Washington State Health Care Authority

# Report to the Legislature

# Health Insurance Partnership: Final Report

Substitute House Bill 2052
Chapter 257, Laws of 2009

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# EXECUTIVE SUMMARY

Section 3 of Substitute House Bill 2052, enacted as Chapter 257, Laws of 2009, and codified as RCW 70.47A.070, directs the Health Care Authority (HCA) to provide a biennial report related to the effectiveness and efficiency of the Health Insurance Partnership (HIP). The aforementioned legislation states:

> Upon implementation of the health insurance partnership program, the administrator shall report biennially to the relevant policy and fiscal committees of the legislature on the effectiveness and efficiency of the health insurance partnership program, including enrollment trends, the services and benefits covered under the purchased health benefit plans, consumer satisfaction, and other program operational issues.

The ability to measure these aspects of the program in a qualitative manner is not possible. Due to discontinuation of federal grant funds, enrollment in HIP health care coverage was open for only four months and coverage was available to small number of enrollees for a total of 16 months. The Health Insurance Partnership began processing applications on September 1, 2010, and HIP health insurance coverage began January 1, 2011. Termination of the federal grant funds was announced in May 2011 and HIP was closed to new enrollment. In July 2011, HCA was notified that covered employees could continue their HIP coverage until grant funds for the current federal fiscal year were expended. This extended subsidized coverage until May 2012 when the program was terminated.

Based on the history of the HIP program, the primary value will be to provide information and experience to the Health Benefit Exchange Board and staff regarding the challenges and complexity of developing the Small Business Health Options Program (SHOP) Exchange as provided under the federal Affordable Care Act (ACA).

Thus, this report is submitted as the final biennial HIP report.

# LEGISLATIVE HISTORY OF THE HEALTH INSURANCE PARTNERSHIP

In the private insurance market, Washington's small employers continue to find it difficult to offer their employees affordable, predictable health insurance coverage. The legislative intent of the Health Insurance Partnership was to "remove economic barriers to health insurance coverage for low-wage employees of small employers by building on the private sector health benefit plan system and encouraging employer and employee participation in employer-sponsored health benefit plan coverage" (see RCW 70.47A.010). The concept was to combine the contributions from small employers and their employees with a public subsidy for low income employees.

In 2006, Engrossed Second Substitute House Bill 2572, enacted as Chapter 255, Laws of 2006, established the Small Employer Health Insurance Program (SEHIP) program administered by the Health Care Authority. The program, codified in Chapter 70.47A RCW, was created to provide premium subsidies to eligible employees and their dependents participating in a health benefit plan offered by a small employer. Eligibility criteria included a family income of less than 200% of the Federal Poverty Level and a monthly premium contribution for the employee of at least 40% by the small employer. The premium subsidy was to be developed similar to the sliding scale used for the Basic Health program. HCA was to begin accepting applications for premium assistance by July 1, 2007. Enrollment in the program was to be limited to the funds appropriated in the state operating budget for this purpose and HCA was to submit a biennial report to the Legislature.

Prior to implementation of the SEHIP program, Engrossed Second Substitute House Bill 1569, enacted as Chapter 260, Laws of 2007, renamed the program the Health Insurance Partnership (HIP). The legislation directed HCA to begin accepting applications for premium assistance on September 1, 2008. A seven member Health Insurance Partnership Board (Board) was established. Responsibilities of the Board included: designating at least four health plans available in the private small group market as eligible for premium subsidy; determining a mid-range plan as the benchmark for the premium subsidy; and determining minimum employee participation requirements and whether there should be a minimum employer contribution. The board was directed to evaluate rating methodologies and impacts on applying small group market rating within a partnership, and to consider options to manage carrier uncertainty through risk adjustment, reinsurance, or other mechanisms. The plans designated for premium subsidy were to provide multiple cost-sharing/deductible options, and range from high deductible/catastrophic to comprehensive. Designated plans were to include innovative components, such as preventive care, chronic care management, wellness incentives, and payment related to quality of care.

