Final Report to the Governor and Legislature

Approaches to Shared Financial Responsibility for Health Coverage of Large Employers' Low-Wage Workers Enrolled on State Plans

As Required by Substitute House Bill 1128,
An Act Relating to Fiscal Matters

March 5, 2008

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EXECUTIVE SUMMARY

Over the last few years there has been growing concern and debate in Washington State about the extent to which low-wage/low-income workers of some large employers get their health coverage through public programs rather than through their employers. The debate has been quite rigorous with divergent views on what steps, if any, the state should take.

The debates recently culminated in two actions. First, in 2006 ESHB 3079 was enacted which requires state agencies to annually report on the employment status of enrollees of state health coverage programs serving low-income persons. Second, in 2007 the Governor signed SHB 1128 (the state's 07-09 biennial budget) which included a provision for the Department of Social and Health Services (DSHS) to ***report on approaches to sharing financial responsibility for health coverage of large employers' (over 50 employees) low-wage workers who are enrolled on state plans.*** The Health Care Authority (HCA) (responsible for the Basic Health (BH) program), the Employment Security Department (ESD), and a Workgroup of legislative and non-legislative members were to be closely involved and consulted.

This report represents the work of DSHS and its partners in addressing this important issue.

The value of the work that resulted from the budget proviso is equal parts process and product. The Workgroup process provided a non-pressured environment for discussing a highly charged issue – people stepped outside their usual boundaries and came looking for common ground. They found it rather quickly – "get people covered".

"Our goal was to look for constructive solutions and dialogue. The Workgroup has done that."
(Group Member)

In the process, the group challenged people's conventional wisdom about the scope and drivers of the shared-responsibility issue, it gave perspective to the issue by placing it within broader health system and work place concerns, and it clearly identified gaps in our knowledge. Finally, there was recognition of the degree to which shared-responsibility is currently occurring among Washington's large employers and state plans.

Building on different philosophical perspectives for reaching the "common ground" of covering people, the Workgroup identified and rank ordered (most to least preferred) eleven shared responsibility approaches. Based on rankings, the Agencies and Workgroup collaborated on selecting a subset of five approaches that merited additional attention.[1] The subset included those approaches that the Workgroup wanted to understand better in terms of policy issues, operational complexity, and future viability. The eleven approaches, with the subset of five in bold, and their ranks (lower rank means more preferred) are:

Reporting and tracking of employer-coverage access	**3.8**
BH Employer-sponsored insurance (ESI) program	**4.9**
DSHS Employer-sponsored insurance (ESI) program	**5.3**
BH vouchers to buy employer coverage	**5.5**
PSHB 2094 (H-3557.2), 2007 Taxpayer Health Care Fairness Act	**5.6**
Public program buy-in	6.0
Stay the course	6.1
B&O tax incentive	6.2
Washington Health Insurance Partnership expansion report	6.3
BH coordination of benefits	6.8
BH incentive to accept employer coverage	7.1

[1] The budget proviso that created this assignment specified that PSHB 2094 be included as one of the approaches to merit additional attention in terms of identifying next steps and implementation issues. It is impossible to know whether this influenced Workgroup members' voting re PSHB 2094.

The Agencies spent considerable time reviewing possible next steps as well as potential policy and implementation issues for the five more-preferred options. Details of their analyses are in Section V.

For **Reporting & Tracking,** specific next steps include:

- Survey state program enrollees to better understand why they choose to enroll in public coverage if employer coverage is available to them (additional funding is required for this effort),
- Enhance ESHB 3079 reports by including a time series component and by providing analysis of the relationship between coverage rates and duration of employment and time enrolled in state programs, and
- Coordinate DSHS and BH ESHB 3079 reports in terms of consistent methodology and reporting format, to provide a better sense of the scope of the issue overall rather than just agency-by-agency.

For the **DSHS-ESI** option, commitments include specific dates for:

- Consolidating DSHS' two employer-coverage-assistance programs (HIPP and ESI),
- Expanding employer participation by working directly with large employers to enroll clients outside of normal open enrollment periods, providing outreach activities, and sharing data to assess cost-effectiveness and to identify potential ESI enrollees,
- Increasing client participation by *requiring* participation in the program (to the extent allowed by law), by including children from SCHIP and the Children's Health Program, and by better targeting clients/families that may potentially have access to employer coverage (e.g., enrollees in Transitional Medical Assistance), and
- Reviewing other states' ESI programs for opportunities to improve what Washington is doing (e.g., in areas of marketing, handling clients with multiple employers, and determining cost-effectiveness.)

With respect to **PSHB 2094**, Taxpayer Health Care Fairness Act, the Agencies propose several technical corrections to allow DSHS to bill and collect fees as required by the proposed legislation. Given previous stakeholder work on the bill, the Workgroup directed the Agencies to limit their review to any *remaining operational issues* that would make it impossible for the Agencies to implement the bill if someone were to pursue it in the future. The analysis was done with the understanding that the Agencies were not taking any position on this approach but simply providing technical assistance.

For the last two of the top-five preferred options, **BH-ESI and BH-Voucher**, the information in Section V lays the groundwork for further policy discussion. Anything more than that would be premature, particularly given the Legislative directive (E2SHB 1569, section 11) to evaluate inclusion of BH into the Washington Health Insurance Partnership. Examples of the types of issues raised in Section V are operational and policy issues such as wraparound coverage, determination of cost-effectiveness, voluntary or required participation, coordination with DSHS programs, impact of the current enrollment information system project, affect on traditional BH's risk pool and therefore its premiums, and continuity of plan and enrollee participation. Federal and legal issues are also raised such as the risk that the federal government would define BH as an employer sponsored plan subject to ERISA requirements and/or coordination with the Medicare program. BH's initial analysis indicates that the challenges of providing a BH-ESI program similar to that of DSHS are substantial and that a voucher approach would be the less complex of the two alternatives.

Combined with its appendices, this report captures much of the conversation and information shared during the Low-Wage Worker process. We hope its contents provide a base for future discussions and solution building.

SECTION I: INTRODUCTION

A: WHY THIS REPORT

In April/May 2007 the Washington State legislature passed and the Governor signed the 2007-09 biennial budget. The budget bill, SHB 1128, included a provision for the Department of Social and Health Services (DSHS) to report on approaches to sharing financial responsibility for health coverage of large employers' (over 50 employees) low-wage workers who are enrolled on state plans. In developing the report, DSHS was to consult with the Health Care Authority (HCA), the Employment Security Department (ESD), and a Workgroup that included legislative members and representatives of various private and public employer and employee groups.

The results of the DSHS Low-Wage Worker process are summarized in this report and presented to the Governor and Legislature as required by the budget proviso. The Agencies thank the Workgroup members for their commitment, advice, and encouragement to think outside usual boundaries.[2]

> **"Our goal was to look for constructive solutions and dialogue. The Workgroup has done that."**
>
> Paraphrased from Workgroup member at December 12, 2007 meeting.

The report is structured as follows: Section I introduces the assignment and its history; Section II frames the issue; Section III identifies the target population; Section IV goes to the heart of the proviso – in it we discuss various approaches, identify how each approach furthers the goal of shared responsibility, and explain the process used to select a subset of more-preferred approaches; and, Section V provides additional detail on implementation issues and next steps for the five approaches ranked more-preferred by the Workgroup.

This report captures much of the conversation and information shared during the process. We hope its contents provide a base for future discussions and solution building.

B: BACKGROUND AND ASSIGNMENT

Over the last few years there has been growing concern and debate about the extent to which low-wage workers of some large employers get their health coverage through public programs rather than through their employers. The debate has been quite rigorous with divergent views on what action, if any, the state should take.

Although history on the issue goes back many years, interest picked up steam in the early 2000s. For example, around 2002 the legislature requested information from DSHS and HCA about employers of DSHS medical assistance and Basic Health (BH) enrollees. Since that time, a variety of bills has been introduced and debated on reporting the employment status of public program enrollees and on approaches for ensuring that large employers financially support health coverage for their workers.

The debates culminated in two actions. First, in 2006 ESHB 3079 was passed that requires state agencies to annually report on the employment status of DSHS medical assistance and BH enrollees; and, for medical assistance, to report on the employment status of non-client parents of enrollees. Data from the first ESHB 3079 reports, and supplemental analyses of that data, provided much of the target population information used in Workgroup discussions of shared responsibility (see Report Section III). A summary of ESHB 3079's requirements is given in Appendix 1-1.

The second action resulting from several years of shared responsibility discussions is the budget proviso that forms the basis of this report. The exact proviso language detailing the assignment to DSHS is provided in Figure 1-1.

[2] Notwithstanding the invaluable role of the Workgroup, this report is a product of the Agencies who take responsibility for its contents.

C: WORKGROUP AND WORKGROUP PROCESS

An important part of the shared responsibility assignment was the formation of a Workgroup, with membership dictated by the proviso (see Figure 1-1). The final group included eight legislative and twelve non-legislative members. Names and affiliations are given in Appendix 1-2.

Five Workgroup meetings were held between September 26, 2007 and December 12, 2007. The first meeting focused on project scope, organization, and process (who would be responsible for what). Meetings two and three were informational; they provided context for future discussions on shared responsibility. Specifically, in meetings two and three the Workgroup was briefed on DSHS and BH programs and activities relevant to the topic, status and trends in employer-sponsored coverage for Washington large employers and their low-wage/low-income employees, and results of the Agencies' analyses of the employment status of current state program enrollees. Finally, meetings four and five focused on the meat of the proviso – possible approaches for sharing financial responsibility for health coverage of large employers' low-wage workers who are enrolled in public coverage programs. A brainstorm list of possible approaches was presented to, and discussed by, the Workgroup; their input on refinements and additional options was sought; and, finally they were asked to rank order the list of approaches (eleven in all). Based on their rankings and follow-up discussions, a "top tier" of five approaches was selected for additional analysis by the Agencies regarding next steps and potential implementation issues. Details on the shared responsibility approaches and the narrowing process used by the Workgroup are described later in this report (see Section IV). Detailed agendas with summary notes from the five meetings are given in Appendix 1-3.[3]

Figure 1-1
Substitute House Bill 1128, An Act Relating to Fiscal Matters,
Section 209(23), 2007 Washington Legislative Session

"$150,000 of the general fund--state appropriation for fiscal year 2008 is provided solely for the department of social and health services, in consultation with the health care authority and the employment security department, to prepare and submit a report and recommendations to the governor and the legislature related to coverage of low-wage workers enrolled on state plans who are employed by employers with more than fifty employees. The report shall address multiple approaches, including but not limited to the proposal included in House Bill No. 2094 (taxpayer health care fairness act). The discussion of each approach included in the report should identify how the approach would further the goal of shared responsibility for coverage of low-wage workers, obstacles to implementation and options to address them, and estimated implementation costs. The report shall be submitted on or before November 15, 2007. The agencies shall establish a workgroup, which shall be closely involved and consulted in the development of the report and recommendations under this subsection. The workgroup shall include the following participants: Persons or organizations representing large employers in the retail, agricultural and grocery trades, other large employers, organizations representing employees of large employers, organizations representing low-wage employees of large employers, state and local governmental entities as employers, and organizations representing employees of state and local governmental entities. In addition, the workgroup shall include three members from each of the two largest caucuses of the House of Representatives, appointed by the speaker, and three members from each of the two largest caucuses of the senate, appointed by the president of the senate."

[3] Although it is somewhat unusual to include meeting summary notes in a final report we have done so because they give a sense of the depth and breadth of Workgroup discussions; the flavor of which is hard to capture in a report and would otherwise be lost.

SECTION II: FRAMING THE SHARED RESPONSIBILILTY DISCUSSION

A. BROADER CONTEXT

Discussions with the Workgroup provided an opportunity to put this issue into perspective, not as a means of diminishing its importance but rather as a reminder of where it fits within a broader picture. As articulated by Workgroup members, some of the bigger concerns to be mindful of during discussions on approaches to shared responsibility included:

- Role of state government in providing rules and incentives for maintaining a competitive business environment;
- Increasing health care costs in general and premium costs in particular (the latter driven to a large degree, but not solely, by the former);
- Degree to which the design and targeting of public programs may contribute to premium and health care cost increases (e.g., cost-shifting onto private employers);
- Overall deterioration of total compensation packages for lower-wage / lower-income workers; and
- Growing uninsured problem, particularly but not exclusively among younger working adults.

In addition, the Agencies paired these broader concerns with a small set of assumptions as a means for keeping Workgroup discussions focused, balanced, and on-topic. The assumptions were:

- The focus of the proviso effort is quite narrow; it is not about comprehensive reform or fundamentally reshaping the missions of state programs;
- Some financial assistance (directly or indirectly) beyond what employers are able to offer is likely needed in order for workers with low-wages / low-incomes to afford coverage;
- Employer's decisions about coverage (what to offer, to whom, for how much) depend on an array of considerations including workforce stability, employees demand for insurance, whether other firms competing in the same field for the same employees are offering this benefit, owner's personal beliefs about the value of coverage, and the insurance price faced by business.

B. LOW-WAGE OR LOW-INCOME

The budget proviso in SHB 1128 specifies the target population as *low-wage* workers; the exact language used is "…low-wage workers enrolled on state plans who are employed by employers with more than fifty employees." However, discussions in Workgroup meetings made it clear that the more apt descriptor is *"low-income"* workers because income, not wages, is used in determining public program eligibility. **In keeping with the proviso language, the report uses the phrase low-wage with the understanding that the true intent is low-income.**

The distinction is not simply a matter of semantics. Recent work by researchers at The Urban Institute helps clarify the difference between being low-wage and low-income; see Figure 2-1 for a summary. All in all, it's safe to say that a low-income family is likely to be a low-wage-earner family but the reverse is not necessarily true (i.e., a low-wage worker can easily be part of a higher-wage family).

Figure 2-1
Low-Wage or Low-Income or Both?

Many low-wage workers actually live in non-low-income families where they are a second source of income or are younger (e.g., teen) workers. Based on one definition, about one in four workers is low-wage but less than half of these are part of low-income families (family income less than 200% of federal poverty). An even smaller percentage, about 5%, of workers is low-wage, living in low-income families *with children*.

Compared to the average worker, this group of low-wage workers living in low-income families is disproportionately young, Hispanic, less educated, in fair or poor health, head of one-parent families, work in very small firms and industries with lower average wages, and less likely to work full time year around.

Among low-wage workers living in low-income families (with or without children), roughly ½ work full time, year around; just under ¼ work full time, part of the year; and the remaining (approximately) ¼ are roughly split evenly between part-timers who work all year or just part of the year.

Employer-sponsored insurance from one's own employer is a relatively rare benefit among low-wage workers living in low-income families (with or without children) – about 20% of these workers have it.[4]

[4] Acs, Gregory and Austin Nichols. 2007. "*Low-Income Workers and Their Employers: Characteristics and Challenges."* Washington, DC: The Urban Institute. Clemans-Cope, Lisa, Genevieve M. Kenney, Matthew Pantell, and Cynthia D. Perry, 2007. "*Access to Employer-Sponsored Health Insurance Among Low-Income Families, Who Has Access and Who Doesn't."* Washington, DC: The Urban Institute. Martinson, Karin, Pamela Winston, and Susan Kellam. 2007. *"Public and Private Roles in Supporting Working Families, An Urban Institute Roundtable."* Washington, DC: The Urban Institute.

C. LARGE EMPLOYER COVERAGE IN WASHINGTON[5]

To put discussions about shared responsibility in context it is useful to know something about the coverage experiences of Washington large employers and their workers.[6] The following is a high level picture of

- Where people work in Washington,
- Workers' coverage by Washington large employers, and
- Health insurance expenditures by Washington large employers relative to state-imposed business expenses.

Where people work in Washington[7]

Most people in Washington work for large firms, even though those firms make up a small percentage of all Washington businesses. [8] (See Table 2-1)

> *Large employers of 50 or more employees are slightly less than 5% of Washington's businesses but they employ about 3 out of 5 Washington workers (~59%).*
>
> *Super-sized employers, those with 1000+ employees, make up a miniscule percentage of Washington businesses (one tenth of one percent) but employ about 1 in 6 (~17%) workers.*[9]

The most prominent industry types for employers and employees overlap, but not completely. (See Table 2-2)

> *Relative to all industry types, high percentages of both employees and employers are found in the Manufacturing and the Health care & social assistance sectors.*
>
> *However, the "top percent" industry type differs between employees and employers: the highest percent of employees is found in the Educational services sector, whereas the highest percent of employers is found in Retail trades.*

---

[5] Whenever the phrase "large employer" is used without definition it refers to employers with 50 or more employees.

In addition, this brief overview generally treats all large employers as one group; however, there are often important differences between *smaller* large employers (e.g., 50-99 employees) and *larger* large employers that a more in-depth analysis should consider.

[6] Because the data often do not support analyses solely for low-wage / low-income workers in Washington (frequently due to sample size issues), much of the information in this section reflects large employers and *all* their employees (regardless of wages or income).

[7] Data were provided by the Employment Security Department. For the years examined, i.e., first quarters of 2002 – 2006, the distributions of employers and employees across firm size and industry type were remarkably similar to the figures presented in Tables 2-1 and 2-2 for first quarter 2006.

[8] The firms or businesses used here are those with at least one employee.

[9] Among large firms alone (those with 50 or more employees), the super-sized firms make up 2% of large firms and employ about 28% of the large employer workforce.

Table 2-1
Washington State Employer Data by Firm Size, First Quarter 2006

Firm Size	Employers			Employees		
	Number	% of all	% of 50+	Number	% of all	% of 50+
50-99 employees	4,852	2.6%	55%	334,975	12.0%	20%
100-499 employees	3,565	1.9%	40%	666,857	24.0%	40%
500-999 employees	278	0.2%	3%	186,814	6.7%	11%
1000+ employees	187	0.1%	2%	462,458	16.6%	28%
Total for firms with 50+ employees	8,882	**4.8%**	100%	1,651,104	**59.4%**	100%
Total for All firms with at least 1 employee	185,387			2,781,164		

Table 2-2
Washington State Employer Data By Industry Type
Employers with 50+ Employees, First Quarter 2006

Industry Type	Employers		Employees	
	Number	% Total	Number	% Total
Educational services	456	5.1%	233,034	**14.2%**
Manufacturing	1,024	**11.6%**	224,306	**13.7%**
Health care and social assistance	1,010	**11.4%**	217,052	**13.3%**
Retail trade	1,316	**14.9%**	159,635	9.8%
Public administration	435	4.9%	137,090	8.4%
Administrative and waste services	565	6.4%	90,538	5.5%
Transportation and warehousing	391	4.4%	77,785	4.8%
Information	287	3.2%	76,375	4.7%
Professional and technical services	438	4.9%	65,790	4.0%
Accommodation and food services	727	8.2%	65,832	4.0%
Construction	530	6.0%	55,173	3.4%
Finance and insurance	323	3.6%	51,275	3.1%
Wholesale trade	437	4.9%	49,585	3.0%
Arts, entertainment, and recreation	243	2.7%	39,364	2.4%
Management of companies and enterprises	112	1.3%	27,242	1.7%
Agriculture, forestry, fishing and hunting	222	2.5%	26,980	1.6%
Other services, except public administration	158	1.8%	16,807	1.0%
Utilities	55	0.6%	11,279	0.7%
Real estate and rental and leasing	115	1.3%	10,372	0.6%
Mining	11	0.1%	1,013	0.1%
Total for Employers with 50+ Employees [10]	8,855	100.0%	1,636,527	100.0%

[10] Totals differ slightly from those in Table 2-1 (e.g., 8,855 versus 8,882 employers) mainly due to missing data.

Workers' coverage by Washington large employers

Do Washington workers continue to get coverage through their large employers? They do, but at somewhat lower rates than in the past.[11]

Availability -- Among all employees who work for large employers in Washington, most work for an employer that makes coverage available to at least some employees. (See Offer Rates in Figures 2-2 and 2-3)

> *Offer rates for employees of large employers in Washington have stayed quite high over the last few years. Depending on how the data are arrayed (yearly rates or three-year moving averages), offer rates generally have hovered in the high nineties for the decade 1996 through 2005.*[12] [13]
>
> *However, working where coverage is available to some workers is not the same as ending up with coverage through one's own employer. For example, a worker may not meet the employer's eligibility criteria, or if s/he does, may choose not to accept the employer's offer of coverage.*

Coverage -- In general, the trend for being covered by one's own employer is downward, that is, over time lower percentages of Washington workers are getting coverage through *their own large employer*. How steep is the decline? That's a bit more difficult to precisely pinpoint. (See Coverage Rates in Figures 2-2 and 2-3)

> *A reasonably conservative response, based on the yearly rates in Figure 2-2, is that coverage through one's own large employer, in Washington, declined about 8 percentage points between 1998 and 2005.*[14]
>
> *An alternate estimate, based on three-year moving average rates (Figure 2-3) is more in the range of an 11 percentage point decline, 1998-2005.*
>
> *Neither estimate is "more right" than the other, they are simply different ways of looking at the data and perhaps are best used as lower and upper bounds on the degree of decline for this time period.*

[11] Data were provided by Office of Financial Management, based on Medical Expenditures Panel Survey, Insurance Component (MEPS-IC), 1996 through 2005.

[12] Moving averages are often used to "smooth" data, that is, adjust for the effects of slight year-to-year swings. This asset of averages also has a downside – flex points (changes in direction) and data anomalies are not readily visible. Unfortunately, the two views of the data (yearly or moving average rates) can sometimes tell different stories as well. For this reason, we have chosen to provide measures of coverage using both forms (Figures 2-2 and 2-3).

[13] A measure of coverage availability that is often confused with employee offer rate is employer sponsor rate. The later is defined as the *percentage of employers* that offer coverage to at least some of their workers (in contrast to employee offer rate which is the *percentage of employees* who work for employers that offer coverage to at least some of their workers).

[14] 1998 (not 1996) is compared to 2005 in order to better ensure that comparable time periods are used for both yearly and moving-average forms of the data. (Note that an even more conservative view of the decline in coverage occurs if 1996 is compared to 2005 (a decline of about 2.5 percentage points); this occurs because of the up-tick in coverage between 1996 and 1998.)

Drivers -- Eligibility is the big determiner of coverage but changes in both eligibility and take-up are likely driving the decline in Washington.[15] [16]

> *There are three components to having coverage via one's own employer – working where it's available, being eligible for it, and (if eligible) accepting the offer.*
>
> *Within a given year, a worker is at greatest risk of not having own-employer coverage because of ineligibility, that is, the worker does not meet the employer's eligibility requirements.*
>
> *Across time however, the worker's ineligibility for coverage and his/her decision to not take-up coverage are both important drivers of declining coverage levels.*[17]

The definitions in Figure 2-4 will help the reader untangle the morass of measures related to coverage that appear in Figures 2-2 and 2-3. Additional information is also provided in Appendix 2-1.

Figure 2-4
Coverage Measures' Definitions

FROM THE EMPLOYEE PERSPECTIVE:

Employee Coverage Rate: *Among all employees*, the percentage of them that have coverage through their own employer. (Coverage rate = offer rate * eligibility rate * take-up rate)

Employee Offer Rate: *Among all employees*, the percentage of them who work where coverage is offered to at least some of the employees.

- **Employee Eligibility Rate: *Among employees who work where coverage is offered*, the percentage of them that are eligible for their own employer's coverage. (a subset of offer)**
  - **Employee Take-up Rate: *Among employees who are eligible* for their employer's coverage, the percentage that take it up. (a subset of eligibility)**
- **Employee Enrollment Rate: *Among employees who work where coverage is offered*, the percentage of them that enroll in their own employer's coverage.**

FROM THE EMPLOYER PERSPECTIVE (not shown on graphs):

Employer Sponsor Rate: *Among all employers*, the percentage of them that offer coverage to at least some of their workers.

[15] Analysis not shown but is based on data in Figures 2-2 and 2-3, with additional information provided in Appendix 2-1.

[16] The decline in coverage rates is one form of what is often referred to as "erosion in employer-based coverage". Another potential form of erosion, not discussed here, is changes in benefit packages, either in terms of fewer covered services and/or higher premium and point-of-service cost sharing by employees.

[17] Workers decide not to accept their own employer's coverage for a variety reasons; for low-income workers the decision most often (but not always) has to do with issues of affordability. Provided in Appendix 2-2 is additional information on the growing gap in Washington between income and health insurance expenditures.

Figure 2-2
Coverage Measures for Washington Employers with 50 or More Employees
1996 through 2005

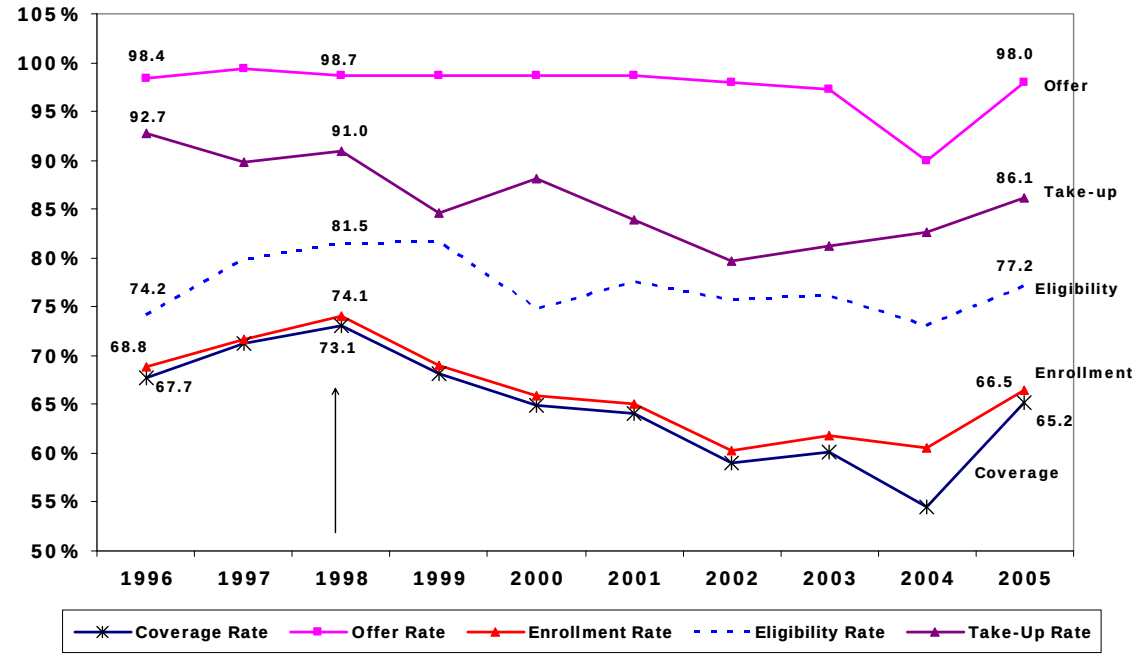
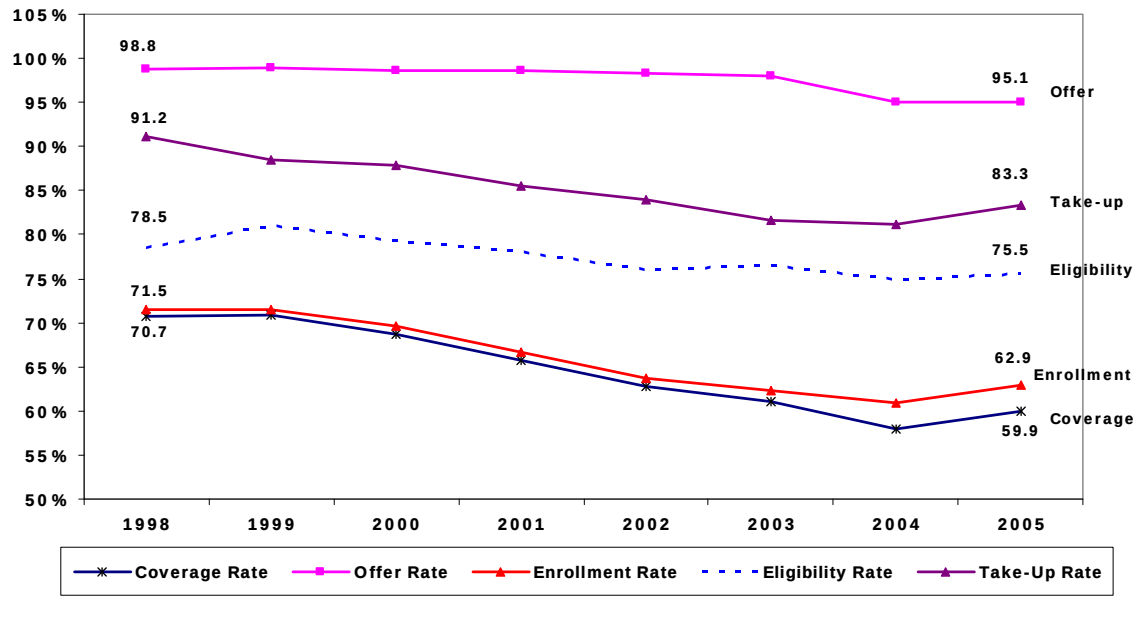


Figure 2-3
Coverage Measures for Washington Employers with 50 or More Employees
3-Year Moving Averages, 1996/98 through 2003/05



Note that Figure 2-2 starts with 1996 and Figure 2-3 starts with a 3-year moving average based on 1996 through 1998. Also note that some data for 2004 (see Figure 2-2) appear to be out of sync with patterns shown by other years and therefore will affect the 3-year moving averages for 2004 and 2005 in Figure 2-3.

