



EXPANDING EMPLOYMENT-BASED HEALTH COVERAGE: LESSONS FROM SIX STATE AND LOCAL PROGRAMS

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February 2001

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff, or to members of the Task Force.

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EXECUTIVE SUMMARY

About 24 million U.S. workers, often employees of small firms, have no health insurance.¹ Together with their families, these “working uninsured” comprise the vast majority of all uninsured people in this country. For them and their employers, insurance coverage is often unaffordable or unavailable.

Finding workable, practical strategies to make coverage accessible to small firms and to broaden coverage for workers is essential. Smaller companies and self-employed individuals need to have access to health coverage they can afford. Employees whose firms offer coverage frequently need help in paying their share of the premium. Workers whose companies do not offer coverage need a place to get it at a reasonable cost, and a way to retain it when they change jobs or experience spells of unemployment.

A recent report published by The Commonwealth Fund summarizes 21 different state and community-wide programs that provide health coverage to the working uninsured.² The following report describes six of these programs in greater detail. These six programs were selected because they represent:

- initiatives that expand private, employer-based health insurance for the working uninsured;
- a combination of community-based, state-only, and state/federal programs;
- a range in approach and design;
- geographic variation; and
- a combination of programs with many years of experience and new initiatives that represent fresh, promising models.

The four state-administered and two community-based programs profiled in this report vary in eligibility, benefits, administration, financing and other design features. Table 1 summarizes the key elements of the programs.

Most of the programs profiled focus on small employers and their employees. Some involve subsidizing premiums so employers and/or employees can afford to purchase coverage in the workplace. These include Massachusetts’ MassHealth Family Assistance Program (FAP), Iowa’s Health Insurance Premium Payment (HIPP) Program, Access Health in Muskegon County, Michigan, and Financially Obtainable Coverage for Uninsured San Diegans (FOCUS) in San Diego, California.

Other initiatives do not subsidize premiums directly, but make private group coverage available to very small groups and self-employed individuals, including high-risk small groups. These include Arizona’s Healthcare Group (HCG) and the New Mexico Health Insurance Alliance (NMHIA). In these two programs, the states also arrange reinsurance and loss subsidies for private health plans, helping indirectly to manage risk and reduce the premiums charged to employers and employees.

Interviews with program administrators and reviews of proposals, legislation, and status reports have revealed that each of the six initiatives has faced obstacles and achieved successes. While their specific experiences differ, certain overarching themes and lessons emerge. Following are some challenges (discussed at greater length in a subsequent section) for policymakers and program planners developing their own approaches to covering the working uninsured:

¹ U.S. Census Bureau. *Health Insurance Coverage 1999*. Publication P60-211, September 2000.

² Silow-Carroll, S., S.E. Anthony, and J.A. Meyer. *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured*. Report prepared by the Economic and Social Research Institute for The Commonwealth Fund Task Force on the Future of Health Insurance, October 2000.

Policymakers must reduce access barriers facing both employers and employees for maximum effect.

To reach a significant number of working uninsured, a program should reduce obstacles that keep employers from offering insurance, as well as financial barriers that keep employees from accepting and maintaining coverage. Massachusetts addresses the problem by including both components in its Family Assistance Program: subsidies for small employers (Insurance Partnership program), and premium assistance for low-income employees (Premium Assistance program). The Muskegon County and San Diego programs reduce the burden on both employers and employees by establishing a three-way split in premiums, with the community (using federal, state, and local funds) or private foundations paying the third portion. Other programs that help make coverage available to small firms and self-employed individuals are more limited—they do not substantially change the affordability of coverage for low-income workers because they provide only small, indirect subsidies.

Planners must define the target population, design the program to fit its specific needs and characteristics, and learn how to direct outreach and marketing to best reach it.

Defining and understanding the target population is critical to an effective program. Eligibility criteria, subsidy levels, outreach strategies, marketing campaigns, and other design features must be shaped to meet the characteristics of the people a program aims to reach. For example, programs that target low-income workers in small firms must acknowledge the mobility of this population and the need to improve continuity of coverage during job changes. In addition to defining the target population during the planning stage, programs should have the flexibility to redefine that population during and after implementation.

Whether operating on a community or state level, program planners must make a serious commitment to educating and informing potential constituents and intermediaries. Sophisticated marketing, based on well-conducted market research, should be combined with grassroots outreach.

Spreading risk and addressing adverse selection are critical to prevent the programs from spiraling into a high-risk pool and to retain private health plan participation.

Many of the programs profiled use guaranteed issue and modified community rating to enable vulnerable, high-risk people in small firms to buy affordable coverage. Yet these important features can cause the programs to spiral into a high-risk pool. Program administrators face the challenge of keeping premiums low enough to retain low- and moderate-risk enrollees (and keeping coverage affordable to higher-risk individuals) while ensuring adequate revenues for the health plans. Access programs will be unable to recruit and retain private health plans unless the plans are protected and perceive real benefits of participating.

The Arizona and New Mexico programs try to protect participating health plans through reinsurance mechanisms that reimburse the plans for claims above a certain level, and/or for losses greater than a certain portion of premiums. With losses exceeding reinsurance funds, however, both programs have required additional subsidies to stay afloat. An alternative to these back-end loss subsidies is to directly subsidize premiums at the front end. Helping employees and employers pay premiums, as in the Massachusetts, Muskegon County, and San Diego programs, may keep coverage affordable and at the same time provide health plans with enough funds to avoid losses. This front-end subsidy approach also has the advantage of retaining incentives for the health plans to manage the cases efficiently.

There is a need for a stable and sufficient funding source.

Policymakers must acknowledge that reaching very small firms, lower-income workers, and higher-risk individuals requires an adequate outside funding source (i.e., beyond enrollee-paid premiums) that is not threatened by competing programs or political whims. Stable funding reassures potential enrollees and participating health plans that the programs will not disappear after a short time. Arizona's HCG began without public subsidies, but adverse selection ensued and the program nearly collapsed before the state

committed additional funds. New Mexico tried to avoid this problem by building into its design from the start an assessment on all health insurers in the state to cover additional losses. Iowa's HIPP and Massachusetts' FAP programs use Medicaid state and federal dollars, which provide a secure source of funding. Muskegon County's Access Health also uses federal funds, creatively reallocating disproportionate share hospital (DSH) dollars to help finance the program.

Program designers must weigh the pros and cons of crowd-out in determining whether to include a look-back period in their eligibility criteria.

The two community-based subsidy programs contain costs and efficiently target public dollars to the uninsured by instituting a look-back period that makes employers and/or employees eligible for subsidies only if they have not offered coverage or been insured over the previous 12 months. The intent is to avoid crowd-out, whereby public dollars merely substitute for private dollars already being spent for health coverage, without significantly expanding the number of insured people.

Look-back periods may raise questions of equity, however, since workers and firms that have bought coverage in the past are essentially penalized for acting responsibly. Subsidies for low-income workers who have been struggling to pay for insurance reduces the financial burden, freeing funds for other important needs. Subsidies for employers already providing coverage may be beneficial because they allow employers to offer a wider range of benefits or contribute a larger portion toward premiums. They also encourage employers who are considering dropping coverage (due to recent double-digit premium increases, for example) to continue to offer benefits. None of the four state programs profiled has a look-back period in its eligibility criteria, yet none views crowd-out as a major problem at this time. In Massachusetts, for example, approximately 60 percent of businesses receiving subsidies did not previously offer coverage.

Community-based public-private partnerships or private initiatives, state-only, and state-federal approaches all present tradeoffs that involve financial resources, independence, and flexibility.

In selecting the scope of a new program, policymakers face tradeoffs that involve access to funds and the level of independence and control. When states develop initiatives that operate under federal programs such as Medicaid or the State Children's Health Insurance Program (CHIP, a Title XXI federal block grant program), they gain continuing access to federal matching funds that finance half or more of the costs, but must comply with numerous federal regulations and reporting requirements, and may need to undergo a lengthy waiver application and review process. The MassHealth Family Assistance Program uses state, federal Medicaid, and federal CHIP funds, requiring complex coordination of eligibility, reimbursement, and reporting under different sets of state and federal guidelines. The reward, however, is access to multiple funding streams that allows the state to expand coverage to a much larger group of people. The Arizona and New Mexico programs are state-only, providing greater independence and flexibility, but smaller scope and greater vulnerability to financial and political crises. Community-based programs tend to be most flexible and serve as good laboratories for new models, but funding is more limited and at times precarious.

Initial and continuing community involvement is critical for local programs.

Though labor-intensive for program organizers, soliciting community involvement and support is critical to sustain local initiatives. Since a group comprising hospitals, insurers, and other community members developed FOCUS, local providers agreed to serve FOCUS enrollees at reduced rates and brokers agreed to participate without commissions. Also, FOCUS has a technical advisory group that provides program oversight and a continuing avenue for community input. Muskegon County's Access Health program planners commented that many of the creative ways in which the program was structured were acceptable to the community because they were ideas that originated locally and were community-owned.

Policymakers should acknowledge that a voluntary program that targets a portion of the working uninsured must be part of a broader, comprehensive approach to expand access. Even the most successful model aimed at expanding work-based coverage that depends upon voluntary participation and that targets a portion of the uninsured will have a limited impact. Initiatives like some profiled in this report represent only one element of a piecemeal approach to covering the working uninsured. Ensuring that all working people and their families have adequate health insurance could require mandatory participation, or total replacement of the current employer-based insurance system with some type of universal health insurance program.

Further, while the working uninsured constitute the majority of those without health insurance, there are millions of uninsured people who are not tied to the workforce. Millions more are underinsured (inadequate coverage) or have noninsurance barriers to health care related to language, culture, staffing shortages, lack of transportation or child care, and other obstacles. Efforts to cover the working uninsured must be part of a broader, comprehensive approach to reach the many subgroups of the uninsured and to address the many obstacles to proper access to health care.

Table 1: Summary of Profiled State and Community Programs to Expand Employer-Based Insurance Coverage

Location/Program	Description	Enrollment	Eligibility	Financing
Arizona Healthcare Group (HCG)	Prepaid medical coverage from three HMOs makes health insurance more accessible to small businesses and self-employed individuals	11,622 persons (workers and family members) from 3,623 small business groups (9/00)	Businesses with two to 50 employees or self-employed individuals; if firm has one to five employees, must have 100% participation of eligible employees (work 32+ hours/week); if firm has six or more employees, must have at least 80% participation of eligible employees	\$700,000 in start-up costs provided by Robert Wood Johnson Foundation; health plans charged \$4/month; employers and employees pay full cost of coverage; state contributes \$8 million/year to reinsurance pool and to reimburse health plans for losses
Iowa Health Insurance Premium Payment (HIPP)	Subsidizes enrollment in employer-sponsored private health insurance plans for Medicaid-eligible individuals and their families	8,000 people, including 5,500 Medicaid-eligible individuals and 2,500 non-Medicaid-eligible family members (8/00)	Be eligible for Medicaid or live in the household of a Medicaid-eligible family member; have access to employer-sponsored coverage; meet cost-effective criteria	State and federal Medicaid matching funds
Massachusetts MassHealth Family Assistance Program (FAP)	<i>Premium Assistance Program</i> offers subsidies to help low-wage workers pay their share of premiums	Approximately 12,000 covered lives subsidized (9/00)	Family income up to 200% of FPL; self-employed or work for small firm OR have children and work for any size firm; employer pays at least half of premium for work-based health insurance	Combination of state-only funds, state Medicaid funds, federal Medicaid matching funds, and CHIP funds
	<i>Insurance Partnership</i> offers subsidies to low-wage self-employed individuals and small businesses to help pay premiums for low-wage workers	1,620 employers are subsidized for premiums of 4,600 individuals (workers and family members) (9/00)	Business employs 50 or fewer full-time (30+ hours/week) workers; offers comprehensive health insurance and pays at least half of the premium	State funds through summer 2000; may become eligible for federal matching funds under a Section 1115 waiver or Title XXI
New Mexico New Mexico Health Insurance Alliance (NMHIA)	Program to make health insurance more accessible to small businesses, self-employed individuals, and individuals who lose group health coverage	8,500 covered lives in 1,800 small businesses and 1,900 individual accounts (11/00)	<i>Employers</i> are eligible if two to 50 eligible (working 20+ hours/week) employees and at least half enroll, or self-employed and purchasing insurance for self and at least one family member; do not offer group coverage other than an Alliance plan. <i>Individuals</i> are eligible if they have lost group coverage and have exhausted COBRA and state continuation plan in prior two months	Employers and/or employees/individuals pay full premium; reinsurance funded by premiums and assessment on all health insurance companies in the state; reimburses participating health plans for losses
Muskegon County, MI Access Health	Health coverage product for the working uninsured targeted to small and medium-size businesses (up to 150 eligible employees)	155 small to medium-size businesses, covering 500 employees and dependents (8/00)	Businesses with up to 150 eligible employees (not seasonal, temporary or otherwise insured); not providing insurance for prior 12 months; median wage of eligible employees of \$10 per hour or less	Three-way shared buy-in among employer (30%), employee (30%), and community match (40%), comprising federal DSH funds and local government, community and foundation funds
San Diego, CA FOCUS (Financially Obtainable Coverage for Uninsured San Diegans)—Sharp Health Plan	Premium assistance program for small employers (less than 50 employees) and low-to moderate-income employees (up to roughly 300% of FPL)	1,766 employees and 232 businesses (8/00)	Small businesses not providing coverage for prior 12 months; full-time employees with incomes up to 300% of FPL previously uninsured; all eligible dependents must also enroll	\$1.2 million grant from Alliance Healthcare Foundation; \$400,000 grant from California Endowment; fixed employer contributions; sliding-fee scale for employees

OVERVIEW

Background—Scope of the Problem

The “working uninsured” are those who are employed full-time or part-time but who do not have health insurance for themselves and their families. There are about 24 million of these workers without coverage in the United States.³ Together with their uninsured dependents, the working uninsured therefore comprise the vast majority of the 42.6 million people without health insurance coverage in this country.

Most nonelderly Americans obtain health insurance through their employment. Employers generally pay 50 percent or more of their employees’ premiums for a group insurance policy (many large firms are self-insured), and employees contribute the remainder. Employers often make coverage available for employees’ dependents, but contribute a smaller portion of the premiums. However, under our current voluntary system, employers may choose not to provide health care coverage as a benefit, and the large number of working uninsured shows that this employment-based health insurance system is not working for everyone. Indeed, some 34 million people worked for an employer who offered no health coverage in 1997, and about 14 million of these lacked coverage from any source.⁴ Another 3.7 million workers were ineligible for the coverage at their workplaces. Also, welfare reform requires people—many of whom are unaware of or who have exhausted Medicaid continuation coverage—to leave welfare and start working in jobs that may not have health benefits.

Small businesses are the least likely to offer coverage, partly because health insurance is simply unaffordable for or unavailable to many employers and employees. Only 60 percent of businesses with three to nine employees offered health coverage in 2000, compared with 97 percent of firms with 50 to 199 workers.⁵ The obstacles that face such employers are many: insuring a small group entails higher administrative and marketing costs. Premiums are more volatile because small-group coverage generally involves medical underwriting—businesses with one or more workers who have prior or preexisting medical conditions are faced with premiums that are unaffordable. Many small businesses, operating on a thin profit margin, are wary of making a commitment to employees that they may not be able to fulfill; and some employers are reluctant to offer coverage to workers who may leave after a few months. Very small firms, especially those with fewer than five employees, find that insurers do not market to them because they are viewed as too risky. Further, the imminent reappearance of double-digit premium increases may lead more small employers to drop coverage in coming years.

There are obstacles for employees, too. Many lower-income families who participate in job-based health coverage make a significant sacrifice to do so. They may receive lower wages or reduced benefits outside of health coverage as their employers try to hold down total employee compensation costs. Workers may find it difficult to pay their share of the premiums, which average \$138 per month for family coverage.⁶ Not surprisingly, an increasing number of workers are turning down employment-based health insurance even when it is offered. Some 2.5 million people are uninsured because they turned down an employer’s offer in 1997.⁷ The primary reason for declining coverage is workers’ inability to afford their portion of the premiums.

³ U.S. Census Bureau, 2000.

⁴ Thorpe, K., and C. Florence, “Why Are Workers Uninsured? Employer-Sponsored Health Insurance in 1997,” *Health Affairs* 18 (March/April 1999).

⁵ Henry J. Kaiser Family Foundation and the Health Research and Education Trust, *Employer Health Benefits 2000 Annual Survey*.

⁶ Gabel, J. et al. “Job-Based Health Insurance in 2000: Premiums Rise Sharply While Coverage Grows,” *Health Affairs* 19 (September/October 2000).

⁷ Thorpe and Florence, 1999.

Those who do not have access to employer-sponsored health insurance, either through their own or a spouse's job, have few options. Frequently, the only way is to buy a nongroup insurance policy in the individual market. But those without access to work-based coverage tend to have low wages and often work part-time. Many earn too much to be eligible for public health insurance programs such as Medicaid, but too little to afford individual coverage. If they have prior medical conditions, nongroup premiums may be exorbitant or coverage may be denied completely.

Any type of serious illness, disease, or accident can financially ruin the working uninsured. Lacking insurance, these workers and their families may neglect their health and delay or forgo effective preventive and primary health care. This takes a toll in human suffering and carries a financial price as well. Care neglected frequently leads to more serious illness, which is more expensive to treat. Further, this contributes to absences from work, which are likely to hurt productivity. Finally, when the uninsured cannot pay for their care, it puts a burden on safety net health care providers and the health care system as a whole.