The Board identified a number of issues that needed to be addressed prior to making subsidized health coverage available to employees of small business through HIP and requested adoption of changes to the Legislation. These issues include: placing limits on an employee's ability to choose a health plan, providing a funding source for subsidies, funding administrative expenses, resolving potential statutory conflicts between the HIP statute and health insurance provisions in Title 48 RCW, providing a longer implementation time line, and allowing employers to participate in HIP regardless of the employees' subsidy status.

The Legislature responded by passing Second Substitute House Bill 2537, enacted as Chapter 143, Laws of 2008. The legislation authorized the Board to limit:

- The number of small group plans to be offered and the plans that will be eligible for a subsidy;
- An individual's health plan choice; and
- Coverage of former employees to those eligible for COBRA continuation coverage for up to two years from when HIP begins to offer coverage.

As the income requirement for an employee to receive a HIP subsidy is based on family income, the requirement that participating employers must have at least one employee eligible for a subsidy was deleted and applicant employers were required to attest they are not currently offering health insurance and at least 50 percent of their employees are low-wage workers. Both the small employer and his or her employees are eligible to purchase health coverage through HIP. Language authorizing the Board to offer and administer the small employer's group health benefit was deleted and the Board will not act in the role of the small employer's health plan sponsor. HCA was directed to coordinate premium subsidies for dependent children with available federal programs. The legislation also required the partnership to offer coverage to small employers and their employees no later than March 1, 2009.

During the 2011 session, the Legislature passed Substitute House Bill 1560, enacted as Chapter 287, Laws of 2011, which clarified that funding for the HIP may come from federal sources. The eligibility requirement that a small employer must not currently offer health insurance was expanded to require that the small employer not have offered insurance for the previous six months. The requirement that a small employer establish a cafeteria plan that allows employees to use pretax dollars for health benefit plan premiums was also eliminated.

Due to a significant budget shortfall, substantial cuts were made to balance the State's 2009-11 biennial budget during the 2009 Legislative Session. Substitute House Bill 2052, enacted as Chapter 257, Laws of 2009, delayed implementation of HIP until January 1, 2011, subject to available funding. Essentially, HIP was delayed indefinitely, implementation of program operations was suspended and the Board was disbanded.

# IMPLEMENTATION OF
# THE HEALTH INSURANCE PARTNERSHIP

On March 11, 2009, the State Health Access Program (SHAP) was authorized by the Omnibus Appropriations Act, P.L. 111-8, signed by the President to assist states to develop innovative approaches to increase health insurance coverage for their uninsured residents. The State of Washington, through the Office of Financial Management, submitted a SHAP grant application Washington's SHAP application which included 5 broad goals. The primary goal was implementation of the HIP program.

In August 2009, HRSA approved a five-year $34.7 million SHAP grant to implement the HIP program. Under the grant, the program was funded to provide over $2 million in subsidies for the first year of the program (through August 31, 2011). In the following years, HIP would be able to provide almost $9 million each year in health insurance premium subsidies for low income employees and their dependents.

As a direct result of SHAP grant funding, the HIP was resurrected. The HIP Board and the Technical Advisory Committee (TAC) were re-established with a commitment from all previous HIP Board members to serve. The HIP Board agreed to implementation of the HIP as previously designed.

The objectives for HIP as presented in the SHAP grant application were to:

- Improve access to employer-sponsored coverage by building on the private health insurance system.
- Achieve health risk that emulates a conventional employer-group.
- Increase small employer offer and employee coverage rates.
- Provide access to managed health care services.
- Offer health plan choice geared toward managing the full cost of coverage and encouraging take-up and retention and thus sustainability of coverage.
- Pilot a quantitative/qualitative program evaluation that offers a template for future coverage expansion evaluations.

