from public funds.[8] Not all states or cities have the resources to initiate or maintain programs.

[6] Kosali Simon, "Research on small group insurance reforms," in *State Health Insurance Market Reform* (New York: Routledge, 2004).
[7] From the Insure Montana website found at http://www.insuremontana.org/taxcredit.asp (accessed on 08/25/08).
[8] Stephen N. Rosenberg, "New York's HealthPASS Purchasing Alliance: Making Coverage Easier for Small Businesses," The Commonwealth Fund, September 2003.

3. **Affordability of health care is increasingly problematic for small employers.** The cost of health insurance is a top concern for small businesses. In fact, it has been the top concern of the National Federation of Independent Businesses as early as 1986 and is now a top legislative priority.[9] From a state's point of view, health care cost growth in general is problematic because it decreases the likelihood that employers can offer coverage and that employees can afford to buy health insurance. The literature on the effectiveness of strategies to increase affordability varies. Much of the literature regarding the effectiveness of tax credits at increasing the affordability of insurance shows that the amount of most existing credits is not sufficient to ease financial barriers that small employers face in offering coverage to their employees. The literature on tax credits indicates that very large tax credits are needed to induce insurance purchases and recommends that tax credits be structured in a way that ensures that firms that already offer coverage do not claim the tax credit. New York's primary method for improving affordability of private insurance has been the Healthy New York reinsurance program. This program reduces risk in the individual and small group markets by reinsuring medical costs between $5,000 and $75,000.[10] Enrollment in the Healthy New York program grew to over 130,000 individuals in 2006.[11] Average monthly premium costs in the Healthy NY program in 2006 were $204 for an individual and $602 for a family — much lower than the premium costs in the absence of a program. Lowered premiums came at a cost to New York State of approximately $62 million dollars (in insurance claims) in calendar year 2005. About $10 million of this went to individuals working for small businesses and $11 million went to sole proprietors. Most of the funds ($40 million) went to cover premiums for individuals.[12] Some states are looking to the Healthy New York program as a potential model. However, because public investment is required to cover the cost of reinsured claims, to date few states have adopted a reinsurance program.[13]

4. **The design of subsidy programs should be simplified when possible because complexity hinders effective implementation and "take-up" (i.e., use of or enrollment in a benefit/program by eligible people).** A 2005 analysis for the state of Connecticut concluded that premium subsidies could be a viable alternative coverage strategy to allow workers to take advantage of available employer sponsored health insurance to cover their families.[14] However, the success of premium subsidies seems partially dependent on how eligibility for the subsidy is structured. If eligibility for the subsidy is confusing to potential clients, fewer people are likely to use the subsidy because it is difficult to understand. Our field research in Maine indicated that the structure of the subsidy was complex and this may have initially impacted take-up. In examining premium support programs more generally — including those available to persons enrolled in public insurance programs — Belloff and Fox's study for the state of New Jersey concluded that very few people who were eligible for premium subsidies actually used the assistance. They attributed the lower enrollment to the "administrative complexity of the

[9] From "Rising Cost of Health Insurance is Top Priority for Small Business**,"** *04/13/2006* found at http://www.nfib.com/object/IO_27804.html

[10] The amount of medical costs between these two figures, sometimes referred to as the "risk corridor," originally did not take effect until medical costs reached $30,000, but the activation point was changed to $5,000 in 2003. The adjustment of the lower amount of the corridor is credited with increasing enrollment in the program because this made it much more affordable for businesses and individuals. Setting the upper amount at $75,000 as opposed to $100,000 or higher is credited with promoting more management of care so that total medical bills do not go over $75,000.

[11] New York State Department of Insurance, "Report on the Health NY Program," January 2007.

[12] Figures are from EP&P Consulting, "Report on the Healthy NY Program 2006", Exhibit IV-3, January 2007, and do not account for the administrative and advertising costs (simply premiums paid) associated with Healthy NY.