State and Community Responses

Government's traditional response to the lack of access to health insurance has been to publicly insure those deemed most vulnerable: the elderly, the very poor, the disabled, and children in low-income families. Medicare and Medicaid, the largest publicly sponsored health insurance programs, focus on populations that typically are not tied to the workforce. However, states and communities are unable to ignore the increasing number of working uninsured, and some are trying to address this population. For example, some states are expanding Medicaid eligibility and using the State Children's Health Insurance Program (CHIP) to include low-income children and working parents in public programs.

Many policymakers believe that the next steps in coverage expansion should build on private, employer-based coverage. Therefore, instead of substituting public coverage for private coverage at the workplace (a phenomenon referred to as crowd-out), policymakers are trying to make private insurance more accessible to employers and employees. To date, these efforts encourage expansion of work-based coverage but do not mandate employers to offer or employees to obtain insurance.

A recent Commonwealth Fund publication summarizes 21 state and community programs that provide health coverage to the working uninsured.⁸ In the following pages, we report in greater detail on six of the programs described in that paper. These four state and two community initiatives were selected because they represent a range in approach and design. The group includes three programs with years of experience—Arizona's Healthcare Group (HCG), the New Mexico Health Insurance Alliance (NMHIA), and Iowa's Health Insurance Premium Payment (HIPP) Program. Three other plans—Massachusetts' MassHealth Family Assistance Program (FAP), Access Health in Muskegon County, Michigan, and Financially Obtainable Coverage for Uninsured San Diegans (FOCUS) in San Diego, California—are new initiatives that represent fresh, promising models. All six make private, work-based health insurance more accessible. Some subsidize premiums so employers and/or employees can afford to buy coverage (FAP, Iowa HIPP, Access Health, and FOCUS). Others (HCG, NMHIA) do not directly subsidize premiums, but make private group coverage available to very small groups, including high-risk small groups, and self-employed individuals. In the case of high-risk groups, the states arrange reinsurance for private health plans, thus helping indirectly to manage risk and contain premiums.

Most of the programs focus on small employers and their employees. One (Iowa HIPP) targets Medicaid-eligible people who have access to private, work-based coverage, and in effect subsidizes many non-Medicaid-eligible family members as well. All of the programs require contributions from employers and/or employees. All use additional funding sources to finance subsidies, administrative costs, and other

⁸ Silow-Carroll, Anthony, and Meyer, 2000.

expenses. Two of the state programs (HCG, NMHIA) use state-only funds or assessments, and two (Iowa HIPP, FAP) tap state and federal matching funds. FOCUS is funded through private grants; Access Health draws money from a variety of sources, including federal disproportionate share hospital (DSH) funds and local government, community, and foundation funds.

Lessons and Challenges from Profiles

Some common themes and lessons emerge from the experiences of the six programs profiled. These form the basis for the following challenges for policymakers as they try to extend health coverage to the working uninsured.

1. If programs are to reach a significant number of the uninsured, policymakers must reduce access barriers that face both employers and employees.

Subsidizing employees' contributions to work-based health insurance does not help if the employer does not offer coverage (for any of the reasons delineated above). Conversely, making group insurance available to very small firms does not directly assist low-income employees if they still cannot afford to pay their share of the premiums. Thus, to reach a significant number of working uninsured, a program should reduce insurance barriers for both employers and employees. Massachusetts's FAP addresses this problem with subsidies for small employers (the IP program), and premium assistance for low-income employees (the PA program). The Muskegon County and San Diego programs reduce the burden on both employers and employees with a three-way split in premiums—private foundations or the community (using federal, state, and local funds) pay the third portion.

Arizona's HCG and New Mexico's Health Insurance Alliance make coverage available to very small firms and self-employed individuals, who normally lack access to private group insurance. They do not require employers to contribute to the premium, thus opening the option for employers to serve as the vehicle for group coverage without paying for that coverage. These programs are limited, however, because they do not substantially improve the affordability of coverage for low-income workers. Other states are developing premium assistance programs for employees, but doing nothing to encourage or financially assist employers to offer health insurance.

2. Planners must define the target population, design the program to fit its specific needs and characteristics, and learn how to direct outreach and marketing to best reach it.

Defining and understanding the target population is critical to an effective program. Eligibility criteria, subsidy levels, outreach strategies, marketing campaigns, and other design features must be shaped to mesh with the characteristics of the people at whom the program is aimed. For example, programs that target low-income workers in small firms must acknowledge the mobility of this population. A key challenge is to design a program that not only enrolls workers, but improves the continuity of coverage for a group that makes frequent job changes or goes in and out of the workforce. Many of the programs profiled here have high disenrollment rates because workers leave jobs or small firms go out of business.

A few examples show that knowing the target population is clearly critical to marketing the program:

- State administrators of the Massachusetts FAP acknowledge that their marketing would be more efficient if it identified and focused efforts on firms with a large proportion of low-income workers.
- A health plan that participates in Arizona's HCG was unsuccessful in reaching employers directly in a state where insurance brokers play a primary role with small businesses. Adjusting its marketing strategy to the realities of the small-group market in that state led to a significant increase in enrollment.

- When designing the program in San Diego, policymakers recognized that they needed to target small businesses since most of the employers (87 percent) in San Diego were firms with fewer than 20 employees.

In addition to defining the target population during the planning stage, programs should have the flexibility to redefine that population during and after implementation. For example, when Muskegon County's Access Health program was initially designed, businesses were allowed to participate only if they had 19 or fewer eligible employees. As the plan was implemented, planners realized that there were many small- and medium-sized businesses with more than 19 employees that could benefit. As a result, they extended eligibility to businesses with up to 150 employees (in certain instances, even larger businesses are eligible if they have a particular class of workers [e.g., part-time workers] who have not been eligible for coverage in the past). Such flexibility ensures that even if the target population changes, programs will be able to adapt and continue to provide health insurance to low-income workers.

Well-conducted market research can also lead to an effective publicity and outreach effort, critical to a successful program. For example, market research in Muskegon County found that the target population of Access Health is largely 18-to 34-year-old women employed in the service sector, many of whom have a negative view of "government entitlements." This information helped shape the language used in the marketing and outreach campaigns.

Whether operating on a community-wide or a state level, program planners must make a serious commitment to educating and informing potential constituents and intermediaries. Depending on the model, outreach efforts must be geared to some combination of: families, employers, health care providers, social service agencies, insurance brokers, and health plans/insurers. Sophisticated marketing should be combined with grassroots outreach. In both San Diego and Muskegon County, learning how to market to small employers and employees has been one of the more difficult challenges, and in each program, initial enrollment was slow because more (and better-targeted) marketing was needed.

In contrast to the other programs discussed in this report, Iowa's Health Insurance Premium Payment (HIPP) does not target the working uninsured per se. Iowa is one of six states that operates or plans to institute HIPP programs (established under Section 1906 of the Social Security Act) as part of their Medicaid programs.⁹ HIPP programs aim to save public money on Medicaid-eligible individuals who have access to private, work-based coverage by subsidizing their premiums for private insurance. In addition, HIPP will also pay for family coverage if such coverage is necessary to cover the Medicaid-eligible person, and if it is cost-effective to the state. If these conditions are met, the program subsidizes workers and family members who are not eligible for Medicaid, and who may be uninsured without the subsidy. While HIPP programs favor private, work-based coverage over public coverage and do achieve their goal of public savings, their indirect, "back door" approach to reaching the working uninsured is unlikely to reach a significant portion of this population.

3. Spreading risk and addressing adverse selection are critical to prevent the program from spiraling into a high-risk pool and to retain private health plan participation.

Access initiatives must struggle to keep coverage affordable while ensuring revenue adequate to sustain the program. Many of the programs profiled enable vulnerable, high-risk people to buy affordable coverage through guaranteed issue and modified community rating across small firms and the self-employed. Yet these features result in higher-than-market rates for lower-risk enrollees. Adverse selection ensues when lower-risk people leave the pool to seek less expensive commercial coverage, thus raising the overall risk of the remaining enrollees and requiring additional revenues to cover claims. Preventing this spiral into a high-risk pool is a major challenge for administrators.

⁹ As of June 2000, Iowa, Massachusetts, Mississippi, Pennsylvania, Texas, and Wisconsin operate or are planning to institute HIPP programs.

Because these plans tend to attract higher-risk people, they need to incorporate protections in order to recruit and retain private insurers and health plans. That is, the sustainability of access programs requires that participating carriers perceive some real benefits of participation. The Arizona HCG and NMHIA experiences underscore the need to assure adequate financing and to be responsive to concerns of participating carriers. Both programs include reinsurance mechanisms that reimburse health plans for claims above a certain level, and/or for losses that exceed a given portion of premium; in New Mexico there is also an assessment on all health insurers in the state to help share risk and cover additional losses. Yet in both states, carriers perceived that they were not adequately compensated, and some saw the access programs as competitors of their commercial products. This dissatisfaction resulted in crises that threatened the viability of the programs. In Arizona, some participating carriers threatened to leave the program, and New Mexico carriers led efforts that will result in large premium increases and possible widespread disenrollment from NMHIA.

Direct subsidization of premiums at the front end is an alternative to the after-the-fact subsidies used in Arizona and New Mexico. Helping employees and employers pay premiums, as in the Massachusetts, Muskegon County, and San Diego programs, may keep coverage affordable and at the same time provide health plans with adequate funds to avoid losses. Further, front-end subsidies retain incentives for the health plans to manage the cases efficiently.

4. There is a need for a stable and sufficient funding source.

Regardless of whether subsidies are direct (premium assistance) or indirect (reinsurance, stop-loss protection), it appears that a sustainable program for covering the working uninsured necessitates some outside funding. Policymakers must acknowledge that reaching very small firms, lower-income workers, and higher-risk individuals requires an adequate funding source that is not threatened by competing programs or political whims. Financing should be viewed as an investment that will pay off in a lower burden of uncompensated care in the community and reduced use of other public programs, as well as better health outcomes and a more productive workforce.

Arizona's HCG began without subsidies, but adverse selection ensued and the program nearly collapsed before the state committed additional funds. Iowa's HIPP and Massachusetts's program use Medicaid funds, which provide a secure source of funding. Muskegon County's Access Health also uses federal funds, creatively reallocating disproportionate share hospital (DSH) dollars to fund the program.

The future of Arizona's HCG is uncertain because of competition for tobacco settlement funds. This illustrates the need for stable, long-term financing. Potential enrollees and participating health plans need to know that the programs will not disappear after a short time. San Diego's FOCUS, though privately funded, faces a similar problem. It was designed to be a two-year demonstration project; funding at the end of those two years is not guaranteed. While this has not seemed to deter businesses from joining, it will clearly be disruptive for enrollees if the program is discontinued and employers can no longer afford to continue offering coverage.

The need for political and financial commitment, however, must be balanced with a need for accountability. This calls for continuing review, evaluation, and modification of programs to ensure their effectiveness.

5. Program designers must weigh the pros and cons of crowd out in determining whether to include a look-back period in their eligibility criteria.

Some programs, including the two community-based initiatives profiled, include a look-back period during which employers and/or employees are eligible for subsidies only if they have not offered coverage or been insured during a designated prior period. FOCUS and Access Health use look-back periods of 12 months. The intent of this requirement is to avoid crowd out, whereby public dollars merely substitute for private dollars already being spent for health coverage, without necessarily expanding the number of insured people. But the disadvantage of look-back periods is that firms that have provided coverage in the

past (and workers who have struggled to maintain coverage) are penalized for acting responsibly. This poses a difficult tradeoff between the desire to hold down the cost of subsidies—which calls for some measures to control crowd-out—and equity considerations that view subsidies for those already paying, but struggling to do so, not as a waste of money but as a reward for sacrifice. In addition, subsidies for those already providing coverage may allow employers to offer a wider range of benefits or contribute a larger portion toward premiums.

Interestingly, the four state programs profiled do not have look-back periods in their eligibility criteria. Yet none seems to be having major problems with crowd-out. In Massachusetts, approximately 60 percent of businesses that receive subsidies did not previously offer coverage. While it is possible that some of these firms and self-employed individuals were planning to begin coverage anyway, it appears that a subsidy for employers may be enough of an incentive to motivate many of them to begin offering health benefits. Also, allowing firms that already offer coverage to receive subsidies encourages those who are considering dropping coverage (due to double-digit premium increases, for example) to continue to offer benefits.

6. Community-based public-private partnerships or private initiatives, state-only, and state-federal approaches all present tradeoffs involving financial resources, independence, and flexibility.

In selecting the scope of a new program, policymakers face tradeoffs involving access to funds, and levels of independence and control. When states develop initiatives that operate under federal programs such as Medicaid or CHIP, they gain access to federal matching funds that finance half or more of the costs. This allows for broader scope and impact. But federal funds are not “free.” States must comply with numerous regulations and reporting requirements. Further, most programs geared toward the working uninsured that use federal funds require the state to submit a waiver application to the Health Care Financing Administration, where the review process can take a long time and approval is granted for a limited time.

The Iowa HIPP program (along with other state HIPP programs) was authorized under Section 1906 of the Social Security Act. Additional waivers were not necessary, but the state cannot veer from the federally designed HIPP model. The Massachusetts Family Assistance Program, however, was designed by the state, and did require a Medicaid Section 1115 waiver, which was approved in 1996 and runs through 2002. The state also decided to include CHIP funding for the premium assistance part of the program, and working out details with the federal government delayed the program’s implementation for one year. As a result, Massachusetts must coordinate eligibility, reimbursement, and reporting under different sets of guidelines. The reward for this complex coordination effort, however, is access to multiple funding streams that allows the state to expand coverage to a much larger group of people than if it were dependent solely on state funds.

The Arizona and New Mexico programs are state-only, providing greater independence and flexibility, and having fewer reporting and regulatory requirements (although they must still meet state legislative guidelines). The more limited funding source, however, also limits the potential scope of the program, and in fact the future of both programs is in question.

Community-based programs tend to be most flexible but funding is more limited and at times precarious. Access Health (Muskegon County) combines federal DSH funds with local government funds, community contributions, and private foundation funds to finance 40 percent of premiums (employers and employees each contribute 30 percent). The combination of public and private funds has made Access Health a more secure program than FOCUS, which is entirely reliant on private foundation grants. FOCUS, still a pilot program, considered public financing options but rejected them because of the restrictions discussed above. Although there is interest in continuing and perhaps expanding FOCUS at the Alliance Healthcare Foundation and California Endowment, it is not clear that private funds will be able to continue to support the program entirely. Program planners may have to consider using public financing with all the advantages and disadvantages that entails.

Community-based programs clearly serve as good laboratories for new models, and have additional advantages as well. Program planners can design initiatives to fit the community's unique characteristics and needs. They can shape the benefits, marketing, and outreach to the target population, and can more easily modify the program than can states or the federal government. The major drawback is the limited scope and often duplicative efforts across communities nationwide.

7. Initial and continuing community involvement is critical for local programs.

To design community programs like the two described here, it is essential to have community involvement and community support. The San Diego program developed out of Community Health Improvement Partners (CHIP), a forum of local hospital representatives, health insurance companies, and health policymakers that was created to discuss community health care access issues. Since FOCUS was developed by community members, the program has local support. For example, providers have agreed to serve FOCUS enrollees at reduced rates and brokers have agreed to participate without commissions. FOCUS continues to have a Technical Advisory Committee, a group with a similar composition to CHIP, that provides program oversight and an avenue for community input.

Muskegon County's Access Health also is very much community-driven and has a community board that continues to provide feedback to program staff. Program planners commented that many of the creative ways in which the program was structured were acceptable to the community because they were ideas that originated locally and were "community-owned." The program appeals to policymakers across the political spectrum in Muskegon County because Access Health has something for everyone.

While community support and buy-in is critical to programs like these, it must be kept in mind that soliciting community involvement is quite labor-intensive for program organizers. The Muskegon County community almost gave up at one point prior to implementing Access Health because it was unclear that local stakeholders would ever agree on how to solve the problem of the uninsured. In addition, local programs designed by communities may be less easily expanded than programs that are developed at the state level.

8. Policymakers should acknowledge that a voluntary program to target a portion of the working uninsured must be part of a broader, comprehensive approach to expand access.

The final lesson that emerges from the experiences of programs profiled in this report is that even the most successful model aimed at expanding work-based coverage that depends upon voluntary participation and that targets a portion of the uninsured will have a limited impact. Regardless of the level of subsidies and other incentives, some employers will not sponsor coverage, and some employees will not accept it. Also, most of the programs profiled are geared to assist a subset of the working uninsured: low-income employees, workers in small firms, or families of Medicaid-eligible individuals. As such, many of these initiatives represent one element of a piecemeal approach to covering the working uninsured. Ensuring that all working people and their families have adequate health insurance could require mandatory participation, or totally replacing the current employer-based insurance system with some type of universal health insurance program. The latter approaches, however, do not seem politically feasible, at least in the near future.

Further, while the working uninsured constitute the majority of those without health insurance, there are millions of uninsured people who are not tied to the workforce. Millions more are underinsured or face noninsurance barriers to health care related to language, culture, staffing shortages, lack of transportation or child care, and other obstacles. Efforts to cover the working uninsured must be part of a broader, comprehensive approach to reach the many subgroups of the uninsured and to address the many obstacles to proper access to health care.

