Washington State
Health Insurance Partnership Board
Preliminary Report

HEALTH INSURANCE
PARTNERSHIP

As Required by Engrossed Second Substitute House Bill 1569
Chapter 260, Laws of 2007

December 1, 2008

HEALTH INSURANCE PARTNERSHIP

The small business connection to health coverage

December 1, 2008

The Honorable Christine Gregoire
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Olympia, WA 98504-0002

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Washington State Senate
P.O. Box 40482
Olympia, WA 98504-0482

Ms. Barbara Baker
Chief Clerk of the House
House of Representatives
P.O. Box 40600
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Dear Governor Gregoire, Mr. Hoemann, and Ms. Baker:

The Health Insurance Partnership Board is pleased to submit our preliminary report as directed by Engrossed Second Substitute House Bill 1569, chapter 260, Laws of 2007.

The Board and I will be glad to address any questions you may have concerning this preliminary report that examines the incorporation of the individual and small group markets into an expanded Health Insurance Partnership.

Sincerely,

Steve Hill, Chair
Health Insurance Partnership Board

Enclosure

cc: Senator Karen Keiser, Chair, Senate Health & Long-Term Care Committee
Senator Cheryl Pflug, Ranking Minority Member, Senate Health & Long-Term Care Committee
Senator Margarita Prentice, Chair, Senate Ways & Means Committee
Senator Joseph Zarelli, Ranking Minority Member, Senate Ways & Means Committee
Representative Eileen Cody, Chair, House Health Care & Wellness Committee
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Health Insurance Partnership Board Vision, Goals, and Principles

HIP Board Vision Statement: Adding value in and increasing access to health insurance for low-income employees of small businesses.

HIP Board Goals:

- Develop a program that covers low-income, uninsured employees of small employers.
- Create a sustainable safety net for the target population to improve coverage.

HIP Board Guiding Principles:

- **Do no harm.** Consider all of the potential consequences, both intended and unintended, from all policy decisions related to the program.
- **Keep it simple.** Build a program that is easy to understand and access.
- **Stay consistent with the Blue Ribbon Commission recommendations.** The program is one component of a larger whole. Include the BRC innovations to advance coverage.
- **Get the most "bang for the buck."** Build on the existing infrastructure, using innovation when necessary.
- **Build in sustainability.** Create a program that will retain participation and value over time.
- **Focus on what's achievable.** The Board's efforts need to lead to covering as many eligible people as possible within the parameters of the legislation. By focusing on what the legislation requires us to do, we can positively contribute to the foundation for larger change.
- **Focus on access, and include cost and quality.** As the program develops, the value proposition must remain an incentive for small employers, their employees, and carriers.
- **Increase education.** People with health insurance are healthier. Access to care benefits individuals and is less costly in the long run. Change the way people--especially younger people--think about health insurance.
- **Emphasize incentives to self-care.** Change or encourage positive health behaviors.
- **Don't let the Perfect be the enemy of the Good.** Be mindful of the positive changes we can affect and recognize this is but one step in incremental change.

Health Insurance Partnership Board Preliminary Report

Background

This report is submitted by the Health Insurance Partnership Board (Board) to Governor Gregoire and the Washington State Legislature as directed by Section 10 of Engrossed Second Substitute House Bill 1569 (E2SHB 1569) and enacted as chapter 260, Laws of 2007 (partial veto). It is a preliminary report that examines the incorporation of the individual and small group health insurance markets into the partnership program. Section 11 of the legislation directs the Board to submit a final report by September 1, 2009.

Section 10 of the legislation directs the Board to examine three specific issues in the preliminary report:

1) The impact of incorporating the individual and small group markets into the partnership, with respect to the utilization of services and cost of health plans offered;
2) The impact of applying small group health benefit plan regulations on access to health services and the cost of coverage to these markets; and
3) Modifications in the composition of the Board to reflect the incorporation of these markets in the partnership.

To assist in completing the preliminary report, the Board engaged Mathematica Policy Research, Inc. (Mathematica) to estimate the coverage and cost impacts of combining the individual and small group markets into an expanded Health Insurance Partnership, and to comment on any related implementation or legal issues. The Mathmatica study was submitted to the Board as a discussion draft and constitutes Mathematica's analysis of a Preliminary Expanded Health Insurance Partnership, or PHIP. The PHIP is a proposal that assumes the incorporation of the individual and small group markets into the Health Insurance Partnership under small group health benefit plan regulations.

This report makes numerous references to the analysis of the PHIP model in the Mathematica study. The study is submitted to Governor Gregoire and the Legislature as an attachment to this report.

Introduction

On March 1, 2009, Washington State's Health Insurance Partnership will begin subsidizing enrollment of low-income workers and their families in private small group plans. The program targets small employers that employ predominantly low-wage workers and do not currently offer health insurance coverage to their workers. The subsidies help pay the low-income worker's premium share.

The legislation that created the Health Insurance Partnership was originally introduced to reform Washington's health insurance market. The legislation was pared down and

adopted as a targeted program, in part, because of questions regarding the impacts of the initial proposed reform. Consequently, the Legislature tasked the Board with examining these questions.

Board Recommendation

After thorough discussion of Mathematica's independent results and consideration of the Board's guiding principles, the Board recommends:

> **PHIP, as modeled, should not be used to publicly-subsidize coverage for low-income uninsured families in individual and small group coverage.**
>
> **As a consequence, the Board did not consider modifying the composition of the Board.**

Impacts That Influenced the Board's Recommendation

Unsustainable health care costs.

Health care expenditures under PHIP are not sustainable. PHIP confronts the same cost drivers as the current health insurance system. These include, for example, variability in treatment, unnecessary and wasteful services, persistent quality problems, and misaligned incentives that do not encourage cost-effective outcomes. These cost drivers and others contribute to health care spending that consistently grows at two to three times the rate of wages. PHIP cannot succeed in extending and maintaining coverage to small employers, their workers, and individuals under the burden of escalating health care expenses.

PHIP, as modeled, was not provided any tools to contain the growing cost of health insurance. Consequently, "building in sustainability" – one of the Board's guiding principles – is not achievable. The concept of enrolling more low-income families through the PHIP depends upon committing public subsidies to a program that cannot contain costs any better than the current health insurance system.

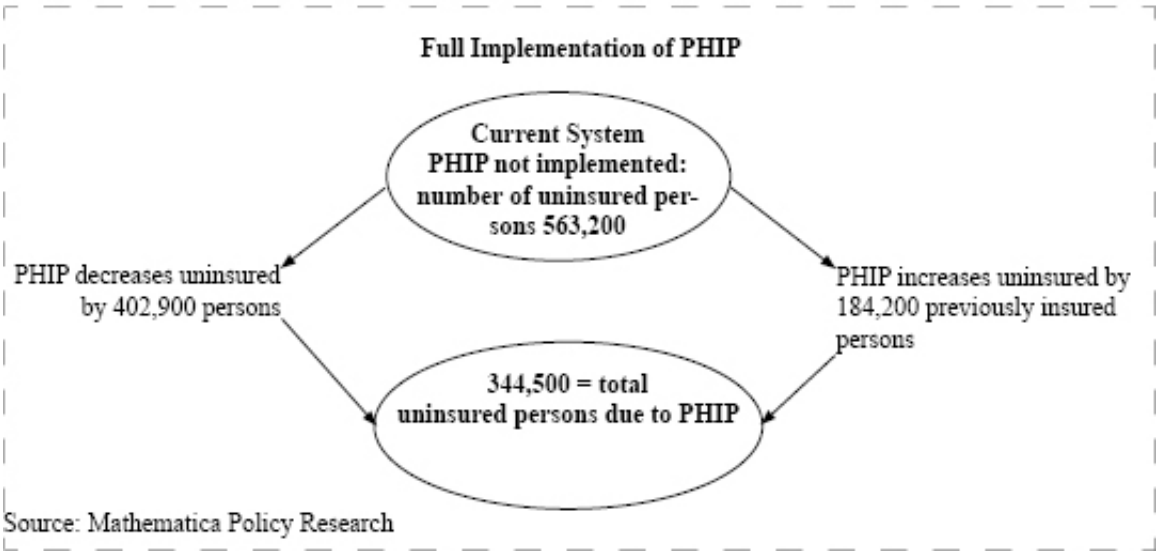
Mathematica estimates that Washington State needs to spend $84 million a month to cover an additional 220,000 uninsured people in PHIP, lowering our state's rate of uninsured persons from 10% to 6%. Even if policymakers decide to spend less than the $84 million a month needed to cover all 220,000 uninsured persons willing to take up coverage under PHIP, any expansion of coverage for subsidized families must contend with a monthly subsidy estimated at $165 per enrollee (*all* individual and small group subsidized enrollees in PHIP).

More low-income families are estimated to enroll in PHIP's individual plans; subsidies for individual plans would cover a larger portion of the premium than in small group plans. About three-quarters of public subsidies would be spent on individual coverage at a greater monthly subsidy estimated at $265 per enrollee (subsidized enrollees in PHIP *individual plans*). Even with public subsidies, many small firms still would not offer

coverage. Thus, too few low-income families could benefit from an employer's premium contribution through small group coverage.

Disruption in coverage.
Mathematica estimates that PHIP will cover more people in Washington State. However, changes in premium that result from individual choice of plan, and the merging of the markets, would cause many people to switch or drop coverage.

Disruption in Coverage
of Uninsured Persons under PHIP 2010 Estimates



It is estimated that full implementation of PHIP would result in a net reduction in the number of uninsured persons in Washington from 563,200 persons to 344,500. But 184,200 previously insured persons would lose their coverage under PHIP. Simultaneously, PHIP must accommodate 73% of the enrollees switching to a different health plan. Two underlying policies are linked to this disruption:

Merging the individual and small group markets. Individual coverage will experience considerable churning under PHIP. In 2010, individual plans will likely cover 285,000 enrollees, 5% of the current health insurance market. In response to merging the markets, Mathematica forecasts an average increase in individual plan premiums of 37%, and individual plans will again cover 5% of enrollees. The result demonstrates anything but a stable market for individual coverage: about 210,000 enrollees would leave individual plans (some who would enroll in small group coverage) to be replaced by roughly 225,000 new individual enrollees.

Worker choice of plan. PHIP creates further disruption because the cost of coverage is no longer shared by workers within the same small firm. Since workers would select their own plan under PHIP, each worker's premium will reflect his or her age, and older workers will pay a higher premium for coverage.

Currently, a small employer chooses the health plan for the firm's workers. Each worker in small group coverage pays a premium share based on the average premium within the firm. Carriers charge higher premiums by age, and so premium shares computed against the firm's average premium lowers the amount paid by older workers.

Under PHIP, workers can choose any health plan. It is assumed that small employers will no longer compute an average premium, and each worker will pay a premium share based on his or her age. Additionally, to guard against paying the extra cost of each worker's choice of plan, employers will no longer pay a percentage of the premium. Instead, employers will contribute the same dollar amount toward each worker's premium. For the plan selected, each worker will pay the difference between the employer's contribution and his or her age-based premium. Older workers will pay higher premium shares than younger workers in the same health plan. Older workers will respond to the premium shock by reducing or dropping their coverage, fueling disruption.

Unsustainable costs and disruptions in coverage make PHIP a program that cannot be successfully implemented. Even if the initial implementation of PHIP could somehow navigate the abundant dropping and switching of coverage, the program could not survive the escalating cost of coverage.

PHIP Enhancements Intended to Add Value

The Board discussed several aspects of PHIP and commented on the value of these enhancements.

Enhancements that help make coverage available

Premium assistance for low-income families.
PHIP's enrollment estimate depends on the availability of significant premium subsidies. When combined with private dollars from employers and workers, premium assistance can extend coverage to more people in small group coverage. The estimated average monthly subsidy for low-income enrollees in small group coverage would be five times lower than for enrollees in individual coverage. Those subsidies assist in covering more low-income families, less healthy people, and more micro firms (2-5 workers) than Washington State's current health insurance system.

Portable health plans.
Mathematica's analysis suggests that portable health plans would improve continuity of coverage in PHIP. Workers in small firms move in and out of coverage with changes in employment – making it difficult to retain their health plan and network of providers. Under PHIP, workers can retain their plan and providers when they move to another job or into individual coverage. Enrollees with individual coverage can also retain their plan when they go to work for a small firm.

Enhancements that could be implemented without PHIP

Tax-advantaged coverage.
Small employers establish Section 125 plans in the current market because savings in federal taxes lowers the cost of their coverage. However, not all eligible small employers have established Section 125 plans, in part, because they do not offer coverage. By providing subsidies and lower employer contributions, PHIP enrolled some additional small employers. Since all small employers covered under PHIP must establish Section 125 plans, federal tax advantages would apply to more eligible small employers and their workers and could reduce the cost of their coverage by an estimate of $14 per month or 5%.

PHIP is not the only alternative for expanding the use of Section 125 plans. The Board believes that other incentives, assistance, or methods of education and outreach could prove effective in boosting the number of small employers who establish Section 125 plans.

Enhancements that did not add value for consumers

Containing costs in large insurance pools.
Insurance pools combine enrollees for the purpose of rating risk and large pools spread risk broadly. However, PHIP does not establish a single large risk pool.

Large programs can usually pursue purchasing strategies not available to smaller programs. However, PHIP does not intrude in the market as a purchaser of health insurance coverage. Outside of designating health plans, the program has no other mechanisms for controlling health care costs.

A large number of enrollees shopping in a transparent market might create competition which slows rising premiums. However, research suggests that enrollees, at this time, are not skilled at expressing their preferences for quality health care services that drive competition between health plans. Enrollees still respond to changes in the market. Enrollees' response to changing premiums in PHIP would be dramatic. When faced with higher premiums, PHIP enrollees will select coverage with greater cost sharing or drop coverage altogether. Other enrollees will take up coverage only because subsidies lower their premium share.

Transparency and simplicity for consumers.
By offering all plans currently available in the small group and individual markets, PHIP likely will not help enrollees navigate a simpler health insurance system.

Principles Recommended for an Exchange

The Board anticipates that policymakers will continue to discuss an exchange as an option for coverage, and Mathematica's modeling revealed some useful principles for further discussion.

Better understand the role of individual choice of health plan.
Consumers clearly want choice. They do not want anyone interfering with their choice of providers. Consumers also want some say in their choice of health plan. Having no choice of health plan is not acceptable to consumers, and yet, Mathematica's modeling demonstrates the perils of unrestricted choice. The eventual level of individual choice of plan should support improvements in better health outcomes and access to coverage.

Align the provision of public subsidies with the efficient delivery of high-quality health care services.
Methods of ensuring good value should dovetail with the specific design of an exchange. If suitably implemented within an exchange, these recent examples may enhance consumer value:

HealthPact plans. Rhode Island inserted consumer expectations into HealthPact plans to reduce premiums. No subsidies are provided for low-income families, but premiums are 15% below plans with comparable benefit designs without a "pact." Enrollees maintain the pact by, for example, receiving regular checkups and participating in disease management programs, when referred. If the pact is broken, the annual deductible for a single enrollee skyrockets from $750 to $5,000. Two private carriers began offering HealthPact plans in 2007, and now cover 350 small employer groups.

eValue8 ("evaluate"). eValue8 strives to maximize the value of health care dollars spent, not necessarily to reduce health care spending. eValue8 promotes continuous quality improvement by providing consumers with relevant information about a health plan. Plan profiles report on accepted measures of health plan performance in the areas of consumer engagement, effectiveness of financial incentives for providers, and assessments of chronic disease management and provider networks. These profiles help place consumers in the driver's seat.

Value-based benefit designs. Successful benefit designs support the needs of the enrollees. For example, if some enrollees rely on a brand medication to manage a disease, co-pays should not eliminate that brand as a treatment option. Value-based benefit design can reduce hospitalizations and increase a worker's performance through better health. The Technical Advisory Committee recognized the value of this concept to early adopters like Pitney Bowes, and expressed an interest in longer-term assessments of its effectiveness.

Continue to assess proposals.
Mathematica's modeling revealed much about covering a diverse population through an exchange and the connection between individual and small group coverage. Other proposals should be similarly assessed and essential concepts should be tested early in their design. For example:

Assess whether to merge markets. At this time, the small group market covers a much higher-cost population than the individual market. Different regulations and risk within markets should be assessed before designing a proposal to merge them. Coordinating the markets could achieve similar or better results.

Select regulations that support the proposal. The compatibility of plan choice with small group rating might be improved by a tighter "age compression" ratio. For example, Massachusetts' small group market uses a 2:1 age group ratio: the highest premium for the oldest enrollees can be no more than twice the lowest premium. Washington State's small group and individual markets use a 3.75:1 age group ratio. The tighter ratio is intended to replace some of the risk sharing lost when small groups are disbanded by a worker's choice of plan.

Reduce premium shock. Some of the disruption caused by merging the markets and implementing choice of health plan in PHIP may be eased with a system of reinsurance or risk adjustments. Also, a system of reinsurance or risk adjustments could be assessed as an initial step in coordinating different markets. The wide scope of the preliminary report relative to the resource limits did not allow for a focused examination of the impact of reinsurance or risk adjustments within PHIP.

Conclusion

The Health Insurance Partnership Board thanks Governor Gregoire and the Washington State Legislature for the opportunity to submit this preliminary report. Board members share the goal of providing affordable health care coverage to individuals and small groups, and hope that the report is received as a thoughtful assessment of an expanded Health Insurance Partnership.

The recommendations in this report demonstrate the difficulty of reforming sensitive markets that cover essential, costly health care services. Yet, the recommendations may prove useful as policymakers explore new ways to offer coverage in a more transparent system that engages consumers, providers, purchasers, and carriers in achieving better health outcomes. Board members are available to further discuss their recommendations.

Attachment

Mathematica Policy Research, Inc. Study

(see following page)

Contract No.: 6000-002056
MPR Reference No.: 6472-300

MATHEMATICA
Policy Research, Inc.

Health Insurance Partnership Board Studies: Enrollment, Cost, and Implementation of a Preliminary Expanded Partnership

Final Report, as Accepted
November 19, 2008

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ACKNOWLEDGEMENTS

The authors are grateful for the cooperation and assistance of numerous individuals in the development of this report. These include especially our project officer, Michael Arnis of the Health Care Authority, who offered valuable suggestions and support throughout the process, and careful reading and comments on all drafts. Many other individuals also responded to questions, offered discussion, and provided valuable comments during the course of the project—including Richard Onizuka, Beth Walter, Anton Cooper, Robert Longhorn, Jennifer Willms, and Heather Masters of the Health Care Authority; and Pete Cutler of the Office of the Insurance Commissioner.

Many others provided data and information, often entailing special data reports, that were essential in projecting population and coverage trends. We are grateful to Roger Gantz, Mary Wood, and Mariko Young of the Department of Social and Health Services; Megan Atkinson, Kim Grindrod, and Christy Vaughn of the Health Care Authority; Jenny Hamilton, Thea Mounts, and Harold Nelson of the Office of Financial Management; and Kirsta Glenn of the Caseload Forecasting Council.

In addition, we are grateful to a number of individuals who generously provided their expertise and perspective about the small group and association insurance markets in Washington State. We especially thank Jim Grazko of Premera Blue Cross, Karen Merrikin of Group Health Cooperative, and Jim Pinkerton of RegenceBlueShield, as well as Donna Steward of the Association of Washington Business and Ben Diederich of Milliman, Inc.

Finally, we would like to acknowledge a number of individuals at Mathematica Policy Research whose assistance was essential in producing this report. We are especially grateful to John Chen, who provided extensive programming support; Daryl Hall, who edited the report; and August Pitt and Donna Dorsey, who produced the draft and final manuscripts.

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EXECUTIVE SUMMARY

Engrossed Second Substitute House Bill (E2SHB) 1569, enacted in 2007, charged the Board of the Health Insurance Partnership (HIP) with reporting to the Legislature and the Governor by December 1, 2008 on a Preliminary Study of the risks and benefits of incorporating the individual and small group markets into the (HIP) under existing small group market rules. The Health Insurance Partnership Board (HIP Board) will produce a Final Study to the Legislature and the Governor by September 1, 2009.

To assist in completing the Preliminary Study, the HIP Board contracted with Mathematica Policy Research to estimate the coverage and cost impacts of combining the individual and small group markets into the HIP, and to comment on any implementation or legal issues related to this change. This report, submitted as a discussion draft, constitutes Mathematica's analysis of a "Preliminary Expanded Health Insurance Partnership" or PHIP.

This report offers estimates of coverage and cost in the PHIP, projected to FY2010. To understand the change that the PHIP would represent, especially for the population that is now uninsured, it was necessary also to estimate the "base case"—that is, projected coverage in the HIP and from all other sources in FY2010, including self-insured coverage, other small group and association coverage, individual coverage, and coverage in public programs. We report these base case projections also.

The HIP Board approved the organization and operating rules for the PHIP for the purposes of this study, as summarized below:

- The PHIP would be simply a market organizer: it would not negotiate rates for any product, nor would it restrict available products or rates.
- The PHIP would serve all small groups as well as individuals. Small groups could still buy association coverage outside of the PHIP or self-insure, but the PHIP would become the exclusive commercial source for individual coverage.
- Carriers in the PHIP could continue to deny individuals, referring them to Washington State Health Insurance Pool (WSHIP) for coverage.
- The PHIP would attempt to coordinate coverage of dependent children with Medicaid and the State Children's Health Insurance Program (SCHIP), but adults and children who are eligible to enroll in Basic Health (BH) could enroll instead in the PHIP and qualify for a subsidy.
- All plans that are currently offered in either the small group or individual market would become available in the PHIP, and any plan available in the PHIP would be eligible for subsidy.

- Employees would have unrestricted choice among all available plans in the PHIP, and employers would adjust to unrestricted employee choice by transitioning to defined-contribution benefits.

- The PHIP would require small employers to contribute at least 40 percent of the single premium for the plan they select, and at least 75 percent of eligible employees must participate in some PHIP plan for the small group to qualify for coverage.

- Small group workers and individuals alike would have the same plan choices and pay the same premiums in the PHIP, differing only by the amount that employers would contribute for small group enrollees. Current small group rating rules would apply to both small group and individual coverage in the PHIP.

- Carriers would "list rate" small groups in the PHIP. In combination with employers paying defined contributions to coverage, list rating would result in employee contributions that vary by the employee's age, as well as their choice of plan and coverage of dependents.

- All employers would offer Section 125 plans to help finance employee contributions to coverage (if the employer offers and the employee is eligible) or individual purchase of coverage through the PHIP. Estimates of enrollment in the PHIP assume that Washington's current individual market would qualify under federal rules for use of Section 125 funds to purchase individual coverage. However, because Washington guarantees access through WSHIP but does not require guarantee issue in the market, making it questionable whether Section 125 funds could be used to purchase individual coverage.

- The subsidies available to both individuals and small group enrollees in the PHIP would be based on the same schedule as those available to small group enrollees in the HIP.

- Finally, the PHIP would deeply subsidize coverage for enrollees below 200 percent FPL, but coverage would continue to be voluntary, as would employer offer of coverage.

Estimates for the HIP Board studies were produced by microsimulation. Two sets of microsimulation estimates were produced: first simulating enrollment and cost in the HIP projected to FY2010, and then simulating FY2010 enrollment and cost in the PHIP. Both sets of estimates should be regarded as full-equilibrium estimates, not projections of actual FY2010 enrollment.

HIP ENROLLMENT AND COST

Key findings related to HIP eligibility and enrollment are as follow:

- The HIP is narrowly targeted. As a result, relatively few workers are eligible, even among those employed in small firms. More important, relatively few uninsured workers are eligible.
- Most HIP-eligible workers are currently insured—usually as a dependent of another group-covered worker, but some buy individual insurance and others are enrolled in Basic Health. Overall, just 37 percent of HIP-eligible workers are currently uninsured.
- Although the HIP provides some incentives for eligible employers to begin to offer coverage, low offer remains the greatest constraint to HIP enrollment. When offered and eligible for the employer plan, a very high percentage of workers take HIP coverage.
- As many as 16,500 workers enroll in the HIP, estimated for FY2010—less than 2 percent of all small-firm workers in Washington State. Very few HIP-enrolled workers take family coverage: just 2,300 dependents are estimated to enroll. We assumed that workers who currently have group coverage as the dependent of another family member do not enroll in the HIP.
- HIP enrollees tend to be low-income, young (under age 35), and without children. Most (70 percent) were uninsured before enrolling in HIP. Most HIP enrollees (78 percent) are subsidized.
- Most HIP enrollees take HIP plans with the lowest premiums and highest cost sharing. Very few enroll in comprehensive coverage.
- At maximum enrollment, the estimated state cost of HIP subsidies in FY2010 is $1.1 million per month—equal to $76 per subsidized enrollee.

PHIP ENROLLMENT

Two features of the PHIP are especially important in driving changes in coverage. First, the PHIP would merge the small group and individual markets, so that carriers would base their rates on blended risk. Second, the PHIP would allow for unrestricted employee choice of plans, compared with employer choice in the current market and the HIP, entailing important changes in employer plan design and carriers' billing practices. We assume that these changes ultimately would result in workers paying age-adjusted contributions—whereas coworkers now typically contribute the same amount, regardless of age.

Key findings with respect to PHIP enrollment are as follow:

- Under the PHIP, the number of uninsured as a percent of the population under age 65 would decline by nearly 40 percent—from 10 percent to 6 percent.

- However, the premium changes that would occur under the PHIP for both the group-covered workers and dependents and those with individual coverage are very disruptive. Many people would lose coverage under the PHIP, offsetting a substantial amount of the gains in coverage that would occur.

- Compared to those who are insured in either small group or individual coverage in the base case, those who are insured in the PHIP would be younger, in generally poorer health, and lower-income.

- Conversely, while there would be many fewer uninsured, the characteristics of the uninsured population would be different. Adults age 45 or older would account for a larger proportion of the uninsured, as would people who report excellent or very good health status. Very few people who qualify for premium assistance in the PHIP would be uninsured. Consequently, most of the uninsured would have income above 200 percent FPL.