Health insurance expenditures by Washington large employers relative to state-imposed business expenses[18]

Among larger firms (100+ employees), those that offer coverage spend a higher percentage of gross business income on health insurance than on state B&O tax, public utility tax, sales and use tax, property tax, unemployment insurance contributions, and workers compensation premiums *combined*.

> *For 100+ employee firms, the combined state taxes, contributions, and non-health-insurance premiums listed above are about 2.4% of gross business income; health insurance expenditures are about 3.0% (the largest firms of 1000+ employees spend about 3.6% of gross income on coverage).*
>
> *The smaller of Washington's large firms (50-99 employees) spend a slightly lower percent of business income on health coverage (2.0%) than on all state taxes, contributions, and non-health-insurance premiums (2.3%).*

Relative to payroll, large employers' health insurance expenditures are about the same regardless of firm size.

> *Among large firms that offer health insurance, those with 100+ employees spend the equivalent of about 8.5% of payroll on health expenditures; firms with 50-99 spend slightly less at about 7.8% of payroll.*

[18] Data provided by Office of Financial Management, 2005.

D. ONE VIEW ON SHARED RESPONSIBILITY BETWEEN EMPLOYERS AND STATE PROGRAMS[19]

From one perspective, Washington employers and government seem to be sharing the load for individuals who have coverage and are living in low-income working families.[20]

Among all Washington families, about 20% are low-income working families and they include about one million individuals (0-64 years old). Among those individuals with coverage, employers and government are each covering a comparable portion (~50% for employers and ~47% for government).[21]

For adults in these low-income working families, employers cover the bulk of those with coverage (~69%). For the 26% of adults getting coverage through public programs, about 3 out of 5 are in families where the primary earner is working full-time.

For children in these low-income working families, public coverage predominates – about 74% with some type of coverage get it through public programs.

This is the picture based on data collected in 2006 from the State Population Survey; data from the 2000 version of the survey show the same picture. In other words, it appears that employers and state government have been, and continue to be, sharing financial responsibility for coverage of individuals in low-income families – employers focusing on adults and state programs focusing on children.

[19] Analysis provided by Office of Financial Management. The data don't support an analysis based solely on low-income working families where the primary earner works for a large employer; therefore, these data reflect an adult working for an employer of any size.

[20] Low-income working families are defined as families in which there is at least one adult employee and where family income is less than or equal to 200% of federal poverty. Families with no employed persons or only self-employed persons are excluded.

[21] The other 3% with coverage are generally purchasing coverage on their own.

E. AGENCY PROGRAMS RELATED TO SHARED RESPONSIBILITY

Although not specific to *large* employers, the Agencies have pursued various initiatives to share responsibility for low-income workers' coverage.

Most notable within DSHS are the current coordination of benefits program and the two employer-coverage-assistance programs: Health Insurance Premium Program (HIPP) and Employer-Sponsored Insurance Program (ESI).[22] HIPP is the older and more established of the two employer-assistance programs – for fourth quarter 2007 it averaged 2,842 clients. The ESI program is a bit newer; it started as a pilot in September 2004 and changed to full program status in July 2005. In January 2008, the ESI program had just over 2,300 enrolled clients (about 85% children).[23] Both the HIPP and ESI programs recognize the potential for doing more (see Section III on target populations) and have been working toward that goal. In fact, one of the shared responsibility alternatives discussed in Sections IV and V of this report focuses on coordinating and maximizing the potential of these two employer-assistance programs. Appendix 2-3 provides additional background on the programs.

Efforts to share responsibility for coverage with employers have also occurred within the Basic Health program. Historically, the employer group program was just such an effort. However, the program has all but died under the weight of a variety of operational and eligibility issues. Two important issues include:

- lack of non-subsidized BH coverage, making it virtually impossible for employers to provide comparable coverage across all employee income levels; and,
- a federal agency ruling that any employer-group program within BH would be impacted by Medicare law, requiring that Medicare-eligibles be allowed to enroll and that coverage be coordinated with Medicare (current state law excludes persons eligible for Medicare from BH).

Appendix 2-4 provides a list of additional issues around the employer program, as well as BH statutory intent regarding coverage of working persons.

A more recent effort related to shared-responsibility that may affect BH's future is the Washington Health Insurance Partnership (WHIP) program.[24] WHIP, established by E2SHB 1569 in 2007, creates a health benefits purchasing "collective" for *small employers*, providing state subsidies for their low-income workers. A report regarding the inclusion in WHIP of various public sector programs, including BH, is due September 2009.

[22] HIPP provides premium assistance/wraparound coverage for clients or their dependents that *are enrolled in employer insurance at the time of their enrollment in Medicaid*. The ESI program provides premium assistance/wraparound coverage to clients or their dependents that *do not have employer-sponsored coverage at the time of their enrollment in Medicaid.*

[23] January's top five ESI employers, based on number of clients enrolled, were Tyson (78 clients), School Districts (70 clients), State of Washington (65 clients), Wal-Mart (39 clients), and Safeway (23 clients).

[24] WHIP replaced a small employer program passed in 2006—Small Employer Health Insurance Partnership (E2SHB 2572), which would have provided premium assistance to eligible low-income workers of small employers.

SECTION III: TARGET POPULATIONS WITHIN DSHS AND BH[25]

The proviso's target population is defined as "low-wage **workers** enrolled on state plans who are employed by employers with more than fifty employees". Thus, the focus is on workers themselves, not spouses nor dependents. Realistically, how large a target population is this for DSHS and BH? The diagrams in Figures 3-1 and 3-2 provide some insight. (See Appendices 3-1 and 3-2 for more detailed versions of Figures 3-1 and 3-2.)

A. DSHS MEDICAL PROGRAMS[26]

In the average quarter in calendar years 2005 and 2006, the size of the target population within DSHS medical programs was roughly 49,000-50,000 adults, as indicated in the shaded boxes of Figure 3-1. On a quarterly average basis, this is a fairly small percentage of *total* medical assistance clients (6% in both years) as well as of *adult* clients (13% in both years). On the other hand, it's a rather sizeable portion (59% in 2005 and 61% in 2006) of all *employed adult* clients.[27] [28]

B. BASIC HEALTH[29]

Unfortunately, the estimate of the target population within BH is somewhat less precise than it is for DSHS, due primarily to two issues: (1) under federal law BH has no legal authority to collect enrollees' social security numbers (SSN)[30] and (2) BH system limitations[31]. Notwithstanding these issues, it is possible to give some "order of magnitude" counts, as shown in Figure 3-2. In the average quarter in calendar years 2005 and 2006, about one-third of BH subsidized adults had earnings reported to the Employment Security Department. Of these employed adults, we estimate that sizeable portions had earnings associated with *at least one large employer*—44% to 74% in 2005 and 48% to 60% in 2006 (see shaded boxes of Figure 3-2).

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[25] Data for this section are drawn from the respective DSHS and BH reports published as a result of ESHB 3079, passed in 2006. In 2005, the Legislature passed a similar reporting bill (SHB 1486) which was subsequently vetoed by the Governor due mainly to privacy and public disclosure restrictions, and funding limitations. However, in the veto the Agencies were directed to produce a modified version of what later became the studies used in this report.

[26] Data sources: *Employment Status of Medical Assistance Clients and Persons with Dependents with DSHS Medical Coverage, As Required by Engrossed Substitute House Bill 3079*, November 15, 2006; *Employment Status of Medical Assistance Clients and Persons with Dependents with DSHS Medical Coverage, As Required by Engrossed Substitute House Bill 3079*, December 14, 2007; and Agency supplemental analyses of this "3079" data. See reports for specific definitions and limitations related to the data.

[27] The target population can be subdivided among several DSHS medical programs, some of which may be more relevant than others to the shared responsibility discussion. For example, in 2005 the quarterly average number of adults employed by large employers, by program was: Family Medical, 31,526; Pregnant Women, 7,268; Adults with Disabilities, 9,945; and Other, 705. (May not sum exactly to the 49,443 shown in Figure 3-1 due to rounding.)

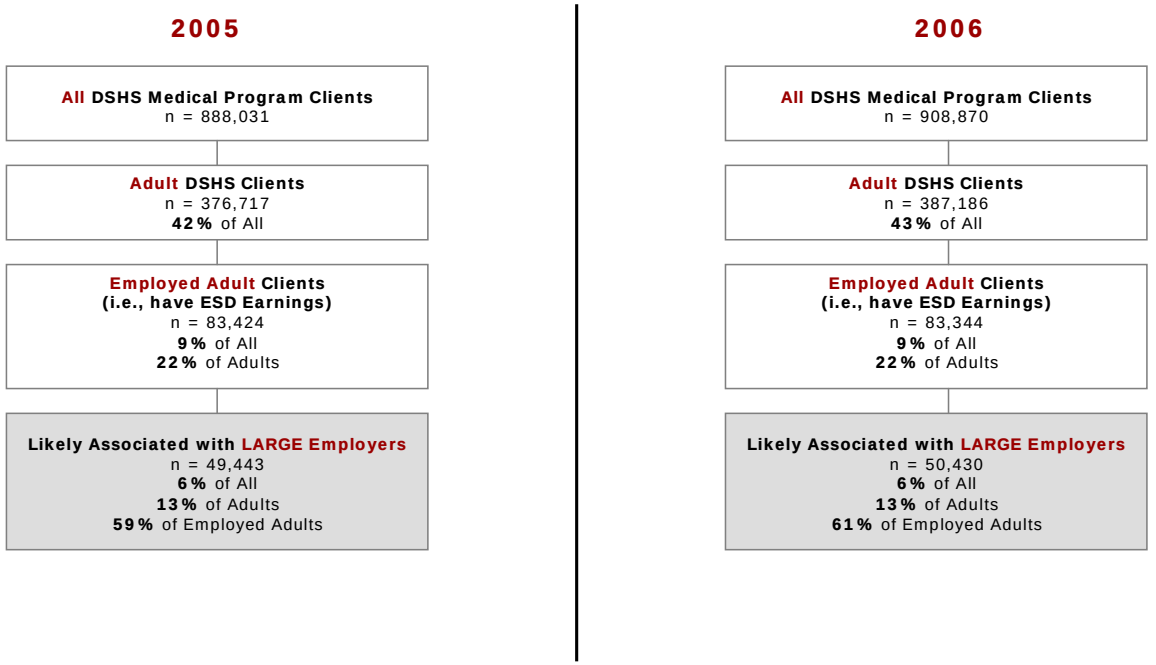
[28] Although the size of the DSHS target population may not be eye-popping, it nonetheless represents some real dollars. On an annual basis, this group accounted for about $212.9 million in total expenditures in 2005 and about $224.8 million in total expenditures in 2006 (split about 50/50 between federal and state governments).

[29] Data sources: *Basic Health Enrollees, Calendar Year 2005 Employment Statistics, January and June 2006 Employers Identified (as directed by Engrossed Substitute House Bill 3079)*, November 15, 2006; *2007 Report on the Employment Status of Basic Health Enrollees, Calendar Year 2006 Employment Statistics, January and June 2007 Employers Identified (as directed by Engrossed Substitute House Bill 3079)*, January 2008; and Agency supplemental analyses of this "3079" data. See reports for specific definitions and limitations related to the data.

[30] In fact, federal law requires that an enrollee's provision of SSN is voluntary and that enrollees be reminded of this fact whenever BH asks for their SSNs. Without an SSN, BH enrollees cannot be matched to Employment Security Department (ESD) records. For both calendar years 2005 and 2006, it's estimated that just under 17% of BH subsidized adults were without SSNs and therefore unmatchable to ESD records. (Whether the percentages based on a calendar year count would be larger or smaller when applied to average quarterly counts, as presented in Figure 3-2, is unknowable.)

[31] The current BH enrollment system long ago reached its capacity to incorporate new data elements that would improve BH's ability to collect and analyze data relevant to the shared responsibility discussion, e.g., enrollees with multiple employers. A new system is in development.

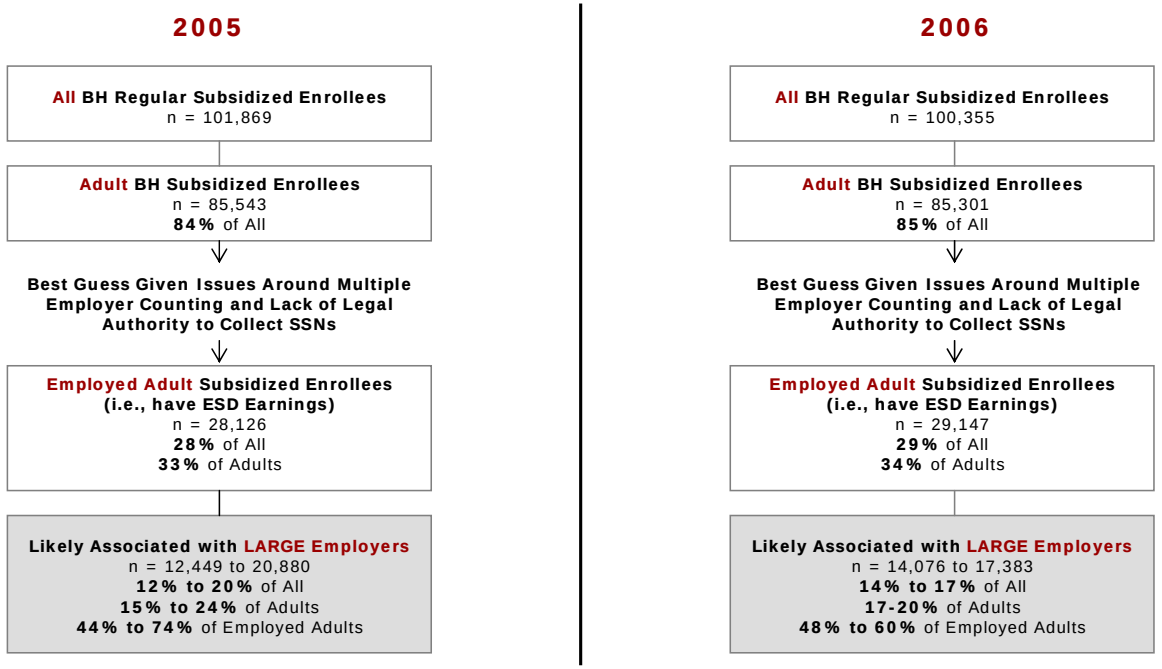
Figure 3-1
DSHS Shared Responsibility Target Population, 2005 and 2006 Average Quarterly Counts



Pretty Precise Estimates
Based on the "Average Quarter" in 2005 and 2006

NOTES:
Clients counts are per quarter averages for calendar 2005 and calendar 2006.
Large Employers are those with more than 50 employees.
***All* DSHS Medical Program Clients includes children and adults.**
***Adult* DSHS Clients are those enrolled in the Family Medical, Pregnant Women, and Persons with Disabilities programs (with a small number collapsed into Other).**

Figure 3-2
BH Shared Responsibility Target Population, 2005 and 2006 Average Quarterly Counts



"Order of Magnitude" Counts
Based on the "Average Quarter" in 2005 and 2006

NOTES:
Enrollee counts are per quarter averages for calendar 2005 and calendar 2006.
Large Employers are those with more than 50 employees.

SECTION IV: ALTERNATIVES FOR SHARED RESPONSIBILITY[32]

This section of the report goes to the heart of the budget proviso—in it we recap the Agency and Workgroup processes that led to a set of five "more preferred" alternatives for shared responsibility. We also identify how the alternatives further the goal of shared responsibility for coverage of low-wage workers, using both a pros/cons review and placement of alternatives on a shared responsibility continuum.

A. AGENCY PROCESS

The Agency process included four major steps, culminating in an initial list of options for discussion by the Workgroup. The steps were:

1. Clarify study purpose
2. Develop guiding principles and assumptions
3. Create a laundry list of possibilities
4. Narrow the possibilities for Workgroup discussion

Clarify Study Purpose
The only issue not entirely clear from the proviso language was around the definition of the target population – low-wage or low-income. As discussed earlier in the report, discussions with the Workgroup made it clear that the more apt descriptor of the target population was *low-income* workers rather than *low-wage* workers.

Develop Guiding Principles and Assumptions
In addition to the short list of assumptions presented earlier in the report (see Section II), the Agencies also developed a set of principles to guide their thinking about approaches that might reasonably be considered. These principles are show in Figure 4-1.

Create Laundry List of Possibilities
Based on a high level review of coverage initiatives historically and currently undertaken in Washington and across the nation, a laundry list of ideas was developed and discussed among the Agencies. This was a brainstorming exercise, ensuring that no stone was left unturned for ideas even remotely related to the shared responsibility agenda.

Narrow the Possibilities for Workgroup discussion
The process of paring the laundry list was based on Agency judgment guided by the principles and assumptions noted above, a short set of "gut-check" questions (see Figure 4-2), and an organizing framework to help ensure that a range of ideas was considered. The organizing framework was dubbed the "shared responsibility continuum"; a final version of it is presented in the next section on Workgroup Process.

In the end, Agency discussions pared the laundry list to a set of nine approaches that was subsequently presented to the Workgroup. These approaches are listed, along with two options added by the Workgroup, in the Workgroup Process section.

[32] For reasons of clarity, the descriptions in this section make the process appear a bit more linear, and less iterative and interactive, than was the actual case.

Figure 4-1
Guiding Principles for Brainstorming Approaches to
Shared Responsibility between Large Employers & Public Programs

The goal is to look for options of "sharing responsibility" that …

- Provide cost predictability for all parties
- Are informed by, but not inhibited by, ERISA[1] considerations
- Include but are not limited to the pay-play / fair share[2] genre
- Are equitable in how they share financial responsibility for coverage
- Retain choice by employers and workers regarding the source of the coverage
- Are objective and equitable without prejudice based on employer characteristics or past practices
- Are sensitive to previous public policy decisions about eligibility for public programs and efforts to encourage employers to hire potentially challenging employees
- Do not impose undue administrative/operational burden or cost on any of the involved parties (state agencies, employers, workers) – the administrative part of implementing and sustaining the option is relatively simple, practical, timely and financially reasonable
- Do no harm to workers in the effort to do them good (e.g., in terms of worsening the economic circumstances of the people the option is designed to benefit)

The principles are guide posts only;
not hard and fast delimiters of what to consider.

[1] ERISA is the federal Employee Retirement Income Security Act of 1974 that prevents states from directly regulating employee health plans – state laws impacting employer health plan benefits, structure, or administration are not OK.

[2] Pay or play / fair share broadly refers to a class of approaches that require employers to pay an assessment that at least partially funds a publicly administered health coverage program or provides subsidies for coverage administered elsewhere, usually with a credit against the assessment for the employer's existing health access expenditures.

Figure 4-2
Questions Considered by Agencies for Each "Shared Responsibility" Idea

1. Is it ***consistent with*** the Workgroup's ***vision*** of shared responsibility between large employers and public programs?
2. Is it directly relevant to and ***within the scope*** of the SHB 1128 proviso?
3. Is it ***complementary*** to and consistent with other coverage-related initiatives already underway?
4. Is it ***realistic*** to believe the idea is achievable both politically and operationally?
5. Does the idea ***divert resources*** from existing Agency efforts regarding coverage that are of equal or higher priority?

B. WORKGROUP PROCESS

As noted in Section I, the entire Workgroup process consisted of five meetings. The first three meetings were organizational and educational. The last two meetings got down to the business of identifying shared responsibility approaches; this section of the report describes that part of the process.

As defined by the proviso, the Workgroup was to be "closely involved and consulted" in developing options. To that end, the Agencies were committed to following the group's advice; not only in terms of identifying a wide range of approaches but also in terms of which ideas merited a more in-depth look by the Agencies.

In general, the "approaches" process with the Workgroup involved four steps:

1. Discuss Agency ideas
2. Seek refinements and additions
3. Rank order the approaches (most to least preferred)
4. Review decisions on more-preferred approaches

Discuss Agency Ideas; Seek Refinements and Additions

In steps 1 and 2 the Agencies' initial list of nine possible approaches was presented to, and discussed by, the Workgroup. Agency ideas were refined and the Workgroup proposed two additional approaches. All in all, eleven approaches for improving shared responsibility were generated. They are, in order of discussion with the Workgroup:

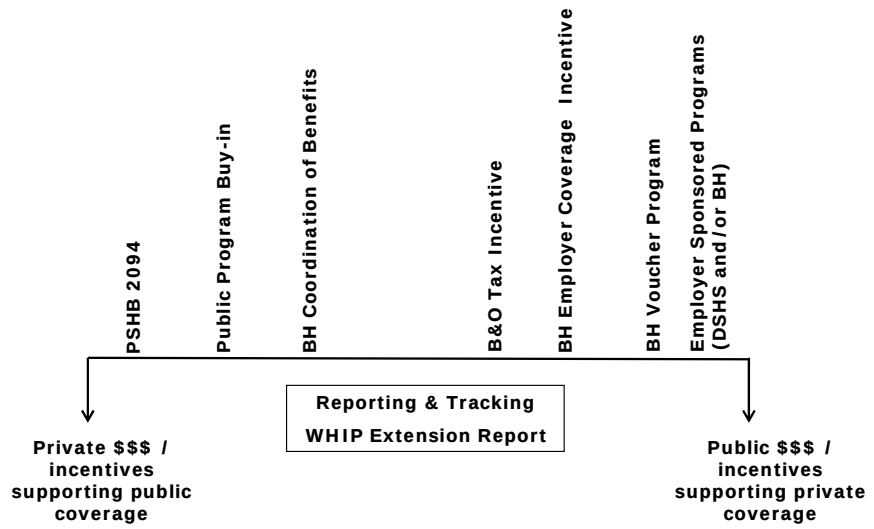
- PSHB 2094 (H-3557.2), 2007 Taxpayer Health Care Fairness Act (specifically required by the proviso),
- DSHS Employer-sponsored insurance program
- Reporting and tracking of employer-coverage access
- BH Employer-sponsored insurance program
- Washington Health Insurance Partnership expansion report
- B&O tax incentive
- Vouchers to buy employer coverage
- Public program buy-in
- Stay the course
- BH coordination of benefits
- BH incentive to accept employer coverage

A matrix of these ideas as initially discussed by the Workgroup, with brief background and description, is given in Appendix 4-1.

To affirm that a range of approaches was generated, they were arrayed along the shared responsibility continuum shown in Figure 4-3. In general, most of the approaches are some version of a private/public partnership but differ somewhat in emphasis. Approaches further to the left on the continuum tend to be more aligned with use of *private dollars/incentives to support public coverage;* ideas further to the right tend to emphasize *public dollars/incentives supporting private coverage*.

In most cases, the details of approaches were kept purposefully broad – the goal was to determine the Workgroup's primary areas of interest and to allow the Agencies (and others) latitude to accommodate variations on the themes as they consider next steps. The Reporting & Tracking and B&O tax incentive options are good examples of general approaches that could take different "implementation" forms, especially because each could be implemented by itself as well as paired with other approaches.

Figure 4-3
Shared Responsibility Continuum



Notes:
Approaches are placed on the continuum according to the end they *tend* to be more aligned with; approaches in the box are more neutral in terms of alignment along the continuum.
Stay-the-Course approach is not included as it does not represent any single approach to improving shared responsibility.

Rank Order the Approaches

In the interim between the fourth and last Workgroup meetings, Workgroup members were e-mailed a ranking exercise as a means for narrowing the options to a smaller subset. They were asked to assign a rank to each of the eleven ideas ranging from 1 as the member's most preferred approach to 11 as the member's least preferred approach ("most or least preferred" *in the context of improving shared responsibility between large employers and state plans*). The information in Appendix 4-1 and the shared responsibility continuum were sent along with the ranking exercise.[33]

Review Decisions on More-Preferred Approaches

The results of the ranking exercise are shown in Figures 4-4 and 4-5; note that a lower score indicates a more preferred option.[34] These results formed the core of the last Workgroup meeting, with the discussion focusing on where to "draw the line". That is, which options, and how many, should be reviewed by the Agencies for next steps and implementation issues?

As can be seen in Figures 4-4 and 4-5, there are roughly four groupings of approaches.

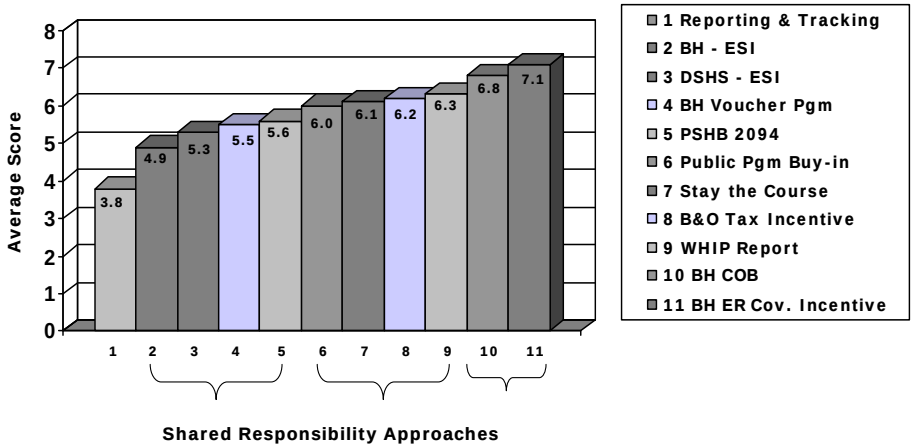
- Reporting & Tracking, with a score of 3.8, was of greatest interest (by far).
- A second tier of approaches had scores ranging from 4.9 to 5.6 – this group included the ESI and Voucher programs as well as PSHB 2094.[35]
- The third tier of approaches included Public Program Buy-in, Staying the Course, B&O Tax Incentive, and WHIP Extension Report (scores of 6.0 to 6.3).
- The last group of two included BH Coordination of Benefits and BH Employer Coverage Incentive (scores of 6.8 and 7.1, respectively).

[33] Minor revisions were made to the continuum in Figure 4-3 relative to what was sent to the Workgroup members.
[34] Final scores (ranks) are averages. That is, for each option the individual member's scores were summed and divided by the number of members who voted.
[35] The budget proviso required that PSHB 2094 be included as one of the approaches to merit additional attention in terms of identifying next steps and implementation issues. It is impossible to know whether this influenced Workgroup members' voting re PSHB 2094.