PROFILES

Arizona

Healthcare Group of Arizona (HCG)

The Healthcare Group of Arizona (HCG) offers prepaid medical coverage through three HMOs to small businesses and the self-employed.¹⁰ While most insurers market their group insurance plans only to businesses with more than five employees, HCG is available to micro groups—very small firms with two or more employees—and self-employed individuals. There are no maximum income limits for employee enrollment, and no requirements that the enrollees must have been uninsured previously or that the employer did not offer coverage before participation in HCG. Participating health plans are required to accept all full-time workers in small firms, regardless of health status, and to charge a modified community rate.

Some of the same design features that were intended to make HCG coverage more accessible also contributed to adverse selection over the years, and medical costs rose faster than premiums (see below). As a result, the participating insurers experienced major losses, culminating in a crisis in 1998 when the health plans threatened to leave the program. The state approved funds to offset some of the insurers' past losses, and established a reinsurance fund to protect the insurers against future losses. This experience provides valuable lessons for policymakers who are planning programs for potentially high-risk populations.

After experiencing declining enrollment for the last few years, HCG appears to have stabilized at nearly 12,000 covered lives in September 2000, including about 2,500 children. About 3,600 small business groups buy coverage through HCG. The future of the program will depend largely on continued public financing to support the reinsurance fund.

Background and History

Development and Goals

Like other states, Arizona has struggled to find a way to finance health care for the uninsured. In 1995, uninsured Arizonans accounted for an estimated \$457 million in medical costs, which were ultimately borne by taxpayers and health care organizations.¹¹ The starting point in addressing this problem was to identify the uninsured population. One study found that 86 percent of approximately 450,000 uninsured adults in Arizona were employed. The majority (59 percent) worked for businesses with 20 or fewer employees, and most (85 percent) worked fewer than 40 hours per week. These uninsured workers generally earn too little to afford individual health insurance policies, but they earn too much to be eligible for public health insurance programs.

At the same time, the state concluded that many small businesses faced obstacles to obtaining affordable group health insurance. For example, most insurers do not actively market to employers with two to five employees, and engage in practices that in effect keep many small firms from buying coverage. These practices include medical underwriting that keeps coverage unaffordable to many businesses, requiring employers to contribute a certain portion of the premium, and minimum group size requirements. Also, insurers and the state's department of insurance do not recognize self-employed persons or firms with one employee as a group, preventing these people from purchasing group insurance coverage.

¹⁰ HCG coverage is also available to political subdivisions (employees of the state, counties, cities, towns, school districts and agricultural districts); however, only 219 people were enrolled through this source as of June 2000.

¹¹ According to a study by William M. Mercer, Inc., 1995, prepared for the Arizona Affordable Health Care Foundation.

In response, the state legislature established the Healthcare Group of Arizona in 1982 with a mandate to reduce the number of uninsured residents by providing health care coverage for small businesses unable to obtain affordable coverage elsewhere. As a state-only program, HCG did not require any federal waivers. The program was not funded and implemented until 1988, however, and it has been modified occasionally since implementation to improve participation and address administrative concerns. HCG is a separate organization within the Arizona Health Care Cost Containment System (AHCCCS), whose primary function is to manage the state's Medicaid program.

HCG addressed the obstacles facing many small firms that try to obtain coverage by contracting with three HMOs to offer prepaid health plans without medical underwriting to very small groups (including part-time workers) and self-employed individuals.¹²

Financial Crisis and State Response

The HCG health plans began to report significant losses about four to five years after the program was implemented, seemingly due to an increasing proportion of higher-risk enrollees. Before the Health Insurance Portability and Accountability Act of 1996 (HIPAA¹³), HCG was the only small-group alternative with guaranteed issue; after HIPAA was enacted, HCG continued to offer coverage without medical underwriting and with community rating—naturally attracting higher-risk individuals. Also, insurance brokers tended to steer lower-risk groups and individuals to commercial insurance and higher-risk people to HCG.

HCG commissioned William M. Mercer, Inc., to evaluate the risk profile of its enrollees to help determine the reasons for the losses. The analysis confirmed a strong correlation between the financial losses and an increasing average health risk of enrollees. Mercer concluded the following:¹⁴

The combined risk of this [HCG] population continues to be higher than the general commercial population and continues to rise in acuity. It appears that costs will continue to grow unless there is a change in the enrollment profile of HCG members (page 1).

The inability of premiums to keep pace with increased costs has been a significant contributing factor to losses of the program.¹⁵ The moderate increases in rates have also exacerbated the increase in the risk of the program as better-risk individuals have left the program as their premium rates have increased (page 4).

In other words, the program had evolved into a high-risk pool—many healthy employees enrolled in commercial plans (through a spouse's group insurance, for example) while high-risk workers enrolled in HCG.

In 1998, two of the three participating health plans sent letters to their HCG enrollees declaring their intent to withdraw from HCG unless the state would provide additional funds to compensate for

¹² Participation was offered only to health plans that provided coverage in the AHCCCS Acute Care program, to ensure AHCCCS experience and to allow the state to evaluate the service levels of the organizations. The participating plans have changed over the years, but University Physicians (University of Arizona Medical Center) and Mercy Healthcare Group (St. Joseph's Hospital) have remained participants.

¹³ HIPAA prohibits insurers from denying coverage to small employers, requires insurers to offer coverage to workers entering the individual market from group plans, and places limits on preexisting condition exclusions.

¹⁴ *Analysis of Utilization, Costs, and Risk of Membership, Health Care Group of Arizona*. Report prepared by William M. Mercer, Inc., February 2000.

¹⁵ The per-member, per-month costs increased an average of 17.3 percent annually from 1996 through 1999, while premiums rose an average of 9.2 percent per year. The HCG plans were profitable in the second half of 1996, but have experienced losses every quarter since then.

their losses.¹⁶ These letters spurred many members to contact their state legislators urging them to save HCG. However, the uncertainty about the future of the program also led many employer groups with healthier employees to leave HCG and obtain commercial insurance. The smaller businesses and firms with less-healthy groups unable to obtain affordable coverage elsewhere remained in HCG, further exacerbating the spiraling effects of adverse selection.

Legislative changes made in 1998–1999 to strengthen the program in fact resulted in further reductions in enrollment. In an effort to reduce adverse selection, group participation requirements were increased from 50 percent for all firms to 80 percent participation for groups of six or more, and 100 percent participation for groups of five or less. Also, the minimum hours worked per week to be eligible was changed from 20 hours per week to 32 hours per week, and this had mixed results. According to one participating health plan, this served to eliminate some higher-risk early retirees who worked as part-time consultants. But for another health plan, it eliminated young and healthy students, who were low utilizers of medical care, actually increasing the average risk of that plan's remaining enrollees. After reaching a peak of more than 21,000 covered lives in 1997, enrollment plummeted to about 17,500 in 1998, and to fewer than 13,000 in 1999.

Under pressure from the HCG health plans and enrollees, the state legislature responded to the crisis by passing legislation to provide a funding mechanism to cover the health plans' losses. House Bill 2498 appropriated \$8 million in 1998 to reimburse the HCG plans that continued to provide coverage for past losses. The stipulation that past losses would be reimbursed only to plans that continued to participate helped ensure that all three plans remained in the program. In 1999, Senate Bill 1357 appropriated \$8 million from the tobacco tax revenue for FY 1999–2000, and \$8 million of tobacco settlement funds for FY 2000–2001 and each year thereafter.¹⁷ These monies constitute a reinsurance fund to cover large claims, and to reimburse health plans for their losses (see below).

Despite these state actions to stabilize the program, competition for the tobacco settlement funds makes HCG's future uncertain. Proposition 204, a ballot initiative passed in November 2000, utilizes the tobacco settlement monies for providing health care services to qualified Arizona residents up to 100 percent of the federal poverty level (FPL). As a result, legislation will be necessary to address the future of the HCG program. It is possible that the state will find alternative funding sources (e.g., tobacco tax money) for HCG or the new initiatives, or that HCG could be restructured or combined with other programs. If HCG is discontinued due to lack of funding, it is not yet known what will happen to current HCG enrollees. As a result of this strong sense of uncertainty, HCG administrators and participating health plans are considering various options. HCG funding is assured through June 2001.

Program Description

Eligibility and Enrollment

Businesses are eligible to buy HCG coverage if they:

- have been located within the state for at least the prior 60 days;
- have 2–50 employees or are self-employed individuals working full time (defined as working at least 32 hours per week); and

¹⁶ One participating health plan stated, after giving formal notice to the state of its intent to leave the program, that if the state did not provide additional funds, it was contractually obligated to send letters to enrollees informing them of the situation.

¹⁷ An assessment on all health insurers to fund a reinsurance pool was considered but was widely opposed by the insurance industry and was rejected.

- achieve 100 percent participation of eligible employees if firm size is one to five employees;¹⁸ or
- achieve at least 80 percent participation of eligible employees if firm size is six or more employees.¹⁹

There are no requirements related to business revenue or employee income, and there is no look-back period. Participating health plans are required to accept all full-time workers in small firms regardless of health status.

As of September 2000, 11,622 persons from 3,623 small business groups were enrolled in HCG.²⁰ Among enrollees are 2,502 dependent children. The average employee member of HCG is between 50 and 59 years old, has a family size of 4.3, and earns \$20,000 to \$29,000 per year. The average employer offering HCG coverage enrolls 1.8 employees, with 91 percent of HCG's enrollment consisting of groups of three or fewer employees. Micro groups are HCG's main customers—the average group size (including dependents) is 3.2 persons.

The Benefit Package

The three participating health plans (one operates in all Arizona counties, the others in a subset of counties) are required to cover inpatient hospital services, outpatient services, physician visits, prescription drugs, lab/radiology/imaging, and emergency and ambulance services. All health plans have similar benefit packages, and offer a choice of deductible and copayment levels.

There is no medical underwriting at the time of enrollment. Rates and annual increases are based on actual cost of services for the entire HCG pool. Premiums are based on modified community rates, determined by the level of cost-sharing selected by the employer, the age of each enrollee, and the tier selected (employee-only, employee plus one dependent, and employee plus at least two dependents).

The state does not directly subsidize premiums, which are fully paid by employers and/or employees.²¹ There is no requirement that employers contribute a certain percentage of premiums—i.e., employers may provide their workers the vehicle for group coverage without actually contributing toward the cost of insurance. It appears that this is indeed occurring among many HCG employer groups that are not sole proprietors.

A number of program features aim to keep the cost of HCG coverage down. As with commercial plans, preexisting-condition limitations reduce reimbursable claims. HCG coverage is more bare-bones than commercial plans and thus is more affordable to many small businesses. Also, because HCG does not require that the employer contribute to the premium, it reaches some small businesses in which the owner cannot afford premium contributions. Despite these features, however, rising acuity of members' health status has led to rising premiums. Under modified community rating, the cost of HCG coverage for those at high risk is competitive with (medically underwritten) market rates, but HCG premiums are higher than market rates for healthy individuals.

Financing

The state did not provide funds when it authorized the program in 1982. Start-up costs were financed with a \$700,000 grant from the Robert Wood Johnson Foundation six years later. Employers and employees pay the full cost of premiums. Four dollars per member per month is deducted from plan premiums and given to HCG to cover administrative costs.

¹⁸ Employees with proof of other existing health care coverage who elect not to participate in HCG are not considered when determining this percentage if the other coverage is either other group coverage through a spouse, parent, or legal guardian, or is coverage available from a government-subsidized health care program.

¹⁹ Ibid.

²⁰ Given the evolution of HCG described above, program administrators do not have a projected enrollment figure with which to compare actual enrollment.

²¹ As described elsewhere, the state does subsidize coverage indirectly by reinsuring the participating health plans to keep them viable.

From its inception, HCG bought reinsurance from a commercial insurer, and participating health plans contributed premiums for the reinsurance and selected their own deductible levels (e.g., the reinsurer would pay all claims over \$20,000 or \$50,000). Nevertheless, the health plans incurred major losses. As noted earlier, the state appropriated \$8 million in 1998 to cover previous losses, and up to \$8 million from the state tobacco tax and \$8 million per year on a continuing basis from tobacco settlement funds to reinsure the health plans for large claims, and to cover future losses. The state self-insures (using the \$8 million annual appropriation) for claims between \$20,000 and \$100,000, and buys formal reinsurance for catastrophic claims of \$100,000 and above. Also, the health plans are permitted to earn up to a 2 percent profit, with any additional profit returned to the reinsurance pool (this has not yet occurred). Modest premium increases of about 7 percent by two of the plans are also helping to reduce losses.

The new reinsurance approach encourages the health plans to better manage the low- to normal-risk enrollees, holding the plans harmless for outliers. Premiums continue to be paid by employees and employers without direct state subsidies. The program does not receive federal funding.

Program Administration and Marketing

HCG is a separate organization within the Arizona Health Care Cost Containment System, the state's Medicaid program. HCG also administers the Premium Sharing Program (PSP), a three-year, four-county demonstration that provides subsidized HMO coverage to uninsured low-income people who are ineligible for Medicaid.²² The same HMOs that participate in HCG also offer the subsidized coverage to PSP beneficiaries. When this pilot program ends in October 2001, it is possible that it will be made into a permanent, statewide program.

Unlike other public health programs, the state does not actively market HCG or conduct all of the administrative functions. Rather, the participating health plans employ brokers who sell the coverage, determine eligibility for the groups, and send the enrollment information to the state for approval.²³ The state enters the data into the HCG information systems database, conducts billing and collections, handles the financial accounting, maintains the reinsurance program, and ensures health plan compliance with program rules.

Given the uncertainty about the future of the program, two of the participating health plans, Mercy Healthcare Group and Arizona Physicians, have ceased active marketing of the program. Some new enrollment continues, however, based on word-of-mouth endorsements from current or past enrollees. A third health plan, University Physicians (affiliated with the University of Arizona Medical Center) continues to actively market in the southern part of the state.

Accomplishments, Obstacles, and Lessons Learned

Policymakers and health plans can learn from the unintended consequences of actions by both the state and the private carriers that offer HCG coverage. Increasing the minimum hours worked per week for HCG eligibility had mixed results and may not have strengthened the program as intended. The more stringent eligibility criteria eliminated higher-risk early retirees, but also eliminated younger, healthy students who worked part-time and who kept the average health risk of the HCG population down. This underscores the need for a thorough understanding of the characteristics of the populations involved.

After two health plans informed the state that they would leave the program absent additional funding, they sent letters to their HCG enrollees informing them of the situation. This led many lower-risk businesses and enrollees to flee the program. Higher-risk enrollees who were unable to buy affordable

²² See Silow-Carroll, Anthony, and Meyer, 2000, for a description of the Premium Sharing Program.

²³ One participating health plan reported that a major direct marketing campaign, which included television and other media advertising, was not very successful, concluding that small businesses purchase insurance almost exclusively through brokers.

commercial insurance elsewhere remained in the program, further destabilizing HCG. In hindsight, it was acknowledged by administrators that a verbal notice to the state would not have obligated the health plan to send letters to members and might have averted the panic that ensued. This experience underscores the need for health plans and state administrators to work together to address and resolve problems before they reach a crisis level.

Overall, HCG's experience exemplifies some of the risks of trying to insure a population that commercial insurers have traditionally tried to avoid. Those very features that make group coverage accessible to very small businesses and uninsured workers—guaranteed issue, availability to groups of one, no medical underwriting, community rating—also open the door to adverse risk selection.

Much of HCG's experience points to the need for serious, continuing public commitment—including financial commitment—to programs geared toward the working uninsured. Whereas it appears that the state of Arizona had to bail out the HCG program, it should be kept in mind that most state programs for the uninsured have received public funding from the start. (HCG managed to remain fully paid through employer and employee premiums for the first 10 years of its existence.) It may be that states need to acknowledge from the beginning the need to appropriate funds to subsidize large claims and thereby keep premiums affordable for lower-risk individuals (a back-end approach), or subsidize premiums for low-income employees or small employers (a front-end approach). Otherwise, the program may evolve—as HCG did—into an unofficial high-risk pool, with an ever-increasing need for public financing.

The fact that the Arizona state legislature mandated HCG in 1982 but did not appropriate start-up funds—thereby delaying its implementation for six years until private funding was procured—also emphasizes the need for a strong public commitment. Finally, the uncertain future of the program (depending on new legislation designating a new funding source), underscores the need for stable, long-term financing.

HCG clearly has made inroads in reaching thousands of working people in need of health insurance coverage, but the total number of uninsured in Arizona has continued to increase. While HCG has established a niche offering group insurance to very small businesses and self-employed individuals, it appears that at best it should be a part of a larger, comprehensive plan to address the problem of uninsured and uninsurable residents.

Contact for More Information

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Iowa

Health Insurance Premium Payment (HIPP) Program

Iowa operates the oldest and one of the largest Health Insurance Premium Payment (HIPP) programs. Authorized under Section 1906 of the Social Security Act, HIPP programs subsidize enrollment in employer-sponsored private health insurance for Medicaid-eligible individuals—and their families—who have access to such coverage and for whom it is cost-effective (compared with the cost of regular Medicaid coverage). States are authorized to spend Medicaid funds on premiums, deductibles, and coinsurance for job-based coverage, and are required to provide wraparound services for Medicaid-eligible beneficiaries if the employer's benefit package is more limited than the state's Medicaid package.