- Given plan choice, most workers and individuals at incomes above subsidy level would retain current coverage or newly accept a current offer of coverage that is comprehensive. When workers who are not subsidy-eligible choose a standard HIP plan, they are more likely to choose the lowest cost sharing (highest premium) standard plan. Those that enroll in higher cost sharing (lower premium) plans are more likely to enroll dependents.

- Subsidy-eligible PHIP enrollees are most likely to accept greater cost sharing (in Tier 2) in response to greater premium assistance for that coverage.

- The PHIP could have a significant impact on association coverage, but only if association-insured employers saw an opportunity to restructure compensation—reducing their contributions to coverage and potentially increasing worker contributions in exchange for worker choice among benefit plans and carriers in the PHIP. If association-insured employers and their workers were unwilling to make this trade, there would likely be little impact on association plans.

PHIP FINANCING

Key findings with respect to financing in the PHIP are as follow:

- At full implementation, state subsidies are estimated to total nearly $84 million per month. Subsidies are estimated to finance nearly 30 percent of premiums in the PHIP overall. Including both subsidized enrollees (with family income at or below 200 percent FPL) and unsubsidized enrollees in the PHIP, state subsidies average $90 per member per month.

- Due to the high proportion of small group premiums that employers would pay, estimated state subsidies for small group coverage in the PHIP are low—just $20 per enrollee month. In contrast, estimated subsidies for individual coverage are 10 times

as high, averaging $236 per enrollee month. An exploration of possible funding sources or potential changes in expenditures related to uncompensated care are beyond the scope of this study.

- On average—and reflecting the high proportion of low-income enrollees in the PHIP—enrollees pay just 16 percent of premiums after subsidies and tax savings. Tax savings average about 4 percent of premiums overall, and about 7 percent of premiums net of employer contributions and premium assistance. At higher levels of income (300 percent FPL or more), tax savings represent nearly 27 percent of net premiums.

- Small employers contribute a similar percentage of premium, on average, for workers who newly gain small group coverage in the PHIP, compared with workers now in small group coverage. This result reflects the insurance industry's high standard for employer contributions in very small firms currently, as well as workers "buying down" coverage in the PHIP to minimize their contributions to premium.

- The immediate potential for crowd out in the PHIP is low: we estimate not more than 8 percent of state subsidy payments would equate to crowd out of worker contributions to coverage. However, the transition to employer defined contributions in the PHIP suggests the potential for increasing crowd out of employer expenditures over time. If the PHIP relies only on enrollee cost sharing to manage rising medical costs, employers' defined contributions might not rise with the cost of coverage in the PHIP, causing the state cost of premium assistance to accelerate.

IMPLEMENTATION ISSUES

The PHIP raises a number of critical questions related to its design and implementation. Among the most important of these are (1) whether the PHIP should be the exclusive source of commercial coverage for small groups and individuals; (2) whether the PHIP should attempt to merge the group and individual markets; (3) employee choice of plans within the PHIP; and (4) contribution, participation and billing requirements for employers. We offer a number of preliminary recommendations for Board consideration on these and other important questions, and summarize the decisions made in Connecticut and Massachusetts—the only states with working health insurance exchanges—with respect to each, where their experience is relevant.

Exclusive Source. If the desire is to sell to both individuals and small groups through the PHIP (as the Massachusetts Connector is designed to do), Washington could begin by allowing individuals and small groups to purchase from the PHIP, but not *require* either to do so. However, this arrangement would further segment Washington's market for small groups and it also would segment the individual market. In light of the difficulties of still more segmented markets in Washington and the limited role envisioned for the PHIP as an organization, it seems to make little sense for it to attempt to operate side-by-side with competing markets. Instead, it would be more practical for the PHIP to be the exclusive source of small group and individual coverage and apparently more consistent with Washington's policy goal of making the individual and small group markets easier for consumers to navigate.

- *In Connecticut, CBIA competes in the small- and large-group markets.*
- *Also in Massachusetts, the Connector operates side-by-side with the merged small group and individual market. However, young adult products (for individuals under age 26) may be sold only in the Connector.*

Blending the Markets. Washington would face an important challenge related to the expected significant increase in average rates for individuals and older workers, as it attempts to blend the small group and individual markets. Instead, Washington may wish to consider options for *coordinating* the markets to help workers negotiate transitions between employment and self-employment, instead of entirely blending the markets. For example, rating factors should be identical for small groups and individuals in the PHIP, and individual coverage could be guaranteed issue, with WSHIP brought into the PHIP as a reinsurance entity for individual coverage. If these measures (combined with subsidies) increase participation in individual coverage, it seems likely that the collective risk experience of those with individual coverage will begin to resemble more closely that for small groups. At that point, Washington could consider blending the small group and non-group markets, potentially reconfiguring WSHIP as a reinsurer for the entire blended market.

- *Massachusetts merged its individual and small group markets. However, in Massachusetts* the *individual market was small and experienced adverse selection, but in the small group market the opportunity for adverse risk selection was low. In Massachusetts, association plans must follow the same rating rules as for other small groups.*

Employee Choice. The PHIP offers a wide variety of plans and unlimited choice of plans to employees. Limiting PHIP plans to those with meaningful differences in cost sharing, network design and/or formularies is an alternative that policymakers may want to consider.

- *In Massachusetts and Connecticut, respectively, the Connector and CBIA restrict the number and types of products they offer. However, in both states, individuals and employers can purchase a non-exchange product in the regular market and as a result, may not perceive the exchange as limiting choice.*

Contribution, Participation, and Billing Requirements. The PHIP would require small employers to contribute at least 40 percent of the single premium for any benchmark plan they would select, and at least 75 percent of eligible employees would need to participate in any PHIP plan in order to qualify for group coverage. Implementation of unrestricted employee choice in the PHIP would cause employee contributions to vary by the employee's age (as well as by their choice of plan and coverage of dependents). To accommodate unrestricted employee choice, we assumed that carriers would list-rate individual employees in the PHIP and employers would pass list rates along to their workers—in contrast to composite rating of the entire group, as is customary now.

- *In Connecticut, CBIA (which serves only groups) requires employers to contribute at least 50 percent of the premium for the lowest cost plan in whichever tier they select, and to meet the same participation rules as in the small group market. Employers may restrict employee choice or not, and in either case they may choose between list or composite rating.*

- *In Massachusetts, employers are not required to contribute toward coverage (although they face a penalty if they contribute nothing). Reflecting the state's blended market, only list rating is used. However, there is restricted choice, and carriers use a composite rating formula that, in effect, cross-subsidizes older workers within firms. Massachusetts requires the same participation rate as in the outside small group market.*

Managing Risk Selection. If the PHIP competes with associations, the market, or both as a source of coverage for small groups and/or individuals, having the same rating rules and mandatory benefits for products both inside and outside the PHIP is essential. In Washington, this would entail allowing association coverage for small groups to be sold only through the PHIP, with the same rating rules and risk pooling by carrier as all other PHIP plans. Alternatively, if association plans competed (side-by-side) with the PHIP, both association plans and the PHIP would need to conform to the same rules and regulations.

In addition, the HIP Board will need to think strategically and creatively about the selection issues associated with incorporating public programs into the PHIP in the Final Study. For example, funding for WSHIP could be used to finance a reinsurance mechanism—but it would be imperative that these dollars remain in the system to buy-down the cost of high-risk individuals.

- *In Massachusetts and Connecticut, employers select a tier of actuarially equivalent plans, within which employees may choose a specific plan. This eliminates the need for risk adjustment but also limits employee choice.*

Standardizing PHIP Plans. Even if the PHIP were the sole source of insured small group and individual products in Washington, it would be advisable to have some standardization of plans for two reasons. First, it would help to avoid risk selection within the PHIP. A self-supporting reinsurance risk pool or system of risk adjustment also could help to address the concerns that carriers will have in selling coverage through the PHIP. Even if plans were standardized, the PHIP would offer portable plans and choice among providers, which has been shown to be more important to consumers than choice among plans.

Second, Washington may want to be more selective about the number and types of products that the PHIP sells and endorses as "good value." Despite the potential for perceiving this as limiting choice, limiting PHIP plans to those with meaningful differences in cost sharing, network design and/or formularies would make sense.

- *Both Massachusetts and Connecticut standardize plan offerings within their exchanges to facilitate employer and consumer understanding of benefits, minimize risk selection, and make purchasing easier.*

Mandatory Offer of Section 125 Plans. Requiring all businesses to offer Section 125 plans to their employees would be easier for employers to move from a noncontributory status to a contributory status without affecting their employees' enrollment in a health plan. Mandating the establishment of Section 125 plans is a relatively easy step for policymakers to take to lower the net cost of coverage for employees, and could help to offset increases in individual coverage, if Washington pursues merging the small group and individual markets.

- *Massachusetts requires all firms with more than 10 employees to offer all employees a Section 125 plan.*

Market Determination of Brokerage Fees. Finally, because brokers' fees are embedded in premiums, it is hard to identify what businesses pay for brokerage services. Therefore, it would be difficult to gauge whether the PHIP represents fair competition for brokers' services, if the PHIP competes side-by-side with an alternative market. Alternatively, if the PHIP is the exclusive source of individual and small group coverage, it would be difficult to gauge whether it offers brokers fair compensation. The PHIP could encourage greater transparency for this transaction throughout the market, without directly addressing brokerage arrangements.

- *In Connecticut and Massachusetts, broker transaction fees are more transparent. Health Connections and the Connector both pay brokers a commission for bringing them business but keep most of the fee for administration of the account. Over time, it would be desirable for broker fees to be separated from the rate, with the market determining the cost of brokerage services.*

I. INTRODUCTION

E2SHB 1569 created the Washington Health Insurance Partnership (HIP) to help small businesses provide affordable health plan options to their employees. The HIP will offer a premium subsidy to employees with family income below 200 percent of the federal poverty level (FPL) who work in low-wage firms that currently do not offer coverage, if their employers newly offer coverage in the HIP.

In addition, E2SHB 1569 charged the HIP Board with reporting to the Legislature and the Governor by December 1, 2008 on a Preliminary Study of the risks and benefits of incorporating the individual and small group markets into the HIP under existing small group market rules. The HIP Board will produce a Final Study to the Legislature and the Governor by September 1, 2009.

Both Studies reflect market reforms that are similar to those introduced in House Bill 1569 (HB 1569), in the 60th Legislature of the 2007 regular session. HB 1569 proposed creating a "Washington State Health Insurance Connector." Beginning January 1, 2009, the Connector would begin consolidating markets for individuals, small employer groups, small employers insured through association- or member-governed groups, Basic Health (BH), and Washington State Health Insurance Pool (WSHIP). In addition, the impact of including active and retired state, political subdivision, and school employees in the Connector would be studied.

As proposed, the Connector would entail substantial reform of Washington's health insurance market, raising questions that could not be fully addressed during the legislative session. HB 1569 subsequently was amended to provide subsidized group insurance to non-offering, low-wage small employers through the HIP. The amended bill directed a seven-member Board to implement the HIP and to examine incorporating additional markets in the HIP, starting with the Preliminary Study.

To assist in completing the Preliminary Study, the HIP Board contracted with Mathematica Policy Research to estimate the coverage and cost impacts of combining the individual and small group markets into an expanded HIP, and to comment on any implementation or legal issues related to this change. This report, submitted as a discussion draft, constitutes Mathematica's analysis of a Preliminary Expanded Health Insurance Partnership, or PHIP.

This report offers estimates of coverage and cost in the PHIP, projected to FY2010. To understand the change that the PHIP would represent, especially for the population that is now uninsured, it was necessary also to estimate the "base case" in FY2010: projected maximum coverage in the HIP, as well as coverage from all other sources—self-insured coverage, other small group and association coverage, individual coverage, and coverage in public programs. We report these base case projections also.

On April 3, 2008, the HIP Board approved the organizational operating rules and modeling assumptions for the PHIP for the purposes of this study, as described below. Some operating

rules were the same as those used to implement the HIP; others differed significantly from those under implementation.

- Like the HIP, the PHIP would remain simply a market organizer: it would not negotiate rates for any product, nor would it restrict available products. All products and rates in the PHIP would be subject to state regulation, as developed and enforced by the Office of the Insurance Commissioner.

- While the HIP serves only low-wage firms with 2-50 employees and that do not currently offer health insurance, the PHIP would serve all small groups as well as individuals. Small groups could continue to buy association coverage outside of the PHIP or self-insure, but otherwise they could obtain coverage only through the PHIP. Similarly, the PHIP would become the exclusive commercial source for individual coverage.

- Washington is a high-risk pool state: it guarantees access to individual coverage via WSHIP, but does not require carriers to guarantee issue. As in the current market, carriers in the PHIP could continue to deny individuals (but not small groups) on the basis of health status.

- The HIP will attempt to coordinate coverage of dependent children with Medicaid/SCHIP. We assume that the HIP will be successful in doing so, and that Medicaid and SCHIP eligible adults and children do not enroll in private insurance that requires a contribution, even when subsidized. However, adults and children who are eligible to enroll in Basic Health (BH) could enroll instead in the HIP through an employer and qualify for a subsidy. Similarly, BH-eligible adults and children could enroll in the PHIP as individuals and qualify for a subsidy.

- While twelve plans (in four tiers) are available in the HIP, all plans that are currently offered in either the small group or individual market would become available in the PHIP—including the twelve plan designs offered in the HIP. For the purposes of this study, any plan available in the PHIP would be eligible for subsidy.

- In the HIP, employers choose the plan that they offer to their workers. However, in the PHIP employees would have unrestricted choice among all available plans. We assume that employers adjust to unrestricted employee choice among plans by transitioning to a defined contribution benefit. That is, the employer would select a benchmark plan for the purpose of satisfying the minimum contribution rule, and employees would then use the employer contribution to enroll in any plan available in the PHIP, for any family type they choose.

- As in the HIP, in the PHIP small employers would be required to contribute at least 40 percent of the single premium for the plan they select. For the small group to qualify for PHIP coverage, at least 75 percent of eligible employees must participate in some PHIP plan—either in the employer-selected benchmark plan or in any of the other PHIP plans.

- In the PHIP, small group workers and individuals alike would have the same plan choices and pay the same premiums, differing only by the amount that employers would contribute for small group enrollees. Current small group and individual rating rules, which allow rates to vary on age within a band of 3.75:1, would apply in the PHIP.

- Unlike in either the HIP or the current small group or association markets, the implementation of employee choice would cause employee contributions in the PHIP to vary by the employee's age (as well as by their choice of plan and coverage of dependents).[1] We assume that employers do not attempt to offset higher premiums for older employees, nor do they reduce contributions for younger employees.

- Because rating in the PHIP would not differ between individuals and small group enrollees, it follows that carriers' nonmedical (administrative) cost rate also would not differ. On average, carriers' average administrative costs as a percent of premium for all products in the PHIP are assumed to equal the average for small group products reported from 2003 to 2007.[2]

- All employers would offer Section 125 plans to help finance employee contributions to coverage (if the employer offers and the employee is eligible) or individual purchase of coverage through the PHIP. Estimates of enrollment in the PHIP assume that Washington's current individual market would qualify under federal rules for use of Section 125 funds to purchase individual coverage. However, because Washington guarantees access through WSHIP but does not require guarantee issue in the market, making it questionable whether Section 125 funds could be used to purchase individual coverage.

- The premium assistance available to both individuals and small group enrollees in the PHIP would be based on the same schedule as those available to small group enrollees in the HIP. For comprehensive coverage (Tier 1 in the HIP), premium assistance would range from 68 percent of the employee or individual contribution to coverage at the lowest income levels to 45 percent at higher income levels below 200 percent FPL. For non-comprehensive coverage (Tiers 2 through 4 in the HIP), premium assistance would range from 90 percent at the lowest income levels to 60 percent at higher income levels below 200 percent FPL. We assume that all current

[1] Age-rated employee contributions are a consequence of various PHIP features in combination: specifically, employer defined contributions in response to unrestricted employee choice among plans, and identical choices and premiums for individuals. While it is possible that some employers would choose to contribute more for older employees to offset their higher premiums, this would be a relatively complex benefit to manage, especially in the context of unrestricted employee choice among many PHIP plans.

[2] As approved by the Board, the administrative cost assumption would average small group and individual rates. Averaged over 2003-2007, administrative cost as a percent of premium was very similar in these markets, with the average individual administrative cost rate slightly below that for small groups. This suggested that the appropriate target administrative cost rate for the combined market would be that which carriers have historically achieved for small group business.

coverage that conveys into the PHIP is considered comprehensive for the purpose of calculating premium assistance.

- Finally, while the PHIP would deeply subsidize coverage for enrollees below 200 percent FPL, coverage for these and all enrollees would continue to be voluntary. Employer offer of coverage also would continue to be voluntary, consistent with federal law.[3]

As envisioned in this study, the PHIP addresses the cost of coverage only to the extent that it might encourage enrollment in plans with greater cost sharing. The PHIP makes no particular provision for cost management or quality improvement, either as an integrated component or as a parallel effort.

The report is organized as follows. In Chapter II, estimates of HIP enrollment are presented. While these estimates are benchmarked to Washington's nonelderly population in FY2010, they are not intended as a forecast of actual HIP enrollment in FY2010. Instead, they represent the maximum enrollment that could occur if the HIP were accepted by carriers, agents, employers, and workers in the same way as any other source of coverage that historically has been available to small groups.

In Chapter III, we turn to estimates of enrollment in the PHIP. As with our estimates of HIP coverage, these estimates also represent an "equilibrium" scenario. Employers and workers, as well as individuals, are assumed to adjust immediately to the changes that the PHIP represents—including employers who offer coverage through association plans and would consider instead obtaining coverage in the PHIP. The chapter includes an analysis of the estimated impacts of the PHIP on the uninsured population in Washington.

In Chapter IV, financing estimates for the PHIP are presented by source of funds. We also explore the potential for crowd out in the PHIP—that is, the extent to which State funding in the PHIP would replace private expenditures for health insurance coverage.

Chapter V concludes the report with a discussion of issues related to transition and implementation. We offer a number of recommendations related to how the PHIP might be designed and implemented to reduce disruption of coverage for those who are currently insured while addressing the PHIP's primary goals of greater access and portable plans.

The microsimulation methods and data that underlie our estimates of HIP and PHIP coverage and cost are described in Appendix A.

[3] Enacted in 1974, the Employee Retirement Income Security Act (ERISA) protects employee benefit plans from state regulation. The states retain the authority to regulate the business of insurance under the McCarran-Ferguson Act, but ERISA precludes them from requiring employers to offer coverage or directly influencing the coverage that they offer. For an extensive discussion of ERISA as it affects state health policy initiatives, see: Patricia Butler (January 2000). ERISA Preemption Manual for State Health Policy Makers (http://www.statecoverage.net/pdf/erisa2000.pdf, accessed August 26, 2008).

II. HEALTH INSURANCE PARTNERSHIP ELIGIBILITY AND ENROLLMENT

This chapter discusses the characteristics of the population eligible for coverage through the HIP and reports estimates of the number of workers who receive an offer of HIP coverage and take up coverage in the HIP. Estimates of enrollees' prior coverage status, family income, age, and health status are presented, as are estimates of enrollment by plan tier. The discussion notes especially eligibility and enrollment among workers who currently are uninsured.

Finally, the estimated cost of financing the HIP is presented, in total and by source of financing. Sources of financing include employers, the state (to subsidize low-income workers), federal tax expenditures (as a result of tax sheltering employee contributions), and employees.

The enrollment estimates presented in this chapter are full equilibrium estimates—that is, they assume that employers, brokers, and workers regard HIP products just as they would any other available health insurance product and are equally informed about them. In contrast, actual enrollment in FY2010 is likely to be less, consistent with other states' experience in launching new health insurance programs.

Key findings related to HIP eligibility and enrollment are as follow:

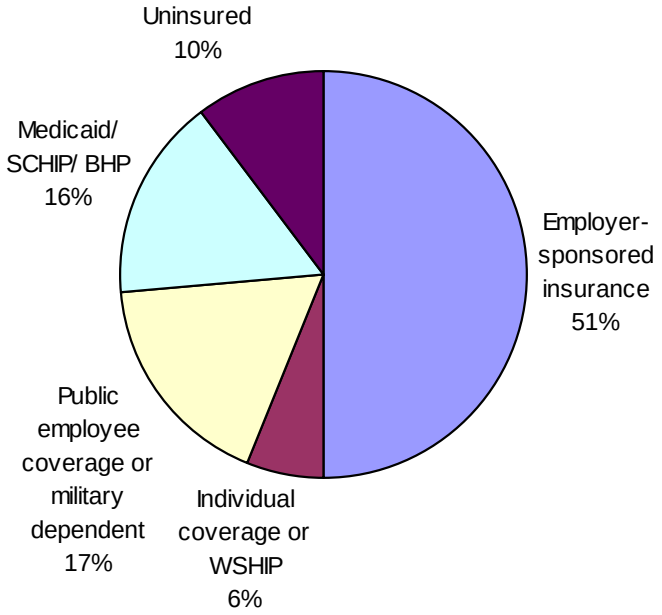
- The HIP is narrowly targeted. As a result, relatively few workers are eligible, even among those employed in small firms. More important, relatively few uninsured workers are eligible.
- Most HIP-eligible workers are currently insured—usually as a dependent of another group-covered worker, but some buy individual insurance and others are enrolled in Basic Health. Overall, just 37 percent of HIP-eligible workers are currently uninsured.
- Although the HIP provides some incentives for eligible employers to begin to offer coverage, the low rate of offer by small employers remains the greatest constraint to HIP enrollment. When offered and eligible for the employer plan, a very high percentage of workers take HIP coverage.
- As many as 16,500 workers enroll in the HIP, estimated for FY2010—less than 2 percent of all small-firm workers in Washington State. Very few HIP-enrolled workers take family coverage: just 2,300 dependents are estimated to enroll.
- HIP enrollees tend to be low-income, young (under age 35), and without children. Most (70 percent) were uninsured before enrolling in the HIP. Most HIP enrollees (78 percent) are subsidized.
- Most HIP enrollees take HIP plans with the lowest premiums and highest cost sharing. Very few enroll in comprehensive coverage.
- At maximum enrollment, the estimated state cost of HIP subsidies in FY2010 is $1.1 million per month—equal to $76 per subsidized enrollee.

A. TARGETING UNINSURED WORKERS IN SMALL GROUPS: HIP ELIGIBILITY

The analysis in this report focuses on the population under age 65 living in the community—in FY2010, an estimated 5.7 million people.[4] Of these, most have coverage from an employer based plan. Prior to implementation of the HIP, 10 percent (576,400) are uninsured.

FIGURE II.1

ESTIMATED PERCENT OF THE WASHINGTON STATE POPULATION UNDER AGE 65 WITH COVERAGE FROM SPECIFIC SOURCES OR UNINSURED, WITHOUT HIP IMPLEMENTATION, FY2010



Source: Mathematica Policy Research.

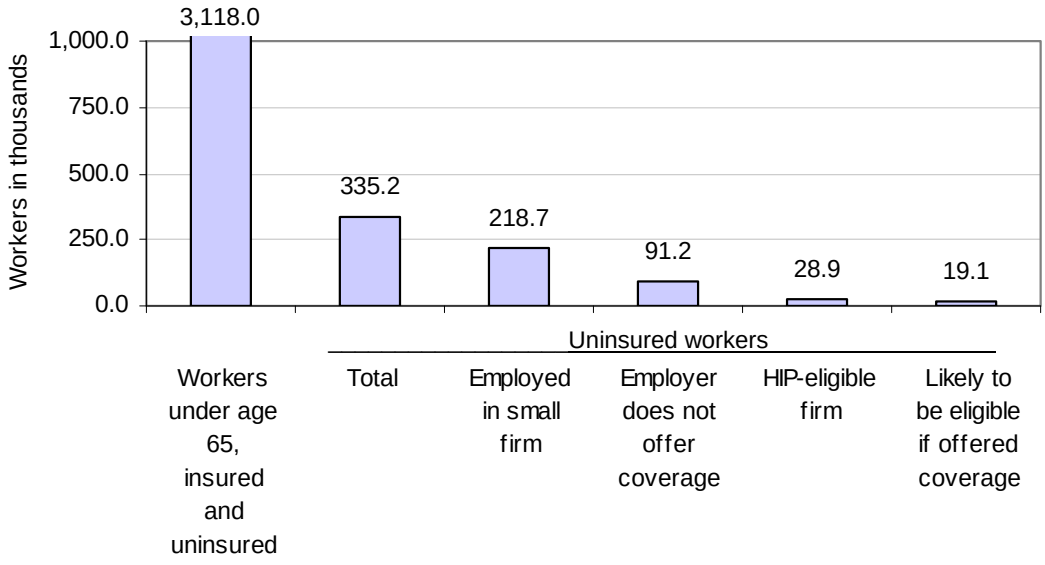
The HIP is intended to improve access to health services for low-wage employees in small firms, focusing on employers that do not currently offer coverage to their employees, presumably for reasons of affordability. Thus, workers can enroll in the HIP only if (1) they work in a HIP-eligible firm, and (2) their employer offers HIP coverage for which they are eligible. Only low-wage firms with 2 to 50 workers that do not currently offer coverage are HIP-eligible. A low-wage firm is defined as one in which at least 50 percent of workers earn no more than the equivalent of 200 percent of the federal poverty level (FPL) for a single-person household. Projected to FY2010, the low-wage standard for the HIP is $10.56 per hour (compared with $10.00 at HIP implementation in FY2009).

[4] In addition to persons who reside in institutions (such as a long-term care facility or prison), two relatively small population groups are excluded from this population estimate and from the analysis: (1) disabled persons under age 65 who are enrolled in Medicare, which typically would be the first payer for their health care services; and (2) active military personnel. Both are excluded because much or all of their health care is federally financed, and because state policy is unlikely to affect them, nor intend to affect them, in the same way as other population groups. The analysis does include the dependents of active military personnel (if any) living in the community.

