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RESEARCH CENTER

Implementing Small Group Insurance Market Reforms: Lessons From the States

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About the Paper and the Intended Audience

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

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

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

Table of Contents

Executive Summary

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

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

A review of state small group insurance coverage strategies shows:

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

Through our field research we also find:

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

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

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

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

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

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

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

I. Overview and Background

Report Structure

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

Problem of Insurance Coverage in the Small Group Market

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

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

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

Overview of State Strategies to Increase Insurance Coverage

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

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

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

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

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

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

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

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

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

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

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

II. Major Findings From the 50 State Scan

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[17] Ibid.

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

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

III. Overview of Field Research

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

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

State Program: New Jersey

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

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

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

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

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

State Program: Minnesota

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

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

State Program: Maine

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

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

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

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

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

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

IV. Major Findings From the Field Research

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[30] From the Maine Case Study.

V. Lessons and Conclusions

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

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

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

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

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

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

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

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

APPENDIX A: About the Field Researchers and their Organizations

New Jersey — The researchers from New Jersey were Dina Belloff and Joel Cantor of the Rutgers Center for State Health Policy. Joel C. Cantor is a professor of public policy at the Bloustein School of Planning and Public Policy at Rutgers University and director of the Center for State Health Policy. Dina Belloff is a senior research analyst at the Center for State Health Policy. The Rutgers Center for State Health Policy is an initiative of the Institute for Health, Health Care Policy, and Aging Research (IHHCPAR), established to create a formal capacity within Rutgers, the State University of New Jersey, for policy analysis, research, training, facilitation, and consultation on state health policy. Made possible by a grant from The Robert Wood Johnson Foundation with additional support from Rutgers University, the Center was conceived in response to recent transformations in the health care/health policy arena that resulted in the devolution of significant policy responsibilities to state governments. The Center combines Rutgers University's traditional academic strengths in public health, health services research, and social science with applied research and policy analysis initiatives. It serves as the focal point within the University for research and related activities relevant to state health policy.

Minnesota — The researchers and authors of the Minnesota field report and case study are Donna Spencer and Lynn Blewett of the State Health Access Data Assistance Center at the School of Public Health at the University of Minnesota. The State Health Access Data Assistance Center (SHADAC) is a health policy research center and health data resource providing targeted policy research and technical expertise on the collection, analysis, and use of policy relevant data on health services, including insurance coverage and access to care and utilization. Housed within the University of Minnesota's School of Public Health and led by Lynn Blewett, PhD, SHADAC's researchers, staff, and faculty advisors maintain an ongoing research agenda related to issues of health insurance coverage, data collection methods, and state health policy. SHADAC's experts in health policy analysis, survey design, sampling, and data analysis specialize in the application of national and state data resources for health policy decisions and strive to make health care data more accessible, improve the quality of data at the state and national levels, and increase its use for making informed policy decisions related to health care coverage and access. SHADAC's goal is to serve as a bridge between state and federal agencies and between data and policy. SHADAC is largely supported by the Robert Wood Johnson Foundation.

Maine — The researchers and authors of the Maine field report and case study are Elizabeth Kilbreth and Kimberly Fox of the Muskie School of Public Service**.** Elizabeth is an associate research professor and Kimberly is a research associate. Through its teaching, research, and public service, the Edmund S. Muskie School of Public Service of the University of Southern Maine educates leaders, informs state and national policy and practice, and works to strengthen civic life. The Muskie School's Institute for Health Policy conducts nationally recognized research and policy analysis to identify and promote solutions to complex health care challenges. The Institute links leading scholarship with policy and practice to improve health care and human services.

NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM FIELD RESEARCH REPORT

I. CONTEXT

Overview of Trends in New Jersey's Health Insurance Markets

In 2005, New Jersey's 8.7 million residents fell into one of several categories of health insurance coverage.[1] One-third of residents were insured by the state or federal government through Medicare, Medicaid, SCHIP, military, or the state or federal health benefits program. Another 26% of residents were insured through self-funded plans with large employers. An additional 13% were covered by fully insured large employers. Less than 1% was insured in the individual market. New Jersey's small employer group health insurance market (businesses of two to fifty employees) insured almost 11% of residents. Finally, 15% of residents remained uninsured.