Among the states with HIPP programs, three (Iowa, Texas, and Pennsylvania) are considered to be “aggressive.”²⁴ Even with these programs, however, HIPP beneficiaries represent less than 1 percent of the total Medicaid population. Small enrollment numbers are attributed to several factors: most Medicaid-eligible persons do not have access to employment-based coverage; it is difficult for the state to identify Medicaid applicants or enrollees with access to job-based insurance; and it is difficult to obtain needed information from the employer and applicant.

This example of a HIPP program is included because although the program targets those eligible for Medicaid (versus uninsured workers, the focus of these profiles), a significant portion of HIPP beneficiaries are non-Medicaid-eligible family members (about 35 percent in Iowa). Many of these family members are working parents of Medicaid-eligible children, parents who are unable to afford their share of employment-based insurance premiums, and who would be uninsured without HIPP. As of August 2000, about 8,000 people participated in the HIPP program, including 5,500 Medicaid-eligible individuals and 2,500 non-Medicaid-eligible family members.

Background and History

Iowa's HIPP program started in 1991 and now operates statewide. It was created in response to Section 1906 of the Social Security Act, enacted in the Omnibus Reconciliation Act (OBRA) of 1990. Section 1906 mandated that states buy employer-based group health coverage for Medicaid-eligible individuals using Medicaid funds if such insurance is available and is more cost-effective than continuing to provide coverage under Medicaid. In addition, states were required to purchase health coverage for non-Medicaid-eligible family members if that were necessary for the Medicaid-eligible person to obtain group coverage, and if it were still cost-effective. Program planners in Iowa also initially considered an initiative that would have targeted certain high-risk populations with high medical costs, but instead chose to develop the program that is now in place because it is more inclusive. State legislation to develop and implement HIPP was unnecessary.

Although OBRA 1996 changed Section 1906 to a voluntary provision, the response to HIPP in Iowa has been strong. When it began in 1991, only two state employees managed it. Subsequent enrollment has grown so much that 17 employees now manage the program.

²⁴ As of June 2000, Iowa, Massachusetts, Mississippi, Pennsylvania, Texas, and Wisconsin operate or are planning to institute HIPP programs. See Steinberg, D., *Expanding Health Coverage to Working Families: State Options*, National Conference of State Legislatures, June 2000.

Program Description

Eligibility

The targeted beneficiaries are Medicaid-eligible persons who are offered (or have access through a family member) employment-based health insurance.²⁵ All HIPP beneficiaries must:

- be eligible for Medicaid or be a household family member of a Medicaid-eligible individual;
- be offered employer-sponsored coverage; and
- qualify based on cost-effectiveness criteria.

The purpose of HIPP is to enable Medicaid-eligible people to enroll in employer-based insurance when it is cost-effective compared with the cost of traditional Medicaid. In Iowa, this means that enrolling the individual or family would save the state at least \$5 per month compared with paying the medical expenses of the eligible person/persons through the regular Medicaid program. The procedure for assessing cost-effectiveness is discussed in more detail in the section on outreach and enrollment. Participation in HIPP is mandatory if a Medicaid-eligible person is offered employer-sponsored coverage and the state determines it is cost-effective for him or her to enroll in the employer's plan.

Since the Medicaid-eligible individual may only have access to employer-sponsored coverage through a family member, Section 1906 allows states to buy employer coverage for those non-Medicaid-eligible family members if doing so allows the Medicaid-eligible individual to enroll in employer-sponsored coverage. The HIPP program will pay for the minimum coverage option that allows the Medicaid-eligible person/persons to be covered. For example, if the employer offers single, single plus dependents, and family coverage and the Medicaid-eligible individual is a child, HIPP will pay for the employee and the dependents (including the Medicaid-eligible child), but not the spouse. If the employer only offers single and family coverage, and the Medicaid-eligible individual is a child, HIPP will pay for family coverage. More than 75 percent of families covered under HIPP are families in which mothers and/or children (primarily children) qualify for Medicaid under the Temporary Assistance to Needy Families (TANF) eligibility guidelines.

When the local Medicaid office becomes aware of a Medicaid-eligible person who is enrolled in or who could be enrolled in private employer-related health insurance, it makes a referral to the HIPP unit. As a result, the HIPP office receives notice of Medicaid-eligible individuals, regardless of their current insurance status, and tries not to miss anyone who is eligible.

In some cases, Medicaid-eligible individuals and their families who do not have access to employer-sponsored insurance may enroll in nongroup private insurance plans if coverage through those plans is more cost-effective than Medicaid. Participation for this group is not mandatory, and approximately 10 percent of HIPP enrollees obtain coverage through a nongroup plan.

²⁵ Not all types of plans are eligible to participate in HIPP. The HIPP program will not pay for premiums when: 1) the policyholder does not live in the household with the Medicaid-eligible person; 2) the insurance plan is an indemnity plan that pays only a predetermined amount for covered services; 3) the plan is a school-based plan offered based on attendance or school enrollment; 4) the premium is used to meet a spend-down obligation for the Medically Needy program if no one in the household is categorically eligible for Medicaid; 5) the plan is only offered for a temporary time period; 6) the eligible individual does not qualify for full Medicaid benefits; 7) the insurance plan is through Iowa's high-risk pool; or 8) the insurance plan is a Medicare supplemental policy (if the HIPP application was filed after March 1, 1996).

The HIPP program is available only to people who are categorically eligible for Medicaid.²⁶ Therefore, children eligible for the State Children's Health Insurance Program (CHIP) cannot obtain coverage through the HIPP program, and thus cannot bring their parents into HIPP-subsidized coverage.

Covered Services

Medicaid-eligible HIPP participants are entitled to the full Medicaid benefit package offered to other Medicaid enrollees in Iowa. If their private plan does not cover the full range of Medicaid services, the enrollees receive wraparound services from Medicaid providers. Non-Medicaid-eligible family members are not eligible for the wraparound services.

HIPP participants access services either through their employer's health plan or their nongroup plan. HIPP enrollees must visit providers who are both associated with the private plan and who have contracted with Medicaid. For most enrollees, this has not been a problem because they have been able to locate providers in their private plan who accept Medicaid reimbursement. In the few instances where there were no providers in the plan who accepted Medicaid, the enrollee reverted back to traditional Medicaid. At the time of the office visit, enrollees present both their private insurance card and their Medicaid card. Since Medicaid is the payer of last resort, the private insurance is always billed first and Medicaid is billed for services not covered under the private plan. Medicaid also covers any required deductibles and coinsurance for the Medicaid-eligible enrollees, but not for the other family members.

The one exception to this billing and payment system is for prescription drugs. There is great variation among private plans for prescription drug coverage. Many plans require that the participant pay for the prescription up front and submit the bill to the insurance company for reimbursement. For HIPP enrollees, the state felt that it was a financial hardship to require the insured individual to pay for prescriptions up front. Therefore, unless the individual's plan can be billed directly for the prescription, Medicaid pays for the prescription and the fiscal agent later arranges for reimbursement from private insurance companies.

Financing

The state pays the employee's share of the premium for family coverage using equal amounts of state and federal matching Medicaid funds. The employer may choose whether to receive HIPP payments for the employee's share of the premium directly, or whether payments should be sent directly to the employee to reimburse him/her for payroll deductions for insurance.²⁷ Over 90 percent of employers choose to have the employee reimbursed directly for the cost of the premiums. The HIPP unit generates these reimbursement checks and a mail service mails them two to five days before the employee's payroll deduction. This addresses cash flow issues and ensures that the participant is not penalized financially for HIPP participation. The program also reimburses the enrollees directly for deductibles and coinsurance if the enrollee has paid the deductible or coinsurance. Most often, however, claims are submitted to the private insurance company and denied because the deductible has not been met. Since the claim has been submitted to the insurance company and denied, Medicaid will then pay the claim. If a copayment is required of the client, the Medicaid provider does not require copayment from the client when services are rendered, but instead bills Medicaid.²⁸ Medicaid providers who provide wraparound services are reimbursed directly by the state.

²⁶ For an individual to be categorically eligible for Medicaid, he or she must qualify under one of the federally mandated or optional state categories of Medicaid eligibility. An individual who qualifies for a Medically Needy program under Medicaid as a result of a spend-down is not considered categorically eligible.

²⁷ As mentioned earlier, a small portion of HIPP beneficiaries receives subsidies toward individual private coverage, if it is available and cost-effective, and those individuals receive payments directly.

²⁸ Medicaid will only pay up to the preestablished Medicaid reimbursement rate and, as a result, the provider does not always receive full payment for services rendered. This accounts for the reluctance of some providers to contract with Medicaid.

If the HIPP participant receives coverage through a nongroup plan, the state pays the insurance carrier directly for the premium (unless the premium payment is made through an automatic bank account withdrawal and then the enrollee may be reimbursed directly).

Outreach and Enrollment

All income-eligible Medicaid applicants are screened to determine whether they have access to employer-sponsored insurance. If so, Medicaid eligibility workers forward the applications to the HIPP office, where workers generally conduct a cost-benefit evaluation. Applicants whose plan provides coverage for Medicaid-eligible pregnant women, or for whom their share of the premium costs \$50 or less per month for a one-person Medicaid-eligible household or \$100 or less per month for a household with two or more Medicaid-eligible individuals are immediately eligible for HIPP. The cost-effectiveness evaluation is initiated for all other applicants. The anticipated cost of the private insurance plan (including premiums and deductibles, with an additional HIPP administrative fee) is determined using information employers provide to the HIPP office. When HIPP began, employers were less willing to provide this information but have now grown accustomed to the program. In addition, the HIPP staff has information on file about a large number of plans so they no longer need to contact employers about each application.

The cost to the state of the employer-sponsored plan is compared with the cost of providing the same set of services under traditional Medicaid for a comparable Medicaid recipient (based on age, sex, federal reporting category, institutional status, and Medicare status). If there are savings of at least \$5 per month, the system recommends that the state buy employer coverage for the individual or family. If there is not a savings of \$5 a month, the applicant is sent a Medical History Questionnaire to determine if there are any chronic health conditions that would result in higher medical costs. Upon learning that there is a chronic medical condition, program planners will take those added medical expenses into consideration and make a manual determination of cost-effectiveness.

If it is deemed cost-effective to subsidize the applicant in the employer-related plan, the applicant is required to enroll in the private plan (if the employee must wait for an open enrollment period, regular Medicaid coverage continues until enrollment occurs). Cost-effectiveness is redetermined annually and the HIPP participant must remain in the program as long as it is cost-effective for the state. If there are changes during the year, such as a change in employment status or insurance coverage, the HIPP enrollee must report the change to the HIPP office. Although the HIPP enrollee is ultimately responsible for reporting changes (the HIPP program has no authority to mandate that employers report changes), many employers do report changes on a regular basis. Medicaid eligibility is monitored daily via a computer system and when Medicaid eligibility ends, a report is generated and sent to the HIPP unit. Cost-effectiveness is recalculated whenever notice of changes is received from the enrollee, the employer, or the Medicaid office.

The state does not actively market HIPP to employers or potential enrollees, although HIPP staff gives presentations about the program to community groups. A HIPP brochure is included in Medicaid application packets, and Medicaid-eligible workers are educated about the program. HIPP program planners are continuing to work on outreach strategies because right now the HIPP program relies heavily on referrals from county staff. To encourage participation, HIPP staff is developing a website that will provide information about the program. One group that the HIPP program would like to target is children who are chronically disabled and have high medical expenses. Many of those children have insurance, but their parents may not realize that they are eligible for HIPP and could have some assistance in paying their health care costs without losing their current employer-sponsored or nongroup coverage.

Although no specific enrollment goals were set when the program began, program planners say that the response was overwhelming and there has been sustained interest in the program. About 8,000 people were enrolled in HIPP-subsidized employment-based health plans as of August 2000. About 5,500 of these were Medicaid-eligible, and 2,500 were non-Medicaid-eligible family members. These numbers

fluctuate, as there is high job turnover in this population. When HIPP enrollees lose their employer-sponsored coverage, they return to the traditional Medicaid program.

Accomplishments, Obstacles, and Lessons Learned

One problem identified when the program began was that employers were resistant and did not want to share information about their benefit plans with the HIPP program. Now, however, employers are more accustomed to the HIPP program and are more cooperative. Some will even call the HIPP office when there are changes in their benefits so the staff can update records and recalculate cost-effectiveness if necessary. When the program began, employees also were wary because they were used to traditional Medicaid, liked it, and found it easy. Enrolling in the HIPP program took more effort and responsibility. Program staff now believe that employees are more used to the idea of participating in the HIPP program.

The HIPP program's primary goal was to save the state money, and it has consistently done that—savings amounted to \$18 million in 1999 and are estimated at \$19 million for 2000. These savings estimates, however, are calculated based on a 1992 study that showed that every dollar spent in the HIPP program saved Medicaid \$3.30. Program planners hope to update the 1992 findings for a more current estimate of savings. The state will finance the study and HIPP will conduct it. Given that it is reaching its goal, there is every expectation that the HIPP program will continue in its current form. This is particularly true given that the emphasis in recent years has been on programs like CHIP and so the state has been more focused on those initiatives instead of on tinkering with the successful HIPP program.

Although HIPP was initially intended to reduce Medicaid costs, there have been several beneficial by-products. One is that since people are able to access insurance through their employer, they still have access to insurance and are able to maintain continuity of coverage even if they lose their Medicaid coverage. These enrollees may have had access to employer-sponsored insurance before they joined the HIPP program and just opted not to take it. However, according to program planners, once people have been enrolled in that insurance with the Medicaid subsidy, they may be more likely to continue with the coverage even when they lose Medicaid eligibility. In addition, since Medicaid-eligible individuals may bring in otherwise non-Medicaid-eligible family members, there are more people with insurance coverage. And, since the entire family is enrolled in the same insurance plan, everyone can go to the same providers and learn how to navigate and use the health system together. Thus, HIPP programs offer one avenue for states to expand employment-based coverage to low-income workers, while achieving cost savings, receiving federal matching funds, and keeping families together in one insurance plan.

It is important to remember, however, that the nature and requirements of this type of program mean that it will reach only a small portion of working uninsured since relatively small numbers of workers qualify for Medicaid. Therefore, HIPP should not be viewed as a potential solution to the access problem per se, but rather as one way to use federal and state dollars (as well as to save money) to insure some low-income people through private, employer-sponsored insurance. The majority of working uninsured people would not be eligible for HIPP programs even if all states enacted them and were aggressive in enrolling eligible people.

Contact for More Information

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Massachusetts

MassHealth Family Assistance Program: Premium Assistance and Insurance Partnership

The MassHealth Family Assistance Program (FAP), established by the Massachusetts' Division of Medical Assistance, is designed to make employment-based coverage affordable to low-income employees and self-employed individuals, and to encourage and assist small employers in offering health insurance to low-income workers. The program provides subsidies to families and employers regardless of whether they have been previously insured or providing coverage. The program is financed in part with federal funds (Medicaid and CHIP) and in part with state money. While the combination of funding streams requires complex coordination of reimbursement and regulatory requirements, FAP offers families and employers a straightforward, seamless subsidy program.

FAP has two components:

- The *Premium Assistance Program (PA)* offers subsidies to help low-wage workers (those with incomes up to 200 percent of the FPL) pay their shares of employer-based insurance premiums;
- The *Insurance Partnership (IP)* offers subsidies to small businesses to help pay for health insurance premiums for low-wage workers and to low-income, self-employed individuals.

Background and History

In 1994, Massachusetts submitted a Section 1115 waiver request for the MassHealth program (the state's Medicaid program) to the Health Care Financing Administration. The state proposed a number of rule simplifications and expansions aimed at improving health care access for low-income residents. Part of this initiative was the design of the Family Assistance Program, a two-part plan geared to improve access to MassHealth and to reduce costs to the state's uncompensated care pool by subsidizing employment-based insurance coverage. The waiver was approved in 1996 and runs through 2002.

The federal CHIP initiative was launched soon after, and the state incorporated the new children's coverage program with its enhanced 65 percent matching federal contribution into its existing Medicaid program, MassHealth.²⁹ The state then had to decide whether to try to include CHIP funding and meet its guidelines in the premium assistance part of FAP. After much discussion, the state decided to do so. However, working out details with the federal government delayed the program's implementation for one year.

FAP was implemented in three phases:

- *Phase 1:* In 1998, the Premium Assistance (PA) part of the program began subsidizing workers' contributions toward employer-based insurance; this phase was limited to low-income employees who have children and who work in large businesses (more than 50 employees). This phase was and continues to be administered by the state's Division of Medical Assistance.
- *Phase 2:* In 1999, PA expanded to workers in very small firms (fewer than 10 employees) that buy coverage through Billing and Enrollment Intermediaries (BEIs, described further below). Also, the Insurance Partnership (IP) began subsidizing the employers' contributions toward premiums for these low-income workers in small firms and for self-employed individuals.

²⁹ Funding for the regular Medicaid program involves a 50 percent federal match.

- *Phase 3:* In January 2000, full implementation of PA and IP subsidies began for workers and employers of firms with 10 to 50 employees. Marketing and administration has been contracted out to an insurance brokerage firm, Employee Benefit Resources Insurance Brokerage, Inc. (EBR).