Relatively few uninsured workers in Washington are employed in HIP-eligible firms. Of nearly 3.1 million workers under age 65, 335,200 (11 percent) are uninsured. Of these, about two-thirds work in small firms. However, we estimate that only 28,900 (9 percent of all uninsured workers) work in firms that are HIP-eligible (Figure II.2). Of these workers, about 19,100 workers are likely to be eligible if offered coverage—in general, they are full-time workers, age 19 or older. Including both HIP-eligible workers and their dependents, the HIP targets about 43,700 uninsured workers and dependents (8 percent of the uninsured population), of whom nearly 29,700 (5 percent of the uninsured population) are likely to be eligible if offered coverage (Figure II.3).

FIGURE II.2

ESTIMATED NUMBER OF UNINSURED WORKERS ELIGIBLE FOR HIP, FY2010

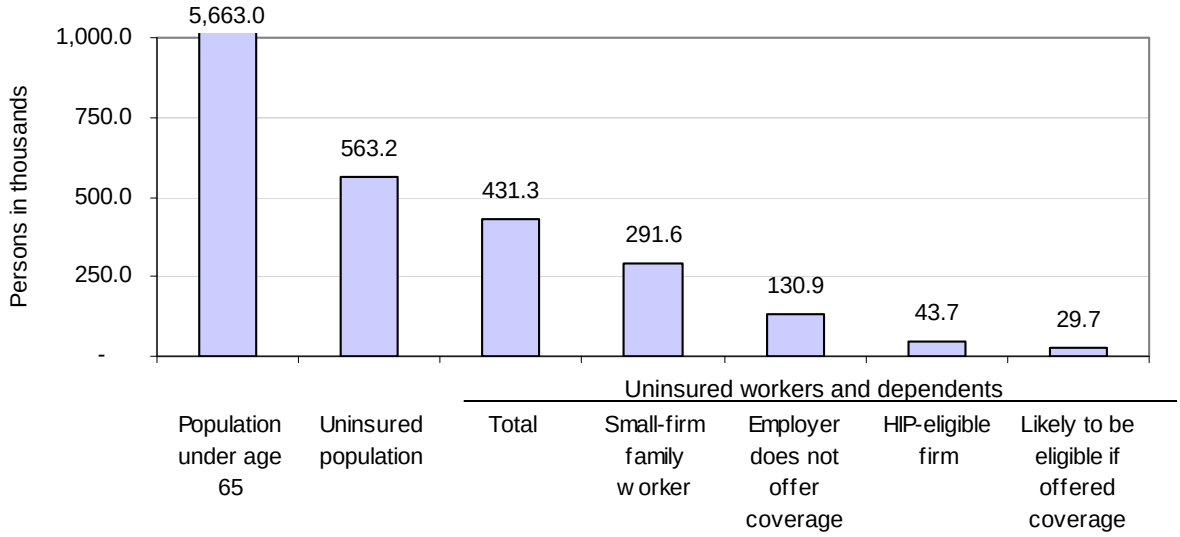


Source: Mathematica Policy Research.

Although firms eligible to participate in the HIP cannot currently offer coverage, nearly two-thirds—63 percent of the estimated 77,200 workers employed in HIP-eligible firms in FY2010—have coverage from some source (Table II.1). Nearly one-third of workers in HIP-eligible firms have employer-sponsored insurance (ESI) as a dependent of another private sector worker (19 percent) or as the dependent of a public-sector or military employee (13 percent). Others have individual coverage (15 percent) or are enrolled in public insurance programs for low-income families—Medicaid, SCHIP, or BH (16 percent). Among all workers in HIP-eligible firms, 37 percent are uninsured.

FIGURE II.3

ESTIMATED NUMBER OF UNINSURED WORKERS AND DEPENDENTS ELIGIBLE FOR HIP, FY2010



Source: Mathematica Policy Research.

Only low-wage small firms are eligible for the HIP, and indeed, workers in these firms generally have lower family incomes than workers in other firms. Of the estimated 77,200 workers eligible for the HIP, 33 percent have family incomes below 100 percent FPL; 54 percent have family incomes below 200 percent FPL (Table II.2). Not surprisingly, uninsured workers in HIP-eligible firms are still poorer than their insured coworkers. More than half of uninsured workers in HIP-eligible firms have family income below 100 percent FPL (54 percent); 82 percent have family income below 200 percent FPL.

B. HIP OFFER

Workers in HIP-eligible firms may enroll only if their employers offer HIP coverage, and the HIP provides some motivation for employers that do not currently offer coverage to reconsider whether to offer. Employers may contribute as little as 40 percent of single premiums for HIP coverage and make no contribution for dependents.

The HIP's contribution requirement differs from the current industry standard, which requires small employers to contribute at least 75 percent of single premiums and 50 percent of premiums for dependents. For the smallest firms (for example, with 2 to 5 employees), this standard may vary by carrier, and it may be more restrictive. For example, a carrier may require an employer to contribute 80 percent or even 100 percent of premiums. Employers that enroll in the HIP also must meet the industry's minimum participation standard: 75 percent of eligible workers must enroll in order for the group to be accepted for coverage.

TABLE II.1

ESTIMATED NUMBER AND PERCENT OF WORKERS BY TYPE OF COVERAGE, FIRM SIZE, AND HIP ELIGIBILITY, FY2010

			Small Firms (2-50)					
	All Workers		All Small Firms		HIP-Eligible Firms		Larger Firms	
	Number (000s)	Percent	Number (000s)	Percent	Number (000s)	Percent	Number (000s)	Percent
Total	**3,098.3**	**100%**	**1,056.9**	**100%**	**77.2**	**100%**	**2,018.9**	**100%**
ESI—Own Employer	1,404.8	45%	348.8	33%	NA	NA	1,056.0	52%
ESI—Dependent	522.8	17%	244.3	23%	14.7	19%	278.5	14%
Individual	145.5	5%	82.7	8%	11.3	15%	53.2	3%
Public Employee/Dependent or Military Dependent	584.0	19%	103.1	10%	10.1	13%	479.8	24%
Medicaid/SCHIP/BHP	105.9	3%	59.4	6%	12.1	16%	45.7	2%
Uninsured	335.2	11%	218.7	21%	28.9	37%	105.6	5%

Source: Mathematica Policy Research.

Note: All workers include self-employed workers, who are excluded in the detail by firm size.

TABLE II.2

ESTIMATED NUMBER AND PERCENT OF WORKERS BY FAMILY INCOME AS A PERCENT OF POVERTY, FIRM SIZE, AND HIP ELIGIBILITY, FY2010

			Small Firms (2-50)					
	All Workers		All Small Firms		HIP-Eligible Firms		Large Firms	
	Number (000s)	Percent	Number (000s)	Percent	Number (000s)	Percent	Number (000s)	Percent
All Workers	3,098.3	100%	1,056.9	100%	77.2	100%	2,018.9	100%
0-100 percent FPL	372.2	12%	199.7	19%	25.8	33%	166.9	8%
101-200 percent FPL	302.0	10%	153.5	15%	15.9	21%	142.1	7%
Over 200 percent FPL	2,424.0	78%	703.7	67%	35.5	46%	1,709.9	85%
Insured Workers	2,763.0	100%	838.2	100%	48.3	100%	1,913.3	100%
0-100 percent FPL	222.5	8%	97.8	12%	10.2	21%	124.5	7%
101-200 percent FPL	207.5	8%	89.5	11%	7.8	16%	114.7	6%
Over 200 percent FPL	2,333.0	84%	650.9	78%	30.3	63%	1,674.1	87%
Uninsured Workers	335.2	100%	218.7	100%	28.9	100%	105.6	100%
0-100 percent FPL	149.8	45%	101.8	47%	15.5	54%	42.4	40%
101-200 percent FPL	94.5	28%	64.0	29%	8.1	28%	27.4	26%
Over 200 percent FPL	91.0	27%	52.8	24%	5.3	18%	35.8	34%

Source: Mathematica Policy Research.

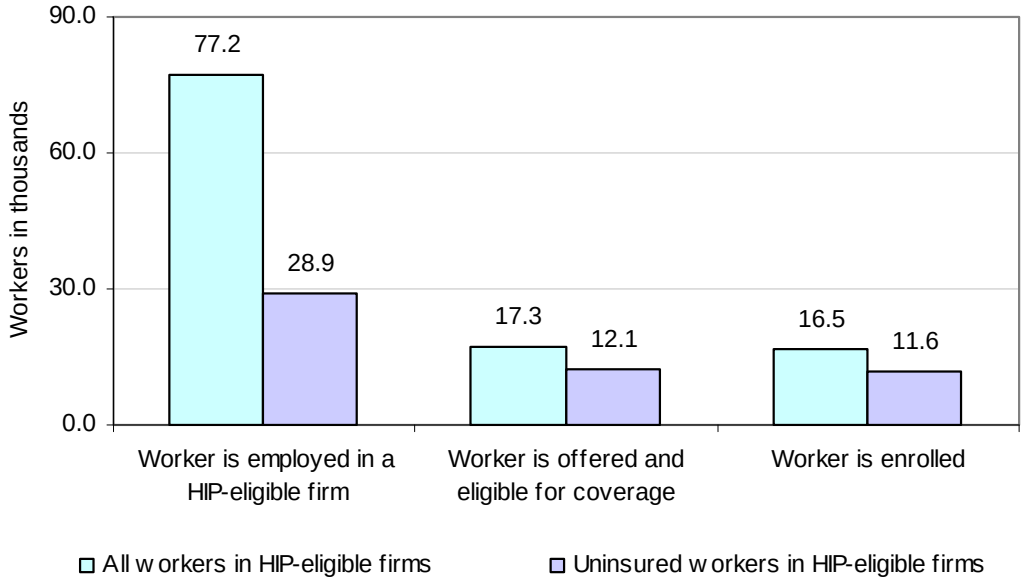
Note: All workers include self-employed workers, who are excluded in the detail by firm size.

We developed econometric estimates of employer offer using Washington State population data (as described in Appendix A). As applied in the microsimulation model, these estimates reflect the maximum level of offer that might be expected at full implementation of the HIP, with no "ramp up" in program enrollment as would likely occur in any new program. Instead, our estimates assume that employers regard the HIP as they would any insurance option, and that the HIP is marketed as aggressively as any other private health insurance plan.

With that caveat, we expect that as many as 17,300 workers in HIP-eligible firms (22 percent) would receive an offer of coverage—that is, their employers would be willing to offer a HIP plan, at least 75 percent of employees would participate, and the worker would be eligible for coverage when it is offered (Figures II.4 and II.5). Among uninsured workers, the expected rate of offer is higher. Of the estimated 28,900 uninsured workers employed in HIP-eligible firms, 12,100 workers (42 percent) are expected to receive an offer of coverage.

FIGURE II.4

ESTIMATED NUMBER OF WORKERS IN HIP-ELIGIBLE FIRMS WHO ARE OFFERED AND ENROLL IN HIP, FY2010



Source: Mathematica Policy Research.

C. HIP ENROLLMENT

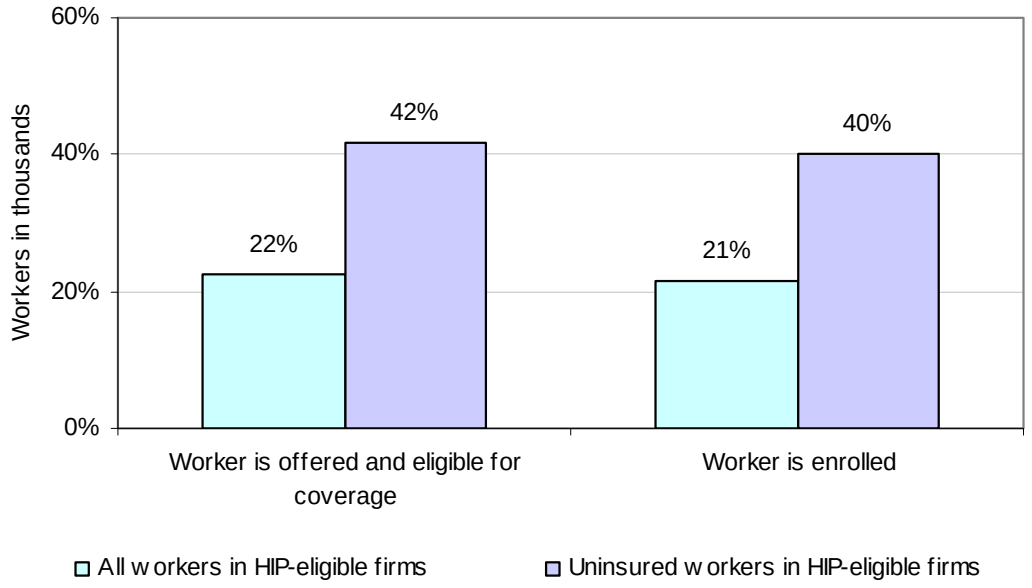
We assume that workers would not enroll in the HIP, even when offered, if they are currently enrolled either in ESI (as a dependent) or in Medicaid or SCHIP. However, workers who are uninsured or enrolled in individual coverage are very likely to enroll when offered HIP coverage, and workers currently in BH may also consider taking HIP coverage if offered.[5]

[5] In generating these estimates, we assumed that workers consider HIP coverage (when offered and eligible) only if they are currently uninsured, purchase coverage as an individual, or are enrolled in BH. Conversely, workers decline an offer of HIP coverage if they are currently covered as a dependent on another worker's ESI, or they are

Among the workers we assume will consider HIP coverage, more than 90 percent take it up. In total, an estimated 16,500 workers are expected to enroll in the HIP along with 2,300 dependents, bringing total HIP enrollment to 18,900 workers and dependents (Table II.3).

FIGURE II.5

ESTIMATED PERCENT OF WORKERS IN HIP-ELIGIBLE FIRMS WHO ARE OFFERED AND ENROLL IN HIP, FY2010



Source: Mathematica Policy Research.

The HIP is expected to cover 1 to 2 percent of small-firm workers. In contrast, 20 percent of small-firm workers are expected to remain uninsured. The HIP has very little impact on the total uninsured population: 10 percent of the population under age 65 were uninsured before the HIP, and 10 percent remain uninsured.

1. Characteristics of HIP-Enrolled Workers

Workers projected to take up HIP coverage are generally younger than average, and their family income is lower (Table II.4). Of workers expected to enroll in the HIP, most (59 percent) are under age 34. Nearly half (49 percent) have income below the poverty level, and 80 percent have income below 200 percent FPL.

(continued)

enrolled in Medicaid or SCHIP. Similarly, workers consider covering only those dependents who are uninsured, enrolled in individual coverage, or enrolled in BH. Individually insured and BH-enrolled workers consider coverage for themselves and dependents if the total value of family expenditures for premiums and expected out-of-pocket costs would be lower in the HIP than in their current insurance arrangement.

TABLE II.3

ESTIMATED HIP ENROLLMENT, OTHER SOURCES OF COVERAGE, AND REMAINING UNINSURED: ALL PERSONS AND WORKERS BY SIZE OF FIRM, FY2010

	All Persons Under Age 65		Workers					
			All Firms		Small Firms (2-50)		Large Firms	
	Number (000s)	Percent	Number (000s)	Percent	Number (000s)	Percent	Number (000s)	Percent
Total	**5,663.0**	**100%**	**3,098.3**	**100%**	**1,056.9**	**100%**	**2,018.9**	**100%**
HIP Total	18.9	--	17.5	1%	17.4	2%	0.1	--
HIP—Own Employer	16.5	--	16.5	1%	16.5	2%	NA	NA
HIP—Dependent	2.3	--	1.0	--	0.9	--	0.1	--
Association	445.1	8%	400.1	13%	254.4	24%	145.7	7%
Other ESI	2,392.6	42%	1,653.4	54%	348.0	33%	1,305.4	65%
Individual	979.7	17%	142.8	5%	79.9	8%	53.2	3%
Other Public Employee/ Military Coverage	344.2	6%	458.2	15%	93.8	9%	363.3	18%
Medicaid/SCHIP/BHP	919.4	16%	103.7	3%	57.2	5%	45.7	2%
Uninsured	563.2	10%	322.6	10%	206.2	19%	105.5	5%

Source: Mathematica Policy Research.

Note: Dashes indicate values less than 0.5 percent.

TABLE II.4

ESTIMATED NUMBER AND PERCENT OF HIP-ENROLLED WORKERS AND DEPENDENTS BY AGE AND INCOME, FY2010

	All HIP Enrollees		Workers		Dependents	
	Number (000s)	Percent	Number (000s)	Percent	Number (000s)	Percent
Total	18.9	100%	16.5	100%	2.3	100%
Family income						
Under 100% FPL	9.5	50	8.1	49	1.4	60
101 to 200% FPL	5.2	28	5.1	31	0.1	4
Over 200% FPL	4.1	22	3.3	20	0.8	35
Age						
18 or younger	0.5	3	0.1	1	0.4	18
19 to 34	11.1	59	9.6	58	1.4	62
35 to 44	2.7	14	2.3	14	0.3	15
45 to 64	4.6	24	4.5	27	0.1	6

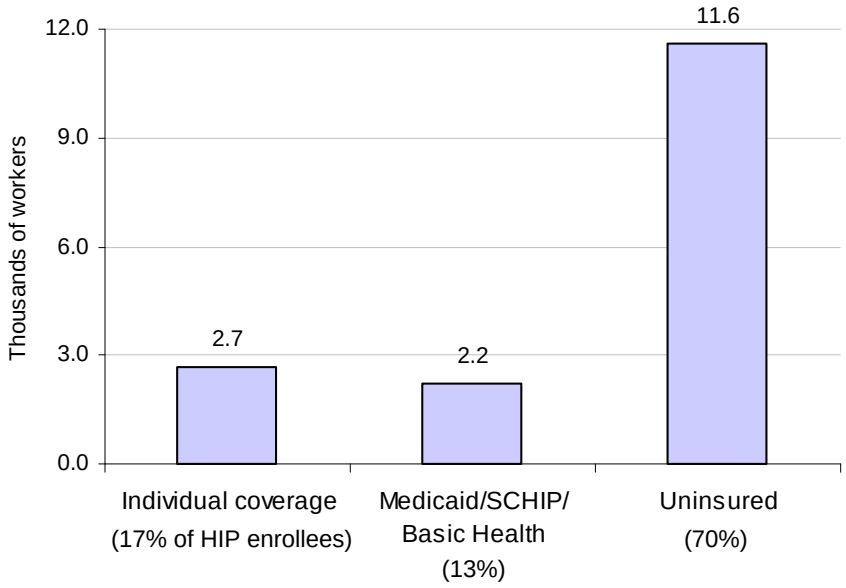
Source: Mathematica Policy Research.

More than half (57 percent) of workers expected to enroll in the HIP are single, and nearly two-thirds (63 percent) are either single or in families without children (data not shown).[6] Nearly all workers eligible for and enrolled in HIP coverage are full-time (that is, they work at least 35 hours per week).

Seventy percent of workers expected to enroll in HIP coverage—11,600 workers—were previously uninsured (Figure II.6). Of the remaining 30 percent of workers, 2,700 dropped individual coverage in order to enroll in the HIP when offered, and approximately 2,200 transitioned out of BH. Of the expected 2,300 dependents who enroll in the HIP, 69 percent (1,600) were previously uninsured; all other dependents had individual coverage before becoming enrolled in the HIP.[7]

FIGURE II.6

ESTIMATED NUMBER AND PERCENT OF WORKERS ENROLLED IN HIP BY PRIOR COVERAGE STATUS, FY2010



Source: Mathematica Policy Research.

Note: Percentages are the percent of all HIP-enrolled workers in each prior source of coverage or uninsured.

[6] For this analysis, families are defined as "insurance families"—that is, including only spouses and children who would be eligible for health insurance as a dependent. Other related or unrelated individuals in the household are considered separate insurance families. Dependent children under age 25 (and eligible for group coverage as a dependent) are identified only if they are living with a parent.

[7] While individuals enrolled in Medicaid and SCHIP were assumed to retain that coverage, individuals who were eligible for Medicaid/SCHIP in the base case but *not* enrolled were tested for take-up of any HIP plan offered to them.

2. Employer Choice of Plan

In the HIP as in the current small group market and association plans, the employer chooses which plan to offer and, therefore, which plan employees may take up. The HIP offers twelve plans in four tiers of coverage, differentiated by the level of cost sharing in the plan (Table II.5). Tier 1 includes three "comprehensive" plans, which have the least cost sharing; these plans are intended to require less cost sharing than is common among small-employer group plans in the current market.

TABLE II.5

SELECTED COST SHARING FEATURES OF HIP PLANS, BY PLAN TIER

	Deductible	Coinsurance Rate	Copayment	Out-of-Pocket Limit	Cost Sharing for Prescription Drugs[a]
Tier 1					
Group Health Welcome 200	$200	20%	$20	$2,500	$10/$30
Regence Innova 80/60/60	$250	20%	$20	$3,250	$10/35%/50%
Group Health Balance 500	$500	20%	$30	$3,000	$10/$30
Tier 2					
Premera Your Balance	$1,000	20%	$25	$4,000	$10/50%
Group Health Balance 1000	$1,000	20%	$30	$5,000	$10/$30
Regence Innova 80/60/60	$500	20%	$30	$3,500	$10/35%/50%
Tier 3					
Regence Regence HSA Healthplan	$2,500	20%	$0	$5,000	20%
Premera Your Future	$2,500	20%	$0	$5,000	20%
Group Health HealthPays 2500	$2,500	20%	$0	$5,100	$10/$30
Tier 4					
Regence Innova 80/60/60	$2,000	20%	$30	$6,000	$10/35%/50%
Premera Your Value	$3,500	20%	$0	$8,500	$10/50%
Regence Engage 80/80/80	$5,000	20%	$0	$8,000	$10/35%/50%

Source: Health Insurance Partnership Board.

[a] Dollar values represent copayments on respective tiers of the plan formulary; percentages are coinsurance rates on the respective tier of the formulary. Tiers are ordered from generic or preferred, to least-preferred.

Tiers 2 through 4 require higher cost sharing and also correspond to a higher subsidy rate in each category of qualifying income below 200 percent FPL (Table II.6). Tier 3 plans qualify under federal rules for tax-exempt contributions to a health savings account (HSA). However, Tier 4 plans require cost sharing that exceeds federal rules for tax qualification, so do not qualify for tax-exempt contributions to an HSA.

TABLE II.6

HIP ENROLLEE SUBSIDY SCHEDULE

Family Income	Percent of Premium Covered by the Subsidy Net of Employer Contributions	
	Comprehensive Plans (Tier 1)	Non-Comprehensive Plans (Tiers 2-4)
0-100 percent FPL	68%	90%
101-150 percent FPL	60%	80%
151-175 percent FPL	53%	70%
176-200 percent FPL	45%	60%
201 percent FPL or more	0%	0%

Source: Health Insurance Partnership Board.

Based on estimates from national survey data, if HIP-eligible employers establish HSAs, we assume they do not fund them.[8] Instead, we assume that all workers enrolled in the HIP have access to a Section 125 plan, so that worker contributions to coverage are exempt from federal income tax as well as FICA, regardless of which HIP plan the employer selects.

Consistent with at least 75 percent of eligible workers in the firm taking up coverage when offered, we estimate that most employees in HIP-eligible firms would be offered only the highest cost-sharing plans: 58 percent of all workers in the HIP enroll in a Tier 4 plan (Figure II.7).[9] These plans require the highest deductibles and annual out-of-pocket maximums, but have the lowest premiums. Along with Tier 2 and 3 plans, Tier 4 plans receive the highest premium assistance as a percent of premiums.

3. Financing HIP Coverage

Reflecting the high rate of enrollment in the lowest-premium (Tier 4) plans, average premiums in the HIP are estimated at $169 per enrollee per month (including both workers and dependents) in FY2010, totaling $3.19 million per month (Table II.7). While employers could contribute more than the minimum (40 percent of the premium for single coverage), we estimate that few are willing to do so. In addition, because employers are not required to contribute to

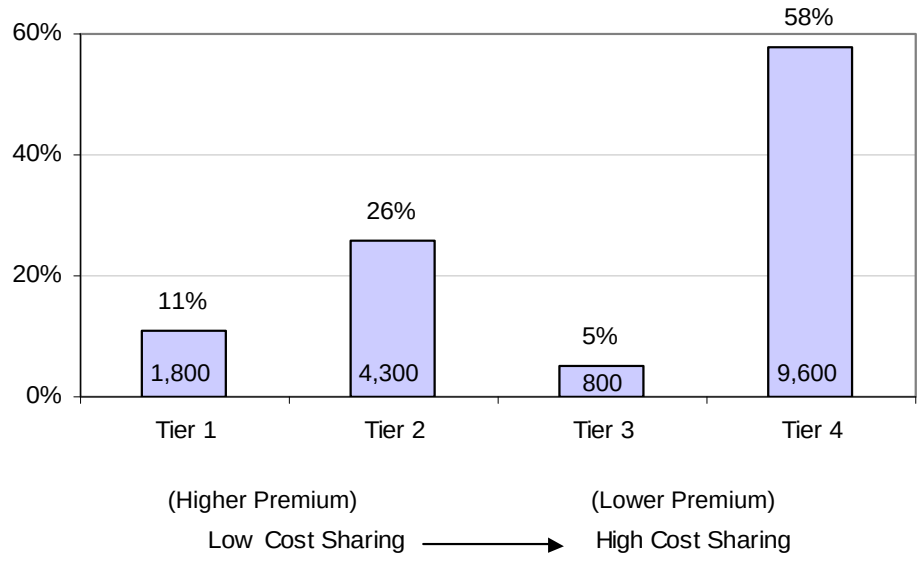
[8] Section 306 of the Tax Relief and Health Care Act of 2006 (Public Law No: 109-432) allowed employers to make larger contributions to HSAs for employees who are not highly compensated, without triggering penalties for discriminatory compensation (http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_public_laws&docid=f:publ432.109.pdf, accessed 9/8/2008). However, there is no evidence that employers have substantially used this provision. Nationally, fewer than 5 percent of ESI-covered workers (highly compensated or otherwise) in firms with 2 to 50 employees were enrolled in HSA-qualified plans in 2007. Of these, about 55 percent received an employer contribution to an HSA; only half of these workers (28 percent of workers enrolled in an HSA-qualified plan) had an employer contribution of $1,000 or more. Source: The Henry J. Kaiser Family Foundation, Employer Health Benefits 2007 Annual Survey (http://www.kff.org/insurance/7672/upload/ 76723.pdf, accessed 9/9/08).