The input of the Workgroup on the question of "where to draw the line" was invaluable – in the end it pushed the Agencies a bit out of their comfort zone, broadening their thinking about possible top options. (See Appendix 1-3, Meeting #5, for insight into the conversation.) As shown in Figure 4-5, the final decision was to select the five top scoring approaches as those to which the Agencies would give additional attention.[36]

Although the ranking exercise forced Workgroup members to look at each approach independent of the others they clearly are not mutually exclusive. Approaches (or pieces of approaches) can be paired. There are obvious examples such as Reporting & Tracking, which can be implemented along side any other option. Likewise, the BH Coordination of Benefits or WHIP Extension Report can be undertaken simultaneous with other options. But there are less obvious pairings as well. For example, some version of a B&O tax incentive could be included as part of a voucher or employer-sponsored insurance program.[37] More than anything, the point is to demonstrate that there is a range of approaches, mixed and matched, for improving the way large employers and state plans share responsibility for coverage of low-wage workers.

Figure 4-4
Workgroup Members' Rank Ordering of Shared Responsibility Approaches



Note: Lower Score = Higher Preference

[36] In addition to averages, the *range* of scores assigned by voters is noted in Figure 4.5. For example, the average score for the Reporting & Tracking approach was 3.8 based on a range of scores that went from 2 to 6. Given concern with the wide range of scores for some options (clearly indicating that Workgroup members were not always of one mind), median scores were also calculated. Based on median scores, the top five approaches remained the top five, albeit in a slightly different order. (Median scores as those where half of the votes are above the score and half are below.)

[37] There was a sense in Workgroup discussions that large employers might be reluctant to participate in employer-sponsored insurance or voucher programs because it could mean additional workers enrolling in the employer's benefit plan (and therefore additional costs to the employer based on employer contribution amounts). A B&O tax incentive could be used to help address this potential issue.

Figure 4-5
More Preferred to Less Preferred Shared Responsibility Approaches, Based on Workgroup Members' Rank Orderings

Approach Title	Brief Description[38]	Rank (Range)[39]
1. Reporting and Tracking of Employer-Coverage Access	Review current law and agency administrative procedures to determine how to better collect and track information on enrollee access to and use of employer coverage. *This option evolved to focus on strategic planning and policy decision-making level information (particularly from the perspective of enrollees not their employers) rather than program-specific operational data.*	3.8 (2-6)
2. BH Employer-Sponsored Insurance (ESI) Program	Explore creating an ESI program within BH along the same lines as the DSHS program. *For purposes of this project, the primary conceptual difference between the BH ESI option and the BH Voucher option is that the ESI program would include both premium assistance and wraparound coverage; the voucher option is solely for premium assistance (i.e., no wraparound coverage is contemplated).*	4.9 (2-10)
3. DSHS Employer-Sponsored Insurance (ESI) Program	Maximize the potential of the current DSHS employer-sponsored insurance (ESI) program to pool large employer and state funds.	5.3 (1-9)
4. BH Vouchers to Buy Employer Coverage	Provide individuals who are eligible for public programs with vouchers to buy-into their employer offered coverage. *Initial discussions did not specifically target BH or DSHS in terms of designing a voucher program. However, based on Workgroup and Agency discussions the Agencies decided it made sense, as a starting point, to focus this discussion on BH because of the design flexibility accorded by a state-only program.*	5.5 (1-10)
5. PSHB 2094, 2007 Legislative Session (Taxpayer Health Care Fairness Act) (Latest version = H-3557.2)	Review the latest version of 2094 and, where feasible, suggest changes (primarily of an operational nature). *This option evolved to a focused review of any operational issues remaining in the bill that would make it impossible to be implemented by the Agencies.*	5.6 (1-11)
ABOVE THIS LINE = TOP OPTIONS FOR FURTHER AGENCY REVIEW		
6. Public Program Buy-in	Allow large employers to buy whole classes of employees (not necessarily their whole workforce but a single class) into public programs at full cost (full premium plus an admin fee).	6.0 (2-11)
7. Stay the Course	Give Agencies time to pursue and improve initiatives already on the table and in progress.	6.1 (1-11)
8. B&O Tax Incentive	Provide a B&O tax incentive to large employers who cover a defined portion of their workers, including (or exclusive to) workers who might otherwise end up enrolled in public programs.	6.2 (1-10)
9. Washington Health Insurance Partnership Expansion Report	Explore adding a 3rd report in September 2010 that evaluates including the large group *private* market in the Partnership for some or all large employer workers.	6.3 (1-11)
10. BH Coordination of Benefits	Determine if there is opportunity to improve the oversight, implementation, and communication to members and plans of requirements to coordinate payment of benefits.	6.8 (3-11)
11. BH Incentive to Accept Employer Coverage	Allow BH to "charge more" to individuals who have coverage available to them by their employer but choose to remain on BH.	7.1 (2-11)

Number of members who voted = 14 **Lower average score = higher preference**

[38] See Appendix 4-1 for additional information on the approaches.

[39] Workgroup members individually ranked each of 11 options from most preferred (rank 1) to least preferred (rank 11). Averages were used to determine the final rank order. Range indicates the spread of scores for each approach, e.g., for Reporting & Tracking at least one member ranked it 2nd and at least one member ranked it 6th.

C. FINAL REVIEW OF TOP APPROACHES – PROS AND CONS

Originally, we planned to do the pros and cons analysis only for the smaller subset of more-preferred options, as part of addressing the proviso's request to identify how an option furthers the goal of shared responsibility. However, in the last meeting the Workgroup suggested that having pros and cons for all eleven options might help clarify why some ideas made the short list and others did not. Following their advice, the matrix in Figure 4-6 was developed. Indeed, this pros/cons work provided additional confirmation that the Workgroup's input on "where to draw the line" (i.e., after the top five scoring options) made considerable sense.[40]

[40] Appendix 4-2 is a brief checklist that more easily identifies the pro & con similarities and differences for the DSHS-ESI, BH-ESI, and BH-Voucher approaches.

Figure 4-6
High Level Pros and Cons of Approaches to Further the Goal of Shared Responsibility
Between Large Employers and State Plans for Coverage of Low-Wage/Low-Income Workers[41]

Approach	Brief Description[42]	Pros	Cons
Reporting and Tracking of Employer-Coverage Access	Review current law and agency administrative procedures to determine how to better collect and track information on enrollee access to and use of employer coverage. *This option evolved to focus on strategic planning and policy decision-making level information (particularly from the perspective of enrollees not their employers) rather than program-specific operational data.*	• Provides more complete information for future policy decision making -- better answers to questions asked by Workgroup that couldn't be adequately answered at the time (e.g., exact size of population that might be impacted, changes over time, why people with access to employer coverage choose public coverage, distribution of full time / part time workers, hours associated with multiple employers, etc.). • Fosters cooperation & standardization of analysis and reporting methods between DSHS & BH re ESHB 3079, creating a more cohesive picture of the issue across Agencies not just within each Agency.	• BH enrollment information system project (in development) may prevent BH from going too-fast/too-soon on collecting new information. • Doesn't lead to any immediate improvement in sharing financial responsibility for coverage of low-income workers. • Will not address some important questions regarding the changing world of the employee, e.g., changes in employer behavior regarding eligibility & waiving coverage (may be opportunities to explore this through other avenues such as Employment Security Department's employer survey or State Population Survey).
BH Employer-Sponsored Insurance (ESI) Program	Explore creating an ESI program within BH along the same lines as the DSHS program. ***Note:*** *For purposes of this project, the primary conceptual difference between the BH ESI option and the BH Voucher option is that the ESI program would include both premium assistance and wraparound coverage; the voucher option is solely for premium assistance (i.e., no wraparound coverage is contemplated).*[43]	• Makes use of existing employer-based coverage system in partnership with public sector. • Adds employer dollars to system (combines employer contribution amount with public subsidy). • Provides opportunity for low-income employees to be seen as no different from co-workers regarding coverage and total compensation. • Lots of ESI-type programs are being developed across states so ample opportunity for lessons on best practices. • Aligns with BH statutory intent to	• Doesn't address issue of shared financial responsibility if enrollee works for an employer that doesn't offer coverage at all (most large employers offer coverage to at least some employees). • Questionable effectiveness in reaching non-standard workers (job-based efforts are most effective for workers with stable & transparent employment relationships). • Depending on design, program can be labor intensive (e.g., upfront work & on-going monitoring to identify who has access to employer coverage & if it is cost-effective for the state to buy the enrollee

[41] Matrix is a mixture of public policy and operational pros and cons – focus is on major, bigger picture issues. Within the Pros and Cons lists, the bullets are not in any order of importance. Cons list tends to include more operational issues than does Pros list. Appendix 4-2 is a brief checklist that identifies similarities and differences in pros and cons for the BH ESI, DSHS ESI, and BH Voucher options.

[42] In most cases, the details of approaches were kept purposefully broad – the goal was to determine the Workgroup's primary areas of interest and to allow the Agencies (and others) latitude to accommodate variations on the themes as they consider next steps.

[43] Wraparound coverage = state pays for services and/or out-of-pocket cost-sharing not covered by the employer up to the limits of the state program.

Approach	Brief Description[42]	Pros	Cons
		discourage decline of employer-based coverage. • Can use current DSHS program as model, with potential for collaborative operational processes, but with more flexibility because not an entitlement program and federal Medicaid laws/rules are not applicable.	into it) raising issue of whether the "push is worth the shove". • Depending on extent of wraparound coverage (either in terms of services or cost-sharing), may leave low-income workers underinsured, i.e., employer coverage may not be "useable" to low-income workers if cost-sharing (e.g., deductibles and point-of-service out-of-pocket) make it unaffordable to seek care. • Employers may be reluctant to support because could cost them more if additional members of their workforce opt for coverage. • Unless premium subsidy amount is pegged to employer's premium, a fixed sliding scale amount based on income or a flat amount may not be enough to allow person to buy employer's coverage (so end up going bare even with subsidy in hand). • Would be virtually impossible to administer wraparound coverage in the absence of a fee-for-service program component, which would be costly to develop & operate solely in support of a BH ESI program (& would be somewhat counter to BH's statute that emphasizes managed care). • Would require separate & distinct administration & funding from regular BH to insulate BH from CMS' concerns over Medicare eligibility & to reinforce the state's position that BH is individual, not employer-group, coverage.[44] • *If* program is subject to ERISA (because of connection to employer-sponsored coverage), program costs may increase,

[44] CMS = Centers for Medicaid & Medicare Services, US Department of Health & Human Services. If viewed by CMS as employer-sponsored group coverage, BH would have to allow Medicare eligible persons to enroll and would have to coordinate coverage with Medicare. Under current BH statute, a person eligible for Medicare is not eligible for BH.

[45] ERISA = federal Employee Retirement Income Security Act of 1974.

Figure 4-6, Pros and Cons of Approaches

Approach	Brief Description[42]	Pros	Cons
			e.g., may be required to cover benefits & services not currently part of BH and/or could face added plan administration & fiduciary responsibilities.[45] • Could create financial problem for worker if s/he loses BH ESI eligibility & cannot opt out of employer coverage & cannot afford the premium payroll contribution amount. • BH enrollment information system project may prevent BH from going too-fast/too-soon on implementing new programs. • Potential negative impact on existing BH rates if ESI program draws healthy, working people out of pool (potentially offsetting any savings). • Unclear if value of adding another option (alongside regular BH and medical assistance programs) for low-income workers outweighs added complexity of choice & program costs. • May be lot of effort for naught depending on outcome of Partnership study to integrate BH into Partnership.
DSHS Employer-Sponsored Insurance (ESI) Program	Maximize the potential of the current DSHS employer-sponsored insurance (ESI) program to pool large employer and state funds.	• Makes use of existing employer-based coverage system in partnership with public sector. • Adds employer dollars to system (combines employer contribution amount with public subsidy). • Provides opportunity for low-income employees to be seen as no different from co-workers regarding coverage and total compensation. • Lots of ESI-type programs being developed across states so ample opportunity for lessons on best practices design. • Builds on existing Agency program (i.e., base infrastructure already in place). • Federal match available for additional employer dollars used to cover enrollees.	• Doesn't address issue of shared financial responsibility if enrollee works for an employer that doesn't offer coverage at all (most large employers offer coverage to at least some employees). • Questionable effectiveness in reaching non-standard workers (job-based efforts are most effective for workers with stable & transparent employment relationships). • Depending on design, program can be labor intensive (e.g., upfront work & on-going monitoring to identify who has access to employer coverage & if it is cost-effective for the state to buy the enrollee into it) raising issue of whether the "push is worth the shove". • Depending on extent of wraparound coverage (either in terms of services or cost-sharing), may leave low-income workers underinsured, i.e., employer coverage may not be "useable" to low-income workers if cost-sharing (e.g.,

Figure 4-6, Pros and Cons of Approaches

Approach	Brief Description[42]	Pros	Cons
			deductibles and point-of-service out-of-pocket) make it unaffordable to seek care. • Employers may be reluctant to support because could cost them more if additional members of their workforce opt for coverage. • Unless premium subsidy amount is pegged to employer's premium, a fixed sliding scale amount based on income or a flat amount may not be enough to allow person to buy employer's coverage (so end up going bare even with subsidy in hand). • Enhanced design features (other than what is in current ESI program) may require federal waiver.
BH Vouchers to Buy Employer Coverage	Provide individuals who are eligible for public programs with vouchers to buy-into their employer offered coverage (i.e., pay for some or all of employee premium contribution). *Initial discussions did not specifically target BH or DSHS in terms of designing a voucher program. However, based on Workgroup and Agency discussions the Agencies decided it made sense, as a starting point, to focus this discussion on BH because of the design flexibility accorded by a state-only program*. ***Note:*** *For purposes of this project, the primary conceptual difference between the BH ESI option and the BH Voucher option is that the ESI program would include both premium assistance and wraparound coverage; the voucher option is solely for premium assistance (i.e.,*	• Makes use of existing employer-based coverage system in partnership with public sector. • Adds employer dollars to system (combines employer contribution amount with public subsidy). • Provides opportunity for low-income employees to be seen as no different from co-workers regarding coverage and total compensation. • Aligns with BH statutory intent to discourage decline of employer-based coverage. • Relative to BH ESI option, limits cost to state because no wraparound coverage (helps pay *only* for employee premium contribution to employer coverage). • Likely to be easier for Agency to administer than ESI (mainly because no wraparound coverage) & (depending on design) likely to be of minimal administrative burden to employer. • For the worker, may be easiest option when "employee contribution to premium" is the only barrier to an employee opting	• Doesn't address issue of shared financial responsibility if enrollee works for an employer that doesn't offer coverage at all (most large employers offer coverage to at least some employees). • Questionable effectiveness in reaching non-standard workers (job-based efforts are most effective for workers with stable & transparent employment relationships). • Depending on design, program can be labor intensive (e.g., upfront work & on-going monitoring to identify who has access to employer coverage & if it is cost-effective for the state to buy the enrollee into it) raising issue of whether the "push is worth the shove". ***Note: Less of a con than for ESI.*** • Given no wraparound coverage, may leave low-income workers underinsured, i.e., employer coverage may not be "useable" to low-income workers if cost-sharing (e.g., deductibles and point-of-service out-of-pocket) make it unaffordable to seek care. ***Note: More of a con than for ESI.***

Figure 4-6, Pros and Cons of Approaches

Approach	Brief Description[42]	Pros	Cons
	no wraparound coverage is contemplated).[46]	for employer's coverage. • Conceptually consistent with direction of some broad-based proposals to move the nation to an individually-based voucher system.	• Employers may be reluctant to support because could cost them more if additional members of their workforce opt for coverage. • Unless premium subsidy amount is pegged to employer's premium, a fixed sliding scale amount based on income or a flat amount may not be enough to allow person to buy employer's coverage (so end up going bare even with subsidy in hand). • Would require separate & distinct administration & funding from regular BH to insulate BH from CMS' concerns over Medicare eligibility & to reinforce the state's position that BH is individual, not employer-group, coverage.[47] • *If* program is subject to ERISA (because of connection to employer-sponsored coverage), program costs may increase, e.g., could face added plan administration & fiduciary responsibilities.[48] ***Note: Less of a con than for ESI.*** • Could create financial problem for worker if s/he loses BH Voucher eligibility & cannot opt out of employer coverage & cannot afford the premium payroll contribution amount. • BH enrollment information system project may prevent BH from going too-fast/too-soon on implementing new programs. • Potential negative impact on existing BH rates if Voucher program draws healthy, working people out of pool (potentially offsetting any savings). • Unclear if value of adding another option (alongside regular BH and medical

[46] Wraparound coverage = state pays for services and/or out-of-pocket cost-sharing not covered by the employer up to the limits of the state program.

[47] CMS = Centers for Medicaid & Medicare Services, US Department of Health & Human Services. If viewed by CMS as employer-sponsored group coverage, BH would have to allow Medicare eligible persons to enroll and would have to coordinate coverage with Medicare. Under current BH statute, a person eligible for Medicare is not eligible for BH.

[48] ERISA = federal Employee Retirement Income Security Act of 1974.

Figure 4-6, Pros and Cons of Approaches

Approach	Brief Description[42]	Pros	Cons
			assistance programs) for low-income workers outweighs added complexity of choice & programs costs. ***Note: Less of a con than for ESI.*** • May be lot of effort for naught depending on outcome of Partnership study to integrate BH into Partnership. ***Note: Less of a con than for ESI.***
PSHB 2094, 2007 Legislative Session (Taxpayer Health Care Fairness Act) (Latest version = H3557.2)	Review the latest version of 2094 and, where feasible, suggest changes (primarily of an operational nature). *This option evolved to a focused review of any operational issues remaining in the bill that would make it impossible to be implemented by the Agencies (assuming someone where to pursue this approach).*	• May reduce state expenditures more than ESI or Voucher by bringing in employer dollars to support cost of public coverage. • Employers who offer and employers who don't offer are equally impacted if they have employees on public coverage programs. • Utilizes state's traditional areas of authority (health care access, taxing, ensuring competitive business environment). • Consistent with components of other state's broad health care reforms (e.g., Massachusetts and Vermont)	• Given recent state history on this approach it doesn't appear to be politically passable. • Questionable whether it would pass ERISA challenge (which likely would happen since little support from business community). • Would require a delicate balance between protecting an individual employee's right to confidentiality and the employer's right to appeal an assessment based on that employee's public program coverage. • Penalizes employers for employees' decisions over which they have no control (employers cannot force employees to take-up their offered coverage). • Even if it pushes employers to change eligibility requirements (for example, shorten waiting times for coverage; cover more part-time employees), it still doesn't mean the coverage is any more affordable & usable for low-income workers. • Likely to be somewhat administratively burdensome for both Agencies and employers (perhaps not by itself but when paired with all other existing state reporting requirements for business—B&O, L&I, ESD, child support enforcement, industry-specific regulatory reporting). • May discourage employees' enrollment in public programs if it will cost employer, causing some employees to go bare.
ABOVE THIS LINE = TOP 5 MORE-PREFERRED APPROACHES			
Public Program Buy-in	Allow large employers to buy whole classes of employees (not necessarily their whole workforce but	• For those large employers who want to focus on their core business and not on health care, it would allow them an option	• Puts added burden on public programs to "manage" additional covered lives & possibly a more complex contracting

Figure 4-6, Pros and Cons of Approaches

Approach	Brief Description[42]	Pros	Cons
	a single class) into public programs at full cost (full premium plus an admin fee).	for reducing their administrative commitment to employee health benefits (but not their financial commitment). • This isn't a completely foreign or untested idea in that PEBB currently functions as a "buy-in" opportunity for political subdivision public employers. • Lessons from the BH employer program could be used to design a more effective program than envisioned for the original BH employer program (e.g., not view this as a revenue generating line of business, which is one reason the BH employer group program failed).	process even if the administrative costs are paid by participating employers. • Depending on the public program used as the buy-in vehicle (BH, Medicaid, Public Employees) there could be problems around ERISA, treating all employees in a class the same, and risk selection & impact on current program rates. For example: ▪ BH or PEBB might risk losing their ERISA exemption status (as government) if private employers are allowed to buy-in as employer groups (e.g., may be required to cover benefits & services not currently offered and/or could face added plan administration & fiduciary responsibilities). ▪ If BH were the vehicle, there are virtually no health plans bidding on the non-subsidized part of BH so a large employer with both low-income & non-low-income employees would have trouble meeting federal labor law to treat all employees in a class the same. ▪ If BH were the vehicle, state law / eligibility criteria would likely have to be changed so that certain workers are not excluded (e.g., Medicare-eligible workers, non-Washington residents employed in WA). ▪ Regardless of which public program might be the vehicle, one has to wonder about the risk profile of any large employer who would do this and the impact on rates for the program (unless the public program and employer-buy-in were separate rating pools). ▪ If BH were the vehicle, would require separate & distinct administration & funding from regular BH to insulate BH from CMS' concerns over Medicare eligibility & to reinforce the state's position that BH is

Figure 4-6, Pros and Cons of Approaches

Approach	Brief Description[42]	Pros	Cons
			individual, not employer-group, coverage.[49]
Stay the Course	Give Agencies time to pursue and improve initiatives already on the table and in progress.	• Gives activities already underway a chance to mature enough to know whether they are worthwhile. • Some improvements (albeit not all) for Reporting & Tracking, especially around the 3079 reports, and the DSHS-ESI program will happen as a part of normal program improvement work & therefore will not be lost independent of the Low-Wage Workgroup process.	• Doesn't push the Agencies to "be better than they would be on their own". • Some initiatives (e.g., BH Vouchers) might not be considered if business-as-usual continues.
B&O Tax Incentive	Provide a B&O tax incentive to large employers who cover a defined portion of their workers, including (or exclusive to) workers who might otherwise end up enrolled in public programs.	• Businesses may like (assuming few strings attached) because they might have additional dollars to use to offer coverage (for those not offering) or expand coverage (for those currently offering, e.g., change eligibility requirements to cover additional workers). • Recognizes cost to employers of providing a public good that is outside their core business.	• No direct tie to sharing cost of coverage of low-income workers (although could monitor to see if lower tax translates to more coverage by employer and/or fewer of employer's workers on public coverage). • Depending on design, could add reporting burden to businesses (size of incentive would need to more than offset burden) and/or increase program costs of Dept of Revenue. • On a per company basis, the amount of B&O available per worker for workers not-covered-by-own-employer is likely to be relatively small compared to premium costs, resulting in a minimally effective incentive to put dollars toward coverage (although may be enough dollars to prompt an employer to expand coverage to *some* additional workers). • State would need to find other revenue sources or make funding changes to accommodate less B&O. • Potential for ERISA challenge if the incentive is specifically tied to benefits.

[49] CMS = Centers for Medicaid & Medicare Services, US Department of Health & Human Services. If viewed by CMS as employer-sponsored group coverage, BH would have to allow Medicare eligible persons to enroll and would have to coordinate coverage with Medicare. Under current BH statute, a person eligible for Medicare is not eligible for BH.

Figure 4-6, Pros and Cons of Approaches

Approach	Brief Description[42]	Pros	Cons
Washington Health Insurance Partnership Expansion *Report*	Explore adding a 3rd report in September 2010 that evaluates including the large group *private* market in the Partnership for some or all large employer workers.	• Consistent with legislative direction to evaluate inclusion of various markets into the Partnership.	• Doesn't lead to any immediate improvement in sharing financial responsibility for coverage of low-income workers.
BH Coordination of Benefits (COB)	Determine if there is opportunity to improve the oversight, implementation, and communication to members and plans of requirements to coordinate payment of benefits.	• Would address gaps in BH statute and operational procedures regarding coordination of "who pays" for services when 2 or more insurers are involved; perhaps reducing BH medical services costs. • Would expand current COB by BH contracted carriers. Currently, COB occurs for the providers within a health carrier's provider network but does not include coordination for provider services outside the carrier's network. (Evidence is that carriers are in compliance with current requirements.)	• Can be administratively complex and costly, potentially raising premiums to cover carrier administrative costs. • Level of savings / avoided expenditures associated with expanded COB is unclear. (Cost-benefit analysis needed to determine if potential savings / avoided expenditures would outweigh administrative costs.)
BH Incentive to Accept Employer Coverage	Allow BH to "charge more" to individuals who have coverage available to them by their employer but choose to remain on BH.	• Maintains choice of individual as to whether to elect employer or public coverage—doesn't require that someone accept available employer coverage but provides incentive to do so. • Consistent with practices used by large employers when covering a spouse / partner who has access to his/her own employer coverage. • Could free-up some state dollars due to reducing a person's subsidy amount as the way to "charge more". • Aligns with BH statutory intent to discourage decline of employer-based coverage.	• Likely to be fairly resource intensive with less likelihood than ESI or voucher options of bringing additional private dollars into the system. • Most BH enrollees have family incomes at or below 125% federal poverty & would likely be unable to afford a higher premium contribution.

Figure 4-6, Pros and Cons of Approaches

SECTION V: NEXT STEPS AND COMMITMENTS

In keeping with the spirit of the budget proviso, the Agencies spent considerable time reviewing possible next steps and potential policy and implementation issues for the top five more-preferred approaches (i.e., steps needed or most important issues to address if someone were to pursue a given approach). The results of their reviews are in Figure 5-1:

- Figure 5-1(a) = Reporting and Tracking of Employer-Coverage Access
- Figure 5-1(b) = BH Employer-Sponsored Insurance (ESI) Program
- Figure 5-1(c) = DSHS Employer-Sponsored Insurance (ESI) Program
- Figure 5-1(d) = BH Vouchers to Buy Employer Coverage
- Figure 5-1(e) = PSHB 2094, Taxpayer Health Care Fairness Act

In some cases, notably the **Reporting & Tracking and the DSHS-ESI approaches** (Figures 5-1(a) and 5-1(c), respectively), fairly specific next steps and/or time commitments are made. For example, DSHS and BH are committed to improving information on the employment status of enrollees by:

- Surveying state program enrollees to better understand why they choose to enroll in public coverage if employer coverage is available to them (additional funding is required for this effort),

- Enhancing their ESHB 3079 reports by including a time series component and by providing analysis of the relationship between coverage rates and duration of employment and time enrolled in state programs, and

- Better coordinating their ESHB 3079 reports in terms of consistent methodology and reporting format, to help provide a better sense of the scope of the issue overall rather than just agency-by-agency.

In a similar vein, DSHS is committed to and already moving forward on many of the suggestions arising from the Workgroup with respect to its ESI-program. For example, Figure 5-1(c) contains specific dates for:

- Consolidating DSHS' two employer-coverage-assistance programs (HIPP and ESI),

- Expanding employer participation by working directly with large employers to enroll clients outside of normal open enrollment periods, providing outreach activities, and sharing data to assess cost-effectiveness and to identify potential ESI enrollees,

- Increasing client participation by *requiring* participation in the program (to the extent allowed by law), by including children from SCHIP and the Children's Health Program, and by better targeting clients/families that may potentially have access to employer coverage (e.g., enrollees in Transitional Medical Assistance), and

- Reviewing other states' ESI programs for opportunities to improve what Washington is doing (e.g., in areas of marketing, handling clients with multiple employers, and determining cost-effectiveness.)

The implementation information for the **PSHB 2094** option, Taxpayer Health Care Fairness Act, is also quite specific, but in a very technical sense. Prior to this Workgroup, significant work over several legislative sessions occurred among stakeholders regarding the direction and content of the bill. Given this extensive history, the Workgroup choose to spend much less time discussing and dissecting this option. Rather, at the last meeting the Workgroup simply directed the Agencies to limit their review to any *remaining operational issues* that would make it impossible for the Agencies to implement the bill if someone were to pursue it in the future. The analysis was done with the understanding that the Agencies were not taking any position on this approach but simply providing technical assistance. Figure 5-1(e) contains technical corrections to the bill that would allow DSHS to bill and collect fees as required by PSHB 2094.

For the last two of the top-five preferred options, **BH-ESI and BH-Voucher**, the information in Figures 5-1(b) and 5-1(d) lays the groundwork for further policy discussion. Anything more than that would be premature, particularly given the Legislative directive (E2SHB 1569, section 11) to evaluate inclusion of BH into the Washington Health Insurance Partnership. Examples of the types of issues raised in Figures 5-1(b) and (d) are operational and policy issues such as wraparound coverage, determination of cost-effectiveness, voluntary or required participation, coordination with DSHS programs, impact of the current enrollment information system project, affect on traditional BH's risk pool and therefore its premiums, and continuity of plan and enrollee participation. Federal and legal issues are also raised such as the risk that the federal government would define BH as an employer sponsored plan subject to ERISA requirements and/or coordination with the Medicare program. BH's initial analysis indicates that the challenges of providing a BH-ESI program similar to that of DSHS are substantial and that a voucher approach would be the less complex of the two alternatives.