Premium Assistance Program

PA Eligibility Criteria

The PA component targets families of low-income workers in small businesses (those with fewer than 50 employees), low-income workers with children in any size firm, and low-income, self-employed individuals. PA covered approximately 12,000 lives in September 2000. This included about 7,400 covered lives under more than 3,000 policies through Phase 1 (workers in firms with more than 50 employees). About 4,600 people are subsidized through Phases 2 and 3 (workers in small firms and the self-employed).

Among workers in small firms, there was a net growth of approximately 200 to 220 enrollees per month during the latter half of 2000, reflecting the number of new enrollees minus the number of people who disenroll due to change or loss of jobs, or when a small firm goes out of business.

To be eligible as a qualified worker, a person must:

- live in Massachusetts;
- be age 19 through 64;
- be self-employed, or work full time or part time for a qualified business with no more than 50 full-time employees; or
- work for any size business and be of any age if one has children;
- have comprehensive health insurance (meets program benefit guidelines) through one's employer;
- have an employer who pays at least half the cost of the premium; and
- have gross annual family income that does not exceed the following amounts:³⁰

<i>Family size</i>	<i>Maximum income</i>
1	\$16,704
2	\$22,500
3	\$28,308
4	\$34,104
5	\$39,900

In addition, the state must determine that the subsidy is cost-effective—i.e., that it is less expensive to subsidize family health coverage through the employer-sponsored plan than it would be to provide direct MassHealth coverage to the family members (generally children) eligible for Medicaid or CHIP.

³⁰ Amounts are valid through March 31, 2001, and will be adjusted annually based on 200 percent of the federal poverty level.

The children in these families are enrolled directly in the MassHealth public program if employer coverage that meets the benefit guidelines is not available, the employer does not contribute at least 50 percent of the premium, or if the arrangement is not cost-effective.

PA Subsidy Amount

The subsidy covers the full employee contribution toward employer-sponsored health coverage for workers with gross incomes between 133 percent and 200 percent of the FPL, except for the following, which the worker must pay:

- Family with children: \$10 per month per child, up to a maximum of \$30 per family (including parents)
- Family without children: \$25 per month per adult, \$50 per couple

If family income is below 133 percent of the FPL, the subsidy covers the entire cost of the employee's share of the premium for the commercial insurance plan, and the state provides wraparound coverage for the services included in the Medicaid program that are not part of the employer's benefit package.

PA Financing

PA is financed through a combination of state and federal Medicaid funds (50 percent federal match rate), and CHIP funds (with the enhanced 65 percent federal match rate). CHIP finances subsidies for PA enrollees who meet certain conditions including: the enrollee is a member of a family with children that was previously uninsured; the family's income is from 150 to 200 percent of the FPL; the employer-sponsored insurance plan meets a defined benchmark plan; the employer contributes at least 50 percent of premiums;³¹ and it is cost-effective for the state to subsidize private insurance premiums as opposed to enrolling eligible persons in the public CHIP program.

Medicaid funds are used to subsidize the remaining PA enrollees, primarily families who are already insured and have incomes from 150 to 200 percent of the FPL, and families with incomes up to 150 percent of the FPL.

Insurance Partnership (IP)

IP Eligibility

The Insurance Partnership is geared to encourage small businesses with low-income employees to offer health benefits. Businesses are eligible for the subsidy if they:

- employ 50 or fewer full-time (30 hours or more per week) workers;
- offer comprehensive health insurance to workers (it is not necessary that it is "new" coverage); and
- contribute at least 50 percent of the premium.

Eligible firms are paid a subsidy for each qualified employee, as defined in the PA section above.

Enrollment began on a limited basis in 1999 (Phase 2), but eligibility was expanded and a major enrollment campaign began in late January 2000 (Phase 3). As of September 2000, 1,620 employers have enrolled; IP subsidizes nearly 2,000 policies representing nearly 4,600 individuals (workers and family members). After six months of full implementation, about 60 percent of the participating firms are offering insurance for the first time; 40 percent had previously provided insurance coverage to their workers.

³¹ Massachusetts has federal approval for a 50 percent employer contribution under CHIP as opposed to 65 percent in the federal statute.

IP Subsidy Amount

IP pays \$400 (individual), \$800 (couple or adult plus child), or \$1,000 (family) per year toward the employer's health insurance costs for each qualified employee.

IP Financing

IP was financed by state-only funds through summer 2000. The federal government has held off on reimbursement under the Medicaid Section 1115 waiver until there is an indication that public dollars would not merely replace private dollars already being spent by businesses (crowd-out). The state planned to present the following arguments to HCFA in fall 2000: First, crowd-out is not occurring among the majority of the policies being subsidized (60 percent represent new coverage). Second, the percentage of Massachusetts firms that offer health insurance has been dropping steadily over the last 15 years, and state officials feel that the IP payments act as an incentive to keep employers offering this benefit. In sum, state staff believes that the IP program is designed to encourage more private sector coverage and should qualify for federal match through either the Section 1115 waiver or the Title XXI (CHIP) legislation.

Program Description

Outreach and Marketing

The regular MassHealth (Medicaid/CHIP) application process has identified many FAP participants. When a MassHealth applicant is determined to have access to employer-based health insurance, the case is referred to the Family Assistance division, which collects information necessary to determine PA eligibility. MassHealth outreach is also conducted through Health Access Network Coalitions, groups of advocates for the uninsured that include community health centers, legal aid organizations, and public hospitals.

In 1999 (Phase 2), marketing to very small firms began through Billing and Enrollment Intermediaries (BEIs), private entities created by state legislation that sell coverage to very small businesses (usually fewer than 10 workers) and provide continuing administrative support. Many firms with fewer than 10 employees that do provide health benefits to workers in Massachusetts buy coverage through BEIs, so these entities were a natural partner for FAP outreach.

Outreach for Phase 3 (to workers and employers of firms with 10 to 50 employees) has been contracted to Employee Benefit Resources Insurance Brokerage, Inc. (EBR), a private insurance brokerage firm that won a statewide procurement contract. In January 2000, EBR launched an advertising campaign designed to familiarize businesses, insurers, brokers and workers with the program. It included:

- mailings to insurance brokers and insurance companies;
- contacts with Chambers of Commerce;
- radio announcements;
- television commercials;
- mailings to nonprofit organizations with 50 or fewer employees;
- calls to small businesses by seven regional representatives;
- telephone cold calls followed with literature mailings to interested employers;
- print media (newspaper advertisements); and
- billboard advertisements.

If it is determined that a MassHealth applicant is employed in a small firm that does not offer coverage, either EBR or a BEI contacts the employer to ask if he/she would consider offering coverage

and receiving IP subsidies for eligible workers. If the employer is interested, EBR or the BEI helps the business find an appropriate health plan.

Enrollment and Administration

The Massachusetts' Division of Medical Assistance oversees FAP and administers the PA program for low-income workers in large firms (more than 50 workers). The state contracts with BEIs and EBR to administer, as well as market, the program for smaller businesses.

Phase 1: For workers in firms with more than 50 employees, the state obtains information from applicants and begins an "Insurance Investigation Period." This involves contacting the employer to obtain information about their current health plan, including details about benefits, the employer contribution, and total premium. Administrators report that in general, employers have been cooperative in providing information on a timely basis.

The state reviews the benefit package. If the family was previously insured, the benefits of the employer's health plan must meet the basic benefit level under the Medicaid Section 1115 waiver. If the family is uninsured, the health plan (either newly offered by the employer, or newly accepted by the worker) must meet Title XXI benefit and cost-sharing rules to receive CHIP reimbursement. Also, the state conducts a cost-effectiveness test to determine whether it is less costly to subsidize family coverage through the employer-based insurance or to enroll eligible family members directly in MassHealth. During this investigation period, uninsured children are presumed eligible, and are enrolled in fee-for-service MassHealth coverage for up to 60 days.

In addition to income and coverage information from employees and employers, the state receives monthly enrollment files from the largest commercial carriers in the state, and conducts an automated data match to determine whether program applicants are currently insured. The state also conducts a quarterly audit to verify continuing coverage for workers and firms receiving subsidies.

PA subsidies to workers in large firms are paid directly to eligible families. They are invisible to employers, so as to reduce the likelihood of employers reducing their contributions for families receiving public subsidies, and to avoid placing an extra administrative burden on the employer. Further, the subsidies are prepaid each month to avoid a cash-flow problem for low-income families.

Phase 2: The BEIs conduct enrollment and provide continuing administrative support for very small firms. The BEIs collect information necessary to determine eligibility for the employer, and verify continuing insurance coverage. Employee eligibility uses the same eligibility process as other MassHealth programs. Both PA and IP subsidies are funneled through BEIs, which withdraw state funds from a special state account. For each employer, the BEI collects money from the state account for the appropriate subsidy amount (which covers part of the premium); then it collects the remainder of the premium from the employer; and then it pays the entire premium to the insurance company. The employers must make appropriate adjustments to the amounts they collect (generally through payroll deductions) from participating workers.

Phase 3: EBR administers the subsidies for employers and workers in firms with up to 50 employees, including very small firms and self-employed people who do not buy coverage through BEIs. EBR reviews applications, conducts employer enrollment, and disenrollment, forwards employee applications to MassHealth, and sends subsidy payments to participating employers.

Each month, a participating employer receives a check or an electronic bank deposit that includes the IP payment and PA payments for qualified employees. These payments cover the following month's premiums, to avoid cash-flow problems for employers and workers. The employers must reduce the payroll deduction from qualified workers when they collect the employees' contributions toward the premiums. The employers submit total premium payments to insurers/health plans.

If an employer stops offering coverage or the employee leaves the job, the employee and/or eligible family members are helped to make the transition to the regular MassHealth program.

Accomplishments, Obstacles, and Lessons Learned

One of the most significant accomplishments of the MassHealth Family Assistance Program is that it successfully weaves together different funding sources and meets a variety of regulatory requirements in a way that is invisible to beneficiaries. For example, low-income working families who have been previously uninsured—eligible under the CHIP program—and those who have had employer-based coverage—eligible under the Medicaid Section 1115 waiver—undergo the same application and enrollment procedures, and receive the same level of subsidies. Further, a single entity (BEIs or EBR) coordinates and administers both PA and IP payments, even though the employer subsidy is financed through state-only funding sources.

FAP's two-pronged approach makes this state program unique. While a number of states are developing premium assistance programs to help workers afford their shares of employer-sponsored coverage, such subsidies are not helpful if employers do not offer health benefits. The reverse is also true—some states have used subsidies for employers but have not assisted workers. Together, PA and IP address the two major obstacles facing low-income, working families: lack of access to employer-sponsored health coverage, and inability to afford their share of the premium when work-based coverage is offered.

FAP is unusual because it does not have a look-back period—i.e., it does not require that workers be uninsured, or employers be offering coverage for the first time in order to be eligible for subsidies. The risk of this policy is crowd-out—public dollars will merely substitute for private dollars spent for health coverage, without necessarily increasing the number of insured people. The benefit is that firms that have provided coverage in the past (and workers who have struggled to maintain coverage) are not penalized for acting responsibly. State administrators are encouraged to know that approximately 60 percent of businesses that receive subsidies were previously uninsured. While it is possible that some of these firms were planning to begin coverage anyway, it appears that the extra incentive to employers may be enough to motivate many of them to begin offering health benefits or to continue to offer benefits if they were considering dropping coverage.

Both the state and the primary contractor that administers FAP are very pleased with the program's progress to date. Administrators had expected to enroll 100,000 during the first year of full implementation, but have revised the projected time frame for this enrollment level to two to three years. Disenrollment has occurred faster than expected, apparently because of the mobility of the target population, and small firms that go out of business. A major challenge is how to improve continuity of coverage for a population that makes frequent job changes.

State officials cite another challenge related to improving the efficiency of the program's marketing efforts: to better identify firms with a large portion of qualified workers. Outreach efforts aimed at all small firms regardless of the income of employees are less efficient than focusing on businesses with a high portion of low-income, potentially qualified employees.

It is too early to assess the program's full impact. Assessment is hindered by the lack of up-to-date data sources (the state only recently obtained baseline coverage information for the pre-waiver period). It may take two to three years to determine the effect on the total number of uninsured, or on the portion of small employers offering coverage to their workers. Meanwhile, it does not appear that the program is at risk of being discontinued. The next time the state legislature takes up the program, there will be an estimated 30,000 covered lives, and it is unlikely the state would discontinue a program of this size.

Contact for More Information

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New Mexico

New Mexico Health Insurance Alliance

The state legislature created the New Mexico Health Insurance Alliance (NMHIA) in 1994 to make private health insurance more accessible to very small businesses, to self-employed people, and to individuals (both employed and unemployed) who lose their group health coverage. Administered by a nonprofit public corporation, NMHIA has contracts throughout the state with 12 insurance carriers that offer HMO or indemnity plans. Coverage is available to businesses that are too small to obtain commercial group insurance, and guaranteed issue and community rating (for the majority of enrollees) has helped to make insurance attainable for many.

Risk is managed through reinsurance and a periodic assessment of the 400 health-insurance carriers in the state. Despite these risk-sharing mechanisms, participating carriers have generally considered NMHIA business unprofitable and in competition with their commercial business. In late 2000, some carriers successfully persuaded NMHIA's board to eliminate community rating and other rate protections beginning in January 2001. This will raise premiums significantly for most NMHIA enrollees and is expected to result in some disenrollment in coming months. Some see the board's action as an adjustment that was necessary to make premiums better reflect the costs of the enrollee pool; others interpret it as a way for the carriers to undermine the program. As a result, NMHIA ended 2000 in some turmoil, with its future uncertain.

As of November 2000, NMHIA covered approximately 8,500 lives through 1,800 small business accounts and 1,900 individual policies.

Background and History

The NMHIA was designed to fill gaps and meet needs specific to the state. New Mexico has one of the highest uninsured rates in the country, a Medicaid program with very stringent income requirements, and an average per capita income that is one of the lowest in the United States. Most of New Mexico's businesses are small—96 percent of firms have 50 or fewer employees, and 60 percent have four or fewer. About 600,000 of the 700,000 workers are employed, often part-time, in service industries, which have low rates of employer-sponsored health insurance. Also, state residents apparently value choice and prefer private sector solutions to public sector solutions.

In response, NMHIA works with private health insurers to offer a basic health insurance package with these features:

- Available to small and very small groups (e.g., a self-employed individual plus one enrolling dependent is considered a "group")
- Open to employees working as few as 20 hours per week
- Employer contributions are not required
- Guaranteed issue
- No medical or industry underwriting
- Rates guaranteed for one year
- Only 50 percent of eligible employees are required to participate
- Available to individuals who have lost their group coverage

- Choice of private plans and providers

Guaranteed issue means all eligible groups and individuals may obtain coverage regardless of medical history or risk, and participating health plans cannot charge higher premiums because of the health status of members of a participating group (as they can to small groups outside NMHIA). While these features make the program vulnerable to adverse risk selection, a reinsurance fund protects participating health plans from losses, and risk is shared among virtually all health insurers in the state (see below).

Though established by the state legislature, NMHIA is considered (and valued as) a private market solution, and an alternative to a single-payer system. Mandated in 1994, the program began enrollment in 1995, and is scheduled to sunset in June 2002. The NMHIA board has recommended that the program continue, but the final decision rests with the state legislature, which will vote in February 2001 on whether to extend the program.

After the first few years of the program, enrollment was flat at about 3,700 covered lives. Losses of about \$1 to \$2 million per year caused concern because they were considered high given the number of insured, and insurers were uneasy since they were also experiencing losses in the commercial market. A new marketing campaign that involved informing brokers throughout the state, training agents, and meeting with the CEOs of insurance carriers helped NMHIA enrollment more than double from 1998 to 1999.

However, the sudden growth in enrollment gave rise to fears of adverse selection (note that in Arizona HCG's experience, it was a sudden fall in enrollment that raised concerns of adverse selection). With the support of the carriers and the Department of Insurance, NMHIA conducted a three-month investigation that found that some businesses were indeed buying individual coverage for healthy employees and NMHIA coverage for higher-risk employees. In response, NMHIA is monitoring enrollment and annual recertification more closely, and there are indications that the incidence of adverse selection has waned.

Meanwhile, the carriers continued to complain that NMHIA business was unprofitable (particularly in the area of reimbursement for administrative expenses), and community rating was keeping premiums artificially low. The participating carriers also saw NMHIA as a competitor of their commercial business. Influenced by carrier representatives on the NMHIA board of directors, the board decided in fall 2000 to discontinue community rating, a 5 percent rural discount, and other rate protections.³² This will move about 80 percent of NMHIA business from community rating to age-adjusted rating (the rates will still not reflect health status), and premiums are expected to double on average, with some accounts experiencing rate hikes of 164 to 204 percent. Groups with younger workers will see rate reductions.

Some in New Mexico contend that this decision reflects the disgruntlement of participating carriers, who were trying to undermine the program and reverse its recent growth. Others view the action as a way to better align premiums with the actual risk of NMHIA enrollees, ultimately strengthening the program. All acknowledge that disenrollment will occur over coming months. An NMHIA administrator projects that about half of enrolled businesses (particularly older, self-employed individuals) will not renew coverage when faced with large premium increases in 2001, leaving most, if not all, of these workers and their families uninsured. Massive disenrollment may lead to a negative decision about whether to extend the program beyond its scheduled 2002 expiration, despite the board's recommendation to postpone or eliminate the sunset provision. Clearly, the future of the program is uncertain, and some type of reorganization is possible.