[9] The microsimulation model developed for this report allows the employer to offer any of the HIP plans, and to settle on the plan with the highest premium (and lowest cost sharing) he or she is willing to offer.

dependents coverage, few employees enroll dependents, which would in effect reduce employer contributions as a share of total (employee plus dependent) premiums. Consequently, employer contributions are estimated to account for 40 percent of aggregate premiums (Figure II.8), totaling an estimated $1.27 million per month.

FIGURE II.7

ESTIMATED NUMBER AND PERCENT OF HIP-ENROLLED WORKERS
BY PLAN TIER, FY2010



Source: Mathematica Policy Research.

Of the 16,500 workers expected to take HIP coverage, 80 percent are in families with income below 200 percent FPL and are subsidized. Of these, nearly half (8,100 workers) have family income below 100 percent FPL and qualify for the highest rate of subsidy (Table II.4). State subsidies to low-income workers and dependents are expected to total $1.1 million per month, equal to $76 per subsidized enrollee. Most of the state's subsidy dollars (62 percent) accrue to the lowest-income enrollees, with family income below 100 percent FPL. Consistent with most HIP enrollees (70 percent) having been uninsured, as well as the lower average income among uninsured workers, an estimated 84 percent of subsidy dollars accrue to HIP enrollees who had been uninsured (data not shown).

While enrollees with income exceeding 200 percent FPL are ineligible for a state subsidy, due to their higher marginal income tax rates they receive the greatest federal tax subsidy associated with use of a Section 125 plan. Assuming all employers that offer coverage in the HIP also sponsor a Section 125 plan to shelter employee contributions to coverage, all workers enrolled in the HIP are expected to obtain federal tax relief equal to $11 per worker per month. HIP-enrolled workers with family income above 200 percent FPL obtain nearly four times that amount: $41 per worker per month.

TABLE II.7

MONTHLY PREMIUMS AND SUBSIDIES FOR HIP ENROLLEES, FY2010 ESTIMATES

	Full Premium	Employer Contribution	State Subsidy	Federal Tax Subsidy	Net Premium
Total (in millions)					
All enrollees	$3.2	$1.3	$1.1	$0.2	$0.6
0-100 percent FPL	$1.4	$0.6	$0.7	--	$0.1
101-200 percent FPL	$1.0	$0.4	$0.4	--	$0.1
Over 200 percent FPL	$0.8	$0.3	$0.0	$0.1	$0.4
Average per enrolled worker(in dollars)					
All workers	$193	$77	$85[a]	$11	$37
0-100 percent FPL	$174	$74	$87	$2	$12
101-200 percent FPL	$187	$78	$83	$6	$20
Over 200 percent FPL	$247	$82	$0	$41	$124
Average per enrolled person (in dollars)					
All enrollees	$169	$67	$76[a]	$10	$32
0-100 percent FPL	$149	$63	$74	$2	$11
101-200 percent FPL	$183	$77	$81	$6	$19
Over 200 percent FPL	$198	$65	$0	$33	$99

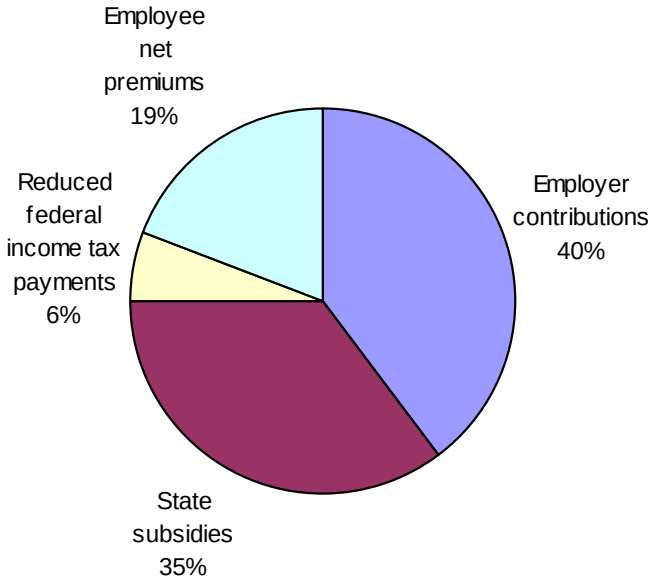
Source: Mathematica Policy Research.

Note: Dashes indicate positive values less than $50,000.

[a] Calculated as the average per subsidized enrollee.

FIGURE II.8

ESTIMATED AGGREGATE HIP PREMIUMS BY SOURCE OF FUNDS, FY2010



Source: Mathematica Policy Research.

Net of subsidies and federal tax relief, employee contributions to premiums average $37 per worker per month, equal to 19 percent of the total HIP premiums. For subsidized workers, net premium payments are much lower—averaging $12 per month for workers with family income at or below 100 percent FPL, and $20 per month for workers with family income from 101 percent to 200 percent FPL. Enrolled workers who are ineligible for a state subsidy (those with family income above 200 percent FPL) pay an estimated $124 per month.

The higher average premiums estimated for higher-income workers reflect a much higher likelihood that they bring dependents into the plan—not enrollment in plans with lower cost sharing. While one dependent is enrolled for every nine workers with family income below 200 percent FPL, at higher incomes one dependent is enrolled for every 4 workers. As a result, full premiums for workers with family income below 100 percent FPL and 200 percent FPL respectively are an estimated $174 and $187 in FY2010, while the full premium for higher-income workers is expected to average $247 per month.

D. CONCLUDING COMMENTS

The HIP is designed to reach a very narrow segment of workers in Washington State and demonstrates the difficulty of targeting coverage through a subset of employers. While most uninsured workers in Washington are employed in small firms, about a third are employed in larger firms.

Employers that currently offer coverage may be very price-sensitive when selecting a particular plan or carrier. However, small employers are not especially price sensitive when deciding *whether* to offer coverage at all. As a result, the greatest barrier to the success of the HIP as a strategy for covering uninsured workers and their families is likely to be employers' continued reluctance to offer coverage. Moreover, when employers are induced to offer coverage in the HIP, they are likely to offer HIP plans with the lowest premiums (with the highest cost sharing), resulting in most workers enrolling in these plans.

Worker take-up in the HIP, when offered, is likely to be very high—largely because so many workers in HIP-eligible firms are eligible for a subsidy. Most workers and dependents expected to enroll in the HIP are uninsured. Thus, HIP subsidies are unlikely to "crowd out" significant private spending for health insurance.

The estimated average state cost of HIP subsidies, $76 per subsidized enrollee, is much lower than the average subsidy of $208 per BH enrollee. This relatively low cost reflects employer contributions to coverage, which reduce the net premium basis for the subsidy calculation. It also reflects much less coverage and therefore lower average cost for the HIP plans that employers offer—in Tiers 3 and 4. Finally, it reflects the demographics of estimated maximum enrollment in the HIP, not necessarily the demographics of actual enrollment in the HIP's first full year of implementation, when many fewer eligible workers are likely to enroll.

Finally, the HIP's impact on the uninsured population is likely to be very small. We estimate that the HIP will reduce Washington's 576,400 uninsured residents in FY2010 by 13,200 persons. Consequently, most residents who are currently uninsured are likely to remain uninsured without broader targeting to a larger segment of workers.

III. PREMIUMS AND ENROLLMENT IN THE PRELIMINARY EXPANDED HEALTH INSURANCE PARTNERSHIP

This chapter provides estimates of potential enrollment in a more broadly targeted program—a "preliminary expanded" HIP, or PHIP. As envisioned, the PHIP would merge the current small group and individual health insurance markets in Washington State. Small groups that are enrolled in association plans could move into PHIP coverage, or not.

While the PHIP would obviously be a much larger entity than the HIP, its essential role would be similar. By assumption, all plan designs now sold in the small group and individual markets also would be available in the PHIP, including the 12 plans that the HIP offers. Like the HIP, the PHIP would not negotiate health insurance premiums with participating carriers, nor otherwise restrict available products and rates. It would administer a premium assistance program for enrollees with family income at or below 200 percent FPL using the current HIP subsidy schedule; premium assistance would be available to group and individual enrollees alike.

Two features of the PHIP are especially important in driving changes in coverage. First, the PHIP would merge the small group and individual markets, so that carriers would base their rates on blended risk. State insurance regulations governing small group coverage would not change, but in the PHIP small group rating rules would apply to group and individual coverage alike. The blended population would be rated in the same age bands, with the highest premium no more than 3.75 times the lowest premium for the same product. Carriers would continue to refer as many as 8 percent of individual applicants to WSHIP, as they do now.

Second, the PHIP would allow for unrestricted employee choice of plans, compared with employer choice in the current market and the HIP. Employee choice is likely to entail a number of changes in employer plan design and carriers' billing practices. We assume that these changes ultimately would result in workers paying age-adjusted contributions to premiums—whereas coworkers now typically contribute the same amount, regardless of age. Taken together, these features of the PHIP drive changes not only in the number of insured lives, but also in the composition of the insured and uninsured populations.

Key findings with respect to PHIP enrollment are as follow:

- Under the PHIP, the number of uninsured as a percent of the population under age 65 would decline by nearly 40 percent—from 10 percent to 6 percent.
- However, the premium changes that would occur under the PHIP for both the group-covered workers and dependents and those with individual coverage are very disruptive. Many people would lose coverage under the PHIP, offsetting a substantial amount of the gains in coverage that would occur.

- Compared to those who are insured in either small group or individual coverage in the base case, those who are insured in the PHIP would be younger, in generally poorer health, and lower-income.

- Conversely, while there would be many fewer uninsured, the characteristics of the uninsured population would be different. Adults age 45 or older would account for a larger proportion of the uninsured, as would people who report excellent or very good health status. Very few people who qualify for premium assistance in the PHIP would be uninsured. Consequently, most of the uninsured would have income above 200 percent FPL.

- Given plan choice, most workers and individuals at incomes above subsidy level would retain current coverage or newly accept a current offer of coverage that is comprehensive. When workers who are not subsidy-eligible choose a standard HIP plan, they are more likely to choose the lowest cost sharing (highest premium) standard plan. Those that enroll in higher cost sharing (lower premium) plans are more likely to enroll dependents.

- Subsidy-eligible PHIP enrollees are most likely to accept greater cost sharing (in Tier 2) in response to greater premium assistance for that coverage.

- The PHIP could have a significant impact on association coverage, but only if association-insured employers saw an opportunity to restructure compensation—reducing their contributions to coverage and potentially increasing worker contributions in exchange for worker choice among benefit plans and carriers in the PHIP. If association-insured employers and their workers were unwilling to make this trade, there would likely be little impact on association plans.

In the following sections we first describe the major assumptions about rating in the PHIP that drive our estimates of enrollment. We then report estimated changes in coverage due to the PHIP—the net change in people with coverage from various sources, as well as the number of people who would gain or lose coverage under the PHIP. We compare the characteristics of PHIP enrollees—by age, self-reported health status, and family income—to those who are currently insured in small group or individual coverage in the separate markets, and then consider the changed characteristics of those who are uninsured.

Finally, we report the types of plans that workers and dependents, and other individuals are likely to choose in the PHIP, and then turn briefly to the impact on association plans.

A. PREMIUMS IN PHIP

As described above, the PHIP envisions two changes that have important implications for both small group and individual premiums compared with the current market. First, the PHIP would merge the small group and individual markets. Second, the PHIP would offer workers in small groups unrestricted choice among all plans offered in the PHIP. Each of these changes and

their expected effects on premiums and employee contributions to coverage, respectively, are discussed below.

1. Impact of Blending the Small Group and Individual Markets

In principle, merging the small group and individual markets in Washington could improve portability between group and individual coverage and reduce job lock—that is, remaining in a job only to maintain access to health coverage. When moving from small group to individual coverage, workers would lose their employer contribution, but otherwise they could purchase the same products at the same prices. However, in Washington, it is unlikely that these markets can be merged easily and with the same results as in some other states.[10]

In Washington, both small groups and individuals are adjusted-community rated: carriers rate coverage based on age, but not on health status or other factors. Carriers may vary rates by age within a rate band of 3.75:1. That is, the rate charged to the oldest group or individual cannot be greater than 3.75 times the rate charged to the youngest group or individual for the same product.

However, individuals and small groups are rated in separate risk pools, each with a very different selection of risk. At least two aspects of insurance regulation in Washington drive differences in risk selection between the small group and individual markets:

- Small group coverage is guaranteed issue: neither whole groups nor workers within groups can be denied coverage. In contrast, carriers in the individual market can deny coverage, referring as many as 8 percent of applicants to WSHIP based on health status, using a Standard Health Questionnaire.[11]
- Small group rating rules do not apply to small groups purchasing coverage through association plans. Instead, insurers may set premiums for small employers in

[10] For example, Washington's situation is much different than that in Massachusetts, which merged its small group and individual markets in 2007. In Massachusetts, the individual market was very small relative to the small group market and on average contained much higher risk. The largest carrier—Blue Cross and Blue Shield of Massachusetts—was the carrier of last resort. Massachusetts had very similar rating rules for small groups and individuals before the markets were combined, and coverage marketed to small groups through associations is regulated in the same way as all other small group coverage. Related to these circumstances, merging the markets in Massachusetts substantially reduced premiums for individuals and increased average premiums for small groups very little. See: Amy Lischko (January 2007), Merging the Massachusetts Small Group and Individual Health Insurance Markets. Presentation to the Robert Wood Johnson Foundation State Coverage Initiatives National Workshop (http://www.statecoverage.net/ 0107/lischko.ppt, accessed 9/13/08).

[11] Elizabeth Leif and John Gabriel (December 1, 2007), Washington State Health Insurance Pool: A Study of Eligibility Standards for Pool Coverage (http://www.wship.org/docs/wship%20eligibility%20study%20120107.pdf, accessed 9/13/08).

association plans with few restrictions.[12] Small employers within an association can be (and sometimes are) rated separately based on the health and risk status. For association members, carriers may determine first-issue premiums and adjustments at renewal using pure experience rating. In Washington, enrollment in association plans has grown significantly; it is not known whether (or how many) association plan enrollees were previously insured in the small group market.

These differences in regulation of coverage for individuals, small groups, and associations in Washington suggest a number of possible results that are important to understanding the changes that the PHIP would entail. First, to the extent that there is favorable selection of small groups into association plans, small group rates may be higher than if association plans followed the same rating rules as apply in the small group market. Following conversations about the rate differences in Washington, we assume that premiums for association coverage, all else equal, are 10 percent lower for association coverage than for small group coverage—equivalent to average premiums for small group coverage that are 11 percent higher than the same plans sold through associations.

Second, the average health status of people enrolled in the individual market may be better than in the small group market because carriers can refer the most costly 8 percent of individual applicants to WSHIP (while small group coverage is guaranteed issue). We assume that carriers have screened out the highest 5 percent of medical risk from the individual market at any point in time. This assumption recognizes that carriers must guarantee renewal regardless of health status, so that over time there is some erosion of initial underwriting (when carriers can deny 8 percent of applicants for health status). To the extent that this estimate is conservative (that is, if more than 5 percent of risk is screened out at any point in time), our calculation of rate changes for individuals in the PHIP is lower than would actually occur.

In light of these characteristics of Washington's market, we estimated the average change in premiums that currently insured small group workers and individuals would encounter when these markets are merged in the PHIP. As described in Chapter II, our estimates use national data on the distribution of insured expenditures for privately insured lives.[13] They incorporate a number of additional assumptions about the medical loss ratio that would prevail in the PHIP and

[12] Rev. Code Wash. § 48.44.024(2), states "Employers purchasing health plans provided through associations or through member-governed groups formed specifically for the purpose of purchasing health care are not small employers and the plans are not subject to RCW 48.44.023(3)." This has been interpreted by state court to exempt association coverage from small group market rating rules (Associated Industries of the Inland Northwest; The Association of Washington Businesses vs. State of Washington Office Of Insurance Commissioner; Mike Kreidler, Superior Court of Washington For Spokane County, August 2007).

[13] William W. Yu and Trena M. Ezzati-Rice (May 2005), Concentration of Health Care Expenditures in the U.S. Civilian Noninstitutionalized Population. MEPS Statistical Brief #81. Agency for Healthcare Research and Quality (AHRQ) (http://www.meps.ahrq.gov/mepsweb/data_files/publications/st81/stat81.pdf, accessed 9/13/08).

carriers' expectations about the relative number of group, individual, and association lives that would enroll in the PHIP.[14]

In Washington, blending the small group and individual markets would substantially increase premiums for individuals (for their current insurance products) and reduce premiums for small groups. Our estimates of PHIP enrollment assume the following effects on premiums associated with merging the small group and individual markets:

- Small group premiums in the PHIP would drop 13 percent for the same coverage.
- Individual premiums in the PHIP would increase 37 percent for the same coverage.
- On average, premiums for small groups insured in association plans would increase 6 percent in the PHIP.[15]

2. Impact of Employee Choice

The HIP Board was instructed to consider unrestricted employee choice among plans in the PHIP. Unrestricted employee choice of plans in the PHIP would likely force a number of changes in how small employers administer group coverage and how carriers bill small groups. As a result, it would likely force significant change in the amounts that employees would pay for group coverage.

If employers continued to calculate contributions as a percentage of the premium—but for any plans their employees might choose—it would be very difficult for employers to anticipate the cost of offering group coverage. Therefore, it seems likely that many employers would convert to a defined contribution benefit: that is, they would select a benchmark plan and calculate their contribution against that plan. As in the HIP, the minimum employer contribution in the PHIP is assumed to be 40 percent of individual coverage, with no contribution to dependents (although, at least in the short run, most employers are likely to contribute much more toward their benchmark plan, as they do now).

Employees then would choose any available PHIP plan (including but not restricted to the benchmark plan) and pay the difference between the amount their employer contributes and the cost of the plan they select. We assume that all small employers who participate in the PHIP would follow this path: that is, all would convert to a defined contribution plan, with the employer contribution set at the current level per covered worker.

[14] Specifically, we assume that: (1) all PHIP business reflects the weighted average medical loss ratio for small group business that carriers in Washington reported from 2003 to 2007 (79 percent); (2) carriers price PHIP coverage assuming the same ratio of small group to individual lives as are currently insured in these markets (approximately 2.2 to 1); and (3) carriers assume that as many as half of the small groups that are now insured through associations would enter the PHIP.

[15] The derivation of these specific assumptions is described in Appendix A.

In addition, unrestricted employee choice would force change for carriers. Currently in Washington, small groups are rated on a "composite" basis—that is employers are quoted a composite (average, per member) rate for each available plan, calculated as if all eligible employees would enroll in each plan. Each employee's contribution is calculated against this composite rate for the plan that his or her employer selects.

The Board considered alternative ways that rating in the PHIP might occur, including:

- Composite rating, which would entail small group enrollees and individuals paying different premiums for the same coverage, as they do now. Small group enrollees would pay an average of the premiums their coworkers would pay, if they all enrolled in the same plan. However, with individual choice it is unlikely that all workers in a firm will enroll in the same plan, so that composite premiums would rarely if ever reflect actual enrollment in a specific plan and a system of risk adjustment and reinsurance would be necessary to stabilize the market.
- List rating, which would entail small group enrollees and individuals paying the same premiums for coverage net of employer contributions to coverage. However, when moving from composite rating to list rating, workers with small group coverage could see significant change in their contributions to premiums, reflecting each worker's own age relative to the average age of their small group.

For the purposes of this study, the Board instructed Mathematica to model list rating for several reasons: (1) it is consistent with individual choice, and connects the enrollee's choice of plan with the cost of that choice; (2) it would support meaningful choice without also requiring an extensive system of risk adjustment and reinsurance; (3) it is consistent with a merged market; and (4) understanding the impacts of list rating in the Expanded HIP would likely be more informative to policy makers, in that list rating would likely cause greater change in coverage among most workers, who are unsubsidized.

Thus, for each available PHIP plan, we assume that employees would see a list of rates for each plan that would vary by the age of the employee. Each employee would then calculate his contribution to the plan he selects as his age-specific list rate minus his employer's defined contribution.

The combination of list rating and defined employer contributions means that employee contributions to coverage would reflect the same age adjustments as individual rates, and would be lower only by the amount of the employer contribution. Thus, except for the effect of the merged market which would reduce small group premiums overall, older employees likely would see an increase in their contributions for their current coverage, while younger enrollees likely would see a decrease.

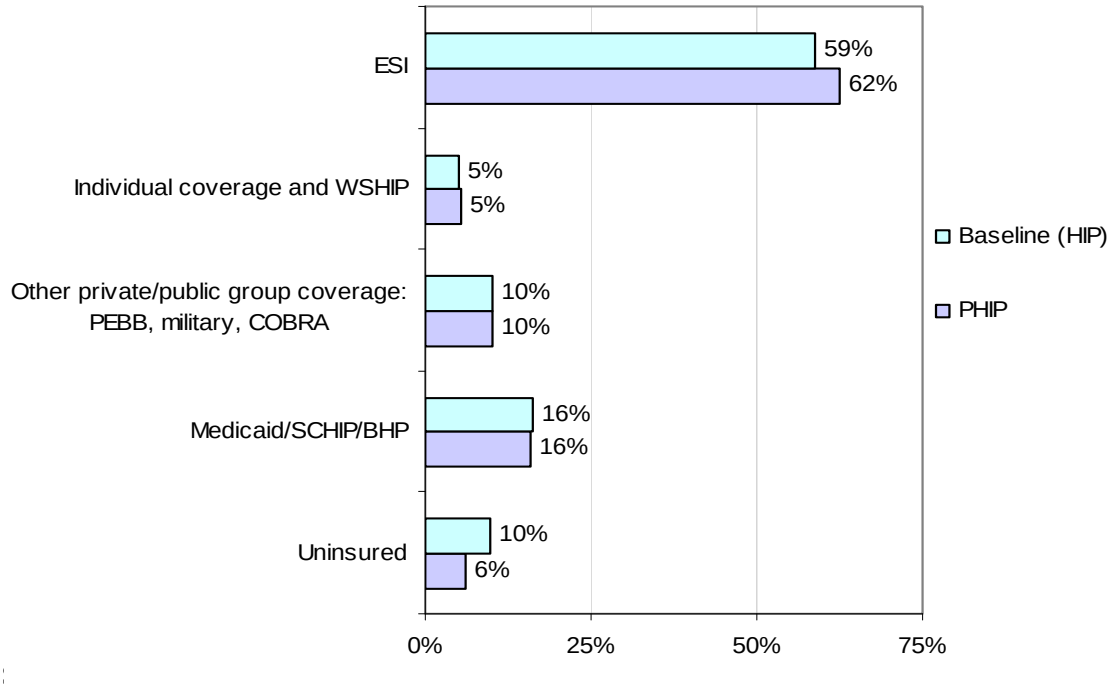
B. CHANGES IN COVERAGE

The PHIP could be quite successful in reducing the expected number of uninsured in Washington. By combining reduced premiums for younger workers, employee choice, and premium assistance to low-income families for group and individual coverage alike, we estimate that the PHIP would reduce the rate of uninsured by nearly 40 percent—from 10 percent at present, to 6 percent (Figure III.1).

A net increase in small group coverage accounts for most of the decrease in the rate of uninsured: as more workers and dependents enroll in group coverage, the proportion of the population under age 65 insured through small groups would increase approximately 3 percentage points, from 59 percent to 62 percent. All of this increase reflects net growth in non-association small group coverage in the PHIP. BH enrollment would decline slightly as low-income workers received premium assistance and accepted small group coverage when offered. Net enrollment in individual coverage also increases slightly, despite the higher average premiums due to pooling small group and individual risks, and only in response to premium assistance.

FIGURE III.1

ESTIMATED PERCENT OF PEOPLE UNDER AGE 65 WITH COVERAGE
FROM SELECTED SOURCES UNDER PHIP, FY2010

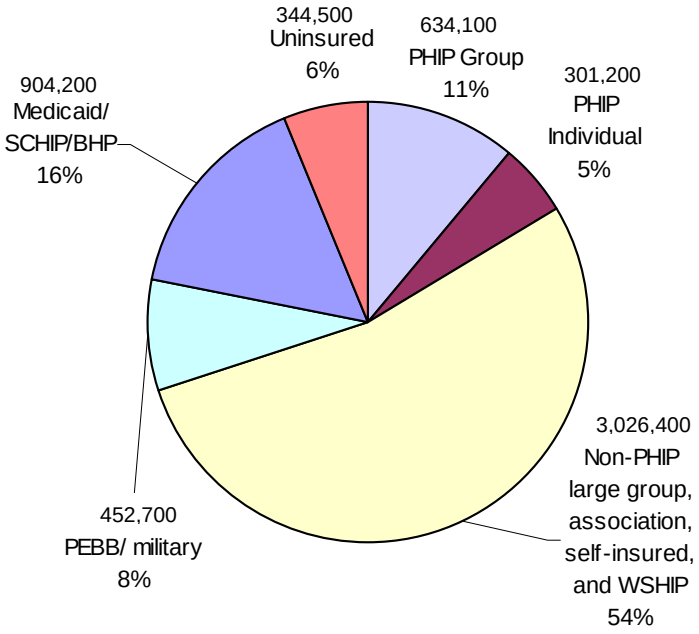


The PHIP, of course, would account for a much larger proportion of coverage in Washington than is expected for the HIP. Nearly 17 percent of the population under age 65 enrolls in the PHIP, including group and individual coverage (Figure III.2).

The net gains in small group and individual coverage likely to occur under the PHIP reflect extensive and countervailing changes in coverage. That is, while many people gain coverage who before were uninsured, substantial changes also occur for the insured population. Some change their source of coverage, and others drop coverage.