Figure 5-1(a)[50]
Reporting and Tracking of Employer-Coverage Access
Major Implementation Issues and Next Steps

Brief Description

Review current law and agency administrative procedures to determine how to better collect and track information on enrollee access to and use of employer coverage. *This option evolved to focus on strategic planning and policy decision-making level information (particularly from the perspective of enrollees not their employers) rather than program-specific operational data.*

Implementation Issue	Next Steps	Target Date	Comments / Cost Estimation (if possible)
Survey employed public program enrollees to better understand why they have chosen to enroll in public coverage.	1. Identify target populations. At a minimum, the target populations should include employed recipients of DSHS and BH medical coverage. For DSHS, "crowd out" of private coverage for full-time workers is primarily an issue for employed non-client parents of dependents with DSHS coverage, which suggests that this group also should be an important target population for the survey. 2. Sampling design. Proposed target of 1,200 total completed interviews based on standard "statistical power" calculations. 400 interviews would be completed for each of three target populations: employed adult DSHS medical recipients; employed adult non-client parents of dependents with DSHS medical coverage; and employed adult BH enrollees. 3. Survey instrument development and testing. Assess existing survey instruments designed to examine health insurance enrollment decisions and modify as necessary to create a survey instrument appropriate for this policy context. Try to use an instrument with available external benchmarks, if feasible. 4. Select survey contractor. In-house surveys conducted by the DSHS Research and Data Analysis Division (RDA) have an established track record of achieving 70 percent response rates, as opposed to the 30 to 40 percent response rates typical for the industry. Cost estimates are based on an estimated $125 per completed interview for the survey to be completed by RDA's survey data collection group. 5. Field survey. Estimated data collection period is 3 months. 6. Implement strategies to maximize response rates. Key strategies include use of lottery incentives, translators to handle multiple languages other than English, high "call-back" thresholds, and database searches to improve the quality of contact information. 7. Data analysis and report writing. Assumed to be contracted to an external entity.	Target dates are expressed relative to project funding date. Steps 1 – 4 could be completed within 3 months of project initiation. Data collection (Steps 5 and 6) could be completed 6 months after project initiation. Data analysis and report writing could be completed 10 months after project initiation.	$150,000 for 1,200 completed interviews with a 70 percent response rate. Additional costs for an external contractor to conduct data analysis and report writing TBD. Costs may be higher if HCA requires additional resources to construct their survey sample.
Make changes to the content of the 3079 reports, including adding a time-series	1. Add a time-series component to the statewide analyses in the 3079 reports that would track trends over time in statewide and by-firm measures that are currently reported on only an annual basis in the 3079 reports. These analyses would indicate whether potential "crowd out" of	The additional analyses specified in step 1 could be incorporated into	No additional cost for step 1. Further analysis is necessary to determine the costs

[50] The five approaches to shared responsibility included in Figure 5-1 are given in order of rank score starting with the most preferred approach.

Implementation Issue	Next Steps	Target Date	Comments / Cost Estimation (if possible)
component and analyses of the relationship between coverage rates and duration of employment and time on public assistance	private coverage by publicly funded coverage is increasing over time, and whether observed changes are concentrated in particular industries or among persons employed by smaller or larger firms. 2. Add analyses measuring coverage rates in relationship to duration of employment. This analysis would help us understand the extent to which reliance on public coverage by employed persons is a temporary phenomenon associated with transitions in employment status, or whether employed persons rely on public coverage for extended periods of time. 3. Add analyses measuring coverage rates in relationship to duration on DSHS or BHP coverage. This analysis would help us understand the extent to which use of public coverage by employed persons is a temporary phenomenon associated with transitions in enrollment in public assistance. Analyses conducted to date show that the rate of full-time employment is relatively high among persons receiving DSHS Transitional Family Medical coverage, which suggests that for many clients their use of public coverage while employed full-time may be a temporary phenomenon. However, many of the children associated with these employed medical assistance recipients may be long-term recipients of Children's Medical coverage, so this analysis would need to pay careful attention to changes in medical coverage status among all the members of the household.	the next annual report at no additional cost. Timing and implementation costs of steps 2 and 3 will depend on the technical specifications of the additional measures and potentially the timing of the implementation of new IT systems in HCA (BAIAS) and DSHS (Provider 1).	associated with steps 2 and 3.
HCA contract with DSHS/RDA to produce its ESHB 3079 reports to standardize measurement and report format	1. Establish contract between DSHS/RDA and HCA to specify terms of data sharing. It is likely that significant data management activities would still need to be conducted by HCA to identify the annual population of BH enrollees for analysis and the associated information necessary to meet ESHB 3079 reporting requirements. Some of the changes to the 3079 reports discussed above would probably increase the amount of "pre-processing" data management HCA would need to perform before "handing off" data to DSHS/RDA. 2. DSHS and HCA would work collaboratively to identify a common reporting format. Key issues would include: how to report information about people employed by multiple employers in the quarter; how to present information related to the DSHS and BH enrollees for whom an SSN is not available for linkage to ESD wage data; and how to report by-firm data related to firms that are likely to be franchised.	Step 1 could be implemented by July 2008 and step 2 could be implemented by September 2008. Propose changing annual report date to December 31 to allow time for the additional coordination activities required by this option	May require additional funding. Amount to be determined based on review of technical requirements for data management and analysis.

Figure 5-1(a-e), Implementation Issues & Next Steps

Figure 5-1(b)
Basic Health Employer-Sponsored Insurance (ESI) Program
Major Implementation Issues and Next Steps

Brief Description

Explore creating an ESI program within BH along the same lines as the DSHS program. *For purposes of this project, the primary conceptual difference between the BH ESI option and the BH Voucher option is that the ESI program would include both premium assistance and wraparound coverage; the voucher option is solely for premium assistance (i.e., no wraparound coverage is contemplated).*

Implementation Issue	Next Steps	Target Date	Comments / Cost Estimation (if possible)
Provide analysis assuming a BH program using DSHS as a model:	Analyze and develop an implementation plan using a model based on: 1. The current DSHS program: *"Voluntary"* enrollment in available employer-sponsored coverage when cost effective for the state. The employee would be required to cooperate with BH. The plan would include the following elements: a. A detailed review of current elements of the DSHS ESI program. b. Identification of participants – participation and document requirements. c. Application process, including recertification requirements and process. d. Recoupment and appeals process for over-subsidized enrollees, if applicable. e. Cost effectiveness review (cost effective for the state) process. f. Mechanism to provide wraparound / coordination of benefits with BH coverage. g. Premium reimbursement process, including monthly verification of coverage. h. Evaluation of administrative / operational functions through the current DSHS ESI program infrastructure to administer portions of the BH program through inter-agency agreement. i. Cost estimate to implement the program. Initial analysis indicates that the challenges of providing a BH ESI similar to the DSHS model are substantial. **A Voucher approach which is coordinated where appropriate with the DSHS ESI program provides the potential to be administratively less complex and less likely to conflict with federal statutory provisions.** Specific elements of the ESI program that would be problematic for BH to implement include: • <u>Determination of the cost effectiveness for the state to enroll an individual in ESI program.</u> The evaluation process to compare an individual employer's coverage with BH managed care coverage is much more complex than the current analysis conducted by DSHS. BH would need an actuarial comparison of the health care services	TBD: 6 - 8 months to complete plan pending a directive to proceed with such analysis.	BH per person admin program costs will exceed DSHS program costs (cost effectiveness evaluations and coordination of benefits). Staff resources and time commitment for both agencies would be substantial.

Figure 5-1(a-e), Implementation Issues & Next Steps

Implementation Issue	Next Steps	Target Date	Comments / Cost Estimation (if possible)
	provided as well as the out-of- pocket costs (co-payments and deductibles). This process would be administratively expensive and not very timely. The alternative is to assume that an employer with 50 or more employees provides health coverage comparable to or more comprehensive than BH. • <u>Provision of wraparound – coordination with employer coverage through a fee-for-service program</u>. DSHS utilizes its fee-for-service program to provide the wraparound / coordination of benefits element of its ESI program. Healthy Options (contracted health plans) does not provide coordination of benefits for ESI. BH does not have a fee-for-service option. The provision of wraparound coverage through BH contracted health plans is not a likely option. The development of a BH fee-for-service process solely for this purpose would be difficult to develop and potentially costly to administer. In addition, program and benefit differences make it unlikely that BH could efficiently utilize the DSHS or the UMP fee–for-service structures to coordinate benefits with the employer's coverage. 2. The expanded DSHS program: *Require* employees and their dependents to enroll in available employer-sponsored coverage when cost effective for the state. Conduct detailed review of expanded DSHS ESI program and develop plan to implement the elements of the program for a BH program. Evaluate whether the DSHS program infrastructure could be utilized to administer portions of the BH program through inter-agency agreements. See comments above. **HCA believes that the Voucher option would be a more appropriate mechanism for HCA to promote employee participation in employer sponsored coverage.**	TBD: 6 - 8 months to complete plan (concurrent with analysis on the current DSHS program) pending a directive to proceed with such analysis.	BH per person administrative program costs will exceed DSHS program costs (cost effectiveness evaluations and coordination of benefits).
Analysis of operational questions	1. Analyze the implications of the BH enrollment information system project (BAIAS) on implementation. Developing a BH ESI product would be directly tied to the current BH program and benefits. This approach would require additional data elements and reporting for BH and thus directly overlaps with the BAIAS project. Thus, implementation of this option will be delayed until successful completion of the BAIAS project. After the BAIAS conversion is completed this project could be added to the list of program upgrades and implemented based on its priority status. 2. Analyze the development of a BH ESI in relation to the directive to the Health Insurance Partnership (HIP) Board to evaluate the risks and	TBD - An initial BAIAS project timeline will not be completed until fall 2008. TBD: Analysis to be conducted	Funding needed for actuarial analysis and review by

Figure 5-1(a-e), Implementation Issues & Next Steps

Implementation Issue	Next Steps	Target Date	Comments / Cost Estimation (if possible)
	benefits of incorporating BH into the Partnership. The report is to be submitted to the legislature by September 2009. An ESI program that applied only to employers with 50+ employees would not overlap with the population to be served by HIP as currently defined. However, given the administrative cost and complexities of implementing an ESI program it would be prudent to wait until it was determined whether BH will be incorporated into the Partnership. In addition, it is likely that a BH ESI program would be applied to all employees (including those who work for small employers). Thus, it is anticipated that overlap of these programs will occur and the agency would need to complete analysis of how the programs would work in tandem. This analysis would include a review of other state's efforts, actuarial analysis and discussion with "national" experts".	concurrent with the implementation plan pending a directive to proceed.	"national experts".
	3. Examine opportunities for coordinating administrative / operational functions with DSHS. The analysis will require a detailed understanding of DSHS processes, identification of specific DSHS resources that could be used by BH, and a cost comparison of utilizing DSHS resources through an inter-agency agreement (where possible) vs. developing the capacity to perform the function at HCA. Initial opportunities for coordination include: a. Accounting processes to provide premium assistance to employees. b. Monthly receipt of employer coverage verification. c. Coordination and marketing with employers to encourage active employer participation.	TBD: Analysis to be conducted concurrent with the implementation plan pending a directive to proceed.	Staff resources and time commitment for both agencies would be substantial.
Analysis of federal and other legal implications	1. Evaluate the risk that CMS would define BH as an employer sponsored plan under the federal Medicare law. Issue – BH does not provide coverage to persons eligible for Medicare. This analysis will require communication with HCA legal consultants. Given HCA's ongoing dialogue with CMS over the last couple of years, it is very probable the federal agency will view any provision of BH resources specifically for employees (e.g. not to all BH enrollees) as a group product resulting in substantial CMS scrutiny. To minimize the potential that CMS would define BH as an employer-sponsored plan, it is essential that the ESI program be developed with the following features: a. Create an ESI program separate from BH with separate funding and administration. b. No direct comparison of an employer's benefit package to the BH benefits. c. No wraparound or coordination of benefits between BH and ESI program. d. A requirement that employees and their dependents are not	TBD: Analysis to be conducted concurrent with the implementation plan pending a directive to proceed.	Funding needed for legal consultation.

Figure 5-1(a-e), Implementation Issues & Next Steps

Implementation Issue	Next Steps	Target Date	Comments / Cost Estimation (if possible)
	eligible to participate in BH while they are participating in the ESI program. e. Specific language in statute and rule clarifying the new program's neutrality regarding Medicare eligibility. This model is more consistent with a voucher approach, rather than the more detailed ESI approach.		
	2. Evaluate risks that the program would be subject to the federal Employee Retirement Income Security Act. Potential issues could include the degree to which BH would have plan administration and fiduciary responsibilities outside it capabilities; and whether BH would be required to provide coverage of specific benefits and services not currently required of contracted carriers.	TBD: Analysis to be conducted concurrent with the implementation plan.	Funding needed for legal consultation.
Impacts on BH	1. Evaluate impact to BH risk pool of a potential change in the pool resulting from ESI enrollees no longer participating in BH. HCA would request an actuarial evaluation of this issue.	TBD: Analysis to be conducted concurrent with the implementation plan.	Funding needed for actuarial evaluation.
	2. Consult with contracted health plans to evaluate continuity of plan participation. HCA would request each contracted health plan to provide an evaluation.	TBD: 1 Month - Communication to be conducted concurrent with the implementation plan.	
	3. Evaluate value of ESI vs. maintaining family coverage through a health care provider network. Provide policy analysis that includes a review of policy articles and documents that discuss the public policy goal of promoting employer provided health care coverage vs. providing coverage to a family through one health care network.	TBD: 1 Month – Policy analysis to be conducted concurrent with the implementation plan.	

Figure 5-1(a-e), Implementation Issues & Next Steps

Figure 5-1(c)
DSHS Employer-Sponsored Insurance (ESI) Program
Major Implementation Issues and Next Steps

Brief Description

Maximize the potential of the current DSHS employer-sponsored insurance (ESI) program to pool large employers and state funds.

Implementation Issue	Next Steps	Target Date	Comments / Cost Estimation (if possible)
Strengthen program administration	1. Consolidate the administration of the ESI and Health Insurance Premium Program (HIPP) to maximize resources and expertise. [51]	3/1/08	
	2. Review, update and submit the cost effectiveness methodology as reflected in the State Plan Amendment (SPA) with the Centers for Medicaid and Medicare Services (CMS).	7/1/08	Risk: CMS disapproval
Expand employer participation in ESI program.	1. Work with large self-insured firms to allow Medicaid clients to enroll at times other than normal open enrollment ("qualifying event provisions)	1/1/09	
	2. Identify data requirements for cost-effectiveness and plan for collection.	3/1/09	
	3. Coordinate with large employers' Human Resource departments for outreach activities to identify potential ESI enrollees.	4/1/09	
	4. Work with large employers to share employment data to identify potential ESI enrollees.	6/1/09	
Expand client participation in ESI and HIPP programs	1. Implement RCW 74.09.470(4) ESI requirements to change "voluntary" enrollment in available employer-sponsored coverage to "required", as a condition for families to be covered in Medical Assistance programs when it is cost-effective for the state and to the extent permissible under Title XIX of the Social Security Act. [52]	SPA 7/1/08 WAC -12/1/08	

[51] The ESI program provides premium assistance/wraparound coverage to clients or their dependents that *do not have employer-sponsored coverage at the time of their enrollment in Medicaid*. HIPP provides premium assistance/wraparound coverage for clients or their dependents that *are enrolled in employer insurance at the time of their enrollment in Medicaid.*

[52] Section 1906 of the Social Security Act allows state Medicaid programs to enroll Medicaid eligible clients in group health plans, which includes employer-sponsored health insurance. Section 1906(a)(2) gives states authority to require Medicaid clients to apply for group health plan coverage as a condition of eligibility. However, Section 1906(b)(2) prohibits state Medicaid programs from dis-enrolling *a child* from Medicaid if their parents do not enroll the child in their group health plans. There are no provisions in Title XIX (Medicaid) of the Social Security Act that give state Medicaid agencies any authority to require employers to offer insurance to their employees or their dependents who are eligible for Medicaid.

[53] The Medicaid program offers up to 12-months of extended medical benefits when the family's earned income exceeds program eligibility income standards. There currently are 69,000 persons enrolled in TMA. According to ESHB 3079 report data for CY 2005, about 15,000 of these adults are employed in firms with more than 50 employees.

Figure 5-1(a-e), Implementation Issues & Next Steps

Implementation Issue	Next Steps	Target Date	Comments / Cost Estimation (if possible)
	2. Evaluate state law that would require Medicaid clients or their parents to notify DSHS when they become employed by firms that offer employer-sponsored insurance. Need to determine whether federal law would allow a state to impose this requirement as a condition for continued eligibility.	6/1/08	Check with Medicaid Eligibility Policy Staff
	3. Submit Title XXI (State Children's Health Insurance Program (SCHIP)) State Plan amendment or waiver that would allow ESI program coverage for SCHIP children in their parent's employer-sponsored coverage when it is cost-effective for the state.	6/1/08	Work with Medicaid Eligibility Policy Staff
	4. Include ESI for families and adult workers (not just children) eligible for Medical Assistance programs in our monthly targeted outreach. For example, work with families in Transitional Medical Assistance (TMA) to evaluate whether they have access to employer-sponsored insurance. [53]	6/1/08	
	5. Expand ESI program to include participation of children enrolled in the Children's Health Program.	12/1/08	Check with Medicaid Eligibility Policy Staff
Evaluate states' ESI "best practices" and Deficit Reduction Act of 2005 (DRA).	Review other states' ESI programs for opportunities to improve Washington's ESI program. Areas to consider may include: 1. Marketing to Medicaid clients and employers. 2. Handling of people with multiple employers and/or frequent job changes. 3. Review of other benefit comparisons and methodology for determining cost-effectiveness. 4. Evaluate whether DRA provisions giving states Medicaid benefit design flexibility for certain populations would help enrollment and reduce cost-effectiveness requirements.	1/1/09	

Figure 5-1(a-e), Implementation Issues & Next Steps

Figure 5-1(d)
BH Vouchers to Buy Employer Coverage
Major Implementation Issues and Next Steps

Brief Description

Provide individuals who are eligible for public programs with vouchers to buy-into their employer offered coverage (i.e., pay for some or all of employee premium contribution). *Initial discussions did not specifically target BH or DSHS in terms of designing a voucher program. However, based on Workgroup and Agency discussions the Agencies decided it made sense, as a starting point, to focus this discussion on BH because of the design flexibility accorded by a state-only program. For purposes of this project, the primary conceptual difference between the BH ESI option and the BH Voucher option is that the ESI program would include both premium assistance and wraparound coverage; the voucher option is solely for premium assistance (i.e., no wraparound coverage is contemplated).*

Implementation Issue	Next Steps	Target Date	Comments / Cost Estimation (if possible)
Develop implementation plan for creation of voucher program for employees of large employers (50+ employees).	1. Develop an implementation plan to provide premium assistance through an employee health care voucher program as follows: a. Create a new statutorily authorized program within HCA that is separate and distinct from BH. Funding for the program would be appropriated separate from BH. Funding from the voucher program and BH would be adjusted through the annual appropriations process. b. Low-income employees of large employers (50+ employees) and their dependents who are eligible to participate in their employer health care coverage *may apply* to HCA for the voucher program (i.e., as a voluntary option). c. Employees could apply to participate in either the BH subsidized program or the voucher program – participation in both programs would be prohibited. d. Income eligibility – similar to BH eligibility. e. Limits for monthly reimbursement for premium assistance would be structured to provide assistance on a sliding scale based on income level (same concept as BH – the lowest income employees can receive the largest monthly reimbursement). Premium reimbursements could be designed to provide a savings to the state (compared to state costs for BH enrollment) or be budget neutral. f. Verification of employer coverage – before an employee could receive assistance the employee would need to provide documentation of coverage through the employer's health insurance. Premium assistance would continue based on the employee providing monthly verification of his or her premiums paid toward the employer coverage. To remain eligible, the employee must meet regular recertification requirements. g. Evaluate coordinating administrative / operational functions through the current DSHS ESI program infrastructure to administer portions of the voucher program through inter-agency agreements. h. Estimate costs to implement the program. i. Examine the implications of a mandatory voucher program –	TBD: 6 - 8 months to complete plan pending a directive to proceed with analysis.	Per person admin program costs will likely be less than DSHS ESI program costs (no cost effectiveness evaluation or coordination of benefits), but greater than BH admin costs based on data from other states. Staff resources and time commitment for HCA would be substantial.

Implementation Issue	Next Steps	Target Date	Comments / Cost Estimation (if possible)
	persons eligible to participate in the voucher program would not be eligible to enroll in BH. This could have significant budgetary impacts because removing all BH enrollees with access to employer-sponsored coverage would mean that more unemployed and very low-income enrollees could be expected to replace them—each eligible for a greater monthly subsidy than an employed enrollee with a higher income.		
Analysis of operational questions	1. Analyze the implications of the BH enrollment information system project (BAIAS) on implementation. There would be overlap with BH and DSHS programs – central process to determine income eligibility and tracking family participation in both programs (e.g. employee receiving voucher and dependents enrolled in BH, BH Plus, S-Medical or the Children's program). The program overlap likely increases if the voucher option is mandatory (see above). HCA assumes the new program would be implemented using an enrollment information system separate from BAIAS. However HCA will still need to identify the specific overlap of the programs to determine any impact to BAIAS. In addition, a separate information system would be more expensive for HCA to develop at this time as HCA's current IS resources are focused on the success of BAIAS, thus requiring additional external resources to create a separate voucher information system.	TBD – 1 month after the initial BAIAS project timeline is completed in fall 2008.	Likely will require development of a separate voucher information system.
	2. Analyze the development of a voucher program in relation to the development of the Health Insurance Partnership and the current BH program. It is possible that the voucher program (large employers) and the HIP (small employers) could be designed to serve different populations based on employer size. However, HCA would need to evaluate how the programs would work in tandem, as well as with the current BH and DSHS programs. This analysis would include a review of other state's efforts, actuarial analysis and discussion with "national" experts". While there may be value in offering a myriad of choices to low-income enrollees, there is also a public policy question whether multiple programs and benefit packages with separate administrative expenses is the best use of limited public resources.	TBD: Analysis to be conducted concurrent with the implementation plan pending a directive to proceed.	Funding needed for actuarial analysis and review by "national experts".
	3. Examine opportunities for coordinating administrative / operational functions with DSHS. The analysis will require an understanding of DSHS processes, identification of specific DSHS resources that could be used by BH, and a cost comparison of utilizing DSHS resources through an inter-agency agreement (where possible) vs. developing the capacity to do the function at HCA. Initial opportunities for coordination include:	TBD: Analysis to be conducted concurrent with the implementation plan pending a directive to proceed.	Staff resources and time commitment for both agencies would be substantial.

Figure 5-1(a-e), Implementation Issues & Next Steps

Implementation Issue	Next Steps	Target Date	Comments / Cost Estimation (if possible)
	a. Accounting processes to provide premium assistance to employees. b. Monthly receipt of employer coverage verification. c. Coordination and marketing with employers to encourage active employer participation.		
Analysis of federal and other legal implications	1. Evaluate the risk that CMS would define BH as an employer sponsored plan under the federal Medicare law. Issue – BH does not provide coverage to persons eligible for Medicare. 2. Evaluate risks that the program would be subject to the federal Employee Retirement Income Security Act. Potential issues could include plan administration and fiduciary responsibilities outside it capabilities; and whether BH would be required to provide coverage of specific benefits and services not currently required of contracted carriers. This analysis will require communication with HCA legal consultants. The program design would be developed to reduce the likelihood of a conflict with federal laws or regulations.	TBD: Analysis to be conducted concurrent with the implementation plan pending a directive to proceed.	Funding needed for legal consultation.
Impacts on BH	1. Evaluate impact to the BH risk pool of a potential change in the pool resulting from voucher program enrollees no longer participating in current BH. HCA would request an actuarial evaluation of this issue. 2. Consult with BH contracted health plans to evaluate continuity of plan participation. HCA would request each contracted health plan to provide an evaluation. 3. Evaluate value of a voucher program vs. maintaining family coverage through a BH health care provider network. Provide policy analysis that includes a review of policy articles and documents that discuss the public policy goal of promoting employer-provided health care coverage vs. providing coverage to a family through one health care network.	TBD: Analysis to be conducted concurrent with the implementation plan. TBD: 1 Month - Communication to be conducted concurrent with the implementation plan. TBD: 1 Month – Policy analysis to be conducted concurrent with the implementation plan.	Funding needed for actuarial evaluation.