[13] New Jersey is an example of one state that examined the possibility of creating a reinsurance program but could not pass legislation establishing a program because it was viewed as too expensive in the current fiscal climate.

[14] OCHA, "Why Premium Assistance Strategies Can Succeed in Connecticut," 2005.

program as well as restrictive program design rules."[15] Other studies have made recommendations for improving the structure of premium assistance in general. A study by the Georgetown Center for Children and Families concluded that public subsidization of private coverage should occur only when it is a cost effective use of public funds.[16] The same study concluded that "premium assistance programs that take advantage of a robust employer contribution and operate in states that offer public coverage to the whole family (including parents) are most likely to save money."[17] Reinsurance, which is another form of subsidy, can be confusing in design, but insurers rather than businesses are the entity exposed to the complex design. As a result of the indirect nature of the reinsurance subsidy, the complexity of administration from an employer's point of view is hidden and may therefore be reduced. "Reinsurance may also help spread risk more broadly, protect the solvency of insurers, and reduce variation in premiums from year to year."[18]

5. **Most initiatives states have undertaken in the small group market have been modest in scale — a tendency that makes it harder to detect program impacts.** Aside from regulatory measures that apply across an entire market, most state initiatives to improve insurance coverage in the small group market have been largely incremental in nature. For example, most premium assistance and tax credit initiatives are targeted to limited groups that must meet certain eligibility criteria. Even reinsurance programs have requirements regarding eligibility and participation for small businesses. It is possible that larger scale reforms not solely targeted at the small group market could have more impact as suggested by the recent success at covering significant numbers of uninsured in Massachusetts.[19] One example of an initiative that was done on a larger scale is a statewide insurance exchange called the Connector. A larger group purchasing arrangement operating on a statewide scale and available to all citizens could have a more notable impact on coverage, so recent larger scale initiatives should be monitored.

6. **Coverage strategies in the small group market are underanalyzed in regard to administrative mechanisms needed for successful implementation and little research has been conducted on more recent strategies.** Examples of recent strategies that are particularly underanalyzed include the use of flexible benefits and dependent coverage, merging the small group and individual markets, reinsurance, and insurance exchanges. We found very little information on how administration, financing, and implementation affected the success of various initiatives. If other states are to implement similar policies, more comprehensive research and evaluation is needed.

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[15] Dina Belloff and Kimberly Fox, "Design and Enrollment in Premium Support Programs for Low Income Populations: State Interviews and New Jersey Data Simulations," New Jersey Department of Human Services, 2006. Kim Fox also indicated through conversations that low take-up of premium support programs may be due to ineligibility for the premium support because the individuals are part time or seasonal workers.

[16] Joan C. Alker, "Premium Assistance Programs: Do They Work for Low-Income Families?" Center for Children and Families, Georgetown University, Health Policy Institute, 2007.

[17] Ibid.

[18] The staff summary in "How States Like New York and Arizona Used Reinsurance to Help Business Control the Cost of Health Insurance," Wisconsin Family Impact Seminars by Randall R. Bovbjerg draws primarily upon Bovbjerg, Randall R. (Summer 1992). "Reform of Financing for Health Coverage: What Can Reinsurance Accomplish?" *Inquiry 29*(2), 158-175 and Bovbjerg, Randall R. (2006). *Implementing Reinsurance: Health Insurance Reform in Missouri* (cover Missouri Project Report 11). St. Louis, MO: Missouri Foundation for Health (available at www.mffh.org/CoverMo11.pdf).

[19] Research has shown that anywhere from one-half to one-third of previously uninsured residents in the state have obtained coverage since the enactment of reforms. See Sharon Lone, "On the Road to Universal Coverage: Impacts of Reform in Massachusetts in One Year," *Health Affairs*, published online June 3, 2008.

III. Overview of Field Research

Knowing about different policy options and their potential for improving coverage in the small group market is only part of understanding how to improve coverage. Understanding **why** a policy or program has worked is also important. To augment understanding of how coverage policies work in terms of administration, financing, and implementation, in-depth field research was conducted in three states: New Jersey, Minnesota, and Maine. These three states have different experiences and results with insurance market reforms.