³² The NMHIA board of directors comprises five directors elected by insurance carrier members, five governor-appointed employer directors, four governor-appointed employee directors, and a superintendent/designee as board chairman.

Program Description

Eligibility

Employers are eligible to buy an NMHIA health plan if:

- the business has from two to 50 eligible employees (working at least 20 hours per week), or if the employer is self-employed and is buying insurance for him- or herself and at least one family member;
- at least half of eligible workers enroll in an NMHIA plan; and
- the employer does not offer group coverage other than NMHIA plans to eligible workers.

Individuals are eligible to buy an NMHIA health plan if:

- their last coverage was group health insurance, a church plan, or a governmental plan;
- they have had at least 18 months of basic health insurance coverage;
- there was no more than a 62-day lapse in prior coverage;
- they participated in but have exhausted either state continuation or COBRA options, if available; and
- they are not eligible for an employer group health plan.

Benefit Package

The benefit package includes hospital, physician, outpatient, maternity, preventive, wellness, and emergency benefits, and limited prescription drug coverage. The HMO plans have a \$20 copayment, and formulary prescription drugs include a \$15 copayment. The indemnity plans offer a choice of deductibles (\$500, \$1,000, \$2,500 and \$5,000), coinsurance, and out-of-pocket maximums. The indemnity plans have a lifetime maximum of \$2 million per covered life. The HMO plans have no lifetime maximum. Employers may change the plan they offer, and individuals may change the plan they select, on an annual basis at renewal. Rates are updated two times per year for new and renewing groups. Rates are guaranteed for renewing accounts for the year unless there is an age bracket change, which becomes effective on the first of the month following a birthday.

NMHIA HMO enrollees who leave New Mexico have been able to convert to an NMHIA indemnity plan and continue coverage indefinitely (those already enrolled in NMHIA indemnity plans may remain in those plans). On average, people who leave the state maintain NMHIA coverage for about one year. However, the board plans to eliminate this option for new accounts beginning this year.

Participating Health Plans

Twelve private insurance carriers participate in NMHIA. Participation is mandatory for insurance companies that cover public employees or retirees, and voluntary for all other carriers. The insurers may offer either a managed care (HMO) or indemnity product with similar benefits. Only an indemnity plan is available in some rural areas, but there is a choice of plans in most parts of the state. Insurance carriers are protected against losses resulting from NMHIA participation (see below).

Administration

NMHIA and participating carriers shared administrative functions until January 2001. NMHIA served as a nonprofit third-party administrator, responsible for: sales, underwriting (while there is no medical underwriting, there is significant eligibility underwriting due to the gaming and adverse-risk-selection issues), broker bonus/reimbursement policy, rating and rate-filing coordination, enrollment, renewals, invoicing, premium disbursement, and assessments on carriers. The NMHIA board defines benefit design, which changes periodically. Participating carriers were and are responsible for: customer service, utilization management, claims administration, benefit administration (identification cards and certifications), broker

commission payments, network development and other managed care functions. Enrollment and billing functions have now shifted from NMHIA to the carriers.³³

Financing and Risk Sharing

Before the board discontinued the policy in fall 2000, about 80 percent of NMHIA accounts were community-rated, based on the average small group rate in New Mexico (the remaining 20 percent were age-adjusted). Employees, employers, and individuals pay monthly premiums of approximately \$1.5 million; there are no state or federal subsidies. The majority of employers contribute a portion of the premium for employees, but often less than the commercial market requirement of 50 percent. Affordability is a concern—while there is much variation in income among enrollees, the majority earn less than \$30,000 per year. Many employees do not sign up because their employers do not contribute anything, and even when some employers contribute 60 percent of the premium, employees who make minimum wage still cannot afford coverage.

NMHIA withholds a reinsurance premium from all premiums. For small groups, this amounts to up to 5 percent in the first year of coverage and up to 10 percent in renewal years; for individuals, withholding is up to 10 percent of premiums in the first year and up to 15 percent for renewal years. NMHIA also deducts an administrative charge to cover its own expenses. This amounts to up to 10 percent in the first year and 5 percent in renewal years for small groups and up to 10 percent of premiums in any year for individuals. The average reinsurance withhold for the overall premium has been 10 percent, while the average overall withhold for NMHIA administration is 7 percent. The 2001 administrative fee will be reduced to a flat 3.5 percent for new and renewing groups and individual accounts, both for simplification and in response to carriers' complaints that their own administrative costs were inadequately covered by premiums.

The reinsurance mechanism is a way to spread risk among participating carriers. Each year the reinsurance fund pays an insurer the amount by which the incurred claims and reinsurance premiums exceed 85 percent of earned premiums. If losses exceed the reinsurance fund's resources, a loss subsidy kicks in. This subsidy effectively spreads risk among virtually all health insurers in the state because an assessment on 400 health insurance companies provides the additional financing to compensate NMHIA for any net reinsurance and/or administrative loss that occurred in the previous calendar year. This assessment has been necessary each year due to losses of up to several million dollars.

The assessment on each insurer is based on the total premiums that insurer collects.³⁴

Outreach and Enrollment

NMHIA uses about 800 certified agents throughout the state, plus sales staff. The program educates these agents, and directs outreach at employees, employers, hospitals, and physicians. Most advertising is done via public relations articles in newspapers and major journals. NMHIA also participates in health fairs, sponsors tables at professional associations, and advertises in quarterly health care supplements of the *New Mexico Business Journal* and the *New Mexico Business Weekly*. There is significant Yellow Pages advertising in all cities. These vehicles have proven to be the most cost-effective. Also, there is some cross-marketing with New MexiKids, New Mexico's CHIP, and groups and individuals are often informed about NMHIA coverage when they are turned down for commercial coverage or do not meet participation requirements at renewal. A statute requires carriers to inform potential enrollees about NMHIA if it is a more affordable option. Paid radio advertising and telemarketing were eliminated in 1998, and the board cut the NMHIA marketing budget by 50 percent for 2000.

³³ This shift was at the carriers' request, to avoid system interface problems that were experienced in the past.

³⁴ These carriers may offset their state premium tax by 30 percent of the NMHIA assessment; the NMHIA board is considering increasing this to 50 percent to address the inability to enforce the assessment on non-ERISA exempt organizations. A credit is given for government, Medicare, and NMHIA premiums.

Of the 8,500 covered lives in November 2000, about 1,900 are enrolled as individuals and the remainder are enrolled through 1,800 small business accounts—the latter represent 7 percent of small businesses in New Mexico. The percentage of individual accounts is growing and is expected to approach 25 percent of the NMHIA enrollees soon. The average age of enrollees is generally from 43 to 47 years, with many young workers and many older, self-employed individuals in second careers. Average group size is 2.6 lives. Most enrollees are lower-income, but there is wide variation, and membership includes service sector workers, physicians, artists, and others. Enrollment was expected to rise in December 2000 because it was the deadline to lock in community rating for one year.

Accomplishments, Obstacles, and Lessons Learned

As with other insurance programs that are open to very small groups, do not medically underwrite, and have guaranteed issue, NMHIA must address the threat of adverse selection. Particularly because it includes individuals who have lost group coverage, the program must actively pursue a broad enrollment base and attract lower-risk people to help keep claims down and to prevent NMHIA from becoming solely a high-risk pool. (State planners currently view it as a mix of a purchasing pool and a high-risk pool.) Indeed, having found that some employers were enrolling higher-risk employees in NMHIA and low-risk employees in commercial health plans, administrators had to become more diligent in monitoring enrollment and renewals, and in assuring that employers do not offer group coverage other than NMHIA plans to eligible workers. The reinsurance mechanism and the loss subsidy are another way NMHIA has helped to protect carriers. Built into the program's original design and funded through reinsurance premiums and insurer assessments, the mechanism spreads the risk among virtually all health carriers in the state.

Yet some carriers—many of whom are required to participate in NMHIA if they want to continue to cover public employees and retirees—contend that these protections are inadequate and that rates are artificially low. The recent board decision to eliminate rate protections and the disenrollment that is expected to ensue underscore the inherent conflict between ensuring adequate revenues and keeping coverage affordable that many access programs encounter.

The recent board action also suggests that carriers must perceive some real benefits of participation if access programs are to be sustainable. Special effort is required to minimize potential conflicts of interest, particularly if carriers are represented on the program's board (which is important to maximize communication and cooperation). If participating carriers think an access program is competing with their commercial coverage, they will regard expansion of the program as negative rather than positive. Consequently, the program will have little chance of success.

NMHIA has a number of accomplishments. It has insured 12,000 to 14,000 people since enrollment began in 1995. It has had 130 percent net growth since 1998, bringing in more than \$1.5 million in monthly premiums. Enrollment is likely to have reached about 9,000 by the end of 2000, meeting administrators' conservative projections of 8,500 to 9,000 lives. With aggressive marketing in December 2000, enrollment may have approached the accelerated projection of 10,000 covered lives.

Further, NMHIA has managed to attract a diverse group of enrollees from a variety of businesses and with wide variation in income (although the majority earn less than \$30,000 per year). This may be because there is no restriction on applicant eligibility based on income. Program sources say NMHIA has saved the state approximately \$10 to \$15 million each year by covering previously uninsured residents and reducing uncompensated care costs (estimated at \$200 million per year in New Mexico). The program administrators estimate that it has contributed about \$75 million toward health care services since 1995 that would otherwise have been uncompensated. Results of a survey of enrollees indicate high satisfaction with the program and much gratitude toward the carriers and NMHIA. Finally, the program's voluntary approach is apparently important to New Mexico policymakers.

Along with CHIP and other state programs, NMHIA appears to be helping to reduce the number of uninsured in New Mexico. Ninety-one percent of enrollees report that they would have been uninsured without NMHIA coverage. The overall portion of the state's uninsured population fell from 28 percent in 1998 to between 21 and 25 percent in 2000. Yet the total number of enrollees is still relatively small given that 500,000 state residents remain uninsured. Clearly, coverage is unaffordable for many uninsured workers because the premiums—although they have been indirectly subsidized through community-rating and risk-sharing mechanisms—are not directly subsidized, and employers are not required to contribute. The elimination of rate protections will make NMHIA coverage unaffordable for even more workers and employers.

Even if NMHIA were able to reach its accelerated enrollment projection (i.e., 10,000), its effect on the number of uninsured in New Mexico would still be limited. Research on New Mexico's uninsured has found that even without expected rate increases, about 100,000 currently uninsured individuals would require a premium subsidy in order to buy health coverage and an additional 300,000 uninsured would require a zero-premium charity/Medicaid type program.

Program administrators acknowledge that NMHIA must be part of a broader, comprehensive plan that would include a family subsidy, Medicaid expansion, and improved functioning of existing programs. The state is currently working with the private sector to create an umbrella of programs that would reduce the number of uninsured while allowing the private health care market to remain competitive. A grant from the Robert Wood Johnson Foundation is supporting task forces that bring together all of the key stakeholders. The task forces are considering a subsidy for working poor families, and are examining other approaches as well.

Contact for More Information

New Mexico Health Insurance Alliance, (505) 989-1600, e-mail: nmhia@nmhia.com.

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Muskegon County, Michigan

Access Health

Access Health is a community initiative in Muskegon County, Michigan, that provides health coverage to working uninsured individuals and their families through employers. The program is financed through a three-way shared buy-in in which employers, employees, and the community each cover a portion of the cost. Access Health represents a true community approach to making coverage affordable to employers and employees.

Access Health enrollment began in September 1999 and will continue until the initial enrollment goal of 3,000 workers is reached. After that, new enrollment will be limited to program expansion or open slots created when member businesses transition to commercial coverage. As of August 2000, 155 small to medium-size businesses were enrolled in the program. About 500 people (including employees and dependents) are covered. This means that the program generally serves very small companies—on average, three to five eligible employees per company (including sole proprietors). If the program were to reach full enrollment of 3,000 covered lives, the annual total revenue generated from employer and employee premiums and the community match is projected to be more than \$4 million.

Background and History

In 1995, the W.K. Kellogg Foundation invited three Michigan counties—Muskegon, St. Clair, and Calhoun—to take part in the Comprehensive Community Health Models (CCHM) initiative. CCHM's purpose is to help these three counties use a community decision-making process to improve residents' health status. Each county has developed a different approach, and each approach has several components. The Muskegon Community Health Project (MCHP) is the organization managing the CCHM initiative in Muskegon County, and Access Health is one component of MCHP.

There were few, if any, community coverage models in existence when Access Health was developed. Program planners knew that they wanted to focus on the working uninsured, and spent a year devising a good benefit package, talking to employers, and listening to providers. After a benefit package had been designed, program planners approached the HMO community, but the HMOs felt they could not provide the benefit package for the price that employers appeared willing to pay (according to a survey conducted by Access Health program staff, up to \$50 per month per employee). As a result, Access Health now exists as an independent private, not-for-profit 501(c)(3) organization that contracts with providers directly rather than through a health plan.

After planners had decided how to manage the program, financing became the make-or-break issue. There was no public support for a local tax to raise money to fund health insurance coverage, and no money was available to run a public relations campaign that would garner support for instituting such a tax. Both CHIP and Medicaid expansions were considered, but the state was not eager to submit the necessary federal waiver requests. However, the state did agree that Access Health could use disproportionate share hospital (DSH)³⁵ dollars if it agreed to develop a coverage product that would cover the indigent uninsured as well as the Access Health target population. Wayne County and several other counties in Michigan already had the authority to use DSH money for coverage expansions so new authority to use DSH funds to support Access Health was unnecessary. Program staff agreed to serve both uninsured populations, and developed two programs: Muskegon Care to cover the indigent uninsured, and Access Health to cover the working uninsured.

³⁵ The federal Medicaid DSH program makes supplemental payments to states to reimburse hospitals that serve large numbers of Medicaid and uninsured patients.

Muskegon Care is a separate program from Access Health, but is mentioned here because it allowed the Access Health program to use DSH money, and because the contrast between the two programs explains part of the success of Access Health. Muskegon Care is a safety net program managed at a community level. Access Health, in contrast, is similar to a group coverage product. Program administrators stress that employees who enroll in Access Health do not think of themselves as “poor” and do not want anything to do with a “government program.” Since the two groups of consumers are different (although there is clearly some overlap as people move in and out of jobs), Muskegon Care and Access Health have been structured differently and use different marketing techniques (see below). The following description relates to Access Health unless otherwise specified.

Program Description

Eligibility

Businesses are eligible to participate in Access Health if they have not offered health insurance to their employees for the past year and the median wage of eligible employees is \$10 per hour or less. The purpose of limiting eligibility to businesses that have not offered coverage over the past 12 months is to prevent crowd-out.

If their employer qualifies, employees are eligible if they work a minimum average of 15.4 hours per week over a 13-week period. Seasonal and temporary employees and employees covered by other insurance are not eligible for the program. Access Health encourages Medicaid-eligible adults to enroll in Medicaid, but allows them to participate in Access Health if they do not want Medicaid coverage. In addition, employers must offer dependent coverage, although families are encouraged to enroll Medicaid- or CHIP-eligible children in Medicaid or MICHild (Michigan’s CHIP program). Children of eligible employees from ages 19 to 23 can enroll in Access Health as adults.

The program now targets up to 3,000 full- or part-time working uninsured individuals and up to 500 small to medium-size businesses in Muskegon County. Medium-size businesses are defined as those with up to 150 eligible full- or part-time employees, although the program is primarily aimed at small businesses, which are generally the ones that have the most difficulty buying insurance in the small-group market. Access Health, however, is fairly flexible about the size of the business. For example, if a large business has never offered coverage to a particular class of employees (e.g., part-time employees), Access Health may allow that business to enroll that group of employees (decisions to do this are made for each business individually). Access Health program planners remain conscious, though, that the intent of the program is not to subsidize large businesses (particularly chain stores) that can afford coverage and just choose not to provide it. In addition, the goal is to maximize the number of people covered who would not otherwise have access to employer-sponsored health coverage, rather than to buy out the private sector.

In determining which businesses would be eligible for Access Health, program planners were concerned that small and medium-size businesses that had been offering coverage to their employees might raise equity concerns. Since the program has been implemented, however, Access Health planners have not heard complaints from businesses that have been excluded from participation.

Access Health staff note that some businesses that do purport to offer coverage have long waiting periods before employees are eligible, or make coverage so expensive for employees that they have a hard time affording the offer. Access Health hopes its program will encourage dialogue among businesses about coverage. In addition, the availability of Access Health may force businesses that currently offer coverage at a rate that employees cannot afford to offer lower-cost plans or else risk losing employees to firms that do offer coverage. Of course, while Access Health may be less expensive than some of the plans employers currently offer, some of the employer plans may be more comprehensive given that coverage under Access Health is limited to care provided in Muskegon County.

Covered Services

Access Health covers physician services, inpatient hospital services, outpatient services, emergency services, ambulance services, prescription drugs (using a formulary and through a pharmacy network), diagnostic lab and x-ray, home health, and hospice care, all on a fee-for-service basis. Individuals are not excluded because of preexisting conditions. Copayments are required for most services (e.g., primary care physician [PCP] office visits require a \$5 copayment and specialist visits require a \$20 copayment), but were designed to encourage primary and preventive care. Enrollees choose a PCP who manages their care. Program planners recognize that there is a potential problem in having PCPs who are paid on a fee-for-service basis manage care because there is no financial incentive for them to strictly manage care. However, they have not noted a problem with overutilization of services.