New Jersey is one of the wealthiest states in the country with an average per capita income of nearly $44,000 per year in 2005 compared to nearly $34,500 for the U.S. as a whole.[2] Still, nearly 17% of state residents under age 65 were uninsured in 2005, a number that has been increasing over the last six years (Figure 1). Young adults in New Jersey have been most affected by increases in the uninsured rate. Health insurance coverage among those ages 19 to 34 has declined over the last several years compared to other age groups.

Similarly, the number of Medicaid and SCHIP beneficiaries in New Jersey has grown from 2000 to 2004, a sign that some New Jersey residents are struggling financially and have sought out coverage through the state's public programs (Figure 2). In fact, in 2007, over a million New Jersey residents were enrolled in Medicaid and NJ FamilyCare, nearly 12% of the state's population.[3]

Like other states, most New Jersey businesses are small and employ fewer than 50 workers (78% in NJ and 75% in the U.S. in 2005).[4] However, most full-time employees work for large firms, leaving a little more than a quarter of New Jersey's full-time employees working for small firms (Figure 3). Most large firms in New Jersey offer health insurance coverage, while far fewer small firms offer coverage (Figure 4). Yet, since 2000, the percentage of large employers offering coverage has declined slightly from 98% in 2000 to 94% in 2005, while the percentage of small firms offering coverage has increased from 56% in 2000 to 62% in 2005. Furthermore, offer rates in New Jersey's small group market consistently exceed the U.S. average for small firms.

In fact, in 2005, most full-time employees worked at establishments that offered health insurance, though employees of small firms were less likely to be offered coverage than those of large firms (81% for full-time employees of small firms and 98% for full-time employees of large firms) (Figure 5). The percentage of full-time employees working for a large employer that offers health insurance coverage has been stable, 99% in 2000 and 98% in 2005, while the percentage of full-time employees working for a small employer that offers coverage increased

from 76% in 2000 to 81% in 2005. In addition, a greater percentage of full-time employees of small firms in New Jersey are offered coverage than in U.S. small firms on average, and in recent years offer rates increased more in New Jersey than in the U.S. small group market.

Health insurance premiums for New Jersey's small firms are much higher than those of large firms. In 2005, small firms paid almost $500 more in total premiums per single enrollee than large firms (Figure 6) and about $900 more per enrolled family (Figure 7). From 2000 to 2005, total premiums for single coverage increased approximately $1,400 for both small and large firms. Premiums for family coverage increased more than $4,000 from 2000 to 2005 for small firms and about $3,800 for large firms.

The proportion of the premium paid by the employer has also remained relatively steady for all New Jersey firms from 2000 to 2005 (Figures 6 and 7). On average over the six-year period, smaller employers contributed a greater proportion of the premium for single coverage than large employers (86.3% for very small employers, 83.6% for small employers, and 82.7% for large employers). For family coverage, very small employers contributed the most toward premiums on average over the six-year period (83.7% for very small employers, 78.3% for small employers, and 79.4% for large employers) though this trend may be because some very small employers in New Jersey employ their spouse.

In short, New Jersey's private employers are managing to maintain offer rates and coverage despite high and rising health insurance premiums over the last several years. In fact, New Jersey's health insurance premiums are among the most expensive in the country, especially in the small group market where premiums are the fourth highest for single coverage and third highest for family coverage.[5] Offer rates have remained steady and even grown in the small group market. Employers continue to contribute more than 80% of total premium costs per enrollee, on average. However, New Jersey's full-time employees continue to share the burden of increasing premiums as their out-of-pocket expenditures toward premium contributions also raise.

New Jersey's Health Insurance Regime

New Jersey's private health insurance market is regulated by the NJ Department of Banking and Insurance (DOBI). In particular, DOBI oversees the individual and small group health insurance markets as well as monitors HMO and other private coverage enrollment and premiums.

In 1992, New Jersey reformed its individual and small group health insurance markets. These changes were implemented in the individual health insurance market in 1993 and in the small group market in 1994. The reformed individual market is now called the Individual Health Coverage Program (IHCP) and the reformed small group market is called the Small Employer Health Benefits Program (SEHBP).

The IHCP covers individuals without access to group coverage, including sole proprietors and their families. Health insurance premiums in the IHCP are based on community rating and standardized plans are offered. Only recently has the IHCP begun offering plans with premiums

based on modified community rating that vary by 3.5 to 1, based on age, gender, and geography, but not health status. These are dubbed "Basic & Essential" plans (B&E) because the standard B&E plan includes only minimum benefits.