New Jersey was chosen as a sample field research state because its regulatory market is similar to New York (a primary target audience for this research) in many ways and because New Jersey has a relatively high small employer insurance offer rate. Minnesota was chosen because it operates what is commonly seen as the most successful high risk pool in the nation, a policy option that is targeted at individuals and not necessarily the small group market, but from which lessons about implementation and administration could be learned. Maine was chosen because it was one of the first states to initiate wide scale reforms designed to significantly affect the rate of uninsured with a specific initiative targeted at the small group market.

State Program: New Jersey

In 1992, New Jersey enacted health reforms to the small group and individual market to improve accessibility, flexibility, and portability of health insurance coverage for these markets. After being implemented in 1993 and 1994, these reforms achieved their objectives through guaranteed issue and renewability, low employer contribution requirements, modified community rating in the small group market, and limits on coverage restrictions for pre-existing conditions. This regulatory environment, known as the Small Employer Health Benefits Programs (SEHBP), has relatively stable enrollment at approximately 900,000. "Offer rates for small firms are high in New Jersey compared to the U.S. and other states, and more full time employees are offered coverage. SEHBP insurance products are commercially viable because state regulation allows carriers in the market to offer products similar to what is offered in the large group market by using riders to add and change standard plan benefits. The low employer premium contribution requirement makes offering SEHBP coverage a financially attractive option, as employees can be made responsible for most of the premium. Still, the average employer contribution for small firms in New Jersey is about 80 percent. On the downside, premiums for New Jersey's small firms are the fourth highest in the U.S. for single coverage and third highest for family coverage."[20,21] In addition, total premiums for small firms are $500 more per year than large firms for single coverage, and $900 more for family coverage. New Jersey was among ten states in 2005 that had small group premiums at least 10 percent higher than premiums in large firms.[22] Therefore, coverage in SEHBP currently is or may become unaffordable for many small businesses in New Jersey. State policymakers and stakeholders in New Jersey are working to implement administrative changes that are

[20] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, "2005 Medical Expenditure Panel Survey — Insurance Component," accessed on 01/17/2008 at www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2.

[21] Dina Belloff and Joel Cantor, "Private Insurance Coverage: A Case Study of the Small Group Market in New Jersey," Rockefeller Institute of Government, August 2008.

[22] In 2005, New Jersey had the eighth highest ratio of small firm premiums for single coverage to large firm premiums. New York ranked third. Agency for Healthcare Research and Quality, "2005 Medical Expenditure Panel Survey."

intended to improve affordability in this market, including reforms that were passed as this study was being written.

State Program: Minnesota

Minnesota's high risk pool, the oldest of the initiatives that was examined, targets individuals who are unable to obtain coverage from another source (known as a high risk pool). To be eligible for the high risk pool, called the Minnesota Comprehensive Health Association or MCHA, applicants must have existing health conditions, not have access to a large or small employer based health plan, and not been able to secure affordable coverage in the individual market. The program is the most expensive state high risk pool in the nation, but it is also viewed as a possible model for providing health insurance coverage for a segment of the population that would otherwise be uninsured, and as a mechanism for potentially mitigating premium cost increases in Minnesota's individual market.

Approximately 30,000 people participate in MCHA, making it the largest high risk pool in the country and an important safety net for its enrollees. Enrollment has fluctuated, but even so, MCHA makes up less than 3 percent of the state's total enrollees in public health programs and overall it supports less than 1 percent of the state's population. Effects of the high risk pool on decreasing costs in the individual market are difficult to measure with precision, although generally it has been viewed as a relatively small but important component of Minnesota's health care system and a safety net for the "uninsurable."[23]