Figure 5-1(a-e), Implementation Issues & Next Steps

Figure 5-1(e)
PSHB 2094, 2007 Legislative Session (Taxpayer Health Care Fairness Act)
Major Implementation Issues and Next Steps

Brief Description

Review the latest version of 2094 and, where feasible, suggest changes (primarily of an operational nature). *This option evolved to a focused review of any operational issues remaining in the bill that would make it impossible to be implemented by the Agencies (assuming someone where to pursue this approach). (Latest version = H3557.2)*

Implementation Issue	Next Steps	Target Date	Comments / Cost Estimation (if possible)
In order for DSHS to be able to bill and collect the fee amounts for persons enrolled in departmental medical programs as set forth in sections 1 through 6 of this act, the department would need collection authority consistent with its existing authority in 43.20 B RCW. This would include amending PSHB 2094 to include a provision for a statute of limitations, procedures for administratively adjudicating debts, and definitions of the terms "notice" and "proof of notice".	PSHB 2094 should be amended as follows: 1. Section 2 would be amended to add the following definition: "(8) "Notice" consists of personal service as defined in RCW 4.28.080." " 2. Section 6(2) would be amended (2) Have authority to inspect **and subpoena** records and conduct investigations and audits of employment and payroll, as the agencies deem necessary or appropriate, to determine whether an employer has complied with sections 1 through 4, 6, and 8 of this act**, using procedures authorized under chapter 43.20B RCW**; 3. Section 6(4) would be amended (4) Deposit employer fees, interest, and civil penalties collected under sections 1 through 4, 6, and 8 of this act into the health services account established under RCW 43.72.900 to offset the state's costs of providing coverage for basic health plan and medical assistance program enrollees and to sustain the state's ability to continue to provide such coverage**. Interest on employer's fees is determined pursuant to RCW 43.17.240.** 4. Section 7 would be amended The department and the health care authority are authorized to collect fees, **penalties and interest** consistent with the provisions of sections 1 through 6 of this act, using the procedures authorized in sections 1 through 4, 6, and 8 of this act **and chapter 43.20B RCW**.	NA	NA

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Appendix 1-1
Summary of ESHB 3079, 2006 Session
Reporting Related to Employment of DSHS & BH Enrollees

Provide a report to the Legislature by November 15 of each year, to include:

	DSHS	BH
Employer specific data for the months of January and June of the reporting year (e.g., January and June 2007 for the report due November 2007).	**Who:** By employer for employers having more than fifty employees as recipients or with dependents as recipients. **What:** • Number of medical assistance recipients who at enrollment or recertification report being employed or report being the dependent of someone who is employed. • Total cost to the state for these recipients, broken out by general fund-state, health services account and general fund-federal dollars • Member months associated with these employees. Above is to be reported by medical assistance eligibility program, including but not limited to family medical coverage, transitional medical assistance, children's medical, or aged or disabled coverage. **Beginning with the 2008 report**: Month and year of hire for the employed recipient or employed parent of the recipient.	**Who**: By employer for employers having more than fifty employees as enrollees or with dependents as enrollees. **What**: • Number of basic health plan enrollees who at enrollment or recertification report being employed or report being the dependent of someone who is employed. • Total cost to the state for these enrollees. **Beginning with the 2008 report**: Month and year of hire for the employed enrollee or employed parent of the enrollee.
Quarterly Aggregate Data for the preceding year (e.g., 2006 quarterly data for the report due November 2007).	**Who:** • Number of employees who are recipients or with dependents as recipients *by private and governmental employers*; • Number of employees who are recipients or with dependents as recipients *by employer size* for employers with 50 or fewer employees, 51-100 employees, 101-1,000 employees, 1,001-5,000 employees, and more than 5,000 employees; • Number of employees who are recipients or with dependents as recipients *by industry type.* **What:** For each aggregated classification (private / governmental, employer size, industry type) include the: • Number of hours worked • Total cost to the state for these recipients • Number of DSHS covered lives	**Who:** • Number of employees who are enrollees or with dependents as enrollees *by private and governmental employers*; • Number of employees who are enrollees or with dependents as enrollees *by employer size* for employers with 50 or fewer employees, 51-100 employees, 101-1,000 employees, 1,001-5,000 employees, and more than 5,000 employees; • Number of employees who are enrollees or with dependents as enrollees *by industry type*. **What:** For each aggregated classification (private / governmental, employer size, industry type) include the: • Number of hours worked • Total cost to the state for these enrollees

Appendix 1-2
Shared Responsibility Team: Workgroup Members & Agency Staff

WORKGROUP MEMBERS

Legislative Members

1. Representative Bruce Chandler
2. Representative Cary Condotta
3. Representative Steve Conway
4. Representative Tami Green
5. Representative Bill Hinkle
6. Senator Karen Keiser
7. Senator Jeanne Kohl-Welles
8. Representative Mark Miloscia

Non-Legislative Members

1. Don Briscoe, International Federation of Professional & Technical Engineers
2. Larry Brown, Aero-Machinists 751
3. John Cedergreen, Columbia Foods in Quincy
4. Holly Chisa, Northwest Grocery Association
5. Patrick Connor, Washington Farm Bureau
6. Dennis Eagle, Washington Federation of State Employees
7. Steve Gano, Wal-Mart
8. Trent House, Washington Restaurant Association
9. Damiana Merryweather, United Food and Commercial Workers
10. Robby Stern, Washington State Labor Council
11. Donna Steward, Association of Washington Business (replaced Mellani Hughes-McAleenan)
12. Jean Wessman, Washington Association of Counties

AGENCY STAFF

Roger Gantz, Department of Social & Health Services, Lead
David Mancuso, Department of Social & Health Services
Robert Longhorn, Health Care Authority
Dennis Martin, Health Care Authority
Jill Will, Employment Security Department
Jenny Hamilton, Governor's Office of Financial Management

Vicki Wilson, Arcadia Point Consulting, Consultant

Appendix 1-3
Workgroup Meeting Agendas with Summary Notes
Meetings 1 through 5

Workgroup Meeting #1: Agenda with Summary Notes
Wednesday, September 26, 2007, 3:30 – 6:30 pm
Conference Rooms A-B-C, Cherberg (Senate) Building, Capitol Campus, Olympia

At the end of the meeting we hope to be clear about …
- the Workgroup's vision of the project's scope
- the Workgroup's desired approach and timing for identifying options and making recommendations
- if and how additional Workgroup members should be added
- how the Workgroup sees itself operating (especially its approach to decision making)

Time	Topic	Who / How	Summary Notes
3:30 - 4:00	Convening & Introductions • Workgroup member introductions • DSHS view of study & how Workgroup membership was selected	Roger Gantz, DSHS, will convene the meeting. Workgroup members will introduce themselves. Roger will give brief history of proviso, how DSHS is approaching this assignment, & how current Workgroup members were selected	No decisions were requested of the Workgroup (WG). WG members started to express concern about the proposed approach, i.e., approach that Agencies would be staff support to the WG & that the product of the process would be a WG (not Agency) product. See "Workgroup Operations" agenda item. **Follow-ups:** Roger indicated that WG materials would be posted to the DSHS website.
4:00 - 4:15	Proposed Agenda Review	Vicki Wilson (facilitator) will review. Group will discuss desired changes.	WG agreed to a set of meeting ground rules. WG agreed to the proposed agenda.
4:15 – 4:45	Workgroup Operations • Approach to decision making • Workgroup election of chair / co-chairs • Final make-up of Workgroup	Vicki will facilitate Workgroup discussion.	WG strongly suggested that this agenda item was premature – the Project Definition (scope) discussion needed to occur first, followed by these items. Nonetheless there was good discussion about several of the sub-topics. There was a long discussion about the approach to the project. Many WG members voiced very strong concerns that we need to follow the language of the proviso in terms of this effort being Agency-led, with the WG "closely involved and consulted". Of those who spoke to this issue (and many did in one way or another), they were clearly uncomfortable with an approach where the report and recommendations are a product of the WG, rather than of the Agencies. The message was fairly clear – follow what the proviso says. The WG agreed to a steering committee (rather than "chair") to work with the Agencies to help guide the WG process (e.g., meeting agendas and work plan). Volunteers for the steering committee are: Representative Chandler,

Time	Topic	Who / How	Summary Notes
			Representative Conway, Steve Gano, Damiana Merryweather, and Representative Miloscia. Some concerns were expressed about the current WG make-up, e.g., that Senate Republicans had declined to participate, the possible imbalance between private employers/employees and public representatives, that local school districts should be at the table, and that some groups specifically called-out in the proviso were not represented (state government as employer; employees of local government). The WG agreed that a representative of "state government as employer" was needed, likely from OFM. The WG also agreed that employees of cities and counties should be included to fill the slot of "employees of local government". There was some desire to include a way for non-workgroup members to share input with the WG (a possible issue for the Steering Committee to address). **Follow-ups:** Roger indicated that the Agencies would seek guidance from the Governor's Office regarding the WG's strong concern that the proposed approach (of the WG being the lead) is counter to the proviso language. Roger will convene the steering committee. Roger will talk with the Governor's Office about getting a representative to the WG for "state government as employers". Robby Stern will find a WG representative(s) for "employees of local government."
4:45 - 6:00	Project Definition – Setting Scope • Brief review of "background information" material • Discussion of "project definition" materials	Vicki will facilitate Workgroup discussion.	Given the WG's concern about the proposed approach to this project (i.e., WG lead vs. Agency lead), much of this Agenda item was premature because it was asking WG members to make decisions about how they envisioned their assignment. Nonetheless it was useful to "skip around" in the material to ferret out data areas of interest and where opinions differ and overlap. It's fairly clear that "data shape this debate". Throughout the agenda, the WG's desire / need for a better understanding of data related to the proviso issue was made clear – data and its interpretation are needed to understand the existence, magnitude, and nuances of any problem prior to being able to discuss solutions. Even with good understanding of the data, there was some skepticism about the ability (or even need) for the WG to come to consensus regarding the problem and its solutions. Given the discussion, it's likely that the 2nd WG meeting will be "data heavy" with presentations from the Agencies (DSHS, HCA, and OFM). Several possible topics arose: (1) Washington's employer-sponsored insurance market, especially as it relates to low-wage/low-income workers and degree of erosion of coverage; (2) In-depth understanding of the "3079" report data for DSHS & BH – nuances,

Time	Topic	Who / How	Summary Notes
			changes over time, ability to capture hours; (3) Public program offerings – the current employer-sponsored insurance program in DSHS, coordination of benefits, changes occurring in DSHS caseloads, basic eligibility and enrollment information for DSHS and BH; and (4) Why people make the choices they do, e.g., who are the people on public programs & why are they there, why do people opt for public coverage if reasonable employer coverage is available. A basic fact sheet for members was suggested (e.g., poverty levels, program income eligibility standards, minimum wage, etc.) Some very specific data questions were asked that can be addressed in the Agency presentations (e.g., is the state paying for a larger share of the workforce today than it did in the past, what portion of DSHS and/or BH clients might realistically be impacted, distinction between low-wage/low-income). The issue of "shared responsibility" was discussed to some degree; ranging from a desired focus on "the fairest way to reallocate dollars & responsibility" to "the need to get more private dollars – employer & individual – into the system and how best to do that". **Follow-ups:** Roger will convene the steering committee to discuss the next meeting's agenda. Agencies will prepare desired data presentations.
6:00-6:20	Work Plan & Future Meeting Logistics • How often & long to meet • November 15 deadline still realistic / doable?	Vicki will facilitate Workgroup discussion.	WG agreed to skip discussion of the work plan, agreeing that it was premature. WG agreed on a tentative time for the 2nd meeting: October 15, 10:00 AM, Olympia. WG agreed that "proxies" could attend meetings in a member's absence. **Follow-ups:** Roger to send meeting notice to WG for October 15 (several WG members had left the meeting by the time this decision was made).
6:20-6:30	Wrap-up & Assignments	Vicki will recap any assignments from the meeting & next steps.	See above notes.

Workgroup Meeting #2: Agenda with Summary Notes
Monday, October 15, 2007, 10:00 am – 1:00 pm
Conference Rooms A-B-C, Cherberg (Senate) Building, Capitol Campus, Olympia

At the end of the meeting we will have …
- Provided substantial information to the Workgroup about public programs and the participation of large employers' workers in those programs
- Provided an opportunity for Workgroup members to ask questions about, and discuss, the above information and its relevance to the "shared responsibility" issue

Time	Topic	Who / What	Summary Notes
10:00 – 10:15	Convene Meeting • Project approach • Today's agenda & future work plan	Vicki will convene the meeting. Roger will briefly review project approach. Vicki will review the day's agenda and the outline for future meetings.	Roger affirmed for the Workgroup (WG) that the result of this effort will be a product of DSHS, completed in consultation with HCA and ESD, and with close involvement and consultation of the WG. He committed that WG ideas will be reflected in the final report. The issue of "accepting the minutes" of previous WG meetings was raised. In the interest of time, Vicki asked that WG members review the meeting #1 summary and e-mail any concerns or comments to her or Roger. (She also noted that these are not intended to be formal meeting minutes but rather only intended to capture some of the highlights.) In response to concerns raised at the first meeting, the Agencies revised the Work Plan to produce a draft report by November 15. However, the Agencies are willing to be flexible if the WG decides that more time is needed. Follow-ups: WG members to send Roger and/or Vicki any comments / concerns etc. regarding the notes from the first WG meeting.
10:15 – 11:20	All About DSHS • Medical programs overview • Current "sharing responsibility" programs (e.g., employer-sponsored insurance program, coordination of benefits program) • Nov 2006 "3079" report findings & issues Q & A and discussion	This section is a primer on DSHS programs and activities relevant to the "shared responsibility" discussion. The purpose of this section is to make sure Workgroup members are familiar with DSHS': 1. Current public program offerings – eligibility, enrollment & caseload, benefits relative to large employer offerings, who enrolls in these programs & which enrollees might be most relevant to this discussion. 2. Current activities within DSHS	The intent of this section was educational; mainly providing WG members the opportunity to ask questions and get clarification on current programs and activities. We did not get to the "Nov 2006 3079 report findings & issues" item; it will be on the agenda for meeting #3. There was good back-and-forth discussion. Rather than trying to capture the totality of the conversation, following are some of the questions asked by WG members. Many of the questions were answered in the meeting; other questions may need follow-up; and for some questions we simply don't have very good information right now. Also, questions asked have varying degrees of direct relevance to the "shared responsibility" focus of the WG. Finally, the following list tries to capture the spirit of what was asked but not necessarily the exact wording, with similar questions collapsed into one overall question. Questions during the DSHS Medical Programs Overview presentation: ▪ Which DSHS programs serve adults without children?

Time	Topic	Who / What	Summary Notes
		aimed at sharing responsibility for coverage of low-income workers. 3. In-depth understanding of the data presented in the required "3079" reports – what the data can and cannot tell us regarding large employers' workers enrolled in DSHS programs. DSHS staff will present this information. Q & A and discussion will happen as presentations are given.	▪ How often is family income monitored for program eligibility? ▪ SCHIP dollars can be used down to what family poverty level? What relevance to our "shared responsibility" discussion is the current Congressional discussion on SCHIP reauthorization? ▪ How many uninsured children are in families with incomes over 300% of federal poverty; and what is the rate of un-insurance for children in this income group? How many of these uninsured children might participate in the "full buy-in" program that becomes effective January 2009? ▪ Do program enrollments reflect general growth in various population groups? Is there variation by certain demographic characteristics such as geography? Specifically, are proportions among various population groups growing, declining, or staying the same (which is different than asking if the absolute numbers are changing, which is also of interest). This question is applicable to a variety of populations eligible for DSHS coverage, whether it's low-income families with children, adults without children, pregnant women, disabled persons in general and those in the Healthcare for Workers with Disabilities (HWD) program, Medicare-Medicaid dual eligibles, etc. ▪ Across the various DSHS programs, are changes occurring over time in the numbers and proportions of enrollees who work; and more specifically, who work for large employers? Are people dropping employer coverage to enroll in public coverage? Is this a growing / declining / static phenomenon? And is the phenomenon different for employee versus dependent coverage? ▪ What factors account for the declining trend in Family Medical caseload? ▪ If greater numbers (and proportions) of people can enroll in public programs, does that change the make-up of the private market risk pool? In a positive or negative way? And what is the resulting impact on premiums for those who remain in the private market? ▪ How do the cost of coverage and benefits covered differ between public programs and large employers? On average, what is the per month premium for adult coverage and children's coverage in DSHS? ▪ Where does the Ticket to Work program fit in? ▪ What % of Washington births are paid for by taxpayer dollars, across all types of public programs whether for low-income persons, employees of all levels of government, military programs, etc. What has been the change over time? ▪ Given the dramatic increase in Medicaid expenditures over the last decade, can the drivers of that growth be identified? That is, what's driving the expenditure increase and what portion of it can be attributed to employees of large employers coming onto public programs? Questions during the COB and HIPP presentation: ▪ For workers applying for, or enrolled in, DSHS programs, what is their obligation with respect to disclosing that they have *active* employer sponsored insurance? Or that they have *access* to employer coverage even

Time	Topic	Who / What	Summary Notes
			though they may not be enrolled in it? Which other states require that workers applying for public coverage report this information? ▪ Can workers with access to and/or active employer coverage be denied coverage in DSHS programs? ▪ By default, are employees covered if an employer pays 100% of the premium? Or can they still opt-out? ▪ What portion of employers allow employees to opt out/waive coverage? Are there conditions for opting out, e.g., coverage through another source? ▪ In the COB program, are there sanctions if an enrollee does not cooperate in identifying third-parties? ▪ What exactly, in simple language, is the difference between the HIPP program and the ESI program? Are they similar programs serving similar groups? Why are they separate? ▪ In both the HIPP and ESI programs, how does DSHS determine if employer coverage is "adequate" in terms of "buying" the person into it? ▪ If a low-income person has employer coverage and is eligible for Medicaid, can Medicaid coverage be used to "wraparound" the employer coverage? ▪ Play out administratively, what happens if a bill for service for a Medicaid enrollee comes to DSHS and the person is working but not covered by the employer. Questions during the Employer-Sponsored Insurance (ESI) presentation: ▪ If a person is "bought into" employer coverage, what does the Medicaid "wraparound" cover? The employee premium share? Other cost sharing such as deductibles, co-pays, and co-insurance? Services covered by Medicaid but not by the employer plan? ▪ For wraparound services, Medicaid pays its standard rates to providers regardless of the provider rates associated with the employer's coverage. Can the practical implications of this be clarified with an example? ▪ Are there unintended impacts on an employer's premiums if that employer has substantial numbers of low-income employees whose cost-sharing is being subsidized by Medicaid (i.e., does subsidizing change the behavioral assumptions that underlie the development of premiums)? ▪ How complex (administratively and cost-wise) does it get with enrollees who have multiple employers in a year? ▪ Does DSHS have a return-on-investment amount for the ESI program (like that developed for the HIPP program)? ▪ Given ERISA, what is the practical implication of E2SSB 5093's language that requires state regulated health insurance to allow Medicaid enrollees to enroll in employer-sponsored coverage outside of established open enrollment periods? ▪ Given federal Medicaid law, what is the practical implication of E2SSB 5093's language requiring families to enroll in available employer coverage as a condition of Medicaid eligibility? How has DSHS changed its practices in response to 5093's language? ▪ If large employers were to encourage their low-income workers to

Time	Topic	Who / What	Summary Notes
			participate in Medicaid's ESI program, would that be perceived by policy makers as a positive step? ▪ Is the newly forming "Connector" (the Health Insurance Partnership Program) being developed by the HCA a possible avenue for large employers and state government to share responsibility? Follow-ups: ▪ For WG members: Not all of the above questions are directly relevant to the "shared responsibility" discussion. However, for those that are, which ones would you like additional information on? ▪ For Agencies: For the questions directly relevant to "shared responsibility", is there additional information that can be provided to the WG?
11:20 11:35	Break		
11:35 – 12:10	All About BH • Program overview • Current "sharing responsibility" programs (e.g., employer program) • Nov 2006 "3079" report findings & issues Q & A and discussion on the above	This section of the agenda parallels the previous one for DSHS. It is a primer on BH programs and activities relevant to the "shared responsibility" discussion. The purpose of this section is to make sure Workgroup members are familiar with BH's: 1. Current public program offerings – eligibility, enrollment, benefits relative to large employer offerings, who enrolls in the program & which enrollees might be most relevant to this discussion. 2. Current activities within BH aimed at sharing responsibility for coverage of low-income workers. 3. In-depth understanding of the data presented in the required "3079" reports – what the data can and cannot tell us regarding large employers' workers enrolled in BH programs.	As with the previous agenda item on DSHS, the intent of this section was educational; mainly providing WG members the opportunity to ask questions and get clarification on current Basic Health programs and activities. We did not get to the "Nov 2006 3079 report findings & issues" item; it will be on the agenda for meeting #3. Repeating what was said above for DSHS: There was good back-and-forth discussion. Rather than trying to capture the totality of the conversation, following are some of the questions asked by WG members. Many of the questions were answered in the meeting; other questions may need follow-up; and for some questions we simply don't have very good information right now. Also, questions asked have varying degrees of direct relevance to the "shared responsibility" focus of the WG. Finally, the following list tries to capture the spirit of what was asked but not necessarily the exact wording, with similar questions collapsed into one overall question. ▪ Have employers been encouraged to sign up for BH? As employer groups? Or, alternatively, by encouraging low-income employees to sign-up as individuals? ▪ Are working enrollees found equally among the subsidized groups or concentrated in some subset of groups? ▪ Do non-provider sponsors coordinate with employers to get dollars to help pay enrollee premiums? ▪ Does BH ask applicants if they have active employer coverage and/or access to employer coverage? If asked, what does BH do with that information? ▪ Does BH actively engage in COB the way DSHS does? ▪ What's the average monthly premium for BH coverage? ▪ What does BH do to track or measure compliance with the legislative intent that BH not replace employer sponsored coverage?

Time	Topic	Who / What	Summary Notes
		BH staff will present this information. Q & A and discussion will happen as presentations are given.	▪ Why is BH keeping enrollment around 105,000 per month if it is funded for 107,500 per month? ▪ Is there a real difference or just a semantics difference between "managing enrollment" and having a waiting list? ▪ Is BH able to say it is meeting X% of the need for its target population (i.e., does BH know the true degree of need for its program and to what degree it is meeting that need)? ▪ Although the BH employer-group program still exists, BH is not accepting new groups. Why? More specifically: (1) What has been the practical effect of the virtual disappearance of non-subsidized BH on the BH employer-group program. (2) What is the CMS decision that has derailed the BH employer-group program, particularly since BH is a state-only funded program? Follow-ups: ▪ For WG members: Not all of the above questions are directly relevant to the "shared responsibility" discussion. However, for those that are, which ones would you like additional information on? ▪ For Agencies: For the questions directly relevant to "shared responsibility", is there additional information that can be provided to the WG?
12:10 – 12:25	Employer-Sponsored Coverage for Washington Large Employers & Their Low-Wage / Low-Income Employees Q & A and discussion	The purpose of this section is to provide context for changes in employer-sponsored coverage, especially for low-wage &/or low-income workers of large employers. Where possible, Washington specific data will be used to look at sources of coverage for low-income families as well as changes over time in large employer/employee offer, eligibility, enrollment, coverage, and affordability. OFM staff will present this information. Q & A and discussion will happen as the presentation is given.	This agenda item was tabled to meeting #3. Follow-ups: Slides for this presentation were distributed at the end of the meeting. Please contact Jenny Hamilton, OFM, at Jenny.Hamilton@ofm.wa.gov with any comments and she will incorporate clarifications into her presentation at meeting #3.
12:25-12:55	What does all this information say about the problem to be solved?	Vicki will facilitate a Workgroup discussion (starting with a recap of major issues raised by the	Much of this discussion occurred in the context of the Q&A and discussion specific to previous agenda items. It seemed to serve no purpose to cut-off perfectly good exchanges of information solely in the interest of saying we

Time	Topic	Who / What	Summary Notes
		Workgroup during presentation discussions).	completed all agenda items. Nonetheless, we will need to return to this question at some point. As facilitator, I'm still not certain that any of us could simply and precisely paint a clear picture of the current scope and trend of the problem.
12:55 – 1:00	Meeting Wrap-up & Next Steps	Vicki will review any assignments and/or next steps from this meeting.	WG agreed to a tentative time for the 3rd meeting: Tuesday, October 30, in the afternoon. Agenda items tabled to meeting #3 are: (1) Employer-Sponsored Coverage for Washington Large Employers & Their Low-Wage / Low-Income Employees (OFM presentation) and (2) November 2006 "3079" Report Findings & Issues for DSHS and BH (Agency presentations). Prior to moving into the focus of meeting #3, i.e., options for shared responsibility, the WG may want to return to a focused discussion on "what does all the information say about the problem to be solved?". As facilitator I have some concern that a 3 hour meeting (for meeting #3) will be insufficient to cover all the tabled items as well as the new topic of "options". Follow-ups: Roger to send meeting notice to WG for 3rd meeting on October 30. Roger to schedule meeting of Steering Committee to discuss agenda, etc.

Workgroup Meeting #3: Agenda with Summary Notes
Tuesday, October 30, 2007, 2:00 pm – 5:00 pm
Senate Hearing Room 4, Cherberg Building, Capitol Campus, Olympia

Meeting # 3 is a continuation of Meeting # 2, with the same goals. That is, at the end of the meeting we will have …
- Provided substantial information to the Workgroup about public programs and the participation of large employers' workers in those programs
- Provided an opportunity for Workgroup members to ask questions about, and discuss, the above information and its relevance to the "shared responsibility" issue

Time	Topic	Who / What	Summary Notes
2:00 – 2:15	Convene Meeting • Today's agenda & future meetings	Vicki & Roger will convene the meeting; review the agenda; and, discuss the proposal for a 5th meeting to occur in late November or early December.	Roger discussed the rationale for the addition of a 5th meeting to occur in late November or early December. No issues were raised about the October 15 meeting summary notes. The format of the notes for today's meeting is similar to that used for the October 15 meeting. Specifically, the notes do not try to capture the totality of the back-and-forth discussion but instead they capture the spirit of questions and issues raised by WG members during presentations. Many of the questions were answered in the meeting; other questions are interesting but a bit out-of-scope; some questions may need follow-up if they will have direct impact on decision making; and for some questions, we simply don't have very good information right now. Follow-ups: See last agenda item for tentative meeting dates for 4th and 5th meetings.
2:15 – 2:45	Employer-Sponsored Coverage for Washington Large Employers & Their Low-Wage / Low-Income Employees Q & A and discussion (Item tabled from meeting #2)	The purpose of this section is to provide context for changes in employer-sponsored coverage, especially for low-wage &/or low-income workers of large employers. Where possible, Washington specific data is used to look at sources of coverage for low-income families as well as changes over time in large employer/employee offer, eligibility, enrollment, coverage, and affordability. Jenny Hamilton, OFM, will present this information. Q & A and discussion will happen as the presentation is given.	Issues raised during the Washington Large Employer presentation: • Interest in understanding how some of the information presented aligns with ESD survey results & recollections of news articles showing definite erosion of large employer coverage. Important to consider that "erosion" may mean different things to different people. • Discussion around changes in employee coverage versus family coverage and differences between hi-wage and low-wage industries. • Interest in better understanding the degree of change in benefit packages, i.e., is the value declining? • Continuing discussion about the issue of employers allowing employees to opt out of coverage and implications for people enrolling in public programs – who opts out of own-employer coverage, can anyone opt out with or without valid alternative coverage, where do workers who opt out get coverage or are they uninsured? Do employers allow people to opt out if they have public coverage? • Interest in better understanding specifically who is and isn't taking-up coverage and why – are there "reasonable" reasons in some instances (e.g., seniors with access to Medicare/social security)? Or less reasonable reasons (e.g., immortal 19 year olds)? • Clarify the answers to 2 basic questions:

Time	Topic	Who / What	Summary Notes
			o # of workers for large employers who don't have any coverage (i.e., end up uninsured) o # of workers for large employers who end up with public coverage • Interest in seeing a comparison of employer income relative to premium increases, over time (similar to slide 10). Some speculation that such a picture could look quite different for different employers (industries). • Interest in more recent data (say 2006-2007) as well as data back further in time, say early 90s, to compare to today. Some speculation that this longer range picture will demonstrate a clear pattern of declining employer coverage and a shift from employer to public coverage. Some of this came up in relation to a discussion of how large a chunk of the state budget health care is today compared to the early 90s (important to clarify if talking dollars minus inflation or caseload counts). • Interest in being clear on who is getting coverage offered to them and who isn't – the overall employer offer rate could mask important information since it is defined as "offering to at least *some* employees" (who are the employees not included in *some*?).
2:45 – 3:45	DSHS' November 2006 "3079" findings & issues Q & A and discussion (Item tabled from meeting #2)	The purpose of this section is to provide an in-depth understanding of the data presented in the required "3079" reports and supplemental analyses – what the data can and cannot tell us regarding large employers' workers enrolled in DSHS programs. David Mancuso, DSHS, will present this information. Q & A and discussion will happen as the presentation is given.	There were many specific clarifying questions asked of David as he presented this information. They are not repeated here. Two issues that came up repeatedly in one form or another were: 1. The data's inability, as now collected, to clearly define full-time versus part-time workers. (There are limits to the data as reported to ESD by employers that would be difficult to readily overcome because of ESD's tie to the federal government.) 2. The ability (or not) of Medicaid to require enrollees to participate in employer coverage if they have access to it. There may be some states (e.g., Oregon and Iowa) that have moved further along this line than WA. DSHS' current employer-sponsored insurance program, in which they "buy" enrollees into employer coverage, is voluntary not mandatory.
3:45 - 4:00	Break		
4:00 – 4:45	BH's November 2006 "3079" report findings & issues Q & A and discussion (Item tabled from meeting #2)	This section of the agenda provides similar information for BH regarding findings of their "3079" analyses. Dennis Martin / Robert Longhorn, BH, will present this information. Q & A and discussion will happen	As with the DSHS presentation, there were many clarifying questions asked of Dennis as he presented this information. They are not repeated here. The main issue raised related in one way or another to the realization that there are big gaps in our knowledge of the employment status of BH enrollees from the "3079" reports because a relatively small percentage are actually matched to ESD records – some of this relates to issues around if and how BH collects social security numbers and some of it may be that many BH enrollees simply don't have ESD reportable earnings.