Unfortunately, the IHCP has been struggling to maintain enrollment and keep premiums affordable. In 2005, the average annual premium per enrollee in the IHCP was $4,744, while in the SEHBP the average annual premium per enrollee was $3,524[6] and enrollees in the individual market usually purchase less rich policies with more cost sharing than those in the small group market. In addition, enrollment in the IHCP declined from 220,384 at the end of 1995 to 77,571 at the end of 2005.[7]

Enrollment increased somewhat in 2006, when the IHCP began to allow insurance carriers to add benefits to the B&E policies through coverage riders. This resulted in a richer benefit package, while premiums were still determined by modified community rating. Since then, enrollment in B&E policies has increased, as these policies are particularly attractive to young adults who benefit from lower premiums. In the third quarter of 2007, enrollment in the IHCP was 87,579, about 29% of which were enrollees in B&E plans.[8] Outside of the B&E policies, enrollment in the IHCP has continued its decline.

The SEHBP covers small businesses with two to fifty employees and their families. Health insurance premiums are determined using modified community rating based on age, gender, and the location of the business. Rates may vary two-to-one across eligible subgroups. Standardized plans are offered, though there is great flexibility in how these standard plans are implemented. Carriers are allowed to alter standard plans by submitting riders that detail any reductions or additions in benefits relative to the standard plan. The result is that a wide variety of insurance products are offered in New Jersey's SEHBP.

Since 1995, enrollment in the SEHBP has been steady at around 900,000.[9] Average annual premiums per enrollee in the SEHBP were similar to New Jersey's fully insured large group market in 2005, $3,524 in the SEHBP and $3,603 in the large group market.[10] In fact, in 2005, the percentage of New Jersey's full-time eligible employees that enrolled in coverage at small firms that offered coverage was slightly higher than the national average, 78.9% in New Jersey and 78.5% in the nation.[11]

New Jersey policymakers consider the IHCP unstable because of declines in enrollment and increases in premiums. In addition, it is widely believed that sole proprietors are fleeing the IHCP by employing their spouse as a means of joining. As a result, the difficulties of the IHCP impact the SEHBP. The incentive for families to move from the IHCP to the SEHBP is magnified by differences in permitted rating variations by age. When policymakers consider solutions for the IHCP they often consider changes to the SEHBP because they were part of the same reform package. However, some in the insurance industry feel this is unfair to the SEHBP, which is currently a healthy and stable market.

Many ideas have been proposed to remedy the difficulties of the IHCP market including reinsurance, risk pools, and merging with the small group market. A reinsurance mechanism could control costs in the IHCP by allowing insurance carriers to share the risk of high cost

enrollees with other carriers or the state government.[12] When claims costs attain a predetermined amount, the reinsurance mechanism covers some or all of the claims until an upper threshold is reached, at which time the originating insurance carrier again assumes full risk for claims. High risk pools separate higher cost enrollees in the individual market from other enrollees, making premiums for healthy individuals much more affordable. Those in the high risk pool may still enroll in a comprehensive private market insurance product at about 125% to 200% more than the average individual market rate. The balance of the cost for insuring these high risk individuals is funded either by the state or through an assessment on health insurance carriers in the state. Reinsurance mechanisms or high risk pools that require state funding are not currently being considered because of New Jersey's current fiscal challenges. Reinsurance or high risk pools funded through assessments on New Jersey's insurance carriers may be possible. However, these assessments are often passed on to the insured population through higher premiums for coverage. As such, these options have garnered little interest among policymakers.

Some have championed the idea of merging the IHCP and SEHBP including Commissioner Steven Goldman of the New Jersey Department of Banking and Insurance. Those who oppose merging the markets are concerned that bringing individuals and sole proprietors into the small group market will increase premiums for all small groups. Insurers report that individuals and sole proprietors are more costly than groups because individuals can self-select into policies that match their medical needs and group contract provisions offer greater protection to insurers than individual policies.[13] Commissioner Goldman would like to merge the markets and add a reinsurance mechanism to control premiums for older individuals in the IHCP, to prevent a negative impact on premiums for those in the SEHBP. Data estimates from the NJ DOBI indicate that merging the individual and small group markets, without a reinsurance mechanism, would increase premiums in the small group by less than 1% and would insure approximately an additional 100,000 people. According to DOBI and an independent study, bringing age rating into the individual market would increase enrollment and stabilize premiums by attracting more young enrollees.[14] In addition, the lower risk profile of the small group market would further stabilize the IHCP.