FIGURE III.2

ESTIMATED NUMBER AND PERCENT OF PEOPLE UNDER AGE 65 WITH COVERAGE IN PHIP, OTHER SOURCES OF COVERAGE, OR UNINSURED, FY2010



Source: Mathematica Policy Research.

Note: Due to rounding, presentation in the text may differ slightly from the sum of percentages shown in the figure.

With the introduction of the PHIP, nearly half a million people (467,800)—about 8 percent of the population—either gain new coverage in the PHIP or change within the PHIP from individual to small group coverage (Table III.1). However, a significant number of workers and individuals would drop small group or individual coverage altogether, responding to age-adjusted list rating for small group coverage and the higher cost of individual coverage when the small group and individual markets are merged. All of those who drop small group ESI (56,300 people) become newly uninsured.

TABLE III.1

ESTIMATED GROSS CHANGES IN COVERAGE UNDER PHIP, FY2010

	Number (000s)	Percent
Total Population	**5,663.0**	**100.0%**
New Coverage		
Total	467.8	8.3%
New small group ESI (PHIP)	237.7	4.2%
New individual (PHIP)	230.1	4.1%
Retained Current Source of Coverage		
Total	4,850.7	85.7%
Insured small groups (PHIP)	240.8	4.3%
Association small groups in PHIP	155.6	2.7%
Individual (PHIP)	71.2	1.3%
Other ESI, PEBB, military, unemployed	3,475.5	61.4%
COBRA		
WSHIP	3.4	0.1%
Medicaid/SCHIP/BHP	904.2	16.0%
Dropped Current Source of Coverage		
Total	281.1	5.0%
Small group ESI	56.3	1.0%
Individual or WSHIP	210.5	3.7%
BHP	15.0	0.3%
Uninsured		
Total	344.5	6.1%
New uninsured	184.2	3.3%
Continued uninsured	160.2	2.8%

Source: Mathematica Policy Research.

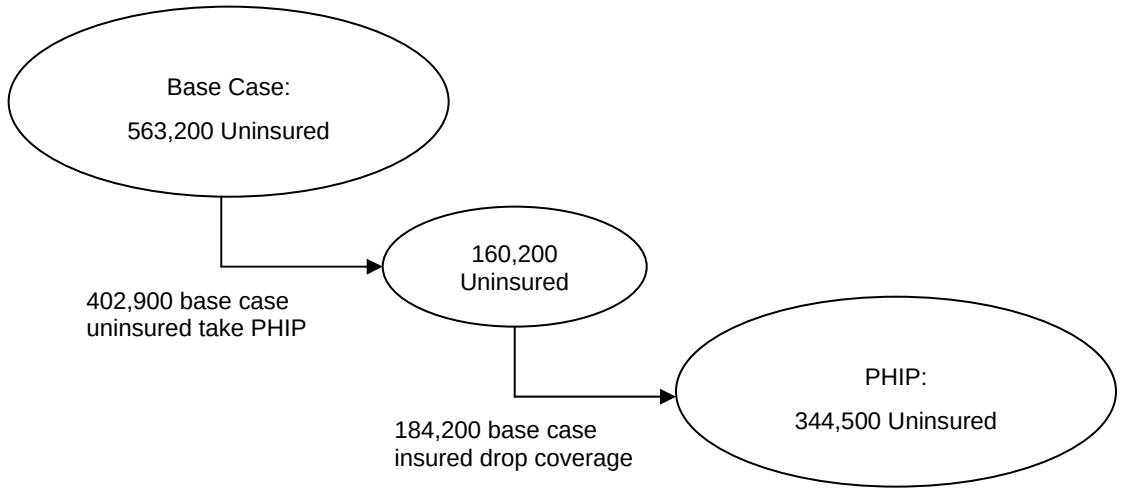
Note: Detail does not add to the total population due to double-counting of people who drop coverage and take new coverage.

In contrast, more than half (61 percent) of the 210,500 people who drop individual coverage do so to take up ESI—either small group coverage that is newly offered in the PHIP or an existing offer that becomes affordable with premium assistance (data not shown). But more than a third (39 percent) become uninsured.

In total, an estimated 184,200 people who had small group or individual coverage in the base case drop coverage and become uninsured. These people account for about half of the uninsured population under the PHIP. Only 160,200 people (3 percent of the population) who are uninsured in the base case continue to be uninsured after the PHIP is introduced (Figure III.3).

FIGURE III.3

ESTIMATED CHANGES IN THE NUMBER OF UNINSURED PEOPLE UNDER PHIP, FY2010



Source: Mathematica Policy Research. Details may not add to totals due to rounding.

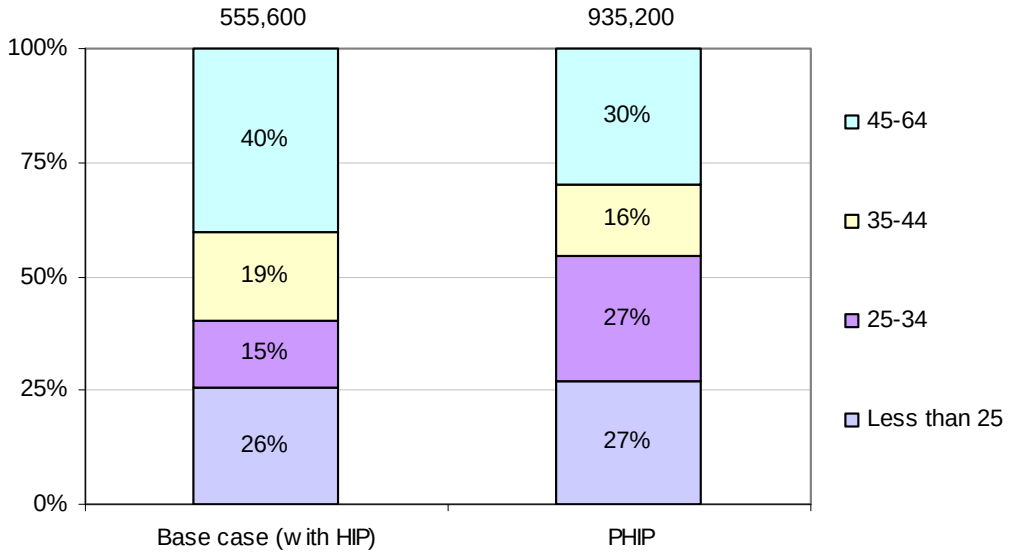
C. THE COMBINED SMALL GROUP AND INDIVIDUAL MARKETS IN PHIP

The premium changes that would occur under the PHIP drive changes not only in the number of people with small group or individual coverage, but also in the types of people with coverage. In this section, we examine the composition of covered lives in the PHIP compared with the separate markets in the baseline. This discussion excludes small-firm workers and dependents who remain in association coverage.

Those who newly enroll in small group or individual coverage in the PHIP are likely to be quite young, significantly changing the age composition of the combined markets. More than half of the people enrolled in the PHIP (54 percent) would be under age 35, compared with 40 percent in the separate small group and individual markets (Figure III.4). Enrollees age 25 to 34 would grow the fastest. Conversely, 30 percent of PHIP enrollees would be age 45 or older, compared with 40 percent in the base case.

FIGURE III.4

ESTIMATED AGE DISTRIBUTION OF PEOPLE WITH SMALL GROUP OR INDIVIDUAL COVERAGE (COMBINED MARKETS): BASE CASE AND PHIP, FY2010



Source: Mathematica Policy Research.

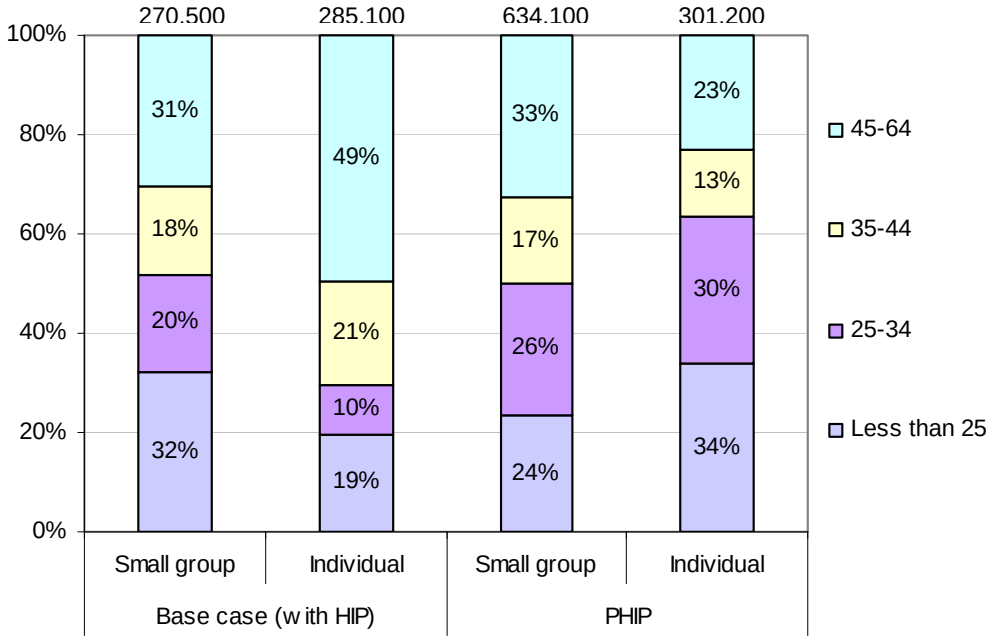
Note: Small group enrollees exclude small-firm workers with group coverage in association plans.

These estimates reflect very different changes in the age distribution of small group and individual enrollees (Figure III.5). Among small group enrollees in the PHIP (workers and dependents), about the same proportion of are under age 35 (50 percent) as in the base case (52 percent). However, a much smaller proportion of small group enrollees are under age 25 (24 percent in the PHIP versus 32 percent in the base case), reflecting net gains in enrollment among young workers without children but a net loss of coverage among dependent children. Many of these children (with family income below 300 percent FPL) would become eligible for SCHIP.

Individual coverage among young adults also would increase, despite the higher average cost of individual coverage in the PHIP at every age. Because young adults generally have lower incomes, they are more likely to qualify for premium assistance and, therefore, more likely to enroll in individual coverage when group coverage is unavailable. Nearly two-thirds of enrollees in PHIP individual coverage (64 percent) are under age 35, compared with 29 percent in the base case.

FIGURE III.5

ESTIMATED AGE DISTRIBUTION OF PEOPLE WITH SMALL GROUP OR INDIVIDUAL COVERAGE (SEPARATE MARKET DETAIL): BASE CASE AND PHIP, FY2010



Source: Mathematica Policy Research.

Note: Small group enrollees exclude small-firm workers with group coverage in association plans.

Despite the larger numbers of young people with coverage in the PHIP, the self-reported health status of small group and individual enrollees in the PHIP is generally lower than in the base case—reflecting entry by many low-income adults who before were uninsured. In the PHIP, 38 percent of enrollees report good, fair, or poor health status, compared with 26 percent across the small group and individual markets in the base case (Table III.2). As a percentage of all enrollees, more than twice as many enrollees in the PHIP report fair or poor health status (7 percent) as in small group and individual coverage in the base case (3 percent).

The greatest change in self-reported health status occurs with respect to coverage of individuals, not in small groups. Despite the fact that carriers refer 8 percent of new applicants to WSHIP based on health status, the number of new applicants is so large that a substantial number who report relatively low health status are accepted for coverage.[16] As a result, 41 percent of individual enrollees in the PHIP are expected to have good, fair, or poor health status, compared with 23 percent in the base case. Conversely, 59 percent of individual enrollees in the

[16] We assume that carriers deny 8 percent of new applicants who self-report fair or poor health status. Of course, people with individual coverage who report fair or poor health in the base case are renewed in the PHIP, regardless of their health status.

PHIP are expected to have excellent or very good health status, compared with 77 percent in the base case. Such significant changes in entering health status suggest that premiums could increase in the PHIP, despite strong entry by young adults—driving larger numbers of unsubsidized individuals from coverage and increasing small group premiums commensurately. This implication is explored further in the context of financing, in Chapter IV.

TABLE III.2

SELF-REPORTED HEALTH STATUS AMONG PEOPLE WITH SMALL GROUP OR INDIVIDUAL COVERAGE: BASE CASE AND PHIP, FY2010

	Base Case (with HIP)			PHIP		
	Total	Small Group	Individual	Total	Small Group	Individual
Number (000s):						
Total	555.6	270.5	285.1	935.2	634.1	301.2
Excellent, very good	413.4	193.7	219.7	584.4	406.5	178.0
Good	124.4	61.3	63.0	282.2	182.3	99.9
Fair, poor	17.8	15.5	2.3	68.6	45.2	23.3
Percent						
Total	100%	100%	100%	100%	100%	100%
Excellent, very good	74%	72%	77%	62%	64%	59%
Good	22%	23%	22%	30%	29%	33%
Fair, poor	3%	6%	1%	7%	7%	8%

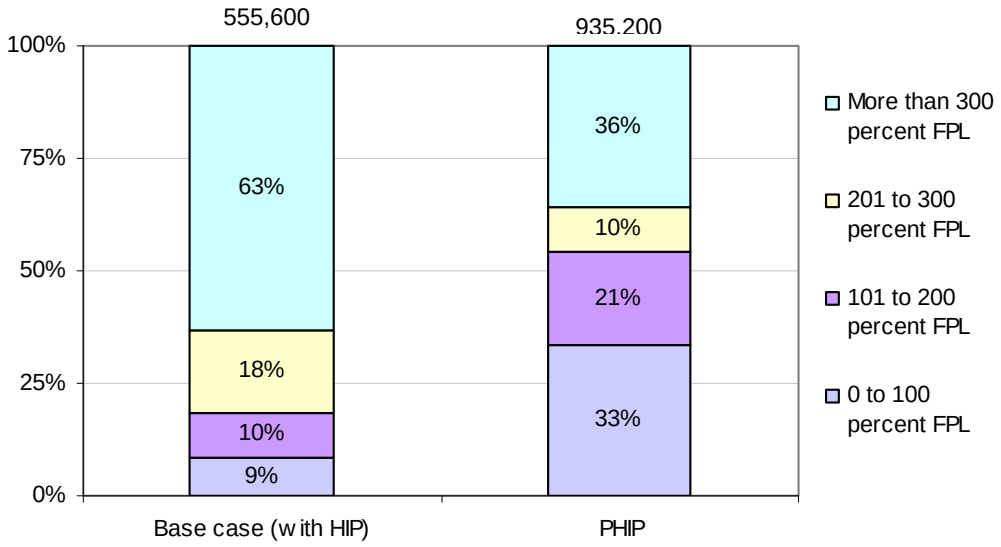
Source: Mathematica Policy Research.

Note: Small group enrollees exclude small-firm workers with group coverage in association plans. Due to rounding, presentation in the text may differ slightly from the sum of the percentages shown in the table.

Finally, reflecting generous premium assistance in the PHIP, a large number of very low-income people gain either small group or individual coverage. We estimate that more than half of PHIP enrollees (54 percent) have family income below 200 percent FPL and receive premium assistance (Figure III.6). In the base case, about 19 percent of those with small group or individual coverage have such low income. Most low-income workers and dependents covered in the base case do not receive premium assistance because their firm is ineligible for the HIP. All of those who newly take individual coverage receive premium assistance.

FIGURE III.6

ESTIMATED INCOME DISTRIBUTION OF PEOPLE WITH SMALL GROUP OR INDIVIDUAL COVERAGE (COMBINED MARKETS): BASE CASE AND PHIP, FY2010



Source: Mathematica Policy Research.

Notes: Small group enrollees exclude small-firm workers with group coverage in association plans. Due to rounding, presentation in the text may differ slightly from the sum of percentages shown in the figure.

The net changes in enrollment that drive these changes are reported in Table III.3. Note that differences in the composition of the small groups in the PHIP result from differences in various population subgroups' rates of net enrollment growth. However, changes in the composition of the population with individual coverage in the PHIP are associated with various population subgroups disenrolling from coverage, either to take small group coverage or becoming uninsured. Net disenrollment from individual coverage occurs among adults 45 and older, those in excellent or very good health status, and those ineligible for premium assistance.

D. NET CHANGE IN THE UNINSURED POPULATION

As the introduction of the PHIP drives substantial changes in size and composition of the population that is insured, there are equally substantial changes in the population that is uninsured. With the PHIP, older adults account for a much larger proportion of the uninsured population, largely due to a net reduction in the number of older adults with individual coverage in the PHIP. Under the PHIP, 30 percent of the uninsured population would be age 45 to 64, compared with 17 percent in the base case (Figure III.7).

TABLE III.3

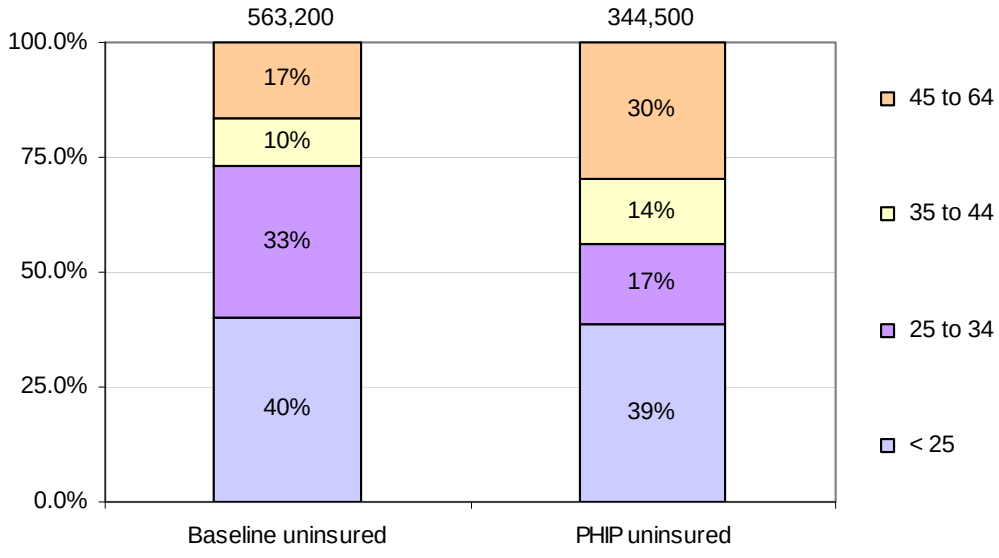
ESTIMATED NET CHANGE IN THE NUMBER OF PEOPLE ENROLLED IN SMALL GROUP AND INDIVIDUAL COVERAGE, AND PERCENT CHANGE FROM THE BASE CASE TO PHIP, FY2010

	Total		Small Group		Individual	
	Net Change in Enrolled Persons (000s)	Percent Change	Net Change in Enrolled Persons (000s)	Percent Change	Net Change in Enrolled Persons (000s)	Percent Change
Total	**379.6**	**68%**	**363.6**	**134%**	**16.1**	**5%**
Age						
Less than 25	109.3	77%	62.8	72%	46.5	84%
25-34	174.7	214%	113.3	213%	61.5	218%
35-44	41.7	39%	62.1	130%	-20.4	-34%
45-64	53.9	24%	125.3	152%	-71.4	-51%
Health Status						
Excellent, very good	171.0	41%	212.8	110%	-41.8	-19%
Good	157.9	127%	121.0	197%	36.9	59%
Fair, poor	50.7	285%	29.7	192%	21.0	901%
Family Income						
0 to 100 percent FPL	265.3	554%	100.7	328%	164.5	960%
101 to 200 percent FPL	141.1	259%	81.9	294%	59.2	223%
201 to 300 percent FPL	-10.5	-10%	24.4	36%	-34.9	-100%
More than 300 percent FPL	-16.3	-5%	156.5	109%	-172.8	-84%

Source: Mathematica Policy Research.

FIGURE III.7

ESTIMATED AGE DISTRIBUTION OF PEOPLE WHO ARE UNINSURED: BASE CASE AND PHIP, FY2010



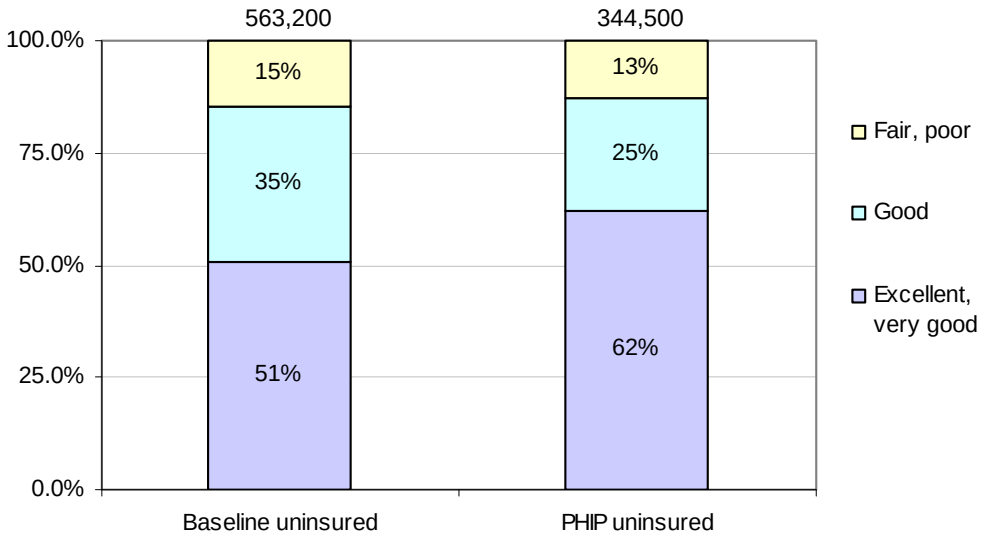
Sou

Under the PHIP, approximately the same proportion of the uninsured are under age 25 as in the base case, 39 to 40 percent. However, children under age 19 account for a much larger proportion of these uninsured residents. We estimate that nearly 36,000 more children would lose coverage under the PHIP than would gain coverage. In about one-third of these cases, one or both parents also lose coverage. In all other cases, their parents respond to an increase in premiums by either dropping dependents from either ESI or individual coverage. Some of these children, in families with income below 300 percent FPL, presumably would qualify for SCHIP.[17]

The introduction of the PHIP also produces changes in the health-status composition of the population that is uninsured. Under the PHIP, those who are uninsured are, on average, healthier than the uninsured population in the base case: approximately 62 percent of the uninsured population would report excellent or very good health, compared with 51 percent in the base case (Figure III.8). Nearly the same percentage of the uninsured report fair or poor health status under the PHIP (13 percent) as in the base case (15 percent), but the number of people in poor health who are uninsured is much lower.

FIGURE III.8

SELF-REPORTED HEALTH STATUS OF PEOPLE WHO ARE UNINSURED:
BASE CASE AND PHIP, FY2010



Source: Mathematica Policy Research.

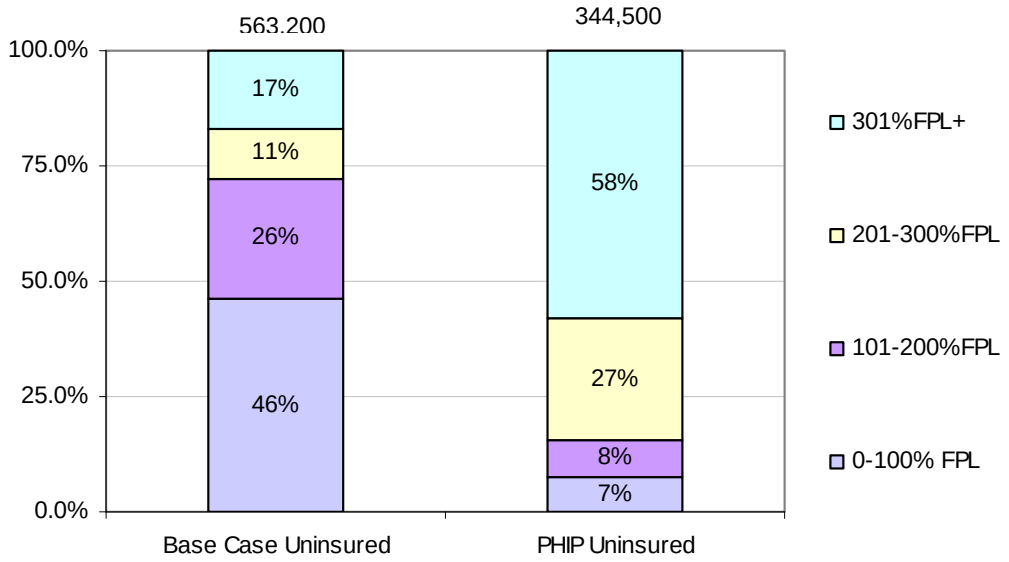
[17] Enrollment in Medicaid, SCHIP, or BH was not modeled. Similarly, we did not model enrollment in WSHIP among applicants for individual coverage who were denied coverage in the PHIP.

Finally, the PHIP offers generous premium assistance for people at or below 200 percent FPL. As a result, people with low income would account for a much lower proportion of the uninsured under the PHIP than in the base case. Whereas 72 percent of the base-case uninsured have family income at or below 200 percent FPL, 16 percent of the uninsured have such low family income under the PHIP (Figure III.9).

Much of the change in the uninsured population relates to people dropping individual coverage when they do not qualify for premium assistance. Most people who currently have individual coverage are in families with income above 300 percent FPL, and these people account for most of the loss of individual coverage. Nearly 6 in 10 people who are uninsured under the PHIP (58 percent) are in families with income above 300 percent FPL.

FIGURE III.9

ESTIMATED FAMILY INCOME AS A PERCENT OF THE FEDERAL POVERTY LEVEL AMONG PEOPLE WHO ARE UNINSURED: BASE CASE AND PHIP, FY2010



Source: Mathematica Policy Research.

Note: Due to rounding, presentation in the text may differ slightly from the sum of percentages shown in the figure.

E. CHOICE OF COVERAGE IN PHIP

Because all plans currently sold to individuals or small groups in the commercial or association markets would become available in the PHIP, people with coverage in the base case have the option of retaining their current plan in the PHIP. Alternatively, if they are disinclined to keep their current coverage, they can choose any of the plans that are offered in the HIP.