Access Health planners, with significant community input, decided that one way to limit program costs was to limit covered services to services received in Muskegon County. As a result, Access Health contracts only with Muskegon County providers. The local health care market is such that Muskegon County providers who contract with Access Health can treat diseases such as cancer or heart disease, but cannot provide resource-intensive, highly specialized care, such as transplants, high-level burn centers, or neonatal intensive care units. Although Access Health does not cover these highly specialized services, PCPs will provide referrals for care outside Muskegon County for those who need these services, and Medicaid will cover their care.³⁶

Financing

The program is financed with a three-way shared buy-in among the employer, employee, and the community. The employer pays 30 percent of the cost of coverage, the employee pays 30 percent, and a community match pays the remaining 40 percent. The employee's share of adult coverage is \$38 per month, and the employee's share of dependent coverage is \$22 per month. If an employee is enrolled in Access Health and opts to enroll his or her child in MIChild, the employer must cover the \$5 monthly premium for that child.

The community match comes from a combination of federal funds and local government, community, and foundation funds. All of the federal funding comes from DSH money. The program is structured to target and leverage resources so that \$2 of private money matches every \$1 of public money, and local money (from employer contributions and community funds) can be used to leverage federal dollars (e.g., \$100 in local funds attaches \$122.80 in DSH funds). This leveraging of resources is one of the reasons that the program is attractive to policymakers who are concerned about increases in public expenditures. Using a public-private partnership to generate funds provides a viable alternative to entitlement approaches that would draw almost exclusively on public dollars. In addition, employee dollars, while not matched by federal funds, contribute to the overall increase in dollars flowing to the health systems to reduce the burden of uncompensated care. Along with these funding sources, 10 percent of provider fees are donated back to the program for continuing administrative costs.

Program Administration

Access Health is an independent, private, not-for-profit 501(c)(3) that contracts directly with providers. There are two third-party administrators, one to handle claims payments and one to manage the pharmacy benefit. Program administrators do not consider Access Health an HMO or an insurance product, but as a health coverage product to fill in the gap between no insurance and commercial insurance. Since Access Health is not an insurer, it does not have to meet reserve requirements or other insurance regulations.

The development of the reimbursement arrangement with providers illustrates the way in which community involvement has shaped the program. Prior to the development of Access Health, providers were covering the costs for all the uninsured who sought care in Muskegon County because they were

³⁶ Access Health enrollees are generally just above Medicaid or CHIP income eligibility limits. Thus, if they experience any catastrophic event, they will qualify for Medicaid through a spend-down.

providing services and not being reimbursed. Therefore, providers were willing to work with Access Health because they felt that some reimbursement was better than none. However, in negotiating with Access Health, the providers requested a fee-for-service payment arrangement because there was no way to assess the pent-up demand for health services in the Access Health population. Access Health started with three-year provider contracts that specified fee-for-service reimbursement for services, in part to assure participating businesses that there would be some degree of stability in premium payments.

Since Access Health is self-insured and does not buy reinsurance, administrators are very careful about managing the program. A community board (with provider representation) oversees the financial management of the program, and the health care community is careful to manage costs in such a way that claims do not exceed premiums. At the moment, claims have been running higher per member per month than anticipated, and the program has adjusted by slowing enrollment. If the cost of claims starts to exceed revenue generated from premiums, program managers would try to obtain more county or state money, or find better ways to manage care. The third-party administrators report claims data, which allows Access Health staff to conduct some data analysis. Specifically, Access Health program administrators look for spikes in claims or pharmacy costs that would provide information about how to better manage care. They hope to eventually develop a computer-based care management tool that would allow them to monitor and improve care management, but as of now, they do not have the resources. If claims really start to rise, Access Health might work with the community board and providers to renegotiate the provider contracts, as a last resort. However, claims have not yet exceeded premiums, and given the high level of fiscal oversight, program planners are not worried about this eventuality.

Outreach and Enrollment

In September 1999, as the program was being developed, Access Health began a public relations marketing campaign (including billboards, and TV, radio and newsprint ads) that was designed to establish the program's identity. This included building on stories in the press that helped people understand the need for health coverage. Marketing consultants conducted consumer market research, developed community support (including gathering input from community working groups), a marketing plan, and helped to launch the product. Some people approached Access Health as a result of this initial marketing and were enrolled in the program. However, the pace of enrollment was slow partly because the state had mandated the development of Muskegon Care, and program planners used the period from September through December 1999 to get Muskegon Care up and running.

Although unanticipated, the initial slow enrollment actually proved beneficial because limited enrollment allowed Access Health to develop the infrastructure needed to support the program and to work out kinks in the system. The real enrollment effort started in January 2000. Enrollment is still not at a level that the program managers would like to achieve, and some steps have been taken recently to increase enrollment, including bringing on a full-time sales person to sell the product to eligible businesses and starting a second marketing campaign. One difficulty, however, is that some private foundations are reluctant to use money for marketing. Access Health has received money from the state for its second round of marketing.

Part of the marketing strategy has been to carefully distinguish Access Health from government programs. As mentioned earlier, Access Health is geared toward workers who do not consider themselves poor and do not want government assistance. As a result, the program has been modeled on a commercial plan and has a customer-oriented approach. To market to businesses, a customer service representative visits the employer two to three times. If the employer is interested, he/she supplies Access Health with median wage information to use in determining whether or not the business is eligible. Once an employer has decided to offer Access Health to his/her employees and has been deemed eligible, the customer service representative meets with the employees to explain the program and enroll employees. They may decline to enroll, but they must sign a waiver saying that they chose not to enroll. There is no open enrollment period so an enrollee may change his or her mind and opt to begin coverage at any time in the

future. Employees hired after the initial group has been offered coverage must wait 90 days before they are eligible to enroll. After enrollment, the employees receive program materials and Access Health cards, and choose a PCP, just as they would with a commercial plan.

There are now more than 150 businesses enrolled in the program with approximately 500 covered lives (employees and their dependents). This number does not include children who have enrolled in MIChild as a result of their parents' enrollment in Access Health. Program staff estimate that about 15 children per month are enrolling in MIChild. Although the program targets 3,000 lives, it will actually break even financially at 1,700 enrollees.

Future of the Program

Access Health has not been in existence long enough to have conducted a formal evaluation of its impact. The state is providing money to conduct an evaluation that will track enrollment data and will ask people who declined why they opted not to enroll. Once the data are collected, the database will be shared with the local Chamber of Commerce. The state also has set aside \$10 million to develop similar models in other areas of Michigan. Enrollees appear to be very satisfied with the program and, according to Access Health staff, have been "thrilled" with their PCPs. Businesses, too, are very happy with the program. Access Health program planners have heard from employers that they have been running employment ads that mention health benefits and are attracting better applicants. In addition, the word on the street has been very positive, and people have been inquiring about the program based on word-of-mouth referrals.

Staff felt several aspects of the program had improved significantly since it began and will need to continue to improve. One area involved developing an operational infrastructure that could handle the program. Access Health is now focused on creating a stronger operational piece because a program's success or failure hinges on the operational component. In addition, Access Health has been learning about its data needs and about how best to evaluate the program. There is a tendency among public policymakers to evaluate programs based solely on numbers. Access Health staff stressed the importance of looking at a wider range of indicators to determine a program's success.

Access Health appears to have now become part of the permanent health care landscape in Muskegon County. Although some portion of the funding used to finance the program is not guaranteed, program planners believe that they will be able to continue to raise money for the program. The federal DSH dollars are available although county money is limited (particularly in the absence of the political will for a tax). Having gotten over the initial financial barriers, the staff has been finding new ways to raise money.

One indication of the program's success has been that the staff is receiving multiple inquiries from communities around the country. For example, representatives from a health plan for the self-employed in New York City and interested individuals from Boise, Idaho, and several counties in Iowa have all come to Muskegon County to learn about Access Health. The Access Health model has been presented in a variety of forums, and Muskegon County has received positive press on the national scene (which has instilled a sense of community pride).

Accomplishments, Obstacles, and Lessons Learned

Program planners stressed that one of the most important lessons learned is that "one size does not fit all." Many types of people end up without health coverage—models that will appeal to a variety of different groups need to be developed. Foundations and policymakers should not pick a few models and tell communities what to do, but encourage variation across a continuum. Program planners suggest that to make a dent in the number of uninsured in this country, policymakers need to be creative and engage in bottom-up thinking.

In Muskegon County, this meant understanding the target demographic group (for Access Health, this includes mostly women ages 18 to 34 employed in the service sector) and conducting research to understand how to market the product. Market research taught program administrators that programs viewed as “government entitlements” would not appeal to the uninsured workers in their community. To garner business and political support, as well as community participation, they knew that it was important to move away from language that focused on entitlement. In addition, survey research revealed other subtle language lessons that affect support for programs such as Access Health. For example, since many of the eligible employees are living right on the margin, there is very little in their lives that they believe they can afford. Consequently, talking about “affordable insurance” does not resonate with people. Instead program planners believe it is better to talk to these workers about health coverage that “fits within their budget.”

Understanding market research and having a marketing campaign, however, is not always enough. As one program planner said, “we thought we would build it and they would come, but they didn’t.” Program planners realized that a good response in the media did not necessarily mean that they were hitting their target—it is critical to combine marketing with sales and outreach.

Program administrators also have learned how to adapt the program to meet the needs of the target population. For example, when the program first began, the size of eligible businesses was limited to 19 employees. However, Access Health found that day care centers, many of which had 20 or 21 employees, were particularly interested in participating. As a result the program has expanded the eligibility criteria to be responsive to community demand.

Another lesson involves the need for creative thinking, exemplified in the use of DSH funds. DSH funds are intended to cover the costs of uncompensated care provided by hospitals that serve a disproportionate number of indigent and Medicaid patients. However, as health care across the country is increasingly being provided in outpatient and primary care centers instead of in hospitals, states are looking for innovative ways to support the provision of uncompensated care in those noninstitutional settings. In some states, DSH funds are being used to support primary care. Michigan, however, has taken the reallocation of DSH funds one step further, while still ensuring that those funds are being used to support the safety net. So DSH funds have been used to pay for health coverage for the working and indigent uninsured. Employees who might earlier have obtained services from providers and rung up charges that became bad debts now are covered by Access Health and are able to pay for their care. In addition, enrollees are less likely to end up in hospitals because they have access to primary and preventive care. So DSH funds are re-deployed and spread out to pay for a whole range of health services instead of being used to support indigent hospital care.

Access Health also has fostered other programs in response to community demand. For example, a new community project has started to explore the misuse of antibiotics. In addition, two competing hospital systems that were unable to work together in the past have developed a collaborative diabetes initiative and a joint dental initiative. Access Health program planners have seen that some barriers that existed between providers have broken down somewhat, and initiatives that would not have been possible before may now be explored.

Finally, one of the most important lessons learned was the importance of community involvement (including the medical community) in developing the program. Access Health continues to have significant community input through a community board that has patient, provider, and community representation. Program officials stated that many of the creative ways in which they structured the program were acceptable to the community because they were ideas that originated in the community, and the product was community-owned. At a time when many perceive that communities have lost control of health care to market forces and public policy, Muskegon County has been given a voice in how health care is delivered.

Access Health staff stressed that this program has appeal across the political spectrum because community involvement during development ensured that the final product had something for everyone. As program planners put it, communities can tackle difficult problems when they work together. This also means that no one group ends up paying for the cost of coverage. With employers, employees, and government each paying their share of the cost, resources are pooled and used in a way that the community believes is to everyone's benefit.

Contact for More Information

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San Diego, California

FOCUS (Financially Obtainable Coverage for Uninsured San Diegans)—Sharp Health Plan

FOCUS was developed to increase the rate of health insurance coverage for workers in San Diego County by providing coverage to small businesses and low- to moderate-income employees at affordable rates. FOCUS is a premium assistance program developed as a partnership between Sharp Health Plan and the Alliance Healthcare Foundation.³⁷ The cost of coverage is shared by the employer, the employee, and FOCUS. FOCUS is funded with a \$1.2 million grant from the Alliance Healthcare Foundation, and has recently received a \$400,000 grant from the California Endowment to cover additional enrollees.

The program operates in San Diego, California, under a two-year grant that began in April 1999. It is targeted at (and financed to cover) more than 150 businesses with 50 or fewer employees and up to 2,000 full-time employees with incomes less than 300 percent of FPL. As of August 2000, 1,766 employees and 232 businesses participated.

Background and History

In 1994, California enacted a law requiring private, not-for-profit hospitals and health care systems to be more accountable for providing services that address community health needs.³⁸ In response, stakeholders in San Diego formed Community Health Improvement Partners in June 1995 to provide a forum to discuss community health care access issues. Members include representatives from hospitals and health systems in the county, the county department of health services, health insurance companies, and others. Since its inception, Community Health Improvement Partners has been looking at a variety of health care access issues, including how to address the historically high rate of uninsurance (approximately 22 percent) among San Diego county residents.³⁹

In 1997 Sharp Health Plan and the Alliance Healthcare Foundation began to explore options to provide health insurance coverage for the uninsured in San Diego. As in the rest of the country, 85 percent of uninsured San Diegans work or live in the household of a worker.⁴⁰ Nationally, most of those uninsured workers are employed in small firms, and San Diego has a particularly high proportion—87 percent—of businesses with fewer than 20 employees.⁴¹ Many of these small businesses are operating month-to-month and do not have the resources to provide health coverage, or to hire human resources staff to handle the administrative complexities of the small-group market. In addition, many of the uninsured are low-wage workers. In California, 85 percent of the uninsured have incomes below 300 percent of the federal poverty level (FPL). As a

³⁷ Sharp Health Plan is a not-for-profit health plan located in San Diego that is an affiliate of Sharp Healthcare, a local health system. Alliance Healthcare Foundation was created after the sale of the nonprofit Community Care Network to a for-profit entity. The Foundation has assets of about \$100 million.

³⁸ Senate Bill 697 (SB 697).

³⁹ U.S. Census Bureau, Current Population Study, March 1997 and 1998 updates as cited in *Options for Expanding Healthcare to Uninsured San Diegans*, Report of the Project Management Committee for Improving Access to Healthcare established by the San Diego County Board of Supervisors in consultation with the Pacific Health Policy Group, December 1999.

⁴⁰ Leadership Education Awareness Development (LEAD), *Health Insurance—Is It the Net We Expect?*, Report submitted June 7, 2000 (www.leadsandiego.com).

⁴¹ Leadership Education Awareness Development, 2000.

result, Sharp Health Plan decided to focus its efforts on designing a group-based product that could be offered to these low-wage workers.

Sharp Health Plan considered public and private options for expanding coverage. It approached the Managed Risk Medical Insurance Board to explore the idea of wrapping a program around some of the existing public programs like Medicaid (Medi-Cal in California) and CHIP. However, designing a wraparound program would have been administratively more difficult and would have taken longer to implement. Also, program planners were not sure that wrapping around public programs would have been the most effective way to target the working uninsured.

Given the perceived limitations of a public program, Sharp Health Plan designed FOCUS, a private, premium assistance program to target small businesses and maximize the number of newly insured individuals from those firms. To ensure that the program reaches individuals without coverage, employees are eligible to participate only if they have been uninsured for one year prior to their enrollment in FOCUS. Employers are eligible to offer FOCUS only if they have not offered coverage for the past year. Since FOCUS is a private program, no state legislation or federal waivers were needed. However, due to some small-group market reforms in California, the program did need a state waiver to exclude businesses that had offered coverage within the previous year from participation.

Enrollment began in April 1999, and each firm is guaranteed that funding will be available for two years from its initial effective enrollment date, regardless of when the firm enrolls. Employers, employees, and Alliance share the cost of the premiums, and primarily Alliance provides funding, with additional funding from the California Healthcare Foundation and Sharp Health Plan. A technical advisory committee, a group with a similar composition to Community Health Improvement Partners, provides program oversight and an avenue for community input.

Program Description

Eligibility

All San Diego small businesses (i.e., with 50 or fewer employees) that have not provided health coverage in the past year are eligible to participate. All full-time employees (as defined by the employer) with incomes up to roughly 300 percent of the FPL who have been uninsured for the past year are eligible to participate. All eligible uninsured dependents must also enroll. There is guaranteed issue to eligible groups and employees, no medical underwriting, and community rates that vary based only on income level, coverage tier, and family size.

A wide range of businesses participate in FOCUS, including restaurants, convenience/liquor stores, medical/legal offices, auto repair shops, and construction, housecleaning, retail, and landscaping businesses. These businesses operate throughout San Diego and have, on average, about 10 employees. On average, there are approximately five covered employees and 10 covered lives per business. One-third of participating businesses have full enrollment of eligible employees. The average FOCUS enrollee has a covered family size of three, an average gross family income of \$18,000 a year, and receives a subsidy of \$35 per enrollee per month.

Benefit Package

FOCUS offers enrollees a standard commercial plan design that includes: physician office visits for a \$5 copayment; 100 percent hospitalization coverage; outpatient prescription drugs (\$5 generic/\$15 brand name copayments); urgent care services for a \$5 copayment; emergency room

services for a \$50 copayment; home health services; and limited mental health and chemical dependency coverage. There are no deductibles or lifetime maximums for this plan, and there is an annual copayment maximum of \$1,500 per individual and \$3,000 per family. The FOCUS provider network includes private practice offices, medical group facilities, and health centers throughout San Diego.