State Program: Maine

Maine's Dirigo Choice program was part of several health care reforms enacted in the state in 2004. The DirigoChoice Program is a state sponsored insurance product available to employers in the small group market. Employers contribute 60 percent of the cost of each employee's premium. The program also provides subsidies for individuals who work for small businesses to help them pay for insurance coverage. After 30 months of operation, the program is providing coverage for over 15,000 people, including employers and employees in 720 small businesses. In the three years prior to the enactment of the Dirigo Reform law, premiums in the small group market in Maine increased, on average, 26 percent per year, compared to, on average, 10 percent per year in the four years since enactment. The program has increased hospital and insurance industry performance transparency and possibly affected cost containment. The early experience of DirigoChoice led to modifications in 2008 to the program design, administrative mechanisms, and funding strategies.[24]

Table 2 provides a brief snapshot of the major features of each of the three state programs examined for this research.

[23] Information from Donna Spencer and Lynn Blewett, "Individual High Risk Pools: A Case Study of The Minnesota Comprehensive Health Association," Rockefeller Institute of Government, August 2008.
[24] Information from Elizabeth Kilbreth and Kimberly Fox, "The Dirigo Health Reform Act: A Case Study of Small Group Market Reform in Maine," Rockefeller Institute of Government, August 2008.

Table 2. Overview of Insurance Coverage Initiatives in Three Field Study States				
State and Program Examined	**Year of Legislative Enactment**	**Targeted Group(s)**	**Type of Strategy**	**Approximate Program Enrollment in 2007**
Maine Dirigo Choice Program	2004	Employees at small businesses (including sole proprietors); individuals	Direct subsidy	15,000 individuals (720 small businesses)
Minnesota Comprehensive Health Association	1976	Uninsured individuals	High risk pooling	30,000
New Jersey Small Employer Health Benefits Program	1992	Employees at small businesses who work 25 or more hours per week*	Regulatory	900,000

*Note: New Jersey also enacted a separate initiative in 1992 targeting the individual market.

It is difficult to determine, without a controlled experiment, the degree to which these three states' initiatives impacted the rate of uninsured. Evaluating the effects of state policy strategies to increase insurance coverage is difficult because larger contextual factors, such as underlying health care cost growth, technology changes, medical sector inflation, or population aging, can also influence what is happening with insurance coverage. The lack of data and methods for proving whether changes in the rate of uninsured were caused by these initiatives is difficult. What was learned from these reform initiatives are lessons about how the reform processes worked and how they were administered, financed, and changed to make them work more effectively. These major lessons are outlined in the following section.

IV. Major Findings From the Field Research

The field research yielded lessons from each state, but there were also several overarching lessons that were common among all three states that can be valuable for governments, which, after considering reform options, must determine how to administer, finance, and implement reforms. Following are the major lessons gleaned from the field research that were common, even under differing circumstances, in the three field research states:

1. **Reform Process: The process used for developing reforms is important to initial and ongoing success.** In all three states, there were successes due in part to the processes used to develop the reform options. In New Jersey, the reform process was highly inclusive and this inclusiveness is credited with helping assure success with initial implementation. High level representatives of all the key stakeholders such as businesses, individuals, insurers, and government officials were able to share their expertise and perspectives early on and positively influence implementation of the legislation. As a result, these stakeholders supported the final market regulations.

   In Minnesota, similar processes were used to develop and implement the high risk pool. Key stakeholders included a wide range of interests such as insurance companies, plan enrollees, and state agencies. Committees were used early in the process of implementation to assure adequate and broad representation and these committees had input into the operating rules.