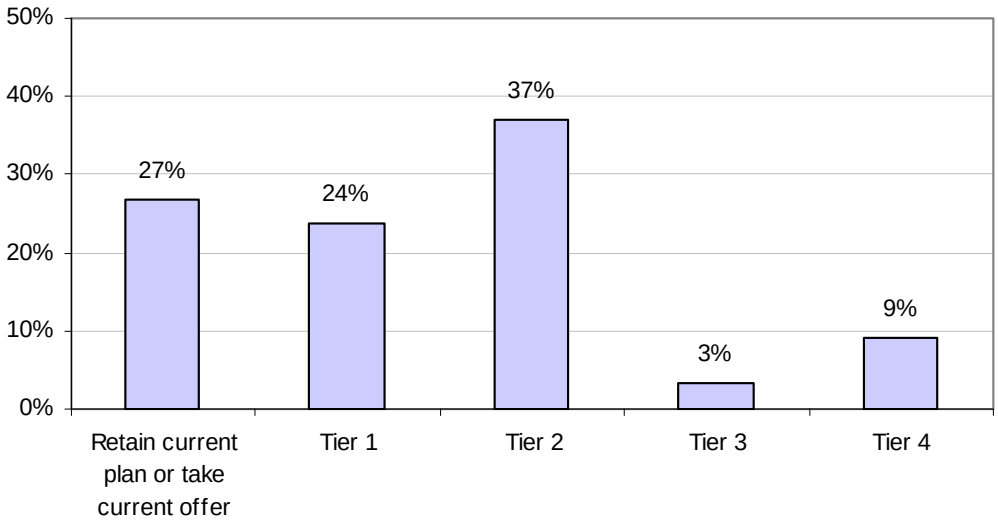
To understand how coverage might change in the PHIP, it is necessary to make a number of simplifying assumptions. Specifically, we assume that all current small group or association

coverage is deemed to be comprehensive coverage for the purpose of premium assistance—drawing a lower subsidy rate. This simplifying assumption was made in lieu of more complex assumptions about the benefit designs of current coverage among people who have small group or individual coverage in the base case. In addition, we assume that workers and individuals who are uninsured in the base case would choose only from among the standard HIP plans, as described in Chapter II. Taken together, these assumptions likely produce a maximum estimate of people who would either move to, or newly enroll in, one of the standard HIP plans in the PHIP.

With this caveat, we estimate that 73 percent of PHIP enrollees take one of the standard HIP plan designs (Figure III.10). Most of those in standard coverage enroll in a Tier 2 plan—which may be most similar to prevailing plan designs and also qualifies for greater premium assistance than either current coverage (if insured) or a Tier 1 plan. Twelve percent of PHIP enrollees take coverage in Tiers 3 or 4.

FIGURE III.10

ESTIMATED DISTRIBUTION OF PHIP ENROLLEES BY CHOICE OF PLAN, FY2010



Source: Mathematica Policy Research.

PHIP enrollees in small group coverage are most likely to either remain in their current plan (29 percent) or take Tier 1 coverage (35 percent) (Table III.4). This compares with 21 percent of individual enrollees—virtually none of whom choose coverage in Tier 1. More than two-thirds of individual enrollees (69 percent) choose Tier 2 coverage—with the highest premium assistance—compared with 22 percent of workers and dependents in small group coverage.

PHIP enrollees eligible for premium assistance—those with family income at or below 200 percent FPL—are least likely to have coverage in the base case and, therefore, most likely to choose a standard HIP plan. We estimate that 79 percent of these enrollees choose a standard HIP plan, and 53 percent choose a plan in Tier 2, corresponding to the highest level of premium

assistance (Table III.5). Note that the majority of enrollees in Tier 2 plans (271,600 people, equal to 78 percent of total enrollment in Tier 2 plans) are in low-income families receiving premium assistance.

TABLE III.4

ESTIMATED NUMBER AND PERCENT OF PHIP ENROLLEES IN SMALL GROUP AND INDIVIDUAL COVERAGE BY CHOICE OF PLAN, FY2010

	Total	Small Group	Individual
Number of Enrollees (000s)			
Total	935.2	634.1	301.2
Retain current plan or take current offer	249.2	185.7	63.5
Enroll in HIP standard plans:	686.0	448.4	237.7
Tier 1	223.2	222.9	0.3
Tier 2	347.4	138.3	209.0
Tier 3	30.8	23.9	6.9
Tier 4	84.7	63.2	21.5
Percent of Enrollees			
Total	100%	100%	100%
Retain current plan or take current offer	27%	29%	21%
Enroll in HIP standard plans:	73%	71%	79%
Tier 1	24%	35%	--
Tier 2	37%	22%	69%
Tier 3	3%	4%	2%
Tier 4	9%	10%	7%

Source: Mathematica Policy Research.

Note: Dashes indicate values less than 0.5 percent.

In contrast, PHIP enrollees at higher incomes are more likely to have coverage or an offer of coverage in the base case. As a result they are much more likely (34 percent) to retain or accept current coverage than lower-income enrollees (21 percent). When they do change coverage, they are much more likely to take coverage in Tier 1 (30 percent versus 19 percent). However, they are also more likely than lower-income people to take standard plans with very high cost sharing (14 percent versus 5 percent) and insure dependents in those plans.

Only premium assistance keeps people at lower levels of income (below 200 percent FPL) from falling disproportionately into very high cost sharing plans. Subsidy-eligible PHIP enrollees are most likely to accept somewhat greater cost sharing (in Tier 2, versus Tier 1) in response to greater premium assistance for that coverage.

TABLE III.5

ESTIMATED NUMBER AND PERCENT OF PHIP ENROLLEES BY FAMILY INCOME AS A PERCENT OF POVERTY AND CHOICE OF PLAN, FY2010

	Total	Retain Current Plan or Take Current Offer	Tier 1	Tier 2	Tier 3	Tier 4
Number (000s)						
Total Enrollees	935.2	249.2	223.2	347.4	30.8	84.7
Eligible for Premium Assistance:						
Total	508.7	104.6	96.5	271.6	11.8	24.1
0-100 percent FPL	311.7	48.4	60.8	198.1	0.1	4.3
101-200 percent FPL	197.0	56.2	35.6	73.6	11.7	19.8
Other PHIP Enrollees:						
Total	426.6	144.6	126.8	75.7	18.9	60.6
201-300 percent FPL	92.1	33.4	36.1	13.9	3.3	5.4
301 percent FPL or more	334.4	111.2	90.7	61.8	15.6	55.2
Percent of Enrollees						
Total Enrollees	100%	27%	24%	37%	3%	9%
Eligible for Premium Assistance:						
Total	100%	21%	19%	53%	2%	5%
0-100 percent FPL	100%	16%	20%	64%	0%	1%
101-200 percent FPL	100%	29%	18%	37%	6%	10%
Other PHIP Enrollees:						
Total	100%	34%	30%	18%	4%	14%
201-300 percent FPL	100%	36%	39%	15%	4%	6%
301 percent FPL or more	100%	33%	27%	18%	5%	17%

Source: Mathematica Policy Research.

F. IMPACT ON ASSOCIATION PLANS

Under the PHIP, association plans continue to compete with the small group market; the PHIP entails no regulatory change that would directly affect association coverage. However, employers that currently offer association coverage can consider the PHIP instead, and we assume that they do so.

In modeling the impact of the PHIP on association plans, we make a number of assumptions about employers that offer association coverage. Specifically, we assume that association-insured employers would consider the PHIP if they expect that they could reduce their contribution to premiums by at least 10 percent without affecting worker take up. Because PHIP coverage is on average 6 percent more costly than association coverage, in effect we are assuming that association-insured employers that move to PHIP coverage restructure compensation to their workers in exchange for giving employees choice among PHIP plans. In contrast, employers that are currently in the small group market are assumed not to restructure compensation, as they are

moved automatically into the PHIP. This divergence in assumptions about association-insured employers versus employers with small group coverage is intended to produce a maximum estimate of the PHIP's potential impact on association plans.

We estimate that as many as 145,000 workers and dependents in association coverage enroll in the PHIP, reducing the number of total enrollees in association plans (in either small or large firms) by 28 percent (Table III.6). The number of small-firm workers and dependents enrolled in association plans fall by nearly 37 percent. Conversely, if association-insured workers were unwilling to trade higher employee contributions (before subsidy) for more employee choice among benefit plans and carriers in the PHIP (the assumption that drives these impact estimates), there likely would be very little impact, if any, on association plans.

TABLE III.6

ESTIMATED NUMBER AND PERCENT CHANGE IN ASSOCIATION AND SMALL GROUP ENROLLEES: BASE CASE AND PHIP, FY2010

	Number of Enrolled Workers and Dependents (000s)		
	Base Case (with HIP)	PHIP	Percent Change
Association Plans	**514.2**	**368.8**	**-28.3%**
Small firms	396.5	251.1	-36.7%
Large firms	117.7	117.7	--
Small Group Plans	**270.5**	**634.2**	**134.4%**
Former association plan enrollees	na	144.8	na
New take up, former association plan	na	10.9	na

Source: Mathematica Policy Research.

Note: Dashes indicate values less than 0.5 percent.

Some association-insured workers and dependents who move into the PHIP would qualify for premium assistance and, as a result, we observe new take up among dependents of workers who in the base case are offered association-insured coverage but do not take it up. Nearly 10,900 dependents who are eligible for association coverage in the base case newly take up coverage in the PHIP, always choosing a lower-premium standard HIP plan in lieu of the association plan product.

The PHIP offers premium assistance to low-income people who were previously insured, as well as to those who were uninsured. As a result, the PHIP sanctions "crowd out" of enrollee contributions to coverage, substituting public expenditure. This strategy may be justified as promoting equity and greater stability and continuity of coverage for low-income residents. However, to the extent that employers also would reduce contributions to coverage for workers eligible for premium assistance, the potential for crowd out is much greater. We consider this topic further in Chapter IV.

IV. FINANCING THE PRELIMINARY EXPANDED HEALTH INSURANCE PARTNERSHIP

This chapter addresses the financing of the preliminary expanded HIP, or PHIP. Like the HIP, financing for the PHIP comes from a number of sources: employer contributions (if group coverage); state subsidies to help enrollees pay their share of contributions to small group premiums, as well as individual premiums; tax savings associated with use of Section 125 plans for group and individual premiums; and net enrollee contributions. First, we consider the amount of funding associated with each source. Second, because estimated employer contributions to coverage are perhaps higher than might be expected, we consider further the levels and patterns of employer contributions to small group coverage in the PHIP. Finally, we discuss the extent of potential crowd out—that is, the substitution of state PHIP subsidy funds for private expenditures.

Key findings with respect to financing in the PHIP are as follows:

- At full implementation, state subsidies are estimated to total nearly $84 million per month. Subsidies are estimated to finance nearly 30 percent of premiums in the PHIP overall. Including both subsidized enrollees (with family income at or below 200 percent FPL) and unsubsidized enrollees in the PHIP, state subsidies average $90 per member per month.

- Due to the high proportion of small group premiums that employers would pay, estimated state subsidies for small group coverage in the PHIP are low—just $20 per enrollee month. In contrast, estimated subsidies for individual coverage are 10 times as high, averaging $236 per enrollee month. An exploration of possible funding sources or potential changes in expenditures related to uncompensated care are beyond the scope of this study.

- On average—and reflecting the high proportion of low-income enrollees in the PHIP—enrollees pay just 16 percent of premiums after subsidies and tax savings. Tax savings average about 4 percent of premiums overall, and about 7 percent of premiums net of employer contributions and premium assistance. At higher levels of income (300 percent FPL or more), tax savings represent nearly 27 percent of net premiums.

- Small employers contribute a similar percentage of premium, on average, for workers who newly gain small group coverage in the PHIP, compared with workers now in small group coverage. This result reflects the insurance industry's high standard for employer contributions in very small firms currently, as well as workers "buying down" coverage in the PHIP to minimize their contributions to premium.

- The immediate potential for crowd out in the PHIP is low: we estimate not more than 8 percent of state subsidy payments would equate to crowd out of worker contributions to coverage. However, the transition to employer defined contributions

in the PHIP suggests the potential for increasing crowd out of employer expenditures over time. If the PHIP relies only on enrollee cost sharing to manage rising medical costs, employers' defined contributions might not rise with the cost of coverage in the PHIP, causing the state cost of premium assistance to accelerate.

A. SOURCES AND LEVELS OF FUNDING IN PHIP

Estimated total and average (per enrollee) expenditures in each category are reported in Table IV.1. Employer contributions are expected to be the largest source of financing in the PHIP, accounting for nearly $140 million per enrollee month, and 74 percent of the cost of small group coverage.

TABLE IV.1

ESTIMATED MONTHLY COST OF PHIP BY SOURCE OF FUNDS, FY2010

	Aggregate Premiums	Employer Contributions	State Subsidies (Premium Assistance)	Tax Savings	Net Enrollee Contributions
Total Expenditures (in millions)					
Total	$ 281.2	$139.6	$83.8	$12.5	$45.2
Small group	$188.6	$139.6	$12.8	$8.9	$27.2
Individual	$92.6	na	$71.0	$3.6	$18.0
Percent of Total Expenditures					
Total	100%	50%	30%	4%	16%
Small group	100%	74%	7%	5%	14%
Individual	100%	na	77%	4%	19%
Average Expenditure Per Enrollee					
Total	$301	$149	$90	$13	$48
Small group	$297	$220	$20	$14	$43
Individual	$307	na	$236	$12	$60

Source: Mathematica Policy Research.

State subsidies are expected to total nearly $84 million per month. Subsidies are estimated to finance nearly 30 percent of premiums in the PHIP overall, and 77 percent of premiums for individual coverage in the PHIP. Including both subsidized enrollees (with family income at or below 200 percent FPL) and unsubsidized enrollees in the PHIP, state subsidies average $90 per member per month.

Reflecting the substantial amount of employer contributions to coverage, estimated state subsidies for small group coverage are low—just $20 per enrollee month. In contrast, estimated subsidies for individual coverage are 10 times as high, averaging $236 per enrollee month. On average—and reflecting the high proportion of low-income enrollees in the PHIP—enrollees pay

16 percent of premiums after subsidies and tax savings. Tax savings average about 5 percent of premiums.

Largely related to the availability of subsidies, enrollees' sources of funding in the PHIP vary widely across income groups (Table IV.2). Among subsidized enrollees (with family income below 200 percent FPL), state subsidies account for 59 percent of total expenditures, averaging $165 per member month. For enrollees below poverty, subsidies cover 67 percent total expenditures, averaging $190 per member month.

TABLE IV.2

ESTIMATED MONTHLY COST OF PHIP BY SOURCE OF FUNDS AND ENROLLEE INCOME AS A PERCENT OF POVERTY, FY2010

	Aggregate Premiums	Employer Contributions	State Subsidies (Premium Assistance)	Tax Savings	Net Enrollee Contributions
Total Expenditures (in millions)					
Subsidized enrollees, total	$141.8	$40.4	$83.8	$2.1	$15.5
0-100 percent FPL	$88.3	$21.3	$59.4	$0.6	$7.1
101-200 percent FPL	$53.5	$19.1	$24.5	$1.5	$8.4
Unsubsidized enrollees, total	$139.4	$99.2	NA	$10.4	$29.8
201-300 percent FPL	$28.0	$21.1	NA	$1.6	$5.4
301 percent FPL or more	$111.4	$78.2	NA	$8.8	$24.4
Percent of Total Expenditures					
Subsidized enrollees, total	100%	28%	59%	2%	11%
0-100 percent FPL	100%	24%	67%	1%	8%
101-200 percent FPL	100%	36%	46%	3%	16%
Unsubsidized enrollees, total	100%	71%	NA	8%	21%
201-300 percent FPL	100%	75%	NA	6%	19%
301 percent FPL or more	100%	70%	NA	8%	22%
Average Expenditure Per Enrollee Month					
Subsidized enrollees, total	$279	$79	$165	$4	$30
0-100 percent FPL	$283	$68	$190	$2	$23
101-200 percent FPL	$272	$97	$124	$8	$43
Unsubsidized enrollees, total	$327	$233	NA	$24	$70
201-300 percent FPL	$304	$228	NA	$17	$59
301 percent FPL or more	$333	$234	NA	$26	$73

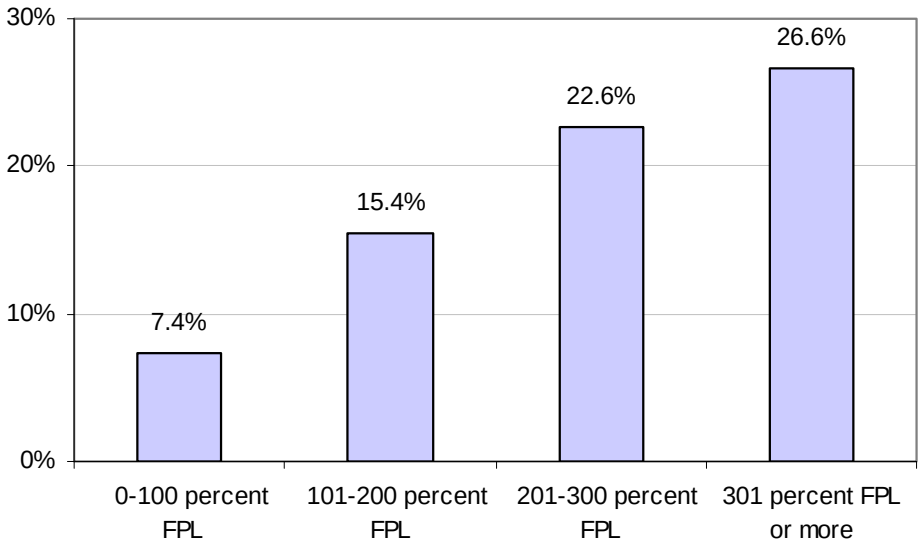
Source: Mathematica Policy Research.

However, for higher-income enrollees, the value of tax-sheltering contributions to premiums is significant—and because marginal federal income tax rates increase at higher levels of income, the value is greatest for the highest-income participants. Above 300 percent FPL, the tax value of sheltering contributions to premiums accounts for nearly 8 percent of total

expenditures—and a still greater percentage at higher threshold levels of income (data not shown). As a percent of expenditure not paid by employers or state subsidies, the tax value of sheltering enrollee premiums ranges from about 7 percent of the amount enrollees otherwise would pay at the lowest levels of income, to more than 26 percent among families above 300 percent FPL (Figure IV.1).

FIGURE IV.1

ESTIMATED TAX VALUE OF SHELTERING ENROLLEE PREMIUMS AS A PERCENT OF TOTAL PREMIUMS AFTER EMPLOYER CONTRIBUTIONS AND SUBSIDIES RECEIVED, FY2010



Source: Mathematica Policy Research.

B. EMPLOYER CONTRIBUTIONS TO SMALL GROUP COVERAGE IN PHIP

State subsidies for small group coverage in the PHIP are relatively small as a direct result of relatively high employer contributions. The level of employer contributions—even for those who were uninsured prior to the PHIP warrants explanation.

The estimated amounts that employers would pay in the PHIP as a percent of premiums are presented in Table IV.3. Note that, as a percent of premium, the amounts that employers are willing to contribute for workers who were uninsured in the base case is as great as or greater than what employers contributed for insured workers in the base case.

TABLE IV.3

ESTIMATED EMPLOYER CONTRIBUTIONS AS A PERCENT OF PREMIUMS BY PLAN TYPE: SMALL GROUP WORKERS WITH OWN-EMPLOYER ESI IN PHIP, FY2010

	Total, with own-employer plan in PHIP	Small group insured in base case	Individual coverage in base case	Uninsured in base case
Total	74%	72%	85%	73%
Current Plan or Offer	73%	73%	na	na
Tier 1	83%	75%	91%	83%
Tier 2	62%	64%	65%	56%
Tier 3	70%	69%	37%	78%
Tier 4	69%	72%	36%	60%

Source: Mathematica Policy Research.

This result reflects the convergence of several factors. First, due to the small group and individual markets having been merged, premiums for small group coverage in the PHIP are generally lower than in the base case. Consequently, the contributions to coverage that some employers are willing to make, calculated against a lower premium, can be well above the current-market minimum contribution as a percent of premium—and of course, much higher than the 40-percent minimum contribution in the PHIP.

This effect is magnified by the fact that a relatively large proportion of workers who gain small group coverage in the PHIP are employed in the smallest firms. Fourteen percent of workers who were individually insured in the base case but enroll in small group PHIP are employed in firms of 2 to 5 workers, as are 21 percent of workers who were uninsured in the base case. These estimates compare with 7 percent of workers who were small group insured in the base case and are employed in such very small firms (Figure IV.2). Because the industry-standard minimum contribution for such small employers is higher than that for larger small groups, the contributions these very small employers are willing to pay in the base case can actually be higher as a percent of premiums than what currently-offering employers are willing to pay.

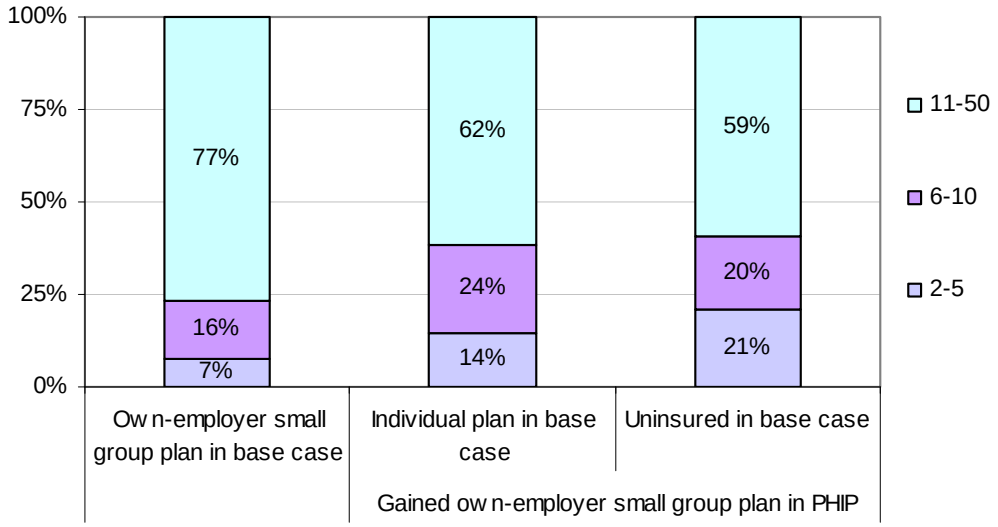
Second, the percentage contribution amounts show substantial sorting among plan tiers by both currently insured workers and newly insured workers. Many workers select coverage in lower tiers, so that the same defined contribution from their employer (all else equal) pays a higher percentage of the premium. However, workers who select plans with higher cost sharing more often cover dependents, in effect reducing the employer contribution to premium. These offsetting patterns are apparent especially among workers who were small group-insured in the base case and workers who were uninsured in the base case. Both are more likely to insure dependents in high cost sharing plans (Tiers 3 or 4) than in low cost sharing plans.

In contrast, workers who entered small group PHIP from an individual plan (compared with workers who were either small group-insured or uninsured in the base case) are higher-income and have a strong demand for health insurance. As a result, they are likely to have a higher employer contribution to premium, choose a higher-premium plan, and also cover dependents in

these plans. The net result of these many offsetting influences is that average employer contributions as a percent of premiums for workers who newly enroll in the PHIP are as high as, or higher than, those for workers who were enrolled in small group coverage in the base case.

FIGURE IV.2

PERCENT OF OWN-EMPLOYER INSURED WORKERS IN PHIP BY SIZE OF FIRM AND COVERAGE STATUS IN THE BASE CASE , FY2010



Source: Mathematica Policy Research.

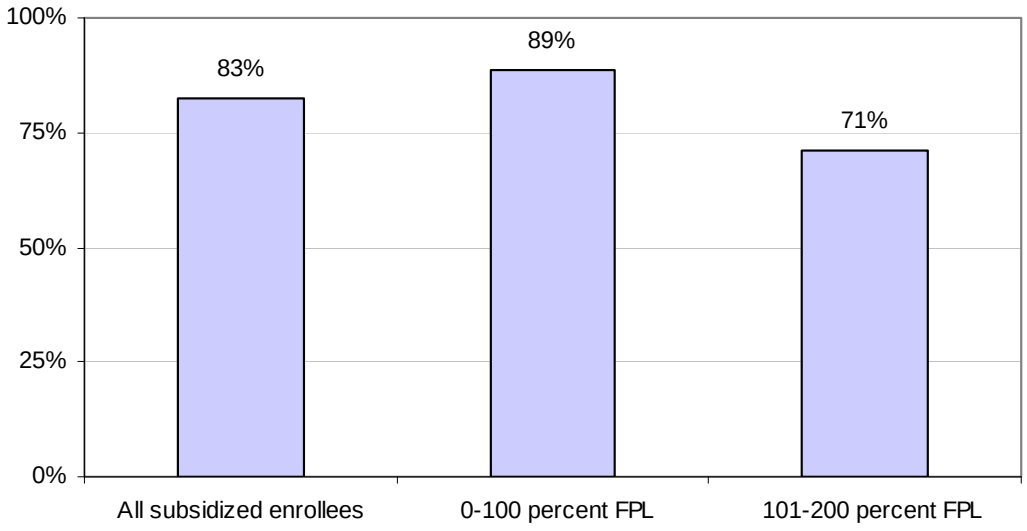
C. CROWD OUT

All workers and dependents who are currently insured in small group plans, as well as individuals who currently buy coverage, are eligible for subsidies to help pay their share of premiums in the PHIP, if their family income equals or is less than 200 percent FPL. As a percent of enrollee premiums net of employer contributions, the amount of subsidy available to low-income families and individuals who enroll in the PHIP is substantial. On average, we estimate that these subsidies pay 83 percent of premiums for subsidized enrollees in the PHIP; for enrollees under 100 percent FPL, subsidies pay 89 percent of premiums (Figure IV.3).