Time	Topic	Who / What	Summary Notes
		as the presentation is given.	[Note: There was a one-page "tree" handed out with the BH materials that included a calculation error which is being corrected. The "tree" was intended to give WG members a succinct *"order of magnitude"* sense of the percent of BH enrollees working full-time for large employers, given some major cautions about the data. In hindsight this handout served only to confuse people because its use of "order of magnitude" numbers differed somewhat from the exact numbers on BH's "3079" report. So to eliminate confusion, WG members should use the exact "3079" report documents and just ignore the 10-30-07 "tree" handout.]
4:45 – 4:55	Parting Thoughts About What All This Information Says About the Problem to be Solved	Final thoughts from Workgroup members resulting from meeting #2 and #3 information.	Additional thoughts included: • Some WG members were clearly interested in the "by employer" information that is part of both the DSHS and BH "3079" reports – not for purposes of pointing fingers but for better understanding what is happening on an industry specific basis. • Concern was expressed that employers who hire a lot of people who want "on the side jobs" get dinged in the "3079" reports. • There was additional discussion on exactly what is asked of public program applicants in terms of access to employer coverage, and how often it is asked. For example, Medicaid asks "do you *have* health insurance" but not "does your employer *offer* health insurance". BH gathers some employer information but often in the context of determining income not in the context of seeing if the person has access to employer coverage. • If the state were to coordinate coverage with employers in terms of having those employers pay for their workers enrolled on public programs (a la SHB 2094), we would need to be able to provide those employers with pretty specific information about who they are paying for. How do we do that? • Discussion (concern?) about the fact that much of the material presented focused on *full-time* workers not all workers (full- and part-time). The budget proviso does not specify full-time and many WG members are interested in both full- and part-timers. (Side note: Agencies focused on full-time in the interest of highlighting that portion of the workforce where it is more likely to find common ground with large employers—as a first step in doing something in partnership this seemed appropriate.)
4:55 – 5:00	Meeting Wrap-up & Next Steps	Vicki will review any assignments and/or next steps from this meeting.	Dates for the final 2 meetings were set: • November 15, 2007 from 9:00 am to noon • December 12, 2007 tentatively 1:00 pm to 5:00 pm (possibly 2:00 pm – 6:00 pm; final time to be set after the November 15 meeting) Follow-ups: • Roger to send notice to all WG members of the dates for the next 2 meetings (some WG members were absent today) • Roger to schedule a meeting of the Steering Committee to discuss the November 15 meeting agenda, etc. • Roger to schedule rooms (in Olympia) for the remaining 2 meetings.

Workgroup Meeting #4: Agenda with Summary Notes
Thursday, November 15, 2007, 9:00 am – noon
A-B-C Conference Rooms, Cherberg Building, Capitol Campus, Olympia

At the end of the meeting we hope to have …
- A clear understanding of Workgroup members' pro & con reactions (individually and collectively) to the Agencies' brainstorm list of ideas regarding shared responsibility
- Learned of other ideas of interest to Workgroup members
- Gotten the Workgroup's input on rank ordering the ideas from highest to lowest priority / interest for detailed analysis

Time	Topic	Who / What	Summary Notes
9:00 – 9:15	Convene Meeting • Today's agenda • October 30 meeting notes	Vicki & Roger will convene the meeting; review the agenda; and ask for any comments regarding the notes from the October 30 meeting.	Final meeting of Workgroup (WG) is scheduled for December 12, 1:00 – 5:00 pm (with possibility to go longer if WG desires). Roger committed to better effort to convene Steering Committee. Follow-ups: Roger to convene Steering Committee to discuss December 12 meeting.
9:15 – 9:50	Context for Today's Discussion of Possible Shared Responsibility Approaches	Vicki & Agency team members will briefly review the following with the Workgroup: • Background Reminders (e.g., proviso target population language, size of target populations within Agencies, guiding principles used by Agencies) • Brief introduction to the Agencies' brainstorm list (e.g., review shared responsibility continuum, summary list of ideas, and discussion questions)	Meeting started late so Vicki did a "whirlwind" review of the process used by the Agencies to develop the list of nine brainstorm ideas that form the basis for the day's discussion of possible approaches to shared responsibility. Items reviewed included: a. Target population per the budget proviso, b. Guiding principles for brainstorming possible approaches, c. Summary list of nine ideas, d. Ideas arrayed on a shared responsibility continuum, and e. Questions considered by the Agencies regarding each idea. To address some confusion from the previous meeting, a revised graphic showing numbers and percents of DSHS adult clients employed by large employers, and most likely working full-time for large employers, was distributed. A 2005 quarterly average of 49,443 adult DSHS clients was employed by large employers; this represents 6% of *all* DSHS medical program clients, 13% of *adult* clients, and 59% of *employed adult* clients. A 2005 quarterly average of 9,368 adult DSHS clients was likely working full-time for large employers. (A revised graphic for BH was still being worked on at the time of the meeting.)
9:50 – 10:30 and 10:45 – 11:45	Discussion and Ranking of Possible Shared Responsibility Approaches	Vicki & Agency team members will facilitate a Workgroup discussion of shared responsibility ideas. • Discussion of ideas generated by Agencies • Discussion of additional ideas	Vicki spent a fair amount of time walking the WG members through the Agencies' list of nine potential approaches to shared responsibility (see Shared Responsibility Brainstorm Packet). Significant time was then spent in general (free-for-all) discussion of the ideas presented and any new ideas of interest to the WG. There clearly was some frustration that the ideas were as high level (conceptual)

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<tr><th>Time</th><th>Topic</th><th>Who / What</th><th>Summary Notes</th></tr>
<tr><td></td><td></td><td>generated by Workgroup
• Ranking or grouping discussion to inform decisions about which ideas deserve detailed analysis</td><td>as they were. Many clarifying questions were asked; they are not captured in these notes but will be useful for the Agencies as they continue to discuss alternative approaches.

Three additional ideas were generated by the WG: (1) A routine, institutionalized method of collecting information on why people “make the coverage choices they do”, i.e., why public program enrollees choose public coverage when they have employer coverage available to them. This suggestion was merged with the Agencies’ Reporting & Tracking idea. (2) Review and possible tightening of Basic Health’s coordination of benefits policies. This followed substantial discussion on the different meanings people attach to the term “coordination of benefits”. (3) Possibly charging more to BH enrollees who have employer coverage available to them but choose to remain in BH (somewhat parallel to a practice used by large employers who charge more to cover an individual that has the option of coverage through his/her own employer but elects coverage through a spouse’s/partner’s employer).

The meeting ended with WG members voting on their preferred approaches—each was given 3 “dots” and asked to place their dots by the three “shared responsibility” ideas they most preferred. The results will be used to help decide which 2 or 3 approaches will be analyzed in more detail by the Agencies. By unfortunate oversight the idea of possibly charging more to BH enrollees with available employer coverage was left off the voting list. Otherwise, the voting results were as follows:

<table>
<tr><td colspan="2">Group Agreement to Exempt from Voting
1. SHB 2094: SHB 2094 has to be included because of budget proviso
2. Reporting & Tracking (including “why make choice you did” survey idea): Consensus on including Reporting/Tracking/Survey</td></tr>
<tr><td>7 votes each</td><td>3. B&O Tax Incentive
4. Vouchers to Buy Employer Coverage</td></tr>
<tr><td>6 votes</td><td>5. Stay the Course</td></tr>
<tr><td>5 votes each</td><td>6. BH – ESI Program
7. Partnership Report (to include large private employers)</td></tr>
<tr><td>4 votes each</td><td>8. Public Program Buy-in
9. BH-COB</td></tr>
<tr><td>1 vote</td><td>10. DSHS – ESI</td></tr>
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</td></tr>
<tr><td>10:30 - 10:45</td><td>Break (occurs mid-way through the above discussion)</td><td></td><td></td></tr>
<tr><td>11:45 - noon</td><td>Meeting Wrap-up & Next Steps</td><td>Vicki will review any assignments and/or next steps</td><td>Follow-ups:
• Agencies will follow-up on WG suggestion to e-mail the list of all ideas to WG</td></tr>
</table>

Time	Topic	Who / What	Summary Notes
		from this meeting. Timing for the December 12 meeting will be finalized.	members individually and ask them to rank order the ideas. • DSHS will provide language to better describe what DSHS is able & not able to require of clients with respect to participating in its existing Employer-Sponsored Insurance (ESI) program (aka premium assistance). • DSHS will provide a list to Senator Keiser of employers currently participating in the DSHS-ESI and DSHS-HIPP programs. • Roger will convene the Steering Committee sooner rather than later to discuss the December 12 meeting.

Workgroup Meeting #5: Agenda with Summary Notes
Wednesday, December 12, 2007, 1:00 – 5:00 PM
A-B-C Conference Rooms, Cherberg Building, Capitol Campus, Olympia

At the end of the meeting we will have …
- Received Workgroup feedback on the analysis issues the Agencies are considering regarding each of the top options from the ranking exercise
- Received any final Workgroup advice regarding the report to the Governor and Legislature
- Thanked the Workgroup members for their time, patience, and consultation

Time	Topic	Who / What	Summary Notes
1:00 – 1:15	Convene Meeting • Today's agenda • November 15 meeting notes	Vicki & Roger will convene the meeting; review the agenda; and ask for any comments regarding the notes from the November 15 meeting.	
1:15 – 1:35	Top Approaches for Shared Responsibility	Vicki will briefly review the ranking exercise results & the "short list" of options for further investigation by the Agencies	The Workgroup (WG) expressed significant concern with where the Agencies had "drawn the line" regarding top options (e.g., perception of arbitrariness and lack of fairness in recognizing options supported by non-majority members of the group). There was substantial discussion about alternative ways to determine the short list or whether to even have a short list (i.e., analyze all options). The WG was reminded that all options will appear in the report to some degree (albeit with more detail provided for options on the short list). Overall, WG members seemed to agree that not all options on the list could or should be examined at the same level of detail, e.g., "that's why we did the ranking". It was suggested that everything ranked above "stay the course" be considered for further analysis – there was some (but not universal) agreement on this suggestion (e.g., it was commented that "stay the course" may be the appropriate option for now, particularly given that the data show a "slow trickle not giant trend, for a variety of reasons" in terms of the magnitude of the issue). The Voucher option generated the most concern in terms of being left off the Agencies' short list. There was considerable support from many WG members that it be considered a top option. Time was reserved at the end of the meeting for further discussion on the Voucher option. The only other option that ranked above "stay the course" was Public Program Buy-in – it generated no discussion by the WG. The clear push-back of the WG on where the line was drawn to select top options (especially with respect to Vouchers) was good feedback and motivation for the Agencies to rethink their strategy. Roger also reminded the WG that given time & resources the final report will stay as true as possible to the budget proviso but will not include detailed implementation plans for top options (that is, major implementation issues will be identified but a detailed operational blueprint will not be developed for each

Time	Topic	Who / What	Summary Notes
			option). Follow-ups: • Agencies to rethink strategy for deciding top options (aka the short list).
1:35 – 2:20	Reporting & Tracking of Employer-Coverage Access	David Mancuso (DSHS) will lead a presentation & group discussion on next steps for refining and improving Agencies' abilities to report on enrollees' access to employer coverage	There was substantial discussion about how to get greater clarity in the Agencies' 3079 reports on franchise employees. Can improvements be made in how the Agencies identify and report on businesses with franchises (keeping in mind the limits of ESD data); perhaps with additional discussion in the reports about the relationship between company structure and making / not making the list of companies with at least 50 employees enrolled in public programs. It was noted that some improvements may be possible in this area but based on available data it's unlikely we will ever be able to untangle it completely. In the discussion around a possible survey it was noted that one thing we don't monitor very well is the changing world of the employee, e.g.., if & how large employers' eligibility requirements change over time – who is eligible and when; conditions, if any, for opting out of coverage; in general, what's happening that might push low-income employees towards public programs, etc. There was discussion that a survey should focus on the group of people choosing to stay on public coverage when private coverage is accessible to them. This would likely require better "continuous" reporting by public program enrollees of changes in employer coverage access (as noted in the DSHS-ESI discussion, this would be somewhat akin to enrollees having to report changes in circumstances for other factors, such as rent, that affect eligibility). The difference between "waiting period" and "open enrollment period" were cited as important to keep in mind regarding the survey population. Also, a population particularly relevant to DSHS is non-client parents of client children – we may want to consider these parents as part of the potential survey population, particularly as the children's income eligibility level rises to 300%. There also was discussion about the usefulness of better information in the 3079 reports on duration of coverage on public programs and duration of employment (relates to eligibility waiting periods), and relationships between the two. Beginning with the 2008 report the Agencies will have information on date-of-hire so some related analyses may be possible. There was some discussion as to how far the Agencies should go (e.g., deny coverage) if someone doesn't provide information about changes in employer-coverage access. Although no conclusion was reached, COBRA was cited as an example – person losses COBRA eligibility if s/he has access to employer coverage. Other issues of importance to the WG in terms of improving reporting were (1) measuring full-time compared to part-time work status, (2) capturing multiple-employer conditions & understanding how the methods impact cost estimates,

Time	Topic	Who / What	Summary Notes
			and (3) capturing who has opted out of employer coverage. (There was a question as to the conditions under which public employers, e.g., PEBB, allow employees to waive coverage.)
2:20 – 2:30	Break		
2:30 – 3:15	DSHS Employer-Sponsored Insurance Program	Roger Gantz (DSHS) will lead a presentation and group discussion on next steps for improvement of DSHS' existing program	It was noted that the Agency needs a goal, a benchmark, for how large an expansion is realistic. It was mentioned that expansion to parents of SCHIP children makes sense as long as it doesn't create administrative burdens to children getting coverage. There was clarifying discussion around the concept of wraparound coverage and how it works. The issue of sanctioning for lack of cooperation was discussed. There was a general sense that denying coverage for non-cooperating adults was acceptable but children definitely should not be negatively impacted. This is consistent with what Medicaid is allowed to do under current law (although in the current ESI program Medicaid does not deny coverage to adults who do not want to cooperate with the existing ESI program). There was additional discussion on the role of employers in making an ESI program work – what do employers have to do and can they be required to do it? The only place in the process that employer cooperation is needed is in providing information on benefit packages so that DSHS can make the cost-effectiveness determination required by federal law (i.e., is it cost-effective to pay for employer coverage compared to enrolling the person in regular Medicaid). There was reference to a possible change in federal law that would require employers to share benefit designs with Medicaid. Beyond sharing information on benefit design, the employer doesn't do anything differently with respect to an ESI enrollee than is done for any other worker. For example, the employee's premium contribution is deducted from her/his paycheck just as it is for everyone else; DSHS then directly reimburses the enrollee (the employer has no role in this). It was again mentioned that employers may be reluctant to see this program expanded because it could cost them if additional members of their work force opt for their coverage. The WG emphasized that it is extremely important for DSHS and BH to coordinate & be unified on anything they do regarding ESI programs—the Agencies can't be coming at employers separately.
3:15 – 3:55	BH Employer-Sponsored Insurance Program	Dennis Martin (HCA) will lead a presentation and group discussion on issues for BH in	BH needs to better clarify the timing issues it sees among BH data system implementation, Partnership report regarding incorporation of BH, and development of a BH-ESI program. A WG member noted that it isn't

Time	Topic	Who / What	Summary Notes
		having an ESI program similar to that of DSHS	necessarily contradictory to have an ESI program now and move it into the Partnership at a later date. There was substantial discussion on what was meant by "using the DSHS-ESI program as a model" and whether that would mean turning BH into an entitlement program (which clearly is not of interest to the WG). The Agencies clarified that the word "model" was used by them only to convey a need to use lessons-learned from the DSHS-ESI program to inform the design of a BH-ESI program and to have coordination between the two programs to the extent it makes sense. It was reiterated that ESI programs are about "buying people into private coverage" not about expanding public coverage. The point was made that ESI programs are intended to leverage public dollars, that is, bring more private employer dollars into the system (which hopefully will free-up some BH dollars to allow additional slots). The issue of BH eligibility criteria was discussed, specifically that Medicaid eligibility does not disqualify someone from BH (i.e., a person can be eligible for Medicaid but choose to enroll in BH). There was some discussion about whether the Legislature should revisit this if the point is to make maximum use of available dollars (especially since there is federal match for Medicaid and not for BH); the counterpoint was made about recognizing that some people don't want to enroll in Medicaid because they see it as "welfare" and want to enroll in an insurance program where they are paying up to their ability to do so. Other issues specifically noted in WG discussions were: (1) potential impact on BH rates if some people are pulled out of the pool because they are getting coverage via their employers, (2) timing for implementation if BH were to pursue this idea, (3) whether there are other state-only (non-Medicaid) programs doing ESI, (4) the need to consider cost impacts across the entire system not just cost impacts for the Agencies, and (5) whether BH-eligibles would be "required" to participate in the ESI program and consequences for lack of cooperation (similar to the discussion under DSHS-ESI). It was noted that since the Agencies are now doing data matches with ESD that it might be easier to identify people with possible access to employer coverage. Because BH can't require social security numbers, the data match process is a bit more incomplete than it is for DSHS. There was some discussion re whether BH contracting with DSHS to do its 3079 reports or administer some parts of the ESI program might help overcome the issue that BH has no grounds for requiring SSNs (since Medicaid *is* allowed to collect SSNs under federal law).
3:55 – 4:05	Break		
4:05 –	SHB 2094 (Taxpayer health	Roger and Dennis will lead a	This was a much shorter discussion than anticipated. Several WG members

Time	Topic	Who / What	Summary Notes
4:45	care fairness act proposal of 2007)	presentation and group discussion on issues the Agencies believe should be raised if someone were to pursue this option.	commented that their goal for the WG was constructive discussion and solutions regarding shared responsibility and they felt the goal had been met (and thus were not dogmatically tied to pushing SHB 2094). There was WG consensus that no further analysis on SHB 2094 (that is, the latest unofficial version, H-3557.2) was needed <u>except</u> for the Agencies to identify any "drop dead" implementation issues (i.e., any issues in H-3557.2 that would make it absolutely impossible for the Agencies to implement it, if it were pursued by someone in the next Session). It was noted that one issue remains that SHB 2094/H-3557.2 addressed but most of the other options discussed by the WG do not and that is the population of *employers who do not offer any coverage to any employees*. (This would largely be an issue among the smaller of large employers, say, those with 50-100 employees but even then the majority of these employers offer coverage to at least some employees – the real issue gets back to eligibility.)
4:45 – 5:00	Meeting & Workgroup Wrap-up and Next Steps	• Last opportunity for Workgroup input re "shared responsibility" issues for inclusion in final report • Timing for agency analyses & final report • Thank you to Workgroup members	Because of the WG's substantial interest in the Voucher option, we reserved some time at the end of the meeting for general discussion of it. Specifically, the Agencies wanted to understand issues of interest and / or concern to the WG (i.e., if we had a bullet list for Vouchers like was done for the other options discussed today, what should appear on that list?). The point was made that the ESI and Voucher options are not completely different concepts; they lie on a continuum of "buying people into their employer coverage" & thus both bring additional employer dollars into the system. The challenge is to be clear on the differences and similarities so decision makers can peg where they fall in preference. One question raised was: Between the ESI and Voucher approaches, which would be easiest for the employer, employee, and Agency to administer? Another question was: Since Voucher programs don't involve wraparound coverage, how does this approach address the situation where employer coverage isn't as complete as public coverage? This led to substantial discussion, with quite different opinions, on whether the employer's benefit plan would need to meet some basic standard (e.g., be equivalent to BH coverage) for ESI contribution. An example given was to consider two people, one at 198% of FPL (& eligible for BH) and the other at 202% of FPL (& not eligible for BH). The question was asked as to whether these 2 people should be treated differently, e.g., if the employer's benefit package is good enough for the person at 202% FPL why isn't it good enough for the person at 198% FPL? It was noted that this is less an issue for large employers than small employers because large employers tend to offer fairly comprehensive packages.

Time	Topic	Who / What	Summary Notes
			There seemed to be some agreement in the WG that if someone's barrier to their employer coverage is solely the monthly premium amount they have to pay, then perhaps a Voucher program is the easiest and most direct way to help this person and support employer-based coverage. Several people made the comment that they see a Voucher approach as one tool but not the only tool for fostering shared responsibility. The WG was asked about preference for a flat dollar or an income-based voucher amount. The general sense was it's hard to answer the question without a better handle on who would be advantaged & disadvantaged under the different approaches. There is also the issue of when someone would get the voucher – pre or post enrollment in coverage? It was suggested that creating a voucher design might be easier if the Agencies focused on a small "test group" (e.g., one group such as food packing houses) and then extrapolated from there. Finally, it was commented that one approach in BH could be side-by-side programs – traditional BH and Voucher BH – giving the applicant a choice as to which program to enroll in. Follow-ups: The Agencies will regroup to think about how best to define the "short list" of options, what analyses are left to complete, and timing regarding the final report. WG members will have an opportunity to provide feedback on a draft of the report. They will receive an e-mail regarding timing.

Appendix 2-1
Untangling the Measures and Components of Own-Employer Coverage

The array of measures related to coverage can be quite confusing. We use rates for 1998[54] and 2005 to track the relationships among the measures – see Figures A2-1(a) and A2-1(b). For each year we ask the question: "For every 100 employees of large employers in Washington, what happens with respect to coverage?" In each figure, the various measures related to coverage are shown on the far right. To the left is the diagram that tracks the 100 employees. Each picture concludes with a summary statement at the bottom.

The Decline – Based on the data in Figures A2-1(a) and A2-1(b), employees of large firms experienced a decline of about 8 percentage points in own-employer coverage between 1998 and 2005. (2005 coverage rate of ~ 65.2% minus 1998 coverage rate of ~ 73.1%)

Decomposing the Decline -- Decomposing the change into its three components (offer, eligibility, take-up) gets a bit complicated due to the co-movement of the factors (i.e., interactions among them).[55] The resulting analysis (not shown) indicates that the decline of 8 percentage points is made up of the following:

- fairly large, and roughly equal, declines in take-up and eligibility (about 3.8 percentage point declines for each), plus
- a relatively inconsequential drop of less than 1 percentage point (.5 of a point) in employees working where coverage is offered.[56] [57]

DEFINITIONS

FROM THE EMPLOYEE PERSPECTIVE:

Employee Coverage Rate: *Among all employees*, the percentage of them that have coverage through their own employer. (Coverage rate = offer rate * eligibility rate * take-up rate)

Employee Offer Rate: *Among all employees*, the percentage of them who work where coverage is offered to at least some of the employees.

Employee Eligibility Rate: *Among employees who work where coverage is offered*, the percentage of them that are eligible for their own employer's coverage. (a subset of offer)

Employee Take-up Rate: *Among employees who are eligible* for their employer's coverage, the percentage that take it up. (a subset of eligibility)

Employee Enrollment Rate: *Among employees who work where coverage is offered*, the percentage of them that enroll in their own employer's coverage.

FROM THE EMPLOYER PERSPECTIVE (not shown on graphs):

Employer Sponsor Rate: *Among all employers*, the percentage of them that offer coverage to at least some of their workers.

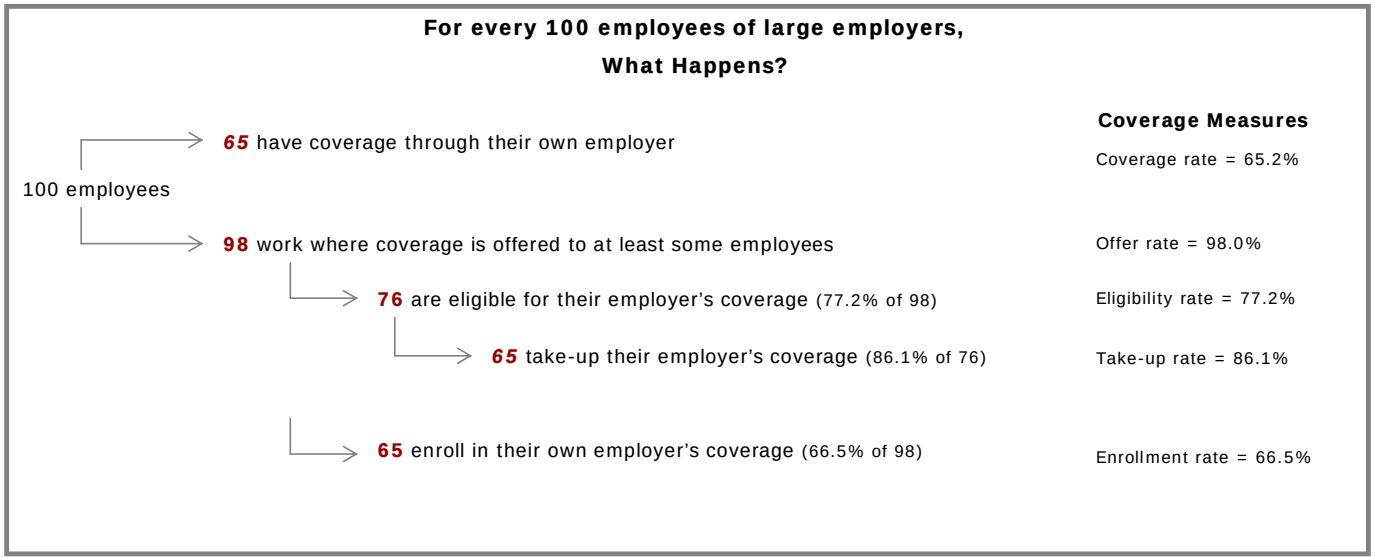
[54] 1998 is used as the base year for comparison in order to be consistent with the presentation in the main body of the report.

[55] A simple comparison of changes in rates between the two periods, for each factor, is not appropriate due to this interaction effect.

[56] The component pieces may not sum exactly due to rounding.

[57] A decomposition analysis also was done using the 3-year moving average data (96-98 compared to 03-05). In this case, the drop in take-up clearly outstripped the other two factors as the key driver of declining coverage levels; accounting for just over half of the decline. It goes without saying that choice of comparison periods can greatly influence conclusions about drivers of change. Nonetheless, it seems safe to say that *within a given year*, ineligibility puts workers at greatest risk of not having own-employer coverage; and, *across years*, both ineligibility and take-up contribute to declining own-employer coverage rates albeit to different degrees depending on the comparison period.

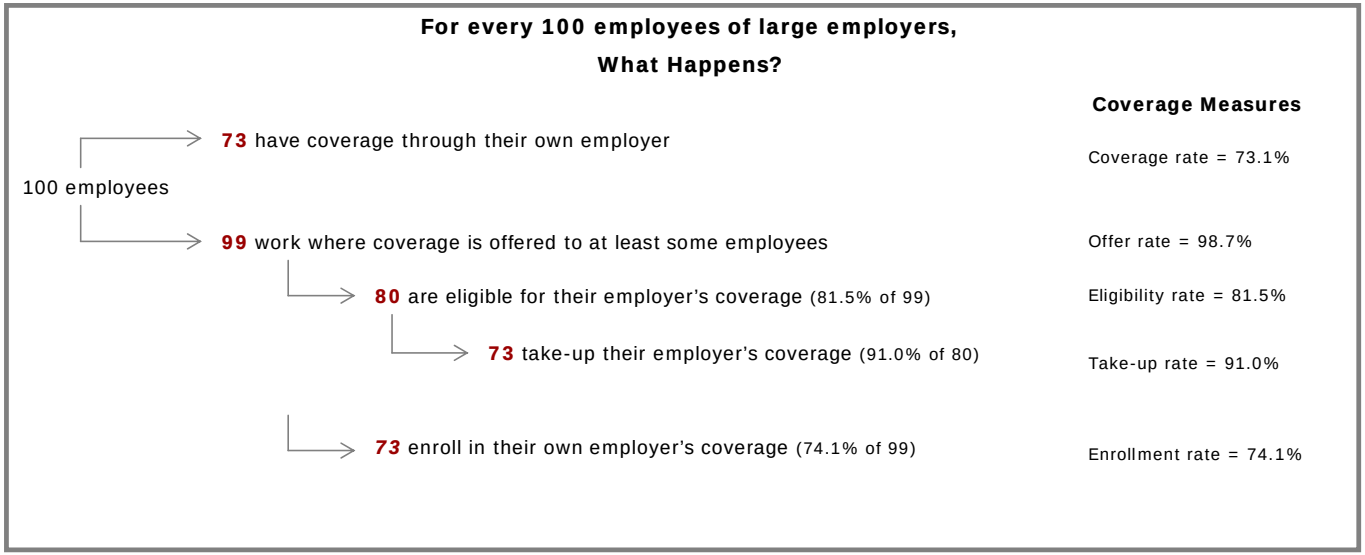
Figure A2-1(a): Relationships Among the Employee-Based Measures of Coverage: An Example for Washington Large Employers, 2005



In the end, the measures converge to one story for 2005: Out of every 100 employees of large Washington employers, 65 end up being covered by their own employer and 35 do not. 24 of the 35 (69%) have little choice in the matter – they work for an employer that doesn't offer coverage to anyone or they are not eligible for what is offered. The other 11 (31%) make a decision (for a variety of reasons) to not take-up the employer coverage for which they are eligible.