   The experiences of New Jersey and Minnesota differ slightly from those in Maine, where the process for reform was more politically contentious from the outset in part because the reforms were much larger in scale, proposed restrictions on insurers and providers, and required substantial funding for new coverage initiatives. The DirigoChoice Act was passed with bipartisan support in a political environment where public support for policy action on health care costs and access was high and when the program had major support from the state's governor. The level of public investment needed for a major access initiative, however, immediately put the DirigoChoice initiative in competition with other state spending priorities. Unrealistic expectations with regard to the rate of change in health care costs and the number of uninsured quickly eroded support in the business community. The Dirigo Agency was limited in its ability to communicate to the public its successes with incremental steps and to correct misinformation because of an insufficient budget for marketing and public education. As described in their Maine field report, Kilbreth and Fox state "political organizations opposed to increased government spending and an increased government presence in the health sector decried the strategy as the wrong approach and tried to build political support for market deregulation and program repeal. Even those who supported the program as an appropriate strategy held the program to a very high performance standard with regard to short-term success … and began to second guess the program's rate of enrollment and spending within the first year of operations."[25] Although Maine's program was contentious when it came to strategies and expectations for insurance coverage, the processes used for other aspects of reform were successful, in particular, reforms related to cost control and quality.

2. **Program Design: Small details in program design may have large impacts on take-up of insurance by eligible employers and employees.** New Jersey's SEHBP is designed to ensure

[25] Elizabeth Kilbreth and Kim Fox, "Maine Field Report," May 8, 2008, p. 38.

higher insurance offer rates by employers by requiring lower employer contribution rates. The lower employer contribution requirements and high employer offer rate relative to other states likely contributes to the program's success (although it may have little impact on the affordability of insurance). Other program features that may contribute to SEHBP's successes or challenges include the fact that employers are permitted to offer an unlimited number of plans. Although this feature allows employees more choice, it may result in adverse selection. Enrollment in multiple plans is complex and costly for carriers to administer. Carriers also contend that adverse selection into richer plans is raising premiums in those plans. Until recently, employees in SEHBP could also switch plans as frequently as they wanted. Plan switching was recently changed so that participants are only allowed to change plans once a year — at the time of renewal.

An important aspect in the design of the Minnesota high risk pool is the inclusion of spouses and dependents. Opening the pool to these populations helps mitigate the overall risk profile and stabilize premiums. Another design feature of the program that has positive effects on participation is the rate at which premiums were set. The premium rate is 125 percent of the average cost of premiums in the individual market, relatively low compared to other states' high risk pools.

Initially, the complex design of the subsidy program in Maine made it difficult to administer and understand, which may have negatively affected public views of the program and hindered enrollment. Private insurers' administrative and billing systems were not designed to accommodate variable pricing based on household income or to match funding streams from two sources (public and private) for premium payments. This complexity limited the state in the number of potential contract partners and impeded expanding the program. In addition, it made marketing the program to small businesses more difficult because of the need to explain the premium structure and the additional paperwork necessary to process subsidy applications. Modifications have since been made to make administration of the subsidy easier.

3. **Administration: Collaborative governance appears important to ongoing success.** In at least two of the three states studied, open, diverse, and flexible governance appears to have contributed to program success. In New Jersey, the diversity of the 18-member board of directors was cited as important to administration and governance of the regulatory policies in the small group market.

   In Minnesota, the governance of the high risk pool was also viewed as successful. As stated in the field research, "the overall private/non-profit health plan arrangement with public oversight and a liberal policyholder appeal process has resulted in a strong, flexible, and efficient design for Minnesota. Inherent in this approach is the involvement of and a 'balance of power' among key stakeholders, including the Department of Commerce, insurance companies, board members, and plan enrollees."

   Maine has managed to administer what is considered a complex program within a relatively small agency (the Dirigo Agency), which has approximately 15 employees that are responsible for information systems, finance, contracts, eligibility determination, enrollment support, a consumer assistance call center, and program marketing. Agency operating costs were a little under 6 percent of program costs in 2006 — a comparatively low cost. The insurance partner's costs are built into the premium and are approximately 20 percent of collected premium

revenues. The state has also regularly engaged stakeholders on an ad hoc basis to participate in program planning and redesign through the Health Action Team, the Savings Offset Payment Workgroup, and the Blue Ribbon Commission. Providing these forums for participation resulted in a process that enabled the program to be sustained and changed through legislative amendments.