Because these subsidies are available to insured families and individuals as well as those who are uninsured, the potential for crowd out—replacing current private expenditures for health insurance with public expenditures—is substantial. However, the magnitude of coverage gains in the PHIP by people who before were uninsured greatly reduces the amount of crowd out that one might expect. An estimated 80 percent of subsidies in the PHIP are paid to workers and individuals who were uninsured in the base case. Including low-income residents who were uninsured as well as those with individual coverage or BH, 92 percent of state subsidies in the PHIP are directed either to the uninsured or those at high risk of losing coverage (Figure IV.4).

FIGURE IV.3

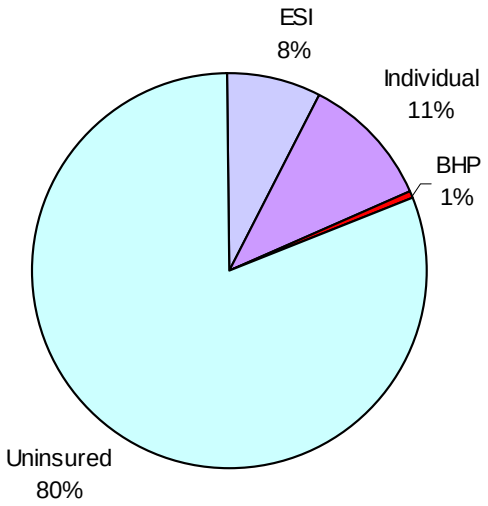
ESTIMATED SUBSIDY PAYMENTS IN PHIP AS A PERCENT OF PREMIUMS NET OF EMPLOYER CONTRIBUTIONS, FY2010



Source: Mathematica Policy Research.

FIGURE IV.4

ESTIMATED PERCENT OF SUBSIDY PAYMENTS BY COVERAGE STATUS OF SUBSIDIZED PHIP ENROLLEES IN THE BASE CASE, FY2010



Source: Mathematica Policy Research.

Thus, state funds substitute for very little private spending for health insurance and, therefore, is likely to represent very little crowd out. Of the estimated $83.8 million per enrollee month in state funds that we estimate the PHIP would require, $6.6 million is paid to low-income families and individuals who previously (in the base case) were enrolled in small group coverage (Table IV.4). This amount—$6.6 million per month, or 8 percent of the state's total payments for PHIP coverage—is our estimate of potential crowd out of enrollee spending for health insurance.

TABLE IV.4

ESTIMATED STATE SUBSIDY PAYMENTS BY THE PRIOR COVERAGE STATUS OF SUBSIDIZED PHIP ENROLLEES, FY2010

	Total	Small group	Individual
Total (dollars in millions)	**$83.8**	**$12.8**	**$71.0**
Prior coverage (base case):			
ESI	$6.6	$6.6	--
Individual plan	$8.9	$0.1	$8.8
BHP	$0.6	$0.6	--
Uninsured	$67.7	$5.6	$62.2

Source: Mathematica Policy Research.

Note: Dashes indicate no enrollment in that source of coverage.

Note that the low level of subsidy payments for group coverage—both absolutely and as a percentage of total subsidies—is in large part based on employers' relatively high contributions to coverage. Especially with a transition to defined contribution coverage, it is possible that small employers would increase their contributions by less than the increase in plan costs over time. To the extent that employers do not maintain contributions at current levels relative to premium, the PHIP could experience growing crowd out and commensurately faster growth in subsidy outlays.

This potential for crowd out of small employer spending over time is an important consideration in the PHIP's design. At least two strategies might be considered to mitigate this problem. First, the contribution rule could be designed with an eye toward preventing growth in employer crowd out. Because the PHIP's minimum employer contribution as a percent of premium (40 percent of single premiums with no contribution for dependents) is so much lower than the average percentage that employers currently pay and (we estimate) would pay, the PHIP could investigate increasing the minimum contribution and fixing it as a percentage of a state-selected benchmark in the PHIP. It would appear that many of the smallest employers that now do not offer coverage might do so if the threshold contribution level simply was set at the same percentage contribution as for larger small employers.

However, this approach to deterring employer crowd out as well as the expected entry of many enrollees with worse health status than in the current small group and individual markets, suggest strongly that the PHIP needs to pay greater attention to cost control—and by means other than enrollee cost sharing. The estimated entry into the PHIP by so many people who were before uninsured and who despite their younger ages report just good, fair, or poor health status is striking, with obvious implications for greater medical cost and rising premiums. It is likely that employers' defined contributions would not keep pace with premiums if medical costs and medical cost growth in the PHIP were not carefully managed. Consequently, cost management in the PHIP would likely be a critical element in deterring crowd out of employer spending in the PHIP.

V. IMPLEMENTATION ISSUES FOR AN EXPANDED HEALTH INSURANCE PARTNERSHIP

Health insurance exchanges have been conceptualized and developed as platforms to improve access for small employers and individuals to coverage that is easy to access, tax-advantaged, portable, and offers choice of plans. This chapter presents discussion and preliminary recommendations for a number of operational and implementation issues associated with an expanded HIP which would operate as an exchange-like entity in Washington. Two case studies (Connecticut and Massachusetts) are used throughout the chapter because in these two states, exchange-like structures currently exist. In both states, the exchanges operate side-by-side with other markets where small employers and individuals can buy coverage.

While this chapter draws heavily from a similar analysis prepared for the State of Minnesota,[18] we have adapted the discussion to the particulars of an expanded HIP in Washington. The discussion anticipates not only issues related to a "preliminary" expanded HIP—which would incorporate and merge the small group and individual markets—but also a "final" expanded HIP that would in addition include other public-private insurance programs.

The chapter is structured as follows. First, major features of the Connecticut and Massachusetts models are reviewed for background information. Second, the operational issues associated with developing an expanded HIP are discussed specifically with respect to (1) the HIP as an exclusive source of non-association small group and individual coverage, and (2) blending the individual and small group markets. Finally, we offer preliminary recommendations on these major questions and related issues.

Many of the implementation decisions presented and discussed in this chapter must be made in sequence, requiring policymakers to approach expansion of the HIP in stages. This discussion does not attempt to structure those stages but rather presents the options and issues that must be considered.

A. OVERVIEW OF CONNECTICUT AND MASSACHUSETTS MODELS

The Massachusetts and Connecticut models are summarized below. A table comparing the key features of the Connecticut, Massachusetts, and PHIP models is provided at the end of the chapter (Table V.1).

[18] Health Insurance Exchange Study. Deborah Chollet, Su Liu, Kate Stewart, Allison Wellington, Allison Barrett, Mila Kofman and Amy Lischko, March 2008 (http://www.mathematica-mpr.com/publications/PDFs/healthinsexchange.pdf, accessed 9/15/08).

1. Connecticut

The Connecticut Business and Industry Association (CBIA) Health Connections is a private-sector purchasing mechanism. Operated as a division of the Connecticut Business and Industry Association for more than 12 years, Health Connections was one of the first statewide, multi-vendor health insurance purchasing alliances in the country. It serves employers with three to 100 employees and provides choice among plans offered by four participating health insurance companies. Currently, more than 6,000 businesses with 88,000 covered lives participate.

Health Connections offers a range of benefits to participating employers. These include a menu of choices for health insurance policies with employee choice among the options. Employers that participate in Health Connections must select either of two suites of plan design options (one more comprehensive than the other) to make available to their employees. Within each suite there are four carriers offering varying levels of cost sharing. Each employer must establish a minimum premium contribution level, equal to at least 50 percent of the premium for the lowest cost plan in the suite. Typically, employers identify a "benchmark" plan of benefits within the suite; that benchmark plan becomes the basis for their premium contribution and monthly premium budget.

Employees may choose to enroll in the "benchmark" plan or opt to 'buy up" or "buy down" to an alternative level of benefits within the suite offered, paying the difference between the premium for the option they choose and the employer contribution. As a condition of group enrollment, at least 75 percent of eligible full-time employees must participate.

Unlike the expanded versions of the HIP studied in Washington, Health Connections operates as a relatively small player in a much larger market. Nevertheless, some aspects of Health Connections' experience seem salient to an expanded HIP. Health Connections' success is attributed to having learned lessons from earlier models and focusing on implementation of best practices. It has maintained a good relationship with businesses, insurers, and brokers. Health Connections executives report that developing and maintaining a role for brokers was essential in order to gain market share. It is aware that use of the same underwriting, rating, and eligibility rules inside Health Connections as outside has been critical to avoiding adverse selection—potentially an issue in Washington, if the association market would continue to operate outside of the expanded HIP. In addition, Health Connections also offers small employers full-service human resources capability, which includes payroll services and assistance in complying with federal laws like COBRA. This particularly appeals to smaller firms without in-house human resources departments; Health Connections has been particularly successful in the three to 25-employee market. This turnkey approach allows small businesses to offer coverage with relatively low administrative burden.

2. Massachusetts

The Commonwealth Health Insurance Connector Authority (the Connector) was established in 2006 as an important part of system-wide reform in Massachusetts intended to cover most uninsured residents. Through a comprehensive law, Massachusetts restructured both how private insurance is purchased, sold, and administered, and how public subsidies are delivered.

The Connector is an independent, quasi-governmental entity designed to help eligible individuals and small groups purchase health insurance at affordable prices. The law allows residents in certain circumstances to purchase insurance through the Connector, including:

- Small businesses with 50 or fewer employees.
- Sole proprietors.
- Individuals working for non-offering companies of any size.
- Individuals working for offering companies of any size who are not eligible for benefits (part-timers, contractors, new employees).
- Non-working individuals.

The Connector is a self-governing, legal entity; it is separate from the state and governed by a 10-member board consisting of private and public representatives. The Connector certified for sale seven plans offered by six carriers, signaling to consumers that the approved plans were both comprehensive and affordable. It began offering subsidized products in October 2006 and private products to individuals in April 2007. It will begin offering private products to small employers in October 2008. After an initial infusion of $25 million in state appropriations, its operations are funded through retention of a percentage of premiums collected on the subsidized and non-subsidized (private) products sold through the Connector.

The Connector makes it easier for all businesses to offer insurance to part-time employees and contractors, as well as full-time employees, on a pre-tax basis. The Connector facilitates pro-rata employer contributions for individuals who work for more than one employer. It administers premium assistance for individuals between 150 percent and 300 percent of the federal poverty levels (FPL), and charges no premium for those who earn less than 150 percent FPL, but who are not eligible for Medicaid. To facilitate purchase of coverage with pre-tax dollars, employers (with 10 or more employees) must offer all employees a Section 125 plan (described later in this chapter), whether the employees are part-time or full-time.

The Connector also expands enrollees' choice of health plans. Beginning in October 2008, employer groups with 50 or fewer employees can be rated as individuals, with employees having the freedom to choose among actuarially equivalent products within any of three tiers selected by their employer. Alternatively, employers can choose to continue purchasing as a group, selecting a single product for eligible employees. Importantly, rating factors are the same both inside the Connector and outside in the marketplace, and for the most part products sold in the Connector can also be sold outside.[19]

By allowing employee choice among plans, the Connector aims to help small group employees to purchase health insurance which meets their needs and which is portable. Portable plans—allowing workers and dependents to continue in the same health plan after leaving a

[19] Only Young Adult Products (offered to 19-26 year olds) may be sold exclusively in the Connector.

job—are important to consumers, and they also are desirable for the system overall: carriers are encouraged to manage member health proactively because members can stay with carriers longer. In addition, easy consumer access to alternative coverage options offers an incentive for carriers to be more responsive to consumers in order to maintain their market share.

Small groups and individuals may purchase Commonwealth Choice products either through the Connector or directly in the private market. All Commonwealth Choice products are available in the private market, and carriers must rate each product based on its combined experience, whether sold through the Connector or directly.

The health care reform act required that the individual market be phased out and merged with the small group market. Massachusetts' individual market was relatively small. Although rating rules in the individual market were almost identical to those in the small group market, the risk in the small group market was much lower. In fact, individual market premiums were 40 percent higher than for similar products in the small group market, primarily reflecting the health of the individuals who bought coverage and the requirement that carriers guarantee issue in the individual market.

The decision to merge markets and allow the Connector to offer products in both markets was made easier by the fact that both markets already had guaranteed issue and rating factors that were nearly identical. Both markets had adjusted community rating, prohibiting underwriting of any kind based on health status; and rates were compressed within a fairly tight 2:1 overall band with age and geography as the primary rating factors.

Small group rates could (and still can) be adjusted modestly for industry-type and group size; group size rate factors were increased when the markets were merged to account for the higher cost of administering plans for smaller groups. The 2006 reforms also changed rating rules to allow insurers to rate individuals and small groups based on smoking status and for participation in wellness programs. The health care reform act imposed a moratorium on any new legislative health insurance mandated benefits through 2008.

B. PHIP AS AN EXCLUSIVE SOURCE OF NON-ASSOCIATION SMALL GROUP AND INDIVIDUAL COVERAGE

In Washington, with the exception of self-insured (also called self-funded) employers and association plans, the PHIP would become the only source of insurance for small groups (with 2 to 50 employees) and individuals: it would entirely subsume both markets. Neither CBIA's Health Connections nor Massachusetts quite fit this model:

- CBIA competes with the conventional small group market. In addition, it does not provide access to very small firms or individuals, thus is missing an important segment of the population that policymakers in Washington want to reach with an expanded HIP.
- In Massachusetts, where the Connector is a quasi public-private entity established as part of a larger reform plan, both small groups and individuals may voluntarily

purchase through the Connector. But they may also purchase coverage in the blended small group and individual market, which remains outside the Connector.

Possibly the most important issue related to whether the PHIP—or any state exchange model—is the exclusive source of coverage or competes with the small group, association, or individual market is the potential for risk selection. There are no clear answers on how to manage risk selection within an exchange, but history provides some guidance on this issue. Older purchasing cooperative models were premised on pooling a number of small employers separately from the market to bargain for lower premiums if not also to achieve some of the efficiencies of a larger group. However, unable to achieve such efficiencies, none succeeded in bargaining for lower rates without also underwriting within the exchange.[20] In contrast, employers are not rated separately in either Connecticut or Massachusetts. The rating rules for products sold in the CBIA and the Connector, respectively, are the same as for those outside. In Massachusetts, products pool risk across the Connector and the balance of the market, essentially mitigating any risk selection either into or out of the Connector.

However, state approaches to regulating health insurance offered through associations vary. When not in conflict with federal law, states may apply more or less stringent standards to health insurance sold through an association than to other types of health insurance, and most states require small group rating reforms to apply to association coverage. In Connecticut and Massachusetts—unlike in Washington—small employers that purchase insurance through associations are rated the same as other small employers.

In Washington, under Rev. Code Wash. § 48.44.024(2), small group plans purchased through associations are exempt from small group rating rules which generally restrict insurers from setting rates based on the health status of the small employer group.[21, 22] This exemption allows insurers to set premiums for small employer association plans with few restrictions. Small employers within the association can be, and sometimes are, rated separately based on the health and risk status of each small employer group. Both new issue and renewal premiums can be so adjusted. Further, in the absence of any renewal rating rules, associations may apply pure experience rating to small group association members. As a result, a small group with low medical costs might find lower premiums in an association plan; similarly, a small group that cannot afford community rated coverage might be able to afford association plan coverage. On

[20] COSE, the small business division of the Greater Cleveland Partnership, is an example of a private Exchange that underwrites applicants. It enrolls approximately 17,000 small groups and groups of one.

[21] Rev. Code Wash. (ARCW) § 48.44.024 Requirements for plans offered to small employers—Definitions: (1) A health care service contractor may not offer any health benefit plan to any small employer without complying with RCW 48.44.023(3). (2) Employers purchasing health plans provided through associations or through member-governed groups formed specifically for the purpose of purchasing health care are not small employers and the plans are not subject to RCW 48.44.023(3). (3) For purposes of this section, "health benefit plan," "health plan," and "small employer" mean the same as defined in RCW 48.43.005.

[22] Rev. Code Wash. (ARCW) § 48.44.023(3).

the other hand, a small group association member with an employee who has, for example, an organ transplant in one year might see renewal rate premiums rise dramatically.[23]

The potential problems arising from adverse selection as association policy holders move between the association, PHIP and small group coverage in search of favorable rates has been described. Making rules for employer coverage consistent within these markets—leveling the playing field—is one option. Of course, the number of people covered and the health status of the covered population would depend upon the consistent set of rules adopted for the markets. Alternatively, the State might put off decisions about aligning market rules and, instead, monitor risk migration to determine its extent and any premium distortion that might result. In this case, the State should develop capacity to monitor these markets and to respond quickly if necessary. Association carriers might be required to report periodically on new enrollments and disenrollment by small employers. Data on premiums (including changes in premiums over time) and claims experience of newly enrolling and disenrolling employer groups might also be reported. In this way, the State could track any movement of risk out of associations into the more regulated markets, as well as out-migration from the PHIP and small group market into association coverage.

In addition to these critical strategic design questions to manage selection, developing an expanded HIP as the exclusive or predominant source of small group coverage and the only source of individual coverage will force a number of policy and political questions. For example:

- Washington may wish to consider restricting the number of plans available in the HIP (as it does now), rather than importing every plan that is currently available in the market. Both Connecticut and Massachusetts restrict the number of plans participating in Health Connections and the Connector, respectively. The reasons for this include a desire to promote competition while reducing confusion in the marketplace.
- While an exclusive program for individuals, small employers or both would offer maximum flexibility, portable plans and convenience for consumers, the political hurdles can be daunting. Massachusetts policymakers considered requiring all individuals and/or small business to purchase insurance through the Connector, but there was tremendous resistance from brokers and carriers who wanted to keep it voluntary. Washington likely will encounter similar opposition from these stakeholders.

1. Advantages

The HIP must enroll a significant number of covered lives to be a financially viable organization. Requiring individuals to purchase through the exchange has several advantages, including: (1) beginning with a large number of covered lives in the HIP; (2) known initial

[23] Some associations, but not all, voluntarily restrict the size of an annual rate increase. For example, both the Association of Washington Business and Associated Employers Trust limit increases to not more than three rate tiers in one year (Michael Arnis, personal communication, October 17, 2008).

medical risk of a number of individuals; and (3) strong incentives for carriers to join the HIP. In addition, it would be easier for individuals to access insurance in one place: they could more easily compare benefit plans and prices across options available to them in the HIP. This could encourage take-up of not only private health insurance, but also other state-sponsored health insurance programs for which people may be eligible if they were offered through the HIP.

The PHIP could generate revenue from an administrative fee built into the premium (as well as a fee charged to employers for HR services that the PHIP might provide).[24] A PHIP that can be broadly marketed to the entire population as the predominant or exclusive source of individual coverage—providing services to both individuals and small employers, and to most or all of the lives in either market—could be more attractive, and in any case would make it easier for the PHIP to achieve enrollment sufficient to be self-supporting. While CBIA has been successful as a business model servicing only a portion of the small group market, limiting the HIP in the same way, or even to the entire small group market, would exclude some of the populations Washington is hoping to assist.

2. Challenges

The greatest challenge facing the PHIP relates to the problem of risk selection. The PHIP can compete, either with an "outside" market or association plans—only if underwriting and rating rules are the same for all. If, with implementation of the PHIP, rating rules remain different for association plans, it is likely that adverse risk selection will continue in the expanded HIP, as it does now in the small group market.

In the "final" expanded HIP, Washington is studying integrating WSHIP, BH, and the Public Employee Benefits Board (PEBB). This could give a merged market initially a relatively poor risk profile, unless WSHIP and BH funding were maintained and used strategically to initially offset high risk, and possibly on an ongoing basis.

Finally, Washington could face significant resistance from brokers and possibly also carriers, especially if the PHIP would become the sole system for selling coverage to small employers. In Massachusetts, there was significant resistance from brokers and carriers to permitting small employers to buy coverage through the Connector even with the alternative broker-market allowed to remain side-by-side.

Experience in both Connecticut and Massachusetts (and in other states where similar purchasing pools have failed) has shown that states need to work with brokers and carriers to successfully implement an exchange such as an expanded HIP. The reasons for this are practical: the HIP depends on carriers to participate, and while the state can require that carriers participate, the relationship is likely to be antagonistic if they see no advantage in doing so. Additionally, brokers rely on commissions for their livelihood; they need reassurance that they will be reimbursed for bringing clients to the PHIP, even if somewhat less than if they brought

[24] In Massachusetts, the Connector charges an administrative fee of 4.5 percent.

them directly to a carrier. In both Connecticut and Massachusetts, the Exchanges have financial arrangements with brokers.[25]

C. BLENDING THE SMALL GROUP AND INDIVIDUAL MARKETS

The PHIP is envisioned as a means of improving access to affordable choice-based coverage to all residents of a state, whether through an employer or on a direct-pay basis. To improve portability between small group and individual coverage—markets where individuals and workers are very mobile—the PHIP would blend the markets, so that all products would be equally available to small groups and individuals, and for the same age-adjusted premiums.

Again, neither CBIA nor Massachusetts quite fit this model:

- While there is nothing to preclude CBIA from selling to individuals or groups smaller than 3, it would need to consider the differences between Connecticut's rating rules in the small group and individual markets. In this study, the authorizing legislation instructed Mathematica to assume that the preliminary expanded HIP (and potentially also the final expanded HIP) would extend the state's small group rate regulation to individuals.
- In Massachusetts, the decision to merge the two markets was a critical part of the reform plan.[26] Preliminary and subsequent analyses convinced public policymakers that it would be feasible to merge the two markets. However, unlike in Washington where the individual market can be denied for reasons of health status, merging the markets in Massachusetts was expected to save individual subscribers an average of at least 15 percent on their premiums while increasing premiums for small group only slightly, by an average of one to 1.5 percent, after accounting for changes in subscriber choices in response to the policy change.

[25] However, some residual broker resistance remains in Massachusetts, as evidenced by a section in the recently passed technical corrections bill to CH58 (the omnibus Health Care Reform Law):

> There shall be a special commission to investigate and study the role of the Connector in providing access to health insurance products. The Commission shall examine the Connector's utilization of private sector entities, including insurance brokers and shall investigate ways to promote efficient enrollment of uninsured individuals into health insurance and prevent unnecessary duplications in the market (CH58 Section 28A Chapter 176Q, 15A).

The House version of the bill had included language to prevent the Connector from marketing plans to employers with existing coverage, a provision supported by health insurance brokers and agents. However, the Senate did not endorse that version.

[26] This decision was made for several reasons. First, policymakers observed that the individual market was in a death spiral, losing significant lives each year with average premiums nearly 40 percent more expensive than similar products in the small group market. Second, the small group market already included "groups of one"; policymakers felt it was inequitable for individuals without access to employer-sponsored health insurance to have different product choices and be rated differently from individuals who qualified as a group of one.

Washington has very different underwriting rules in its individual and small group markets. A merging of the two markets will cause individual rates to increase (by nearly 40 percent) and small group rates to decrease. Without an individual mandate, some individual subscribers would reduce or drop coverage altogether in response to such significant rate increases in a merged market.

1. Advantages

The major advantage to providing access on the same basis to small group and individual coverage through the PHIP is its potential to make it easier for both small group and individual purchasers to negotiate moving between employers and self-employment seamlessly. In addition, a merged market provides for the greatest cross-subsidization among enrollees in the pool, although some individual (or "list") rating on factors such as age may still be desirable as broad indicators of both medical cost and ability to pay.

Blending the markets is consistent with one of the chief objectives of the PHIP: to facilitate transparency of price and quality of coverage and encourage portable plans. A person working for a small employer typically is pooled with other employees of that firm and pays a premium that is based on the average demographics of the small employer. Should he or she leave that job and seek to purchase individual insurance directly in the individual market, the premium could be dramatically different for essentially the same insurance. If the markets are blended with the same underwriting and rating rules the premium would be similar, if not the same, whether the coverage is purchased as an individual policy or through an employer group.

2. Challenges

While it is easier to blend markets when the underwriting and rating rules are the same for individuals and businesses, it is not essential. In Washington, differences between underwriting rules in the individual and small group markets pose a major challenge for merging the small group and individual markets without extensive rate volatility during the initial implementation. Thus, it may be preferable to move towards a blended market in stages.

In addition, employers that sponsor coverage have additional legal responsibilities that are addressed more easily if employees can obtain the same insurance as individuals through the HIP at the same rate. Under certain circumstances in Washington, HIPAA non-discrimination standards may be triggered if the rules in the individual and small group market are different. For example, currently in Washington (like in many other states) insurers are not required to guarantee issue individual policies, and underwriting is different between the individual and small group markets. In group coverage, HIPAA requires guaranteed issue to small groups and prohibits selective underwriting and rating within groups based on individual workers' health status. Absent proper modifications to individual market standards, new reforms might be challenged as preempted by HIPAA in a situation where an employer is contributing to individual health insurance that is underwritten (either for access or rates) by individual health factors.

D. SUMMARY OF CONSIDERATIONS

Washington policymakers face an array of complex issues in considering expansion of the HIP. As each issue is considered, it will be important to assess the impact on all stakeholders, determine which decisions further Washington's policy goals, and consider unintended consequences. This section offers preliminary recommendations on the major questions discussed above and related issues.

Exclusive Source. If the desire is to sell to both individuals and small groups through the HIP, as the Massachusetts Connector is designed to do, then Washington could begin by allowing individuals and small groups to purchase from the HIP, but not *require* either to do so. As the only source of premium assistance for low-income workers, the PHIP would offer affordable options and choice of plans to employers and employees—both unique characteristics of the HIP in the marketplace. However, this arrangement would further segment Washington's market for small groups (which already is split between the small group and association markets) and it also would segment the individual market. Similar to the current HIP, policymakers do not envision that an expanded HIP would negotiate rates; furthermore, it would not restrict the number or type of plans that are offered. In light of the difficulties of still more segmented markets and the limited role of an expanded HIP, it seems to make little sense for it to attempt to operate side-by-side with competing markets. Instead, it would be more practical for an expanded HIP to be the exclusive source of small group and individual coverage and apparently more consistent with Washington's policy goal of making the individual and small group markets easier for consumers to navigate.