Notes:
Large employers are those with 50 or more employees.
Data are from Medical Expenditures Panel Survey, Insurance Component, Washington-specific.
Data may not sum exactly due to rounding.

Figure A2-1(b): Relationships Among the Employee-Based Measures of Coverage: An Example for Washington Large Employers, 1998



In the end, the measures converge to one story for 1998: Out of every 100 employees of large Washington employers, 73 end up being covered by their own employer and 27 do not. 20 of the 27 (74%) have little choice in the matter – they work for an employer that doesn't offer coverage to anyone or they are not eligible for what is offered. The other 7 (26%) make a decision (for a variety of reasons) to not take-up the employer coverage for which they are eligible.

Notes:
Large employers are those with 50 or more employees.
Data are Medical Expenditures Panel Survey, Insurance Component, Washington-specific.
Data may not sum exactly due to rounding.

Appendix 2-2
Income and Health Expenditures in Washington State[58]

Most low-income workers in Washington that are uninsured indicate that affordability of premiums is their primary problem.[59] This isn't hard to understand given the growing gap between premiums and income/wages shown in Figure A2-2(a).

The issue of (un)affordability crystallizes when *employee premium share* is compared to family income. For example, based on 2005 income, ***a working family of four in Washington at 200%*** of federal poverty, working for a large employer, paid about 5.7% of its annual income for its share of employer-based family premiums. For a family of four at 200% of federal poverty, this was about $2,210 out of a total income of $38,700.

Even more telling, however, is the situation for the *average* low-income working family in Washington, – that is, ***the average of all those working families at and below 200%*** federal poverty, working for a large employer.[60] On average, these families were paying about 11.9% of their 2005 annual income toward employer-based family premiums—about $2,210 a year out of an average annual income of around $18,571. And that doesn't include additional out-of-pocket costs (e.g., for deductibles, point-of-service cost sharing, and non-covered services). Based on one estimate of out-of-pocket costs (beyond premium contributions) the average low-income working family of four was likely spending roughly 23% of its 2005 income on health-related expenditures (both family premiums and other out-of-pocket costs).[61]

[58] The analysis for Appendix 2-2 was provided by the Washington State Office of Financial Management, Forecasting Division. The report author takes responsibility for any errors of interpretation regarding the analysis.

[59] Based on responses to the Washington State Population Survey, 2006.

[60] Low-income working families in Washington are defined as families in which there is at least one adult employee and where family income is less than or equal to 200% of federal poverty. Families with no employed persons or only self-employed persons are excluded.

[61] The 2005 Milliman Medical Index national estimate of non-premium out-of-pocket costs for a typical family of four was an annual average of about $2,035.

Figure A2-2(a)
Cumulative Percentage Increase in Health Insurance Premiums Compared to Other Indicators, 2000-2006

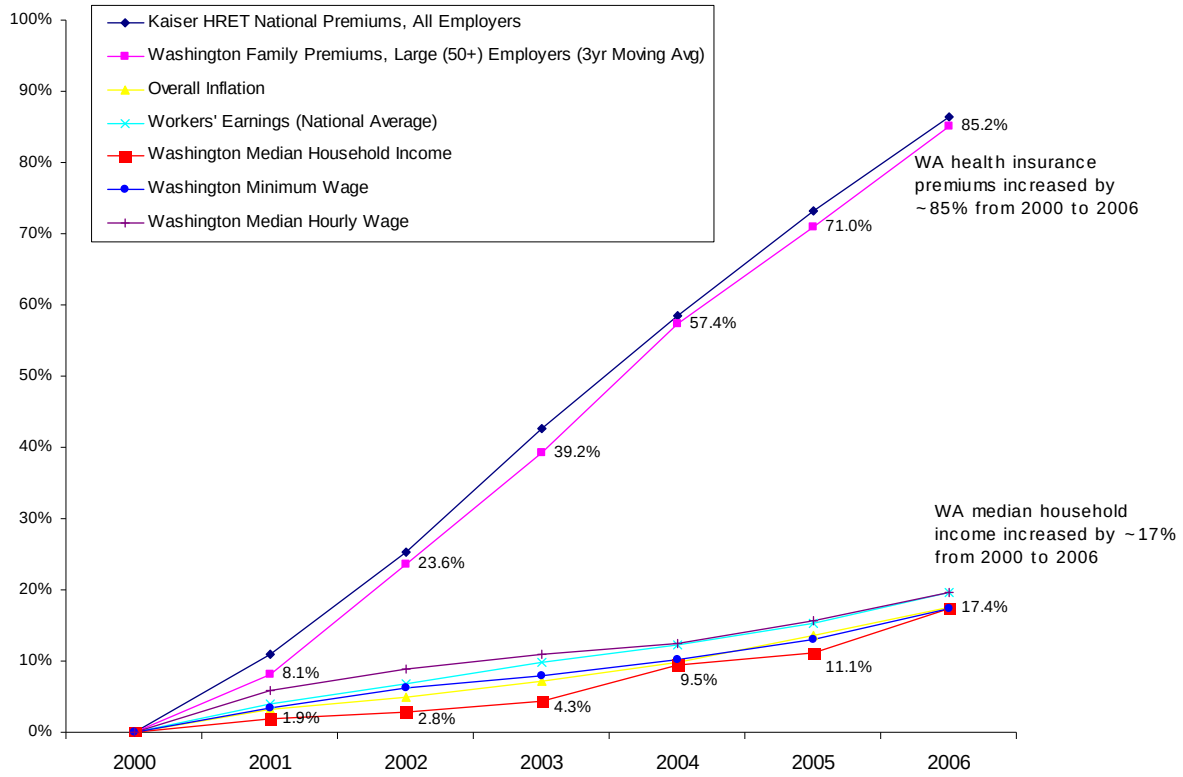


Chart Provided by Washington State Office of Financial Management, Forecasting Division, October 30, 2007

Appendix 2-3
DSHS Coordination of Benefits & ESI Programs
Presentation to Low-Wage Workgroup, October 15, 2007

Department of Social and Health Services
Coordination of Benefits & ESI Program

Andy Renggli, Chief
Coordination of Benefits
Division of Rates and Finance
Health and Recovery Services Administration
Department of Social and Health Services

Roger Gantz, Director
Legislative & Policy
Health and Recovery Services Administration
Department of Social and Health Services

Coordination of Benefits

Coordination of Benefits

In its broadest sense, Coordination of Benefits is the mechanism developed to prevent duplication of payment when more than one insurance plan or payer covers a person.

Third Party – From a Medicaid Perspective

A 'third party' is any individual entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a state plan.

Coordination of Benefits

State Responsibility

•States must make all reasonable efforts to seek reimbursement from third parties who are legally liable to pay for services provided to Medicaid recipients.

•Medicaid recipients must be required to assign their rights to payment from third parties to the Medicaid program.

•Medicaid recipients must agree to cooperate with the State in identifying and pursuing third parties.

Washington State Department of Social & Health Services

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Coordination of Benefits

"Third Parties" include the ones you would expect, such as:

- •Group Health
- •Regence
- •Premera, etc.

But also,

- •Workers' Compensation
- •Medical Child Support
- •Court Judgments or Settlements (tort)
- •Estate Recoveries
- •Self Insured Company Plans
- •Pharmacy Benefit Managers
- •CHAMPUS

Washington State Department of Social & Health Services

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Coordination of Benefits

COB uses the most accurate and efficient tools supporting:

- 100% Verification of Third Party Liability
- On-line Eligibility Inquiry
- Data Matches
- Health Insurance Eligibility, Payment Identification and Maintenance
- Health Insurance Premium Payments (HIPP)
- Cost Avoidance
- Cost Recovery
- Tort Resolution

Coordination of Benefits

SFY 2007 COB SAVINGS

SFY 2007 Target:	$212,526,684
SFY 2007 Actuals:	$293,607,103

SFY 2007 Metric Highlights

•SFY 2007 target exceeded by	$81,080,419
•Cost Recovery:	5.12% of Total
•Cost Avoidance:	94.88% of Total
•Return on Investment:	$1:$69.29
•15,812 calls per month	
•Average Speed of Answer	<30 seconds
•Abandoned Calls	< 5%

Coordination of Benefits

Medicaid's Health Insurance Premium Program (HIPP)

The Federal Government allows states to operate HIPP as part of their Medicaid Programs.

Medicaid clients bring their existing policies to us to determine if they are cost-effective for us to continue paying their premiums.

Current Quarter Averages (July-Sept. 2007)

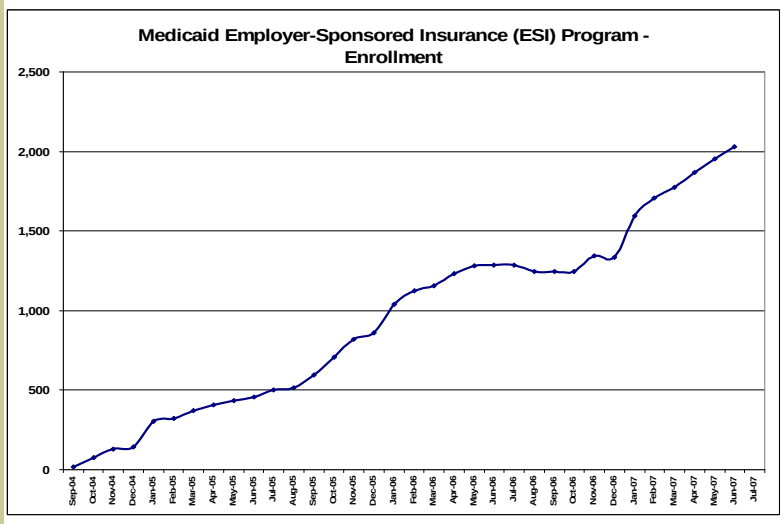
Policy Payments Per Month:	1,947
Number of Clients	2,842
Cost per client	$161.51

Medicaid Employer-Sponsored Insurance Program

- Washington's Medicaid employer-sponsored insurance (ESI) program is a voluntary program. [1]
- ESI eligibility – Medicaid-eligible, no other premium assistance, and not eligible for Medicare or state's Basic Health Program.
- Person enrolled in ESI if they have access to employer-sponsored insurance and it is cost effective.
- Cost effectiveness guideline: employee's premium contribution compared to age/gender adjusted Medicaid per-capita cost.
- ESI program directly reimburses family for employee's premium contribution for family member covered through ESI, and not the employer.
- Medicaid covers wraparound services not covered by employer coverage. Point-of-service cost-sharing also covered.
- Pilot Medicaid employer-sponsored insurance (ESI) program implemented September 2004. Full program began July 2005.
- June 07 enrollment – 2,000, approx. 95% of ESI clients are children.

[1] Pilot implemented under authority of Section 1906 of the Social Security Act.

Medicaid Employer-Sponsored Insurance Program



Medicaid Employer-Sponsored Insurance Program

Revisions to support ESI Enrollment

•2007 state legislation requiring state regulated health insurance coverage to allow for Medicaid clients to enroll in employer-sponsored health plan without regard to any open enrollment restrictions (2SSB 5093, Sec. 7 and E2SSB 5930, Sec. 24)

- (Note: Neither ESSB 5930 or existing Medicaid law preempts ERISA)

•2007 legislation requiring families, to extent permitted under federal law, to enroll in available employer-sponsored insurance as a condition of eligibility for Medicaid (2SSB 5093, Sec.2(4)).

•ESI has begun sending information to new Medicaid clients upon enrollment.

•Marketing to employers about ESI program.

Basic Health Plan Overview

Excerpts from October 15, 2007
Presentation to Low-Wage Worker Workgroup

Dennis Martin
Health Care Authority
Director of Policy and Legislative Relations

Washington State Health Care Authority

Basic Health Statutory Intent

- Provide necessary basic health care services in an appropriate setting to working persons and others who lack coverage, at a cost that does not create barriers to utilization of health care services
- Expand the availability of private health care coverage and discourage the decline of employer-based coverage
- Allow employers and other financial sponsors to financially assist such individuals to purchase health care so long as this does not result in a lower standard of coverage for employees
- Not the intent to provide health care services for those persons who are presently covered through private employer-based health plans, nor to replace employer-based health plans

Washington State Health Care Authority

BH Employer Sponsorship

BH employer sponsored coverage declined from 5,000 enrollees in 1998 to 200 enrollees in 2007

Reasons for the decline:

- Operational Restrictions
  - Minimum employer contribution
  - Employee participation requirements
  - Coverage gaps
    - Enrollment begins the first of the month
    - Enrollment lapses if prior premium payment is not received

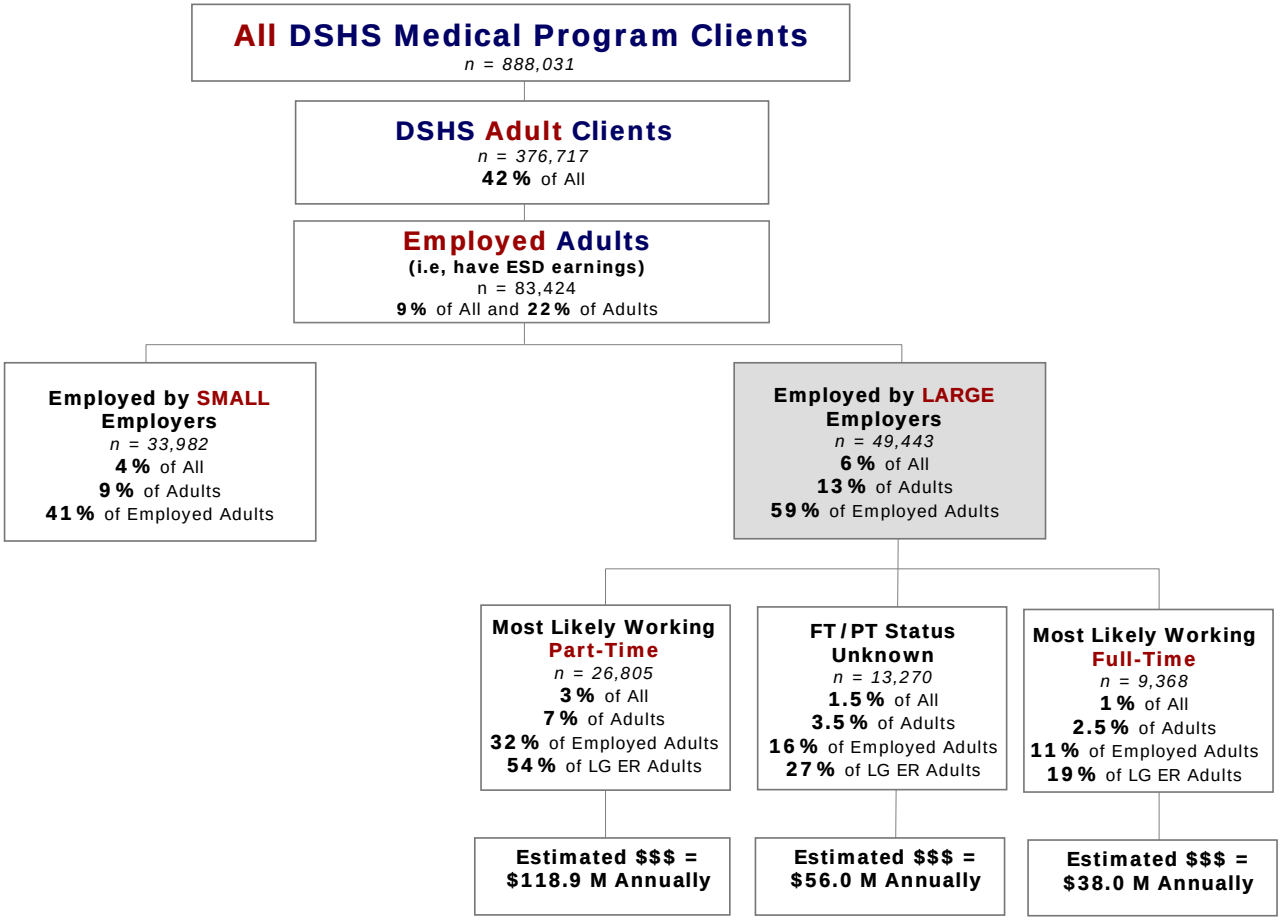
- Eligibility Limitations
  - No coverage for persons eligible for Medicare
  - No coverage for non-residents
  - Maternity coverage for employees not eligible for medical assistance
  - Excludes employees based on income - no non-subsidized Basic Health

- CMS evaluation of BH Employer Sponsor program

Washington State Health Care Authority

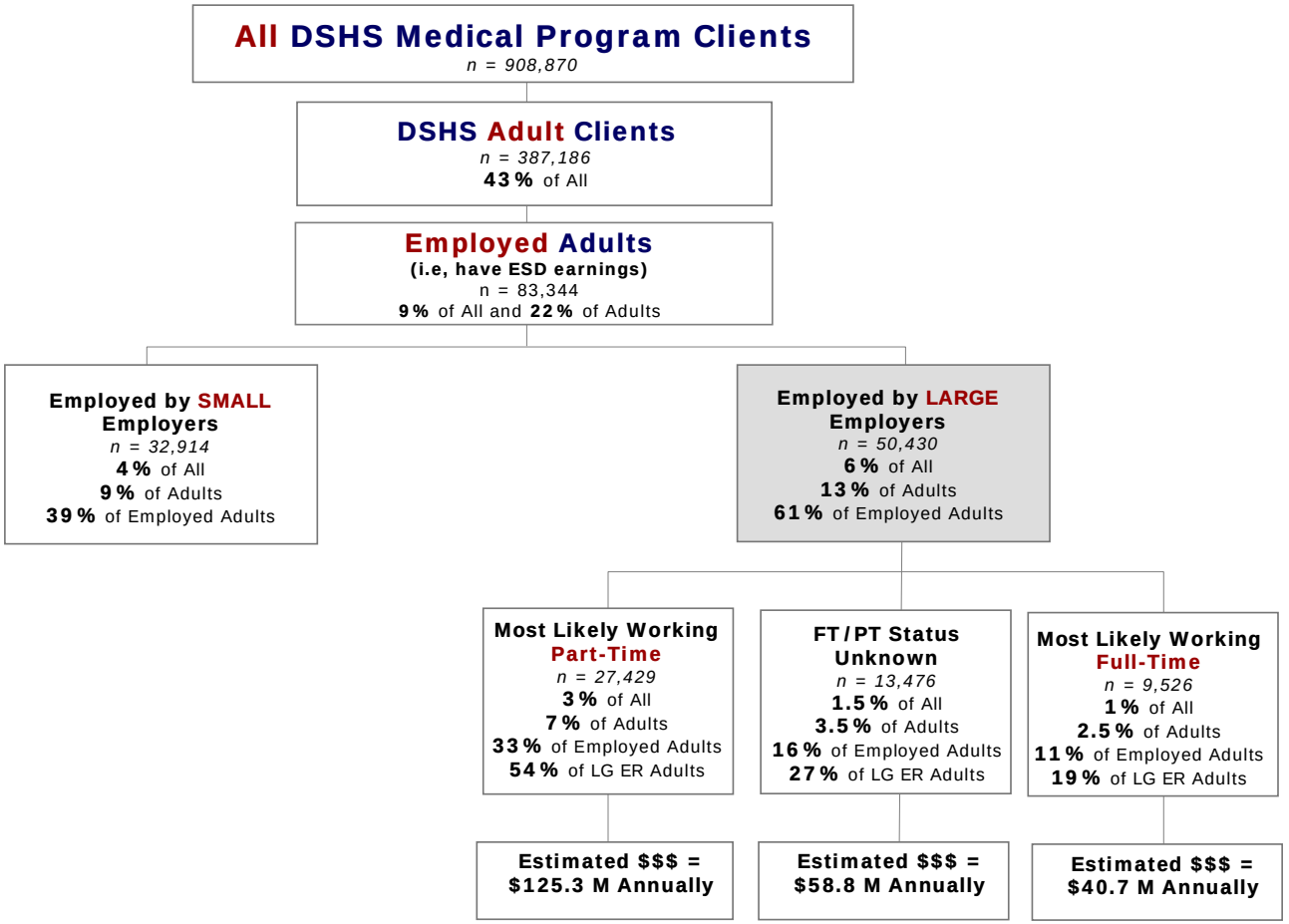
3

Appendix 3-1(a)
DSHS Shared Responsibility Target Population, 2005 Average Quarterly Counts



NOTES: Client counts are per quarter averages for calendar 2005. Dollars ($$$) are annual, i.e., calendar 2005, federal and state. Sums may vary due to rounding.
Large employers (LG ER) are those with more than 50 employees.
All DSHS Medical Program Clients includes children and adults.
DSHS *adult clients* are those enrolled in the Family Medical, Pregnant Women, and Persons with Disabilities programs (with a small number collapsed into Other).

Appendix 3-1(b)
DSHS Shared Responsibility Target Population, 2006 Average Quarterly Counts



NOTES: Client counts are per quarter averages for calendar 2006. Dollars ($$$) are annual, i.e., calendar 2006, federal and state. Sums may vary due to rounding.
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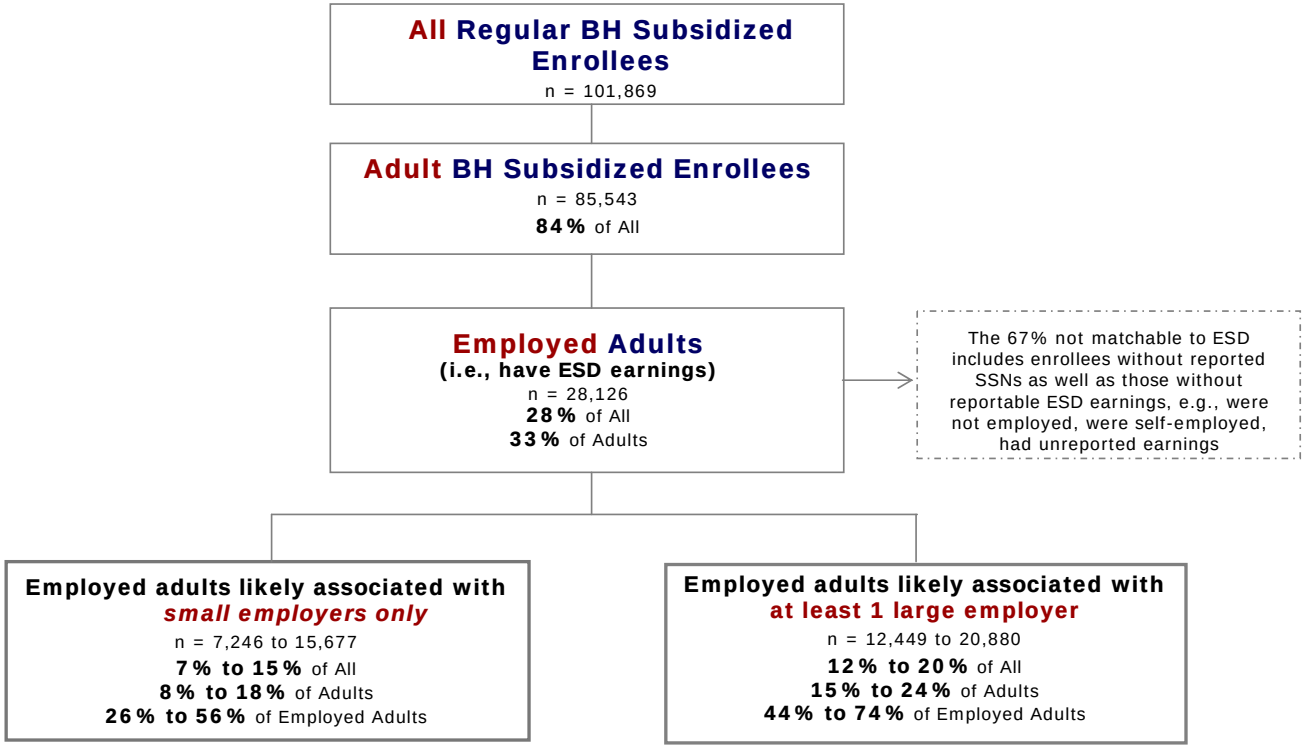
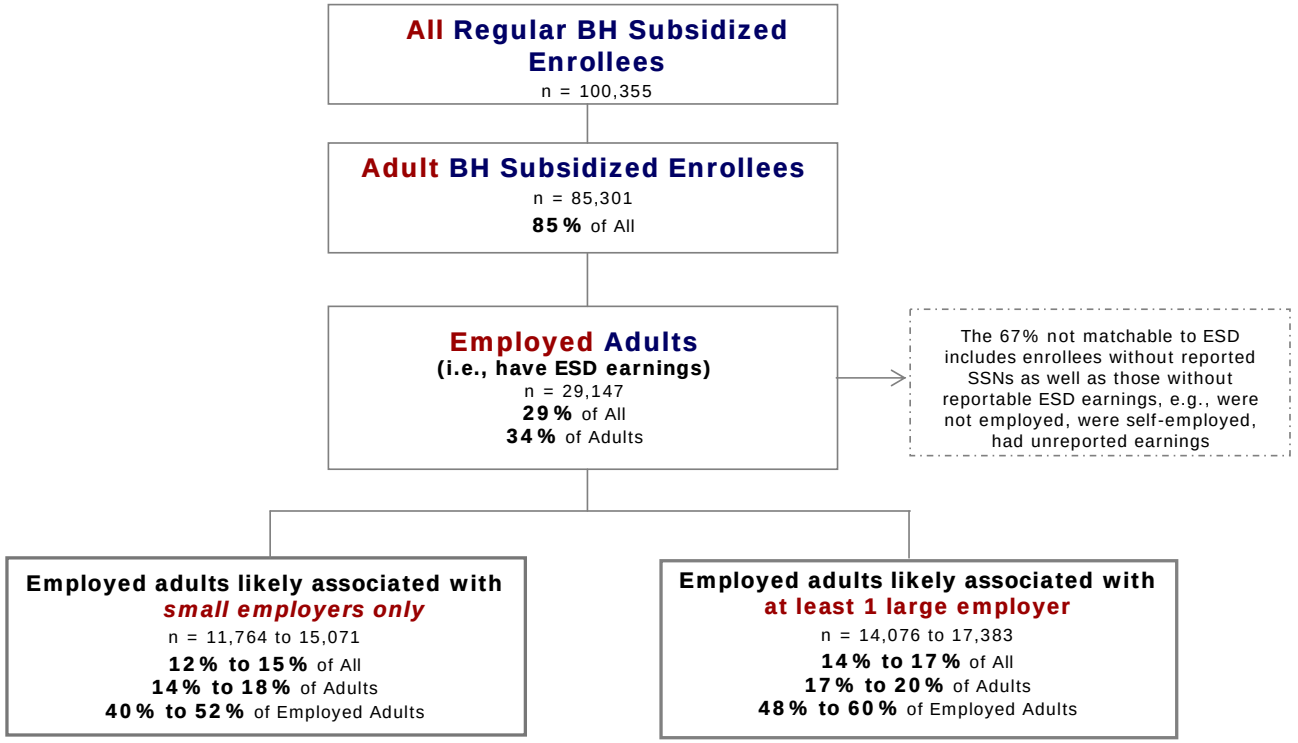
Appendix 3-2(a)
BH Shared Responsibility Target Population, 2005 Average Quarterly Counts



"Order of Magnitude" Counts Given Issues Around Multiple Employer Counting and Lack of Legal Authority to Collect SSNs

Notes:
Ranges for small and large employer estimated counts are based on assumptions about multiple employer counts; workers with at least 1 large employer could have more than 1 large employer as well as 1 or more small employers.
Large employers are those with more than 50 employees.

Appendix 3-2(b)
BH Shared Responsibility Target Population, 2006 Average Quarterly Counts



"Order of Magnitude" Counts Given Issues Around Multiple Employer Counting and Lack of Legal Authority to Collect SSNs

Notes:
Ranges for small and large employer estimated counts are based on assumptions about multiple employer counts; workers with at least 1 large employer could have more than 1 large employer as well as 1 or more small employers.
Large employers are those with more than 50 employees.