Other stakeholders believe that sole proprietors bear similar risk to small groups of two spouses that are permitted to enroll in the small group market. They question the equity in allowing groups of two to benefit from reduced premiums in the small group market, while sole proprietors are subject to higher premiums in the IHCP. However, taking sole proprietors out of the IHCP would damage the IHCP risk pool and reforms to that market would be necessary to maintain access to coverage for those not offered coverage through an employer.

In March of this year, a new bill, introduced by a bipartisan group of state legislators led by Senator Joseph Vitale, would institute regulatory changes in the IHCP and SEHBP with the hope of stabilizing the IHCP and making both markets more affordable. There appears to be strong support among state policymakers for these reforms. The bill proposes modified community rating based on age with 3.5 to 1 rate bands for the IHCP market, in addition to the Basic & Essential plans already offered that allow for rating variation based on age, gender, and geography. The bill also requires that carriers participating in the SEHBP also participate in the IHCP. The number of standard plans required in the IHCP and SEHBP would be reduced from

five to three. Also, carriers offering policies in the IHCP would be allowed to use riders to modify the standard plans with both additions and reductions in specified benefits.

In the large group fully insured market, premiums can be based on age, gender, location of the business, health status, medical claims experience, and other factors. However, the same premiums must be charged to all enrollees in the group without discrimination against individual members of the group that may be higher cost or higher risk than others. All fully insured health insurance plans in New Jersey are guaranteed issue and guaranteed renewable.

New Jersey does require certain mandated benefits in all fully insured health insurance plans including those sold in the SEHBP.[15] These benefits are mandated through legislation. However, the legislature may refer proposed mandate bills to an advisory commission made up of seventeen members. This advisory commission reviews the bill and makes recommendations based on the social and financial impact of the mandate as well as the medical efficacy of the proposed health benefit. There are currently thirty-one mandated benefits in New Jersey including coverage for alcoholism treatment, mental illness, bone marrow transplants, congenital bleeding disorders, home health care, and nursing home care. Infertility and diabetes treatment are mandated for the large group market but not the SEHBP or IHCP. However, coverage for diabetes treatment is already included in SEHBP and IHCP standard plans. Regulators did not feel that New Jersey's benefit mandates affect health insurers' decision to do business in the SEHBP, perhaps because our mandates are not more onerous than in other states.

As with all fully insured health insurance plans in New Jersey, since 2006, the SEHBP allows for health insurance coverage of domestic partners in civil unions. Also, in 2006, New Jersey enacted a coverage expansion to include over-age adult dependents less than thirty years old with continuous coverage under a parent or guardian's policy from age eighteen. These expansions allowed for greater access to health insurance coverage, including the SEHBP.

II. REFORM

Political Origins

Prior to New Jersey's small employer health insurance reforms, the percent of uninsured residents had grown from 7.9 in 1987 to 13.3 in 1992.[16] At that time, insurers could choose not to insure certain individuals or groups if they might be high risk or have known pre-existing conditions.[17] Blue Cross Blue Shield of New Jersey was the insurer of last resort so they did offer coverage to all individuals and small groups. However, premiums charged could be very high and incorporate age, gender, geography, industry, and health rating. Even for individuals and small groups offered coverage, premiums could vary greatly making insurance coverage very expensive for older and sick residents. In fact, insurers could deny coverage for pre-existing conditions forever. This created 'job lock' as employees needed to remain with their current employer in order to hold on to coverage for a health condition. A few insurers would do post claim underwriting and terminate groups based on claims experience.

Legislators in the state Assembly and Senate supported reforming these markets in response to pressure from the public, business associations, most notably the New Jersey Business and Industry Association (NJBIA), and some health insurers that desired a fair chance to compete for contracts offering reliable coverage. In particular, a coalition of business and retail merchant representatives called the HEAL Coalition (Help Establish Affordable Healthcare Laws) was formed to work with carriers to reform the markets and create greater accessibility and portability of coverage. Insurance brokers and agents were initially against the reform because they were concerned that too few plan options would be offered and that small groups would no longer seek or need their assistance in choosing a policy. However, as the reforms were worked out it became apparent that coverage riders would allow small groups many choices for coverage and that brokers could still play a role in assisting them with selecting the best coverage option for their group. In fact, the small group is easier for brokers to manage under the reform because they need not be concerned that individual employees will be denied coverage or premiums could vary greatly across enrollees.