To achieve these objectives, HIP reviewed evaluation from endeavors to improve access to coverage for small employers in other states. On March 17, 2010, SHADAC released an evaluation of HEALTHpact in Rhode Island, where the program reached "less than 10% of its enrollment cap." Recommendations from the report1 suggested that:

> *…"future iterations of small-group reform should consider: (1) instituting a subsidy or other premium support program; (2) prioritizing broker and insurance company buy-in; (3) providing the resources necessary for effective government oversight and outreach; and (4) carefully designing wellness incentives"…*

Some of these recommendations were intentionally built into the design of the HIP program either from the initial program development or as an element of an ongoing activity. The Rhode Island report validated those decisions.

Prior to implementation of the program, focus groups were held statewide; approximately 60 brokers participated. HIP implemented changes to enrollment processes and materials in response to broker feedback. HIP created a "Broker Toolkit" with collateral materials to help walk through HIP's process and to use as tools to inform small employers.

Statewide broker trainings were conducted in August 2010 in 7 locations (Olympia, Tacoma, Seattle, Bellingham, Vancouver, Richland, and Spokane). More than 150 brokers attended the training. Additional trainings were held in October 2010 and January 2011.

The Health Insurance Partnership began processing applications on September 1, 2010, and HIP health insurance coverage began January 1, 2011. Four major insurance carriers participating in HIP offered statewide coverage through 16 health benefit plans. The plans ranged from comprehensive to catastrophic coverage and were designated into four tier levels.

HIP's target employer population was small employers (1-50 employees) in Washington State not offering coverage to their employees at the time of enrollment and who have at least 50% of their workforce who are low-wage. To participate in the Health Insurance Partnership (HIP) a small employer must:

- Not have offered insurance for the previous six months;
- Have no more than 50 employees;
- Have at least half of it's workforce comprised of low-wage workers;
- Enroll at least 75 percent of its employees in HIP coverage; and
- Contribute at least 40 percent of the cost of premiums.

The HIP target employee population was the approximately 175,000 uninsured employees (and their dependents) who work in small businesses for whom affordability issues are most acute. Estimated enrollment for the first year of coverage, based on SHAP grant funding available for subsidies, was approximately 1,150 individuals, about 55% of whom we anticipated to receive a subsidy. HIP projected that approximately 4,000 individuals could receive subsidized coverage by September 2012.

Subject to available funding, employees of participating small employers were eligible for a subsidy for their portion of the premiums, if they were Washington residents and had a family income at or below 200 percent of the federal poverty level. Subsidies were based upon a sliding scale depending on income.

HIP used a "soft-launch" marketing approach to reach small employers, mostly in an effort to be able to manage enrollment without having to establish a waiting list. Much of this approach was dependent on HIP's experience and partnership with the broker community.

However, because of the broker response to insurer changes to address the ACA, HIP was not marketed through the broker community as much as initially anticipated. Rather than the preferred approach of having employers work through brokers, HIP contacted the carriers directly to coordinate rate quotes and applications for coverage. While this process was manageable with the limited enrollment in the program, it would have required more staff resources as enrollment grew and would have become inefficient. Before the loss of funding,

HIP was finalizing contracts with select Washington brokers to assist employers through the process and enrolling in health insurance coverage. Brokers would have been compensated by HIP with a flat fee, according to the group size.

Thus, HIP began marketing directly to small employers through online and print advertising. HIP also created partnerships with organizations that support small business around the state (such as Economic Development Councils, Small Business Development Centers, Chambers of Commerce, etc.), and executed plans to market HIP to their audiences in an effort to raise awareness of HIP and increase the enrollment numbers.

Even with the subsidy for low-income employees, engagement with Washington's brokers, and strong outreach activities, HIP's enrollment did not meet its target. 147 employers initially enrolled in the Health Insurance Partnership. However, of those employers, only 16 employer groups enrolled in health insurance coverage, resulting in 66 covered lives (employees and dependents) enrolled in HIP.

The pace of enrollment was slower than anticipated during the initial months of operation. The pace began to pick up toward the end of March 2011, as evidenced by a greater number of phone calls from employers and brokers interested in the program. HCA projected that enrollment could reach 650 covered lives by the end of the first year.