Blending the Markets. Washington would face an important challenge related to the expected significant increase in average rates for individuals and older workers, as it attempts to blend the small group and individual markets. In Massachusetts the decision to require individuals to maintain health insurance coverage (individual mandate) played a role in bringing stakeholders together, despite the likelihood that some carriers would be disadvantaged by blending the markets. However, Washington will need to confront this issue at the policyholder level. For this reason, it may wish to consider options for *coordinating* the markets to help workers negotiate transitions between employment and self-employment, instead of entirely blending the markets. For example, rating factors should be identical for small groups and individuals (consistent with the PHIP model). In addition, individual coverage in an expanded HIP should be guaranteed issue, with WSHIP brought into the expanded HIP as a reinsurance entity. If these measures, combined with subsidies, increase participation in individual coverage, it seems likely that the collective risk experience of those with individual coverage will begin to resemble more closely that for small groups. At that point, Washington could consider blending the small group and individual markets, potentially reconfiguring WSHIP as a reinsurer for the entire blended market.

Managing Risk Selection. If the PHIP competes with associations, the market, or both as a source of coverage for small groups and/or individuals, having the same rating rules and mandatory benefits for products both inside and outside the PHIP is essential. In Washington, this would entail allowing association coverage for small groups to be sold only through the PHIP, with the same rating rules and risk pooling by carrier as all other PHIP plans. Alternatively, if association plans competed (side-by-side) with the PHIP, both markets would need to conform to the same rules and regulations.

In addition, Washington policymakers will need to think strategically and creatively about the selection issues associated with merging public programs into the HIP. Funding for WSHIP could be used differently—for example, to finance a reinsurance mechanism—but it is imperative that these dollars remain in the system to buy-down risk of these costly individuals. In addition, the PEBB population is likely to be a somewhat older employee population than the other segments—small groups, individuals, and association plans—that would be merged into the HIP. If so, current public-sector funding for PEBB also should be retained, to help stabilize premiums in the expanded PHIP.

Standardizing PHIP Plans. Even if the PHIP were the sole source of insured small group and individual products in Washington, it would be advisable to have some standardization of plans for two reasons. First, it would help to avoid risk selection within the PHIP. To help manage risk selection, both Connecticut and Massachusetts have limited small group employee choice to choice within a suite of plans. This helps to ensure that younger, healthier lives do not enroll predominantly in high-deductible plans (leaving sicker, higher-risk enrollees predominantly in more comprehensive plans), but it may not provide for as much choice as some policymakers desire. A self-supporting reinsurance risk pool or system of risk adjustment also could help to address the concerns that carriers will have in selling coverage through the PHIP—and it would be important to have the carriers contribute to the design of such a mechanism, consistent with clear policy objectives.[27] Even if plans were standardized, the PHIP would offer portable plans and choice among providers, which has been shown to be more important to consumers than choice among plans.[28]

Second, Washington may want to be more selective about the number and types of products that the HIP sells and endorses as "good value." Both the Connector in Massachusetts and CBIA in Connecticut limit the number and types of products they offer. However, in both states individuals and employers can purchase a non-Exchange product in the regular market and as a result, may not perceive the exchange as limiting choice. Nevertheless, limiting PHIP plans to those with meaningful differences in cost sharing, network design and/or formularies would make sense.

Mandatory Offer of Section 125 Plans. If Washington requires all businesses to offer Section 125 plans to their employees, it would be easier for employers to move from a noncontributory status (with no other involvement such that the plan would not legally constitute a group plan) to a contributory status (that is, a group plan) without affecting their employees' enrollment in a health plan. More importantly, mandating the establishment of Section 125 plans is a relatively easy step for policymakers to take to lower the net cost of coverage for employees.

[27] Even an individual mandate is unlikely to avert problems of selection that may arise between plans in the HIP (although it could help the HIP to avoid selection problems overall). Massachusetts is assessing methods for risk-adjustment within the Connector plans but has not implemented such a process to date.

[28] Jeanne M. Lambrew (September 2005). "Choice" in Health Care: What Do People Really Want? The Commonwealth Fund (http://www.commonwealthfund.org/usr_doc/lambrew_853_choice_ib.pdf?section=4039, accessed 9/10/08).

It could also offset the estimated increases in individual coverage which will occur if the two markets are merged.[29]

Market Determination of Brokerage Fees. Finally, brokers may view an expanded HIP as competition for the services they provide to businesses. However, because brokers' fees are embedded in premiums, it is hard to identify what businesses pay for brokerage services. In most states, a broker fee is built into the small group premium rate that small employers pay (typically 3 to 5 percent of premium), whether or not a broker is used.

It would be difficult to gauge whether the PHIP represents fair competition for brokers' services, if the PHIP competes side-by-side with an alternative market. Alternatively, if the PHIP is the exclusive source of individual and small group coverage, it would be difficult to gauge whether it offers brokers fair compensation. An expanded HIP probably would require a similar fee for administrative services as in the current market. However, for that same fee small employers should see significant value—including employee choice of plans and the ability to budget employer contributions, as well as assistance with Section 125 plan administration and other features.

The PHIP could encourage greater transparency for this transaction throughout the market, without directly addressing brokerage arrangements. For example, in Connecticut and Massachusetts, the broker transaction and fee are fully transparent. Health Connections and the Connector, respectively, pay brokers a commission for bringing them business but keep most of the fee for administration of the account. Over time, brokers' fees might be separated from the rate, with the market determining the cost of brokerage services.

[29] The scope of this study was limited to assessing the impact of requiring that small employers offer Section 125 plans to their workers, whether or not they contribute to group coverage. It is possible that Washington could develop other strategies to support the establishment of Section 125 plans, although perhaps not with the same impact on their use. For example, in 2008, Minnesota authorized a tax credit for eligible small employers to encourage them to provide section 125 plans or encourage their employees to participate in existing section 125 plans. As of July 2009, employers that have 11 or more full-time equivalent employees and do not offer health insurance benefits to their employees must establish and maintain a cafeteria or premium-only Section 125 Plan to allow their employees to purchase individual market or employer-based health coverage with pretax dollars. Employers may opt out of this requirement by certifying to the Commissioner of Commerce that they have received education and information on the advantages of Section 125 Plans (http://www.health.state.mn.us/healthreform/sec125plan.html, accessed 10/23/08).

TABLE V.1

KEY FEATURES OF THE CONNECTICUT (CBIA), MASSACHUSETTS (CONNECTOR), AND WASHINGTON STATE (PHIP) MODELS

Key Feature	Connecticut	Massachusetts	Washington (PHIP)
Eligibility	• Employers with 3-100 employees	• Small groups (2-50) • Sole proprietors • Individuals working for non-offering companies of any size • Individuals working for offering companies but not eligible (part timers) • Non-working individuals	• All small groups (2-50) • Sole proprietors • All individuals regardless of employer offer, working or nonworking
Product Choice	• Employer chooses from 2 suites of plans. • Employees choose among 4 carriers with varying cost sharing, within the suite.	• Employer chooses one of 3 plan types (gold, silver bronze). Employees choose among carriers and plan designs within that plan-type.	• Defined employer contribution • Employees choose any plan available in the PHIP.
Carriers	• Four carriers participate in CBIA; all are major carriers in the market. More carriers are available outside CBIA.	• Seven carriers participate in the Connector; all are major carriers in the market. More carriers are available outside Connector.	• PHIP becomes the small group and individual market: all carriers in these markets participate.
Governance	• Private entity	• Quasi-public/private entity with a 10-member board.	• To be determined.
Contribution/participation requirements for employers	• 75 percent of full-time employees must participate. • Employer must contribute 50 percent of premium for the lowest-cost plan in the suite.	• 75 percent of full-time employees must participate. • No employer contribution is required. • Employers with more than ten employees must sponsor a Section 125 plan.	• 75 percent of eligible employees must participate. • Employer must contribute at least 40 percent of the premium for some available plan, but no contribution for dependents is required. • All employers must sponsor a Section 125 plan.
Alternative market(s)	• CBIA competes in the small group market. • Association plans are available, but hold a small share of the market.	• The Connector operates side-by-side with the small group and individual markets. • Young adult products (under age 26) can be sold only in the Connector. • Any firm may self-insure. • Association plans are available, but hold a small share of the market.	• PHIP becomes the small group and individual market. • Association plans continue to operate outside the PHIP and are expected to maintain significant market share. • Any firm may self-insure.

Table V.1 *(continued)*

Key Feature	Connecticut	Massachusetts	Washington (PHIP)
State regulation	• CBIA is subject to small group rating rules. • The small group and individual markets operate under same rating rules • Association plans are subject to small group rating rules.	• The small group and individual markets are blended and are subject to the same rating rules. • Carriers must pool risk by product, and may not offer different products inside and outside the Connector. • Individual coverage is guaranteed issue. • Association plans are subject to small group rating rules.	• Carriers must apply current small group rating rules to small groups and individuals alike. • Association plans are not subject to small group rating rules. • Individual coverage is not guaranteed issue; when denied, individuals are referred to WSHIP.
Composite or list rating	• Employers may choose list or composite rating.	• The Connector requires list rating.	• List rating.
Other features	• Provides full-service human-resources capacity	• Operates premium assistance for low-income enrollees.	• Operates premium assistance for low-income enrollees

APPENDIX A: MICROSIMULATION METHODS

Estimates for the HIP Board studies were produced by microsimulation. This process involved two major steps: first, developing a microsimulation database and then developing and implementing the microsimulation logic. The 2006 Washington State Population Survey (SPS), conducted by the state Office of Financial Management (OFM), is the foundation for the microsimulation database. The microsimulation logic manages the response of each individual in the microsimulation to a policy change. Each component of the model is described below.

A. THE MICROSIMULATION DATABASE

1. Data Sources

The 2006 State Population Survey (SPS) is the primary database for the microsimulation model. The SPS provides person-level information about the family, socioeconomic, and coverage characteristics of a representative sample of the noninstitutionalized population in Washington.[30] However, it lacks some key information that is important to household decisions about insurance coverage—specifically, premiums and insurance plan design. Therefore, we supplemented the SPS with data from two additional surveys: the Medical Expenditure Panel Survey Household Component (MEPS-HC) and the Medical Expenditure Panel Survey Insurance Component (MEPS-IC). To develop a sample adequate for our purposes, we selected only the West and Midwest subsamples of the MEPS-HC and then combined two years of the survey (2004 and 2005). These data provided individual and family level information on employee contributions to premiums, policy premiums, and medical cost experience.

To obtain needed information from MEPS-IC, we asked the federal agency that sponsors the survey—the Agency for Healthcare Research and Quality (AHRQ) on behalf of the HIP Board to produce estimates from the Washington State sample of the survey. Again, to develop sufficient sample size for detailed estimates, three years of the Washington State sample were combined (2003-2005). AHRQ provided statistics measuring the distribution of Washington State firms by self-insured status, offer of a Section 125 plan, and employer contribution to premiums. Information about the percent of workers eligible for coverage in offering firms in Washington State was obtained from tabulations available on AHRQ's MEPS-IC website.

2. Development of a Pre-HIP Base Case

The base case is a representation of the pre-simulation *status quo* of the Washington health care system, built by combining relevant data from multiple sources and estimating a series of

[30] The SPS sample frame is similar to that used by the Census to conduct the Current Population Survey (CPS). The CPS excludes patients in long-term hospitals and other health facilities, as well as inmates of penal or other institutions. Individuals residing in group quarters (such as a rooming house, staff quarters at a hospital, or a halfway house) are not considered to be institutionalized and, therefore, are included in the survey. Neither survey is likely to adequately represent individuals living in temporary shelters.

relationships among the data to establish the determinants of whether an employee has an offer of employer-sponsored insurance (ESI) and whether an individual will take up available coverage, given prices and product design.

a. Database Construction

To focus on populations of primary interest with respect to the policies to be simulated, we created a data set that excluded elderly (65 or older), as well as those enrolled as policyholders in federal or military health care plans (dependents in these plans are retained in the database). To increase the granularity of the microsimulation estimates for the remaining individuals, we duplicated observations in the SPS and adjusted the weight of each observation to one half of the original weight.

The MEPS-HC data were statistically matched to the SPS database, assigning to people represented in SPS the premium and cost sharing reported by MEPS-HC individuals. To assign this information, individuals in the two survey databases were matched by age group, gender, source of insurance coverage, residence in a metropolitan statistical area (MSA), race/ethnicity, self-reported health status, income level, marital status, whether living with children, industry and firm size of employment, and education. MEPS-HC premiums and expenditures (total and out-of-pocket) were scaled to Washington State per member per month (pmpm) averages by payer type.

The SPS data were then re-weighted to match selected features of Washington's population (region, age, race, and gender), as projected to 2010 by the OFM as well as public program enrollment (Medicaid, SCHIP, and other public programs) as projected by the state Department of Social and Health Services (DSHS) and the Washington State Caseload Forecast Council. Medicaid and SCHIP eligibility was benchmarked assuming expanded children's eligibility to 300 percent FPL. Private insurance premiums and medical expenditures were projected to 2010 by the average rate of change observed from 2003 to 2007, as reported to the Office of the Insurance Commissioner (OIC). WSHIP enrollment and expenditures also were extrapolated from 2003-2007 trends.

Finally, each observed worker was assigned coworkers to form a "synthetic firm." Following econometric estimation of employer offer (described below), potential coworkers in the SPS were identified by whether they were offered group coverage, geographic region, and firm size. These potential coworkers were assigned to the observed worker in proportion to their occurrence in the population. In firms that offer coverage, coworkers included those who are variously eligible for coverage or ineligible, benchmarked to the distribution of the eligible percent of workers by firm size reported in MEPS-IC.

b. Econometric Models

To develop base-case information and behavioral assumptions for the model, three econometric models were estimated as described below.[31]

- The offer model estimates the determinants of whether a worker had an offer of employer-sponsored coverage (ESI) that s/he is eligible to take up. These determinants include the employer contribution to premium, whether the worker is a member of a union, the worker's wage, and the size of the firm.[32] The output of the model is a probability of offer-and-eligible status. The model was used to (1) impute offer-and-eligible status to those whose status is missing in the original data[33] and (2) predict which individuals have offer-and-eligible status in either the HIP or the PHIP.

- For workers with an offer of coverage in firms of 2-50 employees, the small group take-up model estimates the determinants of whether the worker chooses to accept coverage. Such determinants include the required employee contribution, self-reported health status, family composition, and income.[34] Similar to the offer model, the output of the small group take-up model is the probability of taking up coverage, contingent on offer. This model was used to predict which HIP plans each individual would take up if offered, in either the HIP or the PHIP.

- For individuals with either non-group (individual) policies or who are uninsured, the non-group take-up model estimates the determinants of whether an individual buys non-group coverage. Such determinants include the premium, self-reported health status, family composition, and whether the individual is employed, as well as a

[31] Because predictive accuracy is of overriding importance in simulations, in all cases model specifications were judged first on the basis of their ability to predict accurately; related criteria for model selection included model fit (how well the model explained the data) and the plausibility of the estimated effects (for example, whether predicted relationships between prices and take-up comport reasonably with those estimated in other states).

[32] The full set of explanatory variables for the offer-and-eligible equation was the following: the employer dollar contribution to single premium; indicators for smallest firm size status (10 or fewer employees) and medium-sized firm status (11–25 employees); weekly wage; indicators for union membership, marital status, children in the family, college graduation, high school graduation, full-time status (35 hours per week or more); and indicators for SPS region and major industry.

[33] Not all household members in the SPS were asked if they had an offer of ESI.

[34] The full set of explanatory variables for the small group take-up equation were the following: the employee's (log-transformed) net required contribution to *single* premium after accounting for the employer contribution and the presence of a Section 125 plan; indicators for smallest firm size status (10 or fewer employees) and medium-sized firm status (11–25 employees); employee age; indicators for union membership, marital status, children in the family, college graduation, high school graduation, full-time status (35 hours per week or more), gender, race/ethnicity, self-reported health status (excellent/very good versus other), whether there is a working spouse in the family, whether the employee is a secondary wage earner for the family; and indicators for SPS region, major industry, and income level.

number of other personal, family, and socioeconomic characteristics.[35] Analogous to the small group take-up equation, the non-group take-up equation predicts which HIP plans an individual would be willing to buy in the PHIP if s/he does not have an employer offer of coverage.

In addition to the primary models, ordinary least squares techniques were used to impute a total premium and the expected OOP amount per total health care expenditure—a proxy for product design—to individuals for whom these data were missing.[36]

B. THE MICROSIMULATION LOGIC

1. HIP Enrollment

In simulating enrollment in the HIP, we first estimated which eligible employers would offer coverage and then which eligible employees, when offered, would take up. By assumption, the coverage status for individuals not eligible to participate in the HIP does not change.

For each worker in the simulation, a group premium was calculated for each of the twelve HIP plans, for four types of coverage (single, adult plus spouse, adult plus children, family). These calculations were based on prior estimation of a regression relationship using nonlinear ordinary least squares techniques to explain total premium (per member per month) as a function of the plan's deductible, out-of-pocket (OOP) maximum, average age of the worker's synthetic firm's employees, type of coverage, and whether the plan has been approved as a HIP plan. Estimation of this relationship used data provided by each of the HIP carriers estimating premiums for HIP and non-HIP plans for a set of small group profiles.

Using the offer model from the base case, we calculated the maximum amount that the eligible employer would be willing to contribute to cover the observed worker. If this amount was at least 40 percent of the single premium for a particular HIP plan, that plan was marked as a potential offer. Conversely, if the employer is not willing to pay the minimum employer contribution to any HIP plan, there is no new offer of coverage. The microsimulation assumes that the employer will offer the plan (among potential offers) with the highest (single) premium for which sufficient participation can be achieved and that the observed worker is willing to take up. Sufficient participation is defined as enrollment by at least 75 percent of eligible employees.

For workers in firms with a potential HIP offer, the required employee contribution is calculated as the total HIP premium minus the employer contribution, adjusted for the HIP

[35] The full set of explanatory variables for the non-group take-up equation were the following: the individual's (log transformed) net single premium; employee age; indicators for employment status, marital status, children in the family, college graduation, high school graduation, gender, race/ethnicity, self-reported health status (excellent/very good versus other); and indicators for SPS region, major industry, and income level.

[36] The premium and out-of-pocket expenditure data were trimmed prior to estimation to prevent outliers from unduly influencing the results.

subsidy (if eligible) and use of Section 125.[37] The HIP subsidy is applied to the total employee contribution to premium, including family premiums if the worker selects family coverage. Expected OOP expenditure under each HIP plan also was calculated for each worker, based on observed total expenditure (as a proxy for the worker's best estimate of expenditure when insured) and the benefit design of each HIP plan. The OOP estimate considers expenditures only for family members who are uninsured, have individual or WSHIP coverage, or are enrolled in BH. By assumption, family members who are group-insured or have Medicaid or SCHIP coverage in the base case are assumed to remain in that coverage.

The microsimulation model estimates the probability of worker take up for each potential offer and each family type, and then discounts the take-up probability for plans that would entail greater cost-sharing based on response estimates reported in the literature.[38] When the estimate indicated that a worker would take up more than one coverage type, they were assumed to take up the option that covered the greatest number of family members who otherwise were uninsured, purchasing individual coverage or WSHIP, or enrolled in BH. Workers or family members enrolled in BH accepted HIP coverage only when they anticipated a significant reduction in premiums and cost sharing in the HIP.

2. PHIP Enrollment

The HIP simulation described above constitutes the "base case" input data base for the PHIP simulation. The microsimulation logic was modified to accommodate differences in eligibility rules and in the types of plans available in the PHIP. Specifically, we assumed that all products currently available to small firms as either small groups or association members remain available to them in the PHIP. Further, we assumed that SCHIP eligibility is extended to children to 300 percent FPL, and that WSHIP remains as it is (and outside the PHIP).

Association plans also remain outside the PHIP, and they remain separately regulated, although association-insured small-employer groups may convert to PHIP coverage. The simulation assumes that an employer in an association plan would consider PHIP coverage if he or she could contribute 20 percent less to an employer-selected benchmark plan, and all employees and dependents who participate in the association plan would continue to participate when the PHIP is offered. Because the PHIP would provide employee choice, with a different premium structure for employees as well as subsidies for low-income workers, an association-insured employer potentially could reduce his or her current contribution to coverage without disadvantaging employees—either at all, or so much as to cause a disruption in coverage. By

[37] To estimate the impact of Section 125, each worker was assigned a marginal personal income tax rate based on the last dollar of family income.

[38] Daniel Polsky, Rebecca Stein, Sean Nicholson, and M. Kate Bundorf (October 2005). "Employer Health Insurance Offerings and Employee Enrollment Decisions." Health Services Research 40(5), Part I: 1259-1277. The authors report several cost-sharing effects. Because approximately 80 percent of offered workers in Washington take up coverage from an alternative source after declining an employer's offer, we use the estimated effect of taking up employer offer measured against another offer, as opposed to the effect measured against remaining uninsured.

assumption, workers who are ineligible for coverage in offering firms in the base case (either association or small group insured) remain ineligible for coverage in the PHIP.

Because Washingtonians with individual coverage are underwritten on the basis of health status and the small group market is not, merging the small group and individual markets would likely increase premiums for individual subscribers and reduce premiums for small groups for the same coverage they have now. To reflect this change, we assumed that individual underwriting removed the highest-cost 5 percent of potential enrollees from the nongroup market and adjusted PHIP premiums accordingly for market-insured small groups, association-insured small groups, and individual enrollees.[39] Assuming 5 percent, not the 8 percent allowed in regulation, accounts for renewals by individuals who become sick after initial underwriting.

Based on this estimate, we assume that carriers reduce small group premiums 13 percent, and increase premiums for individuals by 37 percent to achieve a medical loss ratio equal to the small group market average from 2003 to 2007. In an estimate coordinated with carriers, association-insured employers are assumed to have 10 percent lower premiums (on average) than comparable firms insured in the small group market, and medical cost experience (per member per month) that is 20 percent lower; it follows that premiums for the average association plan enrollee in the PHIP would be 6 percent greater for the same plan design.

To reflect the change to list-rating of small group firm workers, we assume that all employers in the PHIP convert to a defined contribution plan at their current level of contribution. Employee contributions to coverage, however, adjust with age (as do individual premiums), so that workers whose own age exceeds the average age of workers in the firm would pay more for the same coverage (Table A.1). Conversely, workers whose own age is less than the average age of workers in the firm would pay less. We assume (as in the HIP), that the 3.75:1 rate band for small groups applies to list rates for group coverage. Premiums are list-rated for each worker, for the worker's current coverage (if group insured), for each family type.

[39] Premium adjustments were based on national estimates for the privately insured population extrapolated to 2010. See: William W. Yu and Trena M. Ezzati-Rice (May 2005). Concentration of Health Care Expenditures in the U.S. Civilian Non-institutionalized Population, MEPS Statistical Brief #81. Agency for Healthcare Research and Quality (http://www.meps.ahrq.gov/mepsweb/data_files/publications/st81/stat81.pdf, accessed July 30, 2008).

TABLE A.1

FACTORS CONVERTING COMPOSITE RATES TO LIST RATES FOR WORKERS AT DIFFERENT AGES, BY THE AVERAGE AGE OF ELIGIBLE WORKERS IN THE FIRM

Worker's Own Age	Average Age of Eligible Workers in the Firm									
	60-64	55-59	50-54	45-49	40-44	35-39	30-34	25-29	20-24	<20
60-64	1.0000	1.0791	1.1719	1.2821	1.4151	1.5789	1.7857	2.0548	2.4194	3.7500
55-59	0.9267	1.0000	1.0859	1.1880	1.3113	1.4632	1.6548	1.9041	2.2419	3.4750
50-54	0.8533	0.9209	1.0000	1.0940	1.2075	1.3474	1.5238	1.7534	2.0645	3.2000
45-49	0.7800	0.8417	0.9141	1.0000	1.1038	1.2316	1.3929	1.6027	1.8871	2.9250
40-44	0.7067	0.7626	0.8281	0.9060	1.0000	1.1158	1.2619	1.4521	1.7097	2.6500
35-39	0.6333	0.6835	0.7422	0.8120	0.8962	1.0000	1.1310	1.3014	1.5323	2.3750
30-34	0.5600	0.6043	0.6563	0.7179	0.7925	0.8842	1.0000	1.1507	1.3548	2.1000
25-29	0.4867	0.5252	0.5703	0.6239	0.6887	0.7684	0.8690	1.0000	1.1774	1.8250
20-24	0.4133	0.4460	0.4844	0.5299	0.5849	0.6526	0.7381	0.8493	1.0000	1.5500
<20	0.2667	0.2878	0.3125	0.3419	0.3774	0.4211	0.4762	0.5479	0.6452	1.0000

Source: Mathematica Policy Research.

At this point, the logic of the PHIP simulation model is similar to the logic of the HIP simulation. Employers that currently sponsor coverage are assumed to achieve minimum participation in the PHIP with employee choice, as they do now with only employer choice of plan. Employees who are unwilling to continue current coverage (given the change in the employee contribution associated with list rating, even after subsidy and a Section 125 "discount") are allowed to consider coverage in any of the HIP plans. Eligible workers who are now uninsured in offering small groups consider taking up their employer's current offer or any of the HIP plans, in light of the available subsidy (if any) and their Section 125 "discount." Non-offering small firms that were ineligible for the HIP are eligible for the PHIP; these firms consider offering PHIP coverage, and their workers consider take up. The simulation requires newly offering small groups to achieve 75 percent participation of eligible workers, consistent with current participation rules in the small group market.

Finally, individuals—whether individually insured or uninsured in the base case—are eligible for PHIP coverage. For those with individual coverage in the base case, the microsimulation logic determines whether they would continue at a new premium, made higher by merging the small group and individual markets, after the application of a subsidy (if eligible) and a Section 125 discount (if employed). If not, the model allows them to consider taking any of the twelve HIP plans. Individuals who are uninsured in the base case also are allowed to consider "standard" coverage in the PHIP (comparable to plans they currently select) or any of the HIP plans.