4. **Financing: A variety of approaches can be used for financing but some may be more sustainable than others and adjustments may be necessary.** New Jersey's SEHBP does not require direct funding because it relies on market competition to assure availability of plans and affordability of premiums. However, affordability of premiums is increasingly problematic and the state is debating steps to address this issue.

   Funding for high risk pools, which are designed to subsidize care for high risk/high need populations such as the MCHA in Minnesota, can be difficult to pay for since high risk pools "inherently lose money."[26] The primary financing mechanisms for the high risk pool that Minnesota uses include: participants' premiums and an annual assessment on insurers selling in the individual and group insurance markets within the state.

   These financing mechanisms appear to have worked well over three decades of MCHA's existence although, at certain times, the program has required additional funding from the state General Fund and workers' compensation pool. Legislators have recently considered raising the premium range used for MCHA from 125 percent to 150 percent. Raising this rate could improve available financing to make the program more sustainable but also make it unaffordable for potential program enrollees. Another option the state has considered for increasing funding would be making the insurer assessment financing mechanism broader so that insurer assessments are based not just on fully insured plans (consisting of many small businesses and individuals) but also on self insured plans (typically large employers). (ERISA legislation currently prohibits assessments on the self insured plans.) Compounding this concern is the recent growth in self funded plans (representing 59.6 percent in the state's private market in 2005) and the ramifications for the overall size of MCHA's assessment base.

   One of the most controversial aspects of the Maine Dirigo Choice program was the original financing mechanism, known as the savings offset payment (SOP). Although the intent of the SOP was lauded by many as a way to tie savings to coverage expansions, it proved problematic in practice. In fact, the SOP was so politically contentious that it may have distracted from the program's overall success at covering over 15,000 people. The fact that the SOP had to be recalibrated each year through a public adjudicatory process left more opportunities for criticism and challenges. Although using such a financing mechanism was ideal in theory (paying for coverage expansions through savings), it was difficult to implement. The Maine case points to the difficulty of establishing an institutional mechanism that can calculate cost savings over time. Savings from reductions in bad debt and charity care are considered by many Maine policymakers to be real, but are not a dollar for dollar offset against expenditures of newly insured individuals in state programs. In addition, savings from state planning efforts, tightened certificate of need (CON) controls, and enhanced public health are expected to be realized over the course of many years but do not provide immediate cost reductions. Even immediately

[26] Communicating for Agriculture and the Self-Employed (CA), Inc. "Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis," Fergus Falls, MN, 2005.

realized and substantial cost reductions, such as hospital compliance with cost saving benchmarks, turned out to be difficult to measure and required an assessment of actual spending against expected (and unmeasurable) spending in the absence of state reforms.

The complexity of calculating the savings offset payment may have also contributed to general uncertainty about the program's longevity, which may have deterred program enrollment. As a result of the controversy over the savings offset payment, the state enacted reforms in 2008 that replace the SOP with a different financing structure that includes a fixed assessment on paid claims and taxes on things such as alcohol and soft drinks. However, even the newly proposed financing mechanism is contentious and will be subject to a public referendum in the fall of 2008.

5. **Implementation: Flexibility is important because adjustments are often required, which are important to sustainability.** In all three of the field study states adjustments were made to the programs in recent years. These adjustments were seen as necessary to stabilize or maintain enrollment and financing and increase the likelihood for program continuation. Even in New Jersey, where the program is viewed as relatively successful, the increasing lack of affordability of the premiums in the small group market resulted in a series of reforms that passed this spring (2008).

   In Minnesota, the program has remained largely unchanged until recently when it was recognized that cost savings might be accrued with simple program modifications. These modifications are intended to provide more preventive care and managed care. The state implemented some of these reforms in 2008 to increase preventive care services. Because there is no employer or agency to push for change or to promote managed or preventive care, there has been little incentive for MCHA to innovate or become a market leader. MCHA is one of the few fee for service health plans left in Minnesota. With its current writing carrier, MCHA uses disease management services covering multiple conditions, and the pool recently began incentive based health and wellness programs for all members.