While some services, such as chiropractic and infertility coverage, are not included, the benefit plan is reasonably generous. The lower premiums are a result not of fewer benefits but rather of lower provider rates, the lack of broker commissions, and lower administrative charges from Sharp Health Plan.

Financing

Monthly premiums are divided among the employer, employee, and FOCUS. Employer contributions are fixed and range between \$24.29 per month for employee-only coverage and \$48.70 per month for family coverage. Employees pay on a sliding scale that ranges from \$10 to \$194 per month depending on their income and family size. FOCUS, using funds from the Alliance Healthcare Foundation and the California Endowment, subsidizes the remainder of the cost of the premium—between zero and \$175 per month.

Sharp Health Plan has agreed to donate one-third of its typical administrative costs of 15 percent and that is reflected in the premiums. Alliance contributes a \$1.2 million grant to subsidize the insurance premiums. The University of California at San Diego was awarded a \$250,000 grant from the Oakland-based California Healthcare Foundation to evaluate the economic impact of the program. Although the program only began enrollment in April 1999, FOCUS could no longer accept new businesses by the end of that year, because it only had enough money to finance those currently enrolled. However, the California Endowment stepped in with a \$400,000 grant soon after to provide coverage for additional enrollees and to study the impact of the program on children who are undocumented immigrants.

In addition to the direct funding sources mentioned above, providers have agreed to accept below-market rates for FOCUS enrollees. Brokers also have agreed to participate without taking any commission. The willingness of providers to accept below-market reimbursement and of brokers to forgo commissions plays a large role in keeping overall premiums affordable.

Outreach and Enrollment

FOCUS used a variety of outreach and marketing strategies, first to increase awareness of the problem of the uninsured, and then to publicize the program. A media relations campaign used local newspapers, business publications, radio talk shows, and television programs on the uninsured to build awareness and generate sales inquiries. Key local business organizations (e.g., chambers of commerce, economic development councils, and business improvement districts) were targeted for assistance in helping to build awareness through publication in their internal communication vehicles. Enrollee referrals have also helped generate interest.

The initial enrollment projections were about 1,000 enrollees, or about 100 companies, since 10 employees is about the average size of firms in the program. Since the initial enrollment goal was not very high, program staff were concerned about creating demand that they would be unable to meet. As a result, FOCUS took a very conservative marketing approach, relying almost exclusively on media placements in business and general news publications. Perhaps not surprisingly, FOCUS reached very few small business owners using those methods, and growth was slow at the beginning. However, enrollment picked up dramatically as FOCUS began reaching more people through local business organizations. In addition, a single segment on a

television news program generated significant interest, far more than the business and general news publications had generated earlier. Once word spread, there was interest beyond what the program could handle. For months after reaching enrollment capacity, and long after the marketing and outreach efforts ended, uninsured businesses continued to call and request that they be added to the waiting list.

Due to the lack of broker commissions, Sharp Health Plan has handled more of the administrative and sales aspects of FOCUS than it would generally do for a commercial group. Alliance is not involved in the day-to-day administration. Other than handling more administration, Sharp treats FOCUS enrollees just as it does other commercial enrollees. Interested businesses are referred to a certified FOCUS insurance broker. After an initial brief screening to ensure the business is eligible, the business is sent a package of materials describing the program more fully. A representative of Sharp Health Plan then visits the business to discuss the program. (In a standard commercial plan, the broker would generally handle these steps.) Once a business has joined, employees fill out income eligibility and enrollment paperwork. Sharp Health Plan administrators review the paperwork, and if an employee is eligible, he or she is enrolled in Sharp Health Plan and chooses a primary care provider. FOCUS does not ask the employee for any information about their legal status and assumes that some of the people they cover may be undocumented. This is particularly true for children who would seem to qualify for lower-cost existing public programs, based on their family income, but whose parents have not opted to enroll them. FOCUS will enroll eligible individuals and families even if they qualify for public programs, although program planners do encourage people who are eligible for public programs to enroll in those programs. As in other commercial plans, FOCUS enrollees choose a primary care provider to coordinate all of their medical needs.

Accomplishments, Obstacles, and Lessons Learned

The feedback from employers and employees about FOCUS has been very positive. Businesses have seen the program as an opportunity for growth because it helps them attract and retain workers. Some have reported that they wanted to offer health care coverage in the past but have just been unable to manage it. When FOCUS began as a demonstration project, one concern was that businesses might not enroll because they would only be guaranteed premium assistance for the first two years. Although businesses are able to continue with Sharp Health Plan after two years without the premium assistance, the lack of a subsidy may drive the premiums out of reach for either the employers or the employees. While businesses were concerned about the two-year subsidy limit, that did not appear to deter them from enrolling. Although there were some initial concerns about slow growth, program planners have learned more about how to market to and reach small businesses.

In addition to the high administrative burden associated with providing small groups with coverage, marketing to these small businesses continues to be one of the biggest challenges. Once businesses have heard about FOCUS, they are interested in enrolling. In fact, more than 90 percent of eligible businesses that have inquired about FOCUS have joined the program. With such a high take-up rate, program planners suspect that the employer's share of the premium could have been higher. So far, there also have been few if any problems with employers or employees dropping out of the program once enrolled. According to FOCUS staff, early utilization data suggest that there are no problems with adverse selection. Since it is not merely employees with high health costs who are joining, the program clearly has broader appeal. This is probably due to a subsidy that makes coverage affordable for businesses and employees, as well as the immediate

availability of a benefit package without large administrative costs or limitations due to medical underwriting and community rating.

One barrier to continuing the program is that providers have agreed to accept below-market rates for FOCUS enrollees. Accepting lower reimbursement may be tolerable for a project with 1,000 to 2,000 enrollees and limited duration, but program planners recognize that if the program expands, provider rates would have to increase. In addition, under the current program, brokers are not charging FOCUS and, again, if the program were to expand, brokers would require some sort of commission. One of the reasons for the success of the program, however, has been the willingness of brokers to participate. As a result, program staff are committed to keeping brokers involved because brokers are the main distribution channel for small-group health coverage and a program like FOCUS cannot succeed without their help.

The University of California at San Diego's evaluation of FOCUS is still in the early stages—in part because it was not until late fall 1999 that enrollment really picked up. The evaluation will involve surveying employer groups about their experiences participating in FOCUS, and the effect health insurance coverage has on morale and perceived health status. In addition, the evaluation will study the economic impact of FOCUS by looking at changes in employee absenteeism, productivity, retention rates, and workers' compensation costs. FOCUS has always been considered a limited enrollment program, and so its success will be judged by these outcomes outlined in the evaluation plan rather than by high enrollment numbers.

The evaluation team has just completed the first round of baseline data collection from FOCUS businesses. So far, businesses seem to be very happy with the program and there are anecdotal claims that FOCUS has helped businesses hire and retain employees, but as yet no hard data to confirm or deny the anecdotal evidence. The next round of data collection, with individual enrollees, was slated to begin in December 2000.

Although program planners are very interested to hear about the results of the evaluation, a decision will have to be made about whether to continue FOCUS, and in what form, before the evaluation is complete. At this point, there are no finalized plans for expansion or continuation of the program beyond what has been budgeted. One option program planners have explored is to create a community-wide design so that employees could choose similar coverage among a variety of plans. Alliance is very interested in expanding the program. There are still large numbers of uninsured in San Diego, and there are several options being considered by various stakeholders. Even if FOCUS does not continue in its present form, program planners are hopeful that there will continue to be programs that try to provide health coverage to low-income workers. Some of those options may depend on the future of the small-group market.

Contact for More Information

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Acknowledgements

The authors gratefully acknowledge the support of The Commonwealth Fund. We would like to thank the representatives from the state and community programs profiled in this report who were generous with their time and provided valuable information about their programs.

About ESRI

The Economic and Social Research Institute (ESRI) is a nonprofit organization that conducts research and policy analysis in health care and in the reform of social services. ESRI specializes in studies aimed at enhancing the effectiveness of social programs, improving the way health care services are organized and delivered, and making quality health care accessible and affordable.

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Sharon Silow-Carroll, M.B.A., M.S.W., is a senior research manager at ESRI. Ms. Silow-Carroll's areas of expertise include health care reform strategies and improving access to care for vulnerable populations. Her recent projects include: assessments of the strengths and weaknesses of congressional proposals to provide tax credits or deductions for people buying individual health insurance plans; reviews of community-based efforts to reduce financial and nonfinancial barriers to care; and the development of a comprehensive strategy for expanding access to health care for at-risk populations. She is the author of an ESRI book that analyzes the corporate/employer role in providing health insurance coverage to workers and families. She is a coauthor of numerous reports and articles that analyze public and private sector initiatives aimed at enhancing access, containing costs, and improving the quality of health care.

Emily K. Waldman, M.H.S., is a senior research associate at ESRI. Most recently, Ms. Waldman researched and evaluated public and private sector strategies to improve access to health insurance coverage and health care delivery for the District of Columbia Mayor's Health Care Systems Development Commission. She has worked with the District government and various public interest groups to devise a plan for evaluating and monitoring progress of a new initiative to deploy tobacco settlement funds to promote better public health. Ms. Waldman also has conducted policy research and analysis on the issues confronting urban safety net institutions and academic medical centers; studied the implications of managed care programs for people dually eligible for Medicare and Medicaid; and looked at innovative models aimed at increasing health insurance coverage for working Americans.

Jack A. Meyer, Ph.D., is the founder and president of ESRI. Dr. Meyer has conducted policy analysis and directed research on health care access issues for several major foundations as well as federal and state government. He has led projects on community-wide reforms in all regions of the United States. Many of these projects have highlighted new strategies for overcoming barriers to health care access and innovative designs for extending health insurance coverage to the uninsured. Dr. Meyer is the author of numerous books, monographs, and articles on topics including health care, welfare reform, and policies to reduce poverty. Dr. Meyer has also directed recent studies on the viability of safety net providers, the State Children's Health Insurance Program (CHIP) to extend coverage to lower-income children, the conversion of public hospitals to private status, and assessments of reform proposals to extend health coverage to workers in small firms. Dr. Meyer served as the lead consultant in providing technical support to the District of Columbia Mayor's Health Care Systems Development Commission, which explored ways to improve access to health coverage and the health care delivery system in the District.

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#422 Buying into Public Coverage: Expanding Access by Permitting Families to Use Tax Credits to Buy into Medicaid or CHIP Programs (December 2000). Alan Weil, The Urban Institute. Medicaid and CHIP offer administrative structures and plan arrangements with the capacity to enroll individuals and families. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes permitting, but not requiring, tax-credit recipients to use their credits to buy into Medicaid or CHIP.

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#420 A Workable Solution for the Pre-Medicare Population (December 2000). Pamela Farley Short, Dennis G. Shea, and M. Paige Powell, Pennsylvania State University. Adults nearing but not yet eligible for Medicare are at high risk of being uninsured, especially if they are in poor health. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes new options to enable those 62 and older early buy-in to Medicare (or to subsidize other coverage) through premium assistance for those with low lifetime incomes and new health IRA or tax-deduction accounts for those with higher incomes.

#419 Allowing Small Businesses and the Self-Employed to Buy Health Care Coverage Through Public Programs (December 2000). Sara Rosenbaum, Phyllis C. Borzi, and Vernon Smith. Public programs such as CHIP and Medicaid offer the possibility of economies of scale for group coverage for small employers as well as individuals. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes allowing the self-employed and those in small businesses to buy coverage through these public plans, and providing premium assistance to make it easier for them to do so.

#418 A Federal Tax Credit to Encourage Employers to Offer Health Coverage (December 2000). Jack A. Meyer and Elliot K. Wicks, Economic and Social Research Institute. Employers who do not currently offer health benefits to their employees cite costs as the primary concern. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, examines the potential of offering tax credits (or other financial incentives) to employers of low-wage workers to induce them to offer coverage.

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#416 Transitional Subsidies for Health Insurance Coverage (December 2000). Jonathan Gruber, Massachusetts Institute of Technology and The National Bureau of Economic Research, Inc. The unemployed and those switching jobs often lose coverage due to an inability to pay premiums. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, suggests ways that the existing COBRA program could be enhanced to help avoid these uninsured spells.

#414 Increasing Health Insurance Coverage Through an Extended Federal Employees Health Benefits Program (December 2000). Beth C. Fuchs, Health Policy Alternatives, Inc. The FEHBP has often been proposed as a possible base to build on for group coverage. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes an extension of FEHBP (E-FEHBP) that would operate in parallel with the existing program. The proposal would require anyone qualifying for a tax credit to obtain it through E-FEHBP and would also permit employees of small firms (<10 workers) to purchase health insurance through the program. The proposal would also provide public reinsurance for E-FEHBP, further lowering the premium costs faced by those eligible for the program.

#413 Private Purchasing Pools to Harness Individual Tax Credits for Consumers (December 2000). Richard E. Curtis, Edward Neuschler, and Rafe Forland, Institute for Health Policy Solutions. Combining small employers into groups offers the potential of improved benefits, plan choice, and/or reduced premium costs. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes the establishment of private purchasing pools that would be open to workers (and their families) without an offer of employer-sponsored insurance or in firms with up to 50 employees. All tax-credit recipients would be required to use their premium credits in these pools.

#425 Barriers to Health Coverage for Hispanic Workers: Focus Group Findings (December 2000). Michael Perry, Susan Kannel, and Enrique Castillo. This report, based on eight focus groups with

81 Hispanic workers of low to moderate income, finds that lack of opportunity and affordability are the chief obstacles to enrollment in employer-based health plans, the dominant source of health insurance for those under age 65.

#424 *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured* (November 2000). Sharon Silow-Carroll, Stephanie E. Anthony, and Jack A. Meyer, Economic and Social Research Institute. This report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, with a primary focus on programs that target employers and employees directly, but also on a sample of programs targeting a broader population.

#411 *ERISA and State Health Care Access Initiatives: Opportunities and Obstacles* (October 2000). Patricia A. Butler. This study examines the potential of states to expand health coverage incrementally should the federal government decide to reform the Employee Retirement Income Security Act (ERISA) of 1974, which regulates employee benefit programs such as job-based health plans and contains a broad preemption clause that supercedes state laws that relate to private-sector, employer-sponsored plans.

#392 *Disparities in Health Insurance and Access to Care for Residents Across U.S. Cities* (August 2000). E. Richard Brown, Roberta Wyn, and Stephanie Teleki. A new study of health insurance coverage in 85 U.S. metropolitan areas reveals that uninsured rates vary widely, from a low of 7 percent in Akron, Ohio, and Harrisburg, Pennsylvania, to a high of 37 percent in El Paso, Texas. High proportions of immigrants and low rates of employer-based health coverage correlate strongly with high uninsured rates in urban populations.

#405 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This summary report, based on *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70*, reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#391 *On Their Own: Young Adults Living Without Health Insurance* (May 2000). Kevin Quinn, Cathy Schoen, and Louisa Buatti. Based on The Commonwealth Fund 1999 National Survey of Workers' Health Insurance and Task Force analysis of the March 1999 Current Population Survey, this report shows that young adults ages 19–29 are twice as likely to be uninsured as children or older adults.

#370 *Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans* (March 2000). Kevin Quinn, Abt Associates, Inc. Using data from the March 1999 Current Population Survey and The Commonwealth Fund 1999 National Survey of Workers' Health Insurance, this report examines reasons why nine of the country's 11 million uninsured Hispanics are in working families, and the effect that lack has on the Hispanic community.

#364 *Risks for Midlife Americans: Getting Sick, Becoming Disabled, or Losing a Job and Health Coverage* (January 2000). John Budetti, Cathy Schoen, Elisabeth Simantov, and Janet Shikles. This short report derived from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance highlights the vulnerability of millions of midlife Americans to losing their job-based coverage in the face of heightened risk for chronic disease, disability, or loss of employment.

#363 *A Vote of Confidence: Attitudes Toward Employer-Sponsored Health Insurance* (January 2000). Cathy Schoen, Erin Strumpf, and Karen Davis. This issue brief based on findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance reports that most Americans believe employers are the best source of health coverage and that they should continue to serve as the primary source in the future. Almost all of those surveyed also favored the government providing assistance to low-income workers and their families to help them pay for insurance.

#362 *Listening to Workers: Findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. This full-length analysis of the Fund's survey of more than 5,000 working-age Americans finds that half of all respondents would like employers to continue serving as the main source of coverage for the working population. However, sharp disparities exist in the availability of employer-based coverage: one-third of middle- and low-income adults who work full time are uninsured.

#361 *Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. Based on The Commonwealth Fund 1999 National Survey of Workers' Health Insurance, this short report shows that although most working Americans with employer-sponsored health insurance are satisfied with their plans, too many middle- and low-income workers cannot afford health coverage or are not offered it.

#347 *Can't Afford to Get Sick: A Reality for Millions of Working Americans* (September 1999). John Budetti, Lisa Duchon, Cathy Schoen, and Janet Shikles. This report from *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* finds that millions of working Americans are struggling to get the health care they need because they lack insurance or experience gaps in coverage.

#262 *Working Families at Risk: Coverage, Access, Costs, and Worries—The Kaiser/Commonwealth 1997 National Survey of Health Insurance* (April 1998). This survey of more than 4,000 adults age 18 and older, conducted by Louis Harris and Associates, Inc., found that affordability was the most frequent reason given for not having health insurance, and that lack of insurance undermined access to health care and exposed families to financial burdens.