Unfortunately, the program did not see any positive results or increased enrollment due to the loss of continued federal SHAP grant funding. The HIP program was closed to new enrollment in May 2011 after four months of operation and was shut down in May 2012 when funding for subsidized enrollment could no longer be sustained. Thus, the true potential of the program could not be realized or measured.

The HIP program identified two key reasons for the slow pace of HIP insurance coverage enrollment:

a) Compensation given by the carriers to brokers for successfully enrolling employers in health insurance coverage decreased significantly for groups with less than five employees. The loss of broker commissions resulted in a lack of interest on the part of brokers to assist the smallest businesses in finding health insurance coverage;
b) Some employers that enrolled in HIP declined to complete the carrier's group master application for health insurance coverage, reporting that even with subsidies the cost of coverage was still too high.

# THE FEDERAL AFFORDABLE CARE ACT

On March 23, 2010, President Obama signed the federal Affordable Care Act (ACA). Small businesses with fewer than 100 employees will be able to purchase coverage through the Small Business Health Options Program (SHOP) Exchanges beginning in 2014. These state-based exchanges were intended to allow employers to shop for qualified coverage and more easily compare prices and benefits. In 2017, states will have the option to allow businesses with more than 100 employees to purchase coverage through the SHOP Exchanges.

Substitute Senate Bill 5445 (Chapter 317, Laws of 2011) authorized the Health Benefit Exchange (HBE) Board to establish technical advisory committees (TACs) to advise board policy on technical issues. The HBE Board established the SHOP Technical Advisory Committee to provide experience and professional perspectives related to the SHOP.

HIP was the Washington state laboratory for experimenting in the design and early implementation of the small business exchange envisioned in the ACA. HIP structured the designated health benefit tier levels to align with ACA, implementing four tier levels which differed by increasing coverage levels. HIP's plan designation process serves as a testing ground for implementing essential benefits and qualified health plans under the ACA. Some of the work funded with the SHAP grant will benefit the work of the exchange implementation team, most notably the development of a survey for small employers, followed by statewide focus groups on employer choices when given the opportunity to enroll in coverage through the SHOP.

Despite its short lifespan, HIP offers useful insights for development of the SHOP Exchange. It was initially anticipated that experience gained through HIP would inform the exchange work, specifically concerning enrollment trends of small employers, strategies for engaging producers, successful marketing and outreach tools, the selection process of plans to be offered through the exchange, and the implementation of individual choice. While the experience gained through the design and implementation of HIP will not be lost, much of the operational experience is extremely limited due to the short time that subsidies were funded and coverage was provided.

The ACA changed the industry for insurance carriers and they responded by cutting administrative costs. In order to support the Minimum Loss Ratio (MLR) requirements, many insurance carriers significantly reduced the commissions paid to brokers who sell products in the small group market. In addition, ESSB 6538, which passed during the 2010 Legislative Session, changed Washington's small group market to include employers with 1-50 employees (it was 2-50) and most carriers do not pay commissions on groups of one employee. One of the largest carriers in the Washington small group market changed the commission structure from percent of premium to a flat fee per employee per month. For brokers who assist micro employers this equates to a substantial commission reduction. Several brokers notified HIP that they would not able to assist very small groups, especially groups of 1-2. A number of small employers contacted HIP indicating that they were not able to locate a broker who would help them.

# CONCLUSION

The legislature directed HCA to report on the efficiency of HIP, to include "enrollment trends, the services and benefits covered under the purchased health benefit plans, consumer satisfaction, and other program operational issues". However, the ability to measure these aspects of the program in a qualitative manner is not possible. While the HCA database for HIP was developed to collect and measure a number of coverage, enrollment, enrollee demographic, and premium contribution information data elements, this data evaluation was not completed due to loss of funding. New enrollment in HIP health care coverage was open for only four months and coverage was available to small number of enrollees for a total of 16 months.

Based on the history of the HIP program, the primary value will be to provide information and experience to the Health Benefit Exchange Board and staff regarding the challenges and complexity of developing the SHOP Exchange under the ACA. The HCA will make HIP-related information available to the Exchange for their use as appropriate.