   Despite challenges with implementing DirigoChoice, Maine might be considered a case where policy learning resulted in notable changes to program design. As already mentioned, the state replaced its entire financing system and also made several program modifications such as increasing the state role in marketing and revamping the administration of the subsidy program. These changes have sustained the program for the near term despite some fairly negative publicity and provide an example of how reform can be an ongoing process that can be subject to adjustment to assure sustainability.

6. **State Context: Larger factors present in a state such as politics, the status of the insurance market, and economics can affect reform initiatives' success.** In all three field research states there were factors other than program design, administration, financing, and implementation that may have influenced program success. One factor that may have affected the success of New Jersey's Small Employer Health Benefits Program was that employers in the state were already relatively generous in terms of their insurance offer rates. There are other factors that might have been at play such as the economy that can affect the financial well-being of small businesses, their ability to offer coverage, or the benefit structure of the plans they offer.

Prior to New Jersey's small employer health insurance reforms, the percent of uninsured residents had grown from 7.9 in 1987 to 13.3 in 1992.[27] At that time, insurers could choose not to insure certain individuals or groups if they might be high risk or have known pre-existing conditions.[28] Blue Cross Blue Shield of New Jersey was the insurer of last resort so they offered coverage to all individuals and small groups. However, premiums charged could be very high and incorporate age, gender, geography, industry, and health rating. Even for individuals and small groups that were offered coverage, premiums could vary greatly making insurance coverage very expensive for older and sick residents. This created "job lock" as employees needed to remain with their current employer in order to hold on to coverage for a health condition. These contextual factors and pressure from the public, business associations, health insurers, and retail merchants resulted in legislators supporting reforms to the small group and individual markets.

Influencing the success of implementation of Minnesota's high risk pool may have been the existence of broad public support for finding a way to provide insurance for the uninsurable. At the time of the pool's enactment in the late 1970s there was no guaranteed issue for the individual market and a high risk pool was seen as an innovative solution to assure coverage. The broad public support evident at MCHA's inception seems to have never faded and, in fact, may have increased in recent months because of attention to the program from a presidential candidate.

Influencing the success of reforms in Maine was the larger issue of health care cost growth. On one hand, this cost growth created initial broad support for consideration of health system and cost reforms. On the other, the cost growth contributed to concerns about the program's sustainability once it was enacted.

7. **Affordability of health insurance premiums remains a challenge for all three states studied.** New Jersey's SEHBP primarily relies on a minimum loss ratio and mechanisms that encourage market competition to assure availability of plans and improve affordability of premiums. The issue of affordability of insurance for small groups, however, was debated in New Jersey this year. Some stakeholders in the health insurance industry felt that administrative changes in the SEHBP including reductions in regulatory requirements associated with introducing a new plan to the market, reducing the number of plans that small groups could offer to employees, or changing the fee schedule for out of network claims, might help control costs and reduce or stabilize premiums. Other groups in the state thought these changes might adversely affect access to care and affordability of services so the SEHBP board of directors has not yet acted on them. Legislation signed by the New Jersey governor in July 2008 modifies some SEHBP administrative rules including reducing the number of standard plans and increasing price transparency by listing the premium for the standard plan separately from the adjustment for riders and broker/agent commissions.[29] The effect of these changes on affordability remains to be seen but the hope is to reduce premium costs for small businesses and individuals.

[27] U.S. Census Bureau, Current Population Survey, 1988 to 2006 Annual Social and Economic Supplements. Historical Health Insurance Table HI-4. Accessed on 01/23/2008 at www.census.gov/hhes/www/hlthins/historic/hlthin05/hihistt4.html.
[28] J.C. Cantor, "Health Care Unreform: The New Jersey Approach," Caring for the Uninsured and Underinsured, *Journal of the American Medical Association*, Vol. 270, No. 24, December 22/29, 1993, pp. 2968-2970.
[29] For more information on the legislation see http://www.state.nj.us/governor/news/news/2008/approved/20080708a.html.