Appendix 4-1
Approaches to Further the Goal of Shared Responsibility Between
Large Employers and State Plans for Coverage of Low-Wage/Low-Income[62] Workers

The following matrix is a set of possible approaches to sharing financial responsibility with large employers for the coverage of their low-wage/low-income workers enrolled on state plans (DSHS medical assistance and Basic Health). In most cases, the details of approaches are kept purposefully broad – the goal is to determine the Workgroup's primary areas of interest and to allow the Agencies (and others) latitude to accommodate variations on the themes as they consider next steps.

Approach[63]	Background (bolding in text indicates an attachment)	Brief Discussion of Approach (bolding in text indicates an attachment)
PSHB 2094, 2007 Legislative Session (Taxpayer Health Care Fairness Act) **(Latest version = H3557.2)**	A summary of the **2007 Taxpayer Health Care Fairness Act** is attached. The proposed legislation establishes a mechanism to reimburse the state for providing health coverage to low-income workers of large employers. For employees, of large employers, who are enrolled in state coverage programs, the employer must pay a fee to offset the state's costs for providing coverage.	Review the latest version of 2094 and suggest changes that, *if someone were to pursue this approach*, (1) would make it as operationally feasible as possible to Agencies and large employers and/or (2) might enhance its ability to withstand an ERISA challenge. Required by the budget proviso to be included as one of the shared responsibility approaches to be studied by the Agencies. *This option evolved to a focused review of any operational issues remaining in the bill that would make it impossible to be implemented by the Agencies (assuming someone were to pursue this approach).*
DSHS Employer-Sponsored Insurance (ESI) Program	Employer-sponsored insurance (ESI) programs are also known as premium-assistance programs. Broadly speaking, they use public dollars to pay for the employee's portion of premium for his/her employer coverage, when that person would otherwise be eligible for public coverage, and often provide wraparound coverage (described below). The current program in DSHS "buys" medical program enrollees into their employer's coverage, *when it is cost-effective for the state to do so*. For these enrollees the program also provides wraparound coverage, that is, cost-sharing and services that are not covered by the employer plan are covered by the ESI program	Maximize the potential of the current DSHS employer-sponsored insurance (ESI) program to pool large employer and state funds by (1) moving from voluntary to required participation to the extent allowed by federal law, (2) emphasizing ESI for *adult workers* (not just children) eligible for DSHS programs, and (3) creating active ESI partnerships with certain employers that have large low-income workforces. To-date DSHS has been less rigorous than federal law might allow in terms of requiring some clients to participate in employer coverage when it is available and cost effective for the state.[64]

[62] The budget proviso in SHB 1128 uses the phrase *"low-wage"* workers. However, discussions in Workgroup meetings have made clear that the discussion is really about *"low-income"* workers in that income, not wages, is used in determining public program eligibility.

[63] The order of the approaches in this Appendix is slightly different than other documents in the report; it is the basic matrix and order used by the Workgroup in its initial discussions.

[64] Section 1906 of the Social Security Act allows state Medicaid programs to enroll Medicaid eligible clients in group health plans, which includes employer-sponsored health insurance. Section 1906(a)(2) gives states authority to require Medicaid clients to apply for group health plan coverage as a condition of eligibility. However, Section 1906(b)(2) prohibits state Medicaid programs from dis-enrolling a child from Medicaid if their parents do not enroll the child in

Approach[63]	Background (bolding in text indicates an attachment)	Brief Discussion of Approach (bolding in text indicates an attachment)
	up to the normal limits of Medicaid. The current program is voluntary. The premium contribution amount goes to the family not the employer. As of June 2007, 95% of the approximate 2,000 ESI enrollees were children.	In addition, current emphasis in the ESI program has been on paying for employer coverage of children because (1) it supports the state's decision to share responsibility for covering all children by 2010 and (2) a sizeable portion of DSHS clients are children, many of whom have working parents. However, there is no reason to avoid an *additional emphasis on employed adults*. Finally, the current program tends to take an enrollee-by-enrollee approach. This could be augmented by adding an employer-by-employer approach – *work collaboratively with large employers who have substantial low-income workforces* to have them actively assist in getting their eligible workers into the ESI program.
Reporting and Tracking of Employer-Coverage Access	DSHS and BH track enrollee access and enrollment in employer coverage to varying degrees of specificity and consistency. Some individual-level information is collected at enrollment and re-verification/recertification; other information is collected based on **ESHB 3079, 2006 Session** (see attached).	Review current state and federal law, and agency administrative procedures, to determine how to better collect and track information on enrollee access to and use of employer coverage (for both DSHS and BH enrollees.) This might include looking at ESHB 3079 to see if there are changes that could enhance understanding of large employers' workers enrolled in public programs. Also, there is significant agreement among Workgroup members for some type of routine data collection, perhaps via survey, to better understand why public program enrollees choose public coverage when they also have employer coverage available to them. This suggestion is included as part of Reporting & Tracking. *This option evolved to focus on strategic planning and policy decision-making level information (particularly from the perspective of enrollees not their employers) rather than program-specific operational data.*
BH Employer-Sponsored Insurance (ESI)	Although one of the legislative intents for BH is that it not replace employer sponsored coverage there is no specific program within BH to actively support this goal.	Explore creating an ESI program within BH along the same lines as the DSHS program. For example, if a person were eligible for BH and had reasonable employer coverage available to him/her,

their group health plans. There are no provisions in Title XIX (Medicaid) of the Social Security Act that give state Medicaid agencies any authority to require employers to offer insurance to their employees or their dependents who are eligible for Medicaid.

Approach[63]	Background (bolding in text indicates an attachment)	Brief Discussion of Approach (bolding in text indicates an attachment)
Program	(The employer-group program within BH, which is all but defunct, was not an ESI program but rather the reverse – it allowed employers to buy-into BH and participate in it as part of a purchasing pool.)	the person would be enrolled in the employer coverage, *assuming it is cost-effective for the state*. Availability of "wraparound" coverage by BH would need to be decided. The program could be voluntary or required. If required then the option of subsidized employer coverage would need to be exhausted before enrolling in traditional BH. Partnerships with large employers that have substantial low-income / low-wage workforces could apply equally to the DSHS and BH ESI programs. ESI as a way for using BH subsidy dollars has not been piloted, as has been the case with the DSHS program. Issues around impacts on BH rates of pulling people out of the pool and placing them in employer coverage would need to be fully explored. *For purposes of this project, it was eventually decided that the primary conceptual difference between the BH ESI option and the BH Voucher option is that the ESI program would include both premium assistance and wraparound coverage; the Voucher option is solely for premium assistance (i.e., no wraparound coverage is contemplated).*
Washington Health Insurance Partnership Expansion *Report*	The Washington Health Insurance Partnership was established by E2SHB 1569, 2007 and creates a health benefits purchasing "collective" for employees of small employers. A small employer may designate the Partnership as its health benefits administrator if the employer (1) has at least one low-income, resident employee and (2) establishes a federal Section 125 plan (to allow premium contributions to be pre-tax). If the small employer meets these criteria, all employees regardless of income participate. As a Partnership participant, purchasing is done by the individual enrollee (not by the employer). Many operational decisions are in development by the Partnership Board, including for example, subsidies for low-income participants, employer contribution amounts, benefit plans to be available, etc. Coverage is scheduled to begin in early to mid 2009. A report on incorporating the individual & small group health	Evaluate the opportunity for large employers to participate in the Washington Health Insurance Partnership for all or some (e.g., a particular class) of their workforce. This is a longer-term option because the Partnership is in its early stages of development with a focus on small employers. At best, there might be an opportunity here to explore adding a 3rd report in, say, September 2010, that evaluates including the large group *private* market in the Partnership (the report due September 2009 includes large *public* groups); e.g., assessing the risks and benefits of allowing large *private* employers to participate in the Partnership for all or some subsets of their employees.

Approach[63]	Background (bolding in text indicates an attachment)	Brief Discussion of Approach (bolding in text indicates an attachment)
	insurance markets into the Partnership program is due December 2008. A report regarding the inclusion of additional *public* markets (e.g., high risk pool, BH, PEBB, K-12) in the Partnership and of implementing a statewide individual mandate is due September 2009.	
B&O Tax Incentive	The tax system, either in terms of credits or deductions, is often used to provide incentives for publicly valued behavior. This approach would allow large employers to have a reduced B&O tax liability based on the degree to which they cover their low-income/ low wage workforce.	There are several variations of a tax incentive that could be considered, either alone or paired with other approaches. Examples include: Provide a B&O tax incentive to large employers who cover a defined portion of their workers, including (or exclusive to) workers who might otherwise end up enrolled in public programs. The tax incentive could take the form of a credit or deduction. A threshold for percent covered could be established, i.e., if the employer covers over the threshold s/he qualifies for the credit/deduction. Alternatively, a sliding scale credit/deduction based on percent covered could be established. The threshold could be applied to all employees or just a subset, that is, those employees who might otherwise end up enrolled in public programs. The incentive could also be paired with a requirement that large employers not allow their workers to opt-out of coverage unless they have alternative private coverage (i.e., public coverage would not suffice as a reason for waiving employer offered coverage).
Vouchers to Buy Employer Coverage	Low-income employees of large employers would be eligible to receive a voucher from the state that could be used to cover all or some portion of the worker's share of premium for the coverage offered by his/her employer.	Provide individuals who are eligible for public programs with vouchers to buy-into their employer offered coverage. As with the ESI program, this could be voluntary or required to the extent allowed by federal law (for DSHS). Unlike the ESI programs that generally involve wraparound coverage, the vouchers would solely help cover the worker's portion of the premium. Also unlike the ESI programs, the relationship would be between an individual and the public program with no specific coordination taking place between large employers and public programs. If not used within a defined period of time to buy-into employer coverage, the voucher would expire.

Approach[63]	Background (bolding in text indicates an attachment)	Brief Discussion of Approach (bolding in text indicates an attachment)
		Initial discussions did not specifically target BH or DSHS in terms of designing a voucher program. However, based on Workgroup and Agency discussions the Agencies decided it made sense, as a starting point, to focus this discussion on BH because of the design flexibility accorded by a state-only program. *For purposes of this project, it was eventually decided that the primary conceptual difference between the BH ESI option and the BH Voucher option is that the ESI program would include both premium assistance and wraparound coverage; the Voucher option is solely for premium assistance (i.e., no wraparound coverage is contemplated).*
Public Program Buy-in	This approach is the reverse of the ESI and/or voucher programs. Rather than buying eligible enrollees into their employer coverage, this approach would allow employers to buy-into one or more of our public programs (as an employer group), at full cost.	Allow large employers to buy whole classes of employees (not necessarily their whole workforce but a single class) into public programs at full cost (full premium plus an admin fee). This would be somewhat along the lines of public programs having employer-group options, i.e., employers rather than individuals would be buying-into the coverage offered by public programs. Which public program (e.g., Medical Assistance or BH) would serve as the buy-in option would need to be decided. Lessons from the "all but defunct" BH employer-group program would be important here (there are many practical issues & potential interactions with federal law to consider).
Stay the Course	Sometimes the best course of action is "no *new* action". Staying-the-course doesn't mean nothing would be occurring relevant to shared responsibility. It simply means the Agencies would be given time to pursue and improve initiatives already on the table and in progress.	Examples of "staying the course" activities include: DSHS would continue to improve its existing ESI program as currently configured. BH would be given time to get its new information system in place, without which BH is extremely limited in terms of its capacity for making any large programmatic changes. The Partnership would continue to be fleshed out, including in 2009 a report on adding BH to the Partnership (which might negate any steps taken now to change BH). DSHS and BH would continue to refine and better coordinate their annual "3079" reports on employment & employers of public program enrollees (e.g., the November 2006 reports for DSHS & BH will use common hour definitions to approximate

Approach[63]	Background (bolding in text indicates an attachment)	Brief Discussion of Approach (bolding in text indicates an attachment)
		full-time versus part-time employment), incorporating the new information required beginning 2008.
BH Coordination of Benefits (COB)	As used here, coordination of benefits (COB) refers to an administrative, claims processing activity in which health plans coordinate payment of claims (once a service has been provided) for individuals covered by two or more plans. BH provides coverage through contracted health plans. The contracted plans collect information from enrollees about other sources of coverage. BH enrollee responsibilities include complying with health plan requests for such information. BH advises its health plans (via contract) and its members (via Member Handbook) that BH coverage is secondary to other coverage (to the degree allowed by state or federal law).	Determine if there is opportunity to improve the oversight, implementation, and communication to members and plans of requirements to coordinate payment of benefits. There are several things this might include, for example: (1) clarifying statutory authority of BH as secondary payer to other coverage, especially employer coverage, (2) stronger contractual requirements regarding if and when coordination of benefits should occur, and (3) enhanced member responsibility to proactively disclose other employer coverage, and consequences for not doing so (similar to what is now done with respect to third party liability for injury or illness). Consistent with the Reporting & Tracking option described earlier in this matrix, BH itself may want to take steps to gather information on other coverage in order to provide enhanced oversight of health plan handling of COB. COB can be administratively complex and costly so careful evaluation of the cost-benefit of changes to current practice is important.
BH Incentive to Accept Employer Coverage	Some large employers charge more to cover an individual that has the option of coverage through his/her own employer but elects not to take it. The above situation may occur when both people in a marriage or domestic partnership are employed and offered health care insurance from their respective employers. In this case, an individual might elect to take the coverage offered by his/her spouse's or partner's employer rather than take their own-employer's coverage. Because the person has coverage available from his/her own employer, the employer of the spouse/partner charges above what it normally would if the individual did not have his/her own-employer coverage available.	Allow BH to "charge more" to individuals who have coverage available to them by their employer but choose to remain on BH. One approach to "charging more" could be that the person receives a reduced subsidy compared to someone without own-employer coverage available to him/her.

Attachments: Summary of PSHB 2094 (Proposed taxpayer health care fairness act)
Summary of ESHB 3079 (Agency reporting related to employment of DSHS & BH enrollees)

Attachment to Appendix 4-1
Summary of Proposed Taxpayer Health Care Fairness Act, 2007 Washington Legislative Session

	SHB 2094	H-3557.2: Latest 2094 Draft Revision
Basic concept	Establish a mechanism to reimburse the state for providing health coverage to low-income workers of large employers.	Establish a mechanism to reimburse the state for providing health coverage to low-income workers of large employers.
General approach	For employees, of large employers, who are enrolled in state coverage programs, the employer can either ▪ pay an assessment designed to cover the state's costs of providing coverage, or ▪ enter into an agreement with the state to reimburse the state for 100% of its costs for covering the employees, or ▪ cover the employees in their own benefit plans. State programs include Basic Health and Medical Assistance (with some exceptions).	For employees, of large employers, who are enrolled in state coverage programs, the employer must pay a fee to offset the state's costs for providing coverage. State programs include Basic Health and Medical Assistance (with some exceptions).
Reimbursement / Offset amount	Based on state program the employee is enrolled in: Per capita cost for medical assistance or Basic Health coverage.	Based on state program the employee is enrolled in: Per capita adult cost for medical assistance (based on employee's eligibility category) or for Basic Health coverage. The employer owes a graduated percentage of the applicable per capita cost: 25% for SFY 2009 quarters, 50% for SFY 2010 quarters, 75% for SFY 2011 quarters, and 100% thereafter. If an employee has multiple employers in a quarter, the amount due is prorated among the employers based on the hours worked for each employer.
Employers impacted	Any employer (RCW 49.46.010) with 1,000 or more employees in all locations combined in Washington for a given reporting calendar quarter, EXCEPT an employer … ▪ already paying for coverage of all employees enrolled in a medical assistance or Basic Health program, or ▪ considered seasonal, i.e., generally operates 26 or fewer of 52 consecutive weeks or employs at least 50% of its employees for 26 or fewer of 52 consecutive weeks (construction industry is not considered seasonal)	Any employer (RCW 50.04.080) with 1,000 or more employees in all locations combined in Washington for a given reporting calendar quarter, EXCEPT an employer … ▪ already paying an acceptable amount for coverage of all employees enrolled in a medical assistance or Basic Health program, or ▪ considered seasonal, i.e., generally operates for a recurring period within only 2 of 4 consecutive quarters or generally employs at least 50% of its employees for a recurring period within only 2 of 4 consecutive quarters. (construction industry is not considered seasonal)

	SHB 2094	H-3557.2: Latest 2094 Draft Revision
Employees impacted	Any individual employed by an employer EXCEPT an employee … ▪ employed for less than 90 days, or ▪ who, for the first 12 months of employment, was placed in the job through state job placement services, or ▪ of a franchisor's franchisees (these are employees of the franchise), or ▪ receiving Social Security disability benefits. (no full-time / part-time distinction)	Any individual employed by an employer EXCEPT an employee … ▪ employed for 2 or fewer consecutive quarters, or ▪ of a franchisor's franchisees (these are employees of the franchise). Also exempt are employed medical assistance enrollees … ▪ less than 19 years old, or ▪ receiving disability benefits or SSI benefits (Title II or Title XVI of social security act), or ▪ receiving TANF / tribal TANF grants, or ▪ participating in the premium assistance / ESI program of medical assistance. (no full-time / part-time distinction)
Dependents	Not addressed	Not addressed
Reporting & reimbursement schedule **(See below for sample schedule)**	Step 1: 30 days after the end of the calendar quarter, the employer reports to the state on its employees for that quarter. Step 2: 30 days later the state reports to employers the number of their employees enrolled in state programs, a profile (at aggregate level only) of those employees (no employee names), and the assessment due by the employer. Step 3: 30 days later the employer has to pay the assessment, make an agreement with the relevant state agency to reimburse up to 100% of the state's coverage costs, or file for a hearing.	Step 1: 30 days after the end of the calendar quarter, the employer reports to the state on its employees for that quarter. Step 2: 200 days after the end of the calendar quarter, the agencies complete (1) a comparison between their records and the employers' reports to determine the number of each employer's employees enrolled in state programs and (2) a profile (at the aggregate level only) of those employees (no employee names). (unclear whether this information is due to employers at this time or as part of Step 3) Step 3: 30 days later the agencies notify employers how much is owed the state to offset its costs for covering the employer's employees. Step 4: 30 days later the employer has to pay the amount owed or file for a hearing.
Premium assistance	DSHS may require an employee to enroll in available employer coverage if it is cost-effective for the state.	(see Employees Impacted)
Employer penalties	▪ $250 for each offense of not filing timely & complete reports ▪ progressively increasing penalties for not making timely payments or for not establishing timely reimbursement agreements (5%, 10% or 20% of payment due depending on if 1, 2 or 3 months late in paying, plus interest)	▪ $250 for each offense of not filing timely & complete reports ▪ progressively increasing penalties for not making timely payments (5%, 10% or 20% of payment due depending on if 1, 2 or 3 months late in paying, plus interest)

	SHB 2094	H-3557.2: Latest 2094 Draft Revision
Start date	Calendar quarter ending June 30, 2008	Calendar quarter ending June 30, 2008
Other	▪ Agencies (DSHS, ESD, HCA) must coordinate with each other. ▪ Human Rights Commission & court remedies for employee discrimination related to this statute.	▪ Agencies (DSHS, ESD, HCA) must coordinate with each other. ▪ Human Rights Commission & court remedies for employee discrimination related to this statute.

Approximate Reporting & Payment Schedule
(dates are approximate only, not the exact 30 and/or 200 day periods cited in the legislation)

SHB 2094

	Q1 (Jan-Mar)	Q2 (Apr-Jun)	Q3 (Jul-Sep)	Q4 (Oct-Dec)
Step 1: Employer reports due to state	Apr 30	Jul 31	Oct 31	Jan 31
Step 2: State notifications due to employers	May 31	Aug 31	Nov 30	Feb 28
Step 3: Employer payments or agreements or hearing requests due	Jun 30	Sep 30	Dec 31	Mar 31

H-3557.2: Latest 2094 Draft Revision

	Q1 (Jan-Mar)	Q2 (Apr-Jun)	Q3 (Jul-Sep)	Q4 (Oct-Dec)
Step 1: Employer reports due to state	Apr 30	Jul 31	Oct 31	Jan 31
Step 2: Agency – Employer match complete	Mid-Oct	Mid-Jan	Mid-Apr	Mid Jul
Step 3: State notifications due to employers	Mid-Nov	Mid-Feb	Mid-May	Mid-Aug
Step 4: Employer payments or hearing requests due	Mid-Dec	Mid-Jan	Mid-Apr	Mid-Jul

Attachment to Appendix 4-1
Summary of ESHB 3079, 2006 Session, Reporting Related to Employment of DSHS & BH Enrollees

Provide a report to the Legislature by November 15 of each year, to include:

	DSHS	BH
Employer specific data for the months of January and June of the reporting year (e.g., January and June 2007 for the report due November 2007).	**Who:** By employer for employers having more than fifty employees as recipients or with dependents as recipients. **What:** • Number of medical assistance recipients who at enrollment or recertification report being employed or report being the dependent of someone who is employed. • Total cost to the state for these recipients, broken out by general fund-state, health services account and general fund-federal dollars • Member months associated with these employees. Above is to be reported by medical assistance eligibility program, including but not limited to family medical coverage, transitional medical assistance, children's medical, or aged or disabled coverage. **Beginning with the 2008 report**: Month and year of hire for the employed recipient or employed parent of the recipient.	**Who**: By employer for employers having more than fifty employees as enrollees or with dependents as enrollees. **What**: • Number of basic health plan enrollees who at enrollment or recertification report being employed or report being the dependent of someone who is employed. • Total cost to the state for these enrollees. **Beginning with the 2008 report**: Month and year of hire for the employed enrollee or employed parent of the enrollee.
Quarterly Aggregate Data for the preceding year (e.g., 2006 quarterly data for the report due November 2007).	**Who:** • Number of employees who are recipients or with dependents as recipients *by private and governmental employers*; • Number of employees who are recipients or with dependents as recipients *by employer size* for employers with 50 or fewer employees, 51-100 employees, 101-1,000 employees, 1,001-5,000 employees, and more than 5,000 employees; • Number of employees who are recipients or with dependents as recipients *by industry type.* **What:** For each aggregated classification (private / governmental, employer size, industry type) include the: • Number of hours worked • Total cost to the state for these recipients • Number of DSHS covered lives	**Who:** • Number of employees who are enrollees or with dependents as enrollees *by private and governmental employers*; • Number of employees who are enrollees or with dependents as enrollees *by employer size* for employers with 50 or fewer employees, 51-100 employees, 101-1,000 employees, 1,001-5,000 employees, and more than 5,000 employees; • Number of employees who are enrollees or with dependents as enrollees *by industry type*. **What:** For each aggregated classification (private / governmental, employer size, industry type) include the: • Number of hours worked • Total cost to the state for these enrollees

Appendix 4-2
Comparison of High Level Pros and Cons for Three Shared Responsibility Options:
Employer Sponsored Insurance (DSHS and BH) and BH Voucher[65]

For purposes of this project, the primary conceptual difference between the ESI options and the Voucher option is that the ESI programs include both premium assistance and wraparound coverage; the Voucher option is *solely* for premium assistance (i.e., no wraparound coverage is contemplated).[66]

X = is a pro (or con) for that particular option; blank = pro (or con) is not relevant to that particular option

Pros	DSHS ESI	BH ESI	BH Voucher
Makes use of existing employer-based coverage system in partnership with public sector	X	X	X
Adds employer dollars to system (combines employer contribution amount with public subsidy)	X	X	X
Provides opportunity for low-income employees to be seen as no different from co-workers regarding coverage and total compensation	X	X	X
Lots of ESI-type programs are being developed across states so ample opportunity for lessons on best practices	X	X	[67]
Aligns with BH statutory intent to discourage decline of employer-based coverage		X	X
Can use current DSHS program as model, with potential for collaborative operational processes, but with more flexibility because not an entitlement program and federal Medicaid laws/rules are not applicable		X	
Builds on existing Agency program (i.e., base infrastructure already in place)	X		
Federal match available for additional employer dollars used to cover enrollees	X		
Relative to BH ESI option, limits cost to state because no wraparound coverage (helps pay *only* for employee premium contribution to employer coverage)			X
Likely to be easier for Agency to administer than ESI (mainly because no wraparound coverage) & (depending on design) likely to be of minimal administrative burden to employer			X
For the worker, may be easiest option when "employee contribution to premium" is the only barrier to an employee opting for employer's coverage			X
Conceptually consistent with direction of some broad-based proposals to move the nation to an individually-based voucher system			X

[65] Matrix is a mixture of public policy and operational pros and cons – focus is on major, bigger picture issues. Cons list tends to include more operational issues than does Pros list. Summarized from Figure 4-6 in main body of report.

[66] Wraparound coverage = state pays for services and/or out-of-pocket cost-sharing not covered by the employer up to the limits of the state program.

[67] To-date voucher-type options have been primarily associated with providing individuals with voucher subsidies to purchase coverage *in the non-group market* rather than buying-into employer-based coverage, so there are not many direct "learning opportunities" available (although proposed non-group voucher programs and refundable, advanceable tax credit designs should be reviewed as part of detailed implementation planning).

Cons	DSHS ESI	BH ESI	BH Voucher
Doesn't address issue of shared financial responsibility if enrollee works for an employer that doesn't offer coverage at all (most large employers offer coverage to at least some employees)	X	X	X
Questionable effectiveness in reaching non-standard workers (job-based efforts are most effective for workers with stable & transparent employment relationships)	X	X	X
Depending on design, program can be labor intensive (e.g., upfront work & on-going monitoring to identify who has access to employer coverage & if it is cost-effective for the state to buy the enrollee into it) raising issue of whether the "push is worth the shove"	X	X	X **(less of a con than for ESI)**
Depending on extent of wraparound coverage (either in terms of services or cost-sharing)*, may leave low-income workers underinsured, i.e., employer coverage may not be "useable" to low-income workers if cost-sharing (e.g., deductibles and point-of-service out-of-pocket) make it unaffordable to seek care (*in the case of the BH Voucher program, there is *no* wraparound coverage)	X	X	X **(more of a con than for ESI)**
Employers may be reluctant to support because could cost them more if additional members of their workforce opt for coverage	X	X	X
Unless premium subsidy amount is pegged to employer's premium, a fixed sliding scale amount based on income or a flat amount may not be enough to allow person to buy employer's coverage (so end up going bare even with subsidy in hand)	X	X	X
Would be virtually impossible to administer wraparound coverage in the absence of a fee-for-service program component, which would be costly to develop & operate solely in support of a BH ESI program (& would be somewhat counter to BH's statute that emphasizes managed care)		X	
Would require separate & distinct administration & funding from regular BH to insulate BH from CMS' concerns over Medicare eligibility & to reinforce the state's position that BH is individual, not employer-group, coverage[68]		X	X
If program is subject to ERISA (because of connection to employer-sponsored coverage), program costs may increase, e.g., may be required to cover benefits & services not currently part of BH and/or could face added plan administration & fiduciary responsibilities.[69]		X	X **(less of a con than for ESI)**
Could create financial problem for worker if s/he loses BH ESI/Voucher eligibility & cannot opt out of employer coverage & cannot afford the premium payroll contribution amount		X	X
BH enrollment information system project may prevent BH from going too-fast/too-soon on implementing new programs		X	X
Potential negative impact on existing BH rates if ESI/Voucher program draws healthy, working people out of pool (potentially offsetting any savings)		X	X
Unclear if value of adding another option (alongside regular BH and medical assistance programs) for low-income workers outweighs added complexity of choice & program costs		X	X **(less of a con than for ESI)**
May be lot of effort for naught depending on outcome of Partnership study to integrate BH into Partnership		X	X **(less of a con than for ESI)**
Enhanced design features (other than what is in current ESI program) may require federal waiver	X		

[68] CMS = Centers for Medicaid & Medicare Services, US Department of Health & Human Services. If viewed by CMS as employer-sponsored group coverage, BH would have to allow Medicare eligible persons to enroll and would have to coordinate coverage with Medicare. Under current BH statute, a person eligible for Medicare is not eligible for BH.

[69] ERISA = federal Employee Retirement Income Security Act of 1974.