While Minnesota's high risk pool premiums are relatively low (capped at 125 percent of the private individual market average), many enrollees still cannot afford the premiums and may not reach the deductible, especially in the case of the high deductible plans. One feature MCHA has used to enhance its affordability for enrollees is a split deductible — one for medical services and a separate deductible for prescription drugs. Excluding preventive care from the required deductible is another example of an affordability option that has been considered. Additionally, the state has utilized federal grant funding to support low income subsidies in recent years.

High health care costs led to significant resistance in Maine to the establishment of any funding source for coverage expansions that would result either directly or indirectly in an increased cost to the business community. Tying program funding to demonstrated savings was a mechanism to try to ensure that new state dollars did not stimulate more inflation in the health economy, but also was politically necessary to gain support from key stakeholders. The subsidy program has been helpful for individuals to afford the cost of health insurance but the need for assistance with premiums exceeded expectations and was greatest for the lowest income populations. Views about the affordability of the premiums in Dirigo vary depending on who is asked. "Critics tend to emphasize the total public dollars as an excessive cost, while proponents point to the per member per month cost that is lower than private coverage trends."[30]

[30] From the Maine Case Study.

V. Lessons and Conclusions

A review of 50 states' coverage strategies and in-depth field research in three states lead us to conclude that states have tried many different strategies and have had success with improving and maintaining access to insurance for small groups. However, our study did not uncover any clear evidence of a comprehensive or highly successful solution to the small group problem.

Instead we found that most strategies to address small group coverage have been too small in scale to make a major impact on the rate of uninsured and that each strategy appears to have both benefits and drawbacks. For instance, regulatory mechanisms, such as guaranteed issue and portability, which have been adopted by most states, improve the supply of insurance products but not necessarily the demand. Pooling strategies, such as group purchasing arrangements, have had success in certain instances but can be difficult to initiate, administer, and sustain. There is also little understanding of why policies have worked in some instances but not in others. Tax credits and premium subsidies both seem to suffer from being too administratively complex, resulting in low take-up among employers.

Reinsurance appears promising as a way to reduce the cost of insurance and increase take-up. However, very few states have initiated such programs and doing so requires initial and sustained investment. Extension of dependent coverage could be effective at increasing coverage but is targeted at a limited population. There are newer administrative simplification strategies such as insurance exchanges, and larger pooling mechanisms such as merging the small group and individual markets that are promising. Yet little is known thus far about how effective such policies are under different circumstances, and how they can be effectively implemented on a large scale.

We conclude that now that most states have adequate regulatory mechanisms in place to improve the supply of insurance products, issues with affordability for both employees and employers must be better addressed. Unfortunately, most affordability strategies such as reducing insurance costs or providing subsidies for purchasing insurance have been limited; nor have they been adequately evaluated or studied to determine why they are working or not, and how they might work better.

Affordability strategies, in particular, have been constrained by a number of factors including the limited scope of programs, problems of sustained funding, difficulty with implementation or administration (including outreach), an inability to adjust policies to make them work better, and weak support for further expansion.

The programs studied in New Jersey, Minnesota, and Maine, which used very different reform approaches, were generally viewed as being at least partially successful at assuring access to insurance for targeted groups. These states demonstrated that certain methods were essential to successful administration and implementation of reforms such as inclusive processes, flexibility in modifying reform approaches, attention to program design details, and sustainable funding. Many of the lessons from the field research are particularly relevant for New York where the biggest challenge to reform may be creating political and administrative structures that involve a wide range of stakeholders who have been traditionally under-represented in the legislative process and finding sustainable funding.

As states move forward with reform efforts, it will be important to continue to monitor what is happening in states, and also determine the effectiveness of certain strategies at balancing access and

affordability. As learned from the field research, it will be equally important to re-evaluate and make timely adjustments after initial implementation of reforms. Maine's ability to change its reform program after enactment provides the best example in our study of the importance of state flexibility and readjustment.