Stakeholders in the SEHBP including regulators, insurers, and brokers report that the SEHBP is healthy. Enrollment is considered good and there are many coverage options with several different carriers. The loss ratios are high so the premiums are appropriate relative to claims. However, small businesses and their employees feel that premiums are expensive in the SEHBP. This is a reflection of medical inflation that has increased insurance costs for all group sizes. Some stakeholders feel that high premiums in this market keep enrollment below what could be achieved and that lack of enrollment growth in the SEHBP may indicate that the market is not meeting the needs of all small businesses.

When stakeholders were asked whether the SEHBP has become institutionalized and broadly supported or controversial, all responded that it is institutionalized. Some stakeholders have concerns about the market, but in general they feel that it is broadly supported.

Description of the Small Employer Health Benefits Program

The SEHBP is based on five standardized plans and an HMO. All insurance carriers in the SEHBP must offer the five standard benefit plans, A through E.[18] Plan A is the most basic, covering only hospitalization. Plans B through E are comprehensive medical plans covering the same medical and hospital services but at different rates of coinsurance (the percentage of costs covered by the insurance plan). Plan B has a 60% coinsurance rate, plan C has a 70% coinsurance rate, plan D has an 80% coinsurance rate, and plan E has a 90% coinsurance rate. Carriers are allowed to be flexible in how they structure these plans. For example, they can offer PPO or POS plans as long as either the in-network or out-of-network coinsurance rate matches the rate of one of the standard plans. A standard HMO plan designed by the Board is also available. In March 2008, legislation was introduced that may reduce the number of standard plans offered in the SEHBP to three.

Insurers are also permitted to submit riders to these five standardized plans that either add to or take away from benefits of the standard plans. So, in practice, many plans are available to small

businesses in this market. Policies sold in the SEHBP vary greatly by coverage, premium, and network of providers.

The SEHBP, like other small employer markets, is guaranteed issue. So, small employers and their employees can not be denied coverage or renewal. In order for a small employer to participate in the SEHBP, 75% of the business's full-time (25 hours per week or more) employees must be enrolled in group coverage, through that small employer, another group plan, or Medicare. Small employers in the SEHBP must also contribute a minimum of 10% of the total health insurance premium.

Premiums in the SEHBP are determined using modified community rating where rates can vary by 2 to 1 and can be based on age, gender, and the location of the business, but not health status of the employees. When the SEHBP reform was first implemented the plan was to start off rating the small group market using 3 to 1 rate bands and then move the market to 2 to 1 rate bands, and then pure community rating. However, soon after the legislation was passed, the Board did a study to assess the impact of moving this market to pure community rating and found that they should not. New legislation was later passed to freeze the rate bands for the SEHBP at 2 to 1.

Health insurance carriers may impose a six-month limitation on coverage of pre-existing conditions for small businesses with 2-5 employees for conditions that were diagnosed or treated within six months of enrollment in the SEHBP (except pregnancy).[19] Enrollees can receive credit toward the pre-existing condition waiting period with prior health insurance coverage. Therefore, those insured for the six months prior to enrollment in the SEHBP plan would not be subject to the pre-existing condition exclusion. Carriers may not impose pre-existing condition exclusions on small businesses with 6-50 employees.[20]

Implementation and Management

As described earlier, the New Jersey Department of Banking and Insurance oversees and regulates health insurance markets in the state including the SEHBP. A staff of three or four does the administrative work of managing the SEHBP as well as the IHCP. This staff reviews and approves insurers' requests for modifications to the standardized plans. Enrollment reporting, premium comparisons and the loss ratio requirement described below are also managed by the DOBI staff.

The SEHBP is run by a Board of Directors made up of eighteen members including insurance carriers, brokers, a physician, representatives of small businesses and others.[21] Members of the Board of Directors are nominated by the SEHBP Executive Director and appointed by the Governor's office. The Board meets monthly and members serve without compensation. The Board is a state agency with rulemaking authority and its administrative costs are funded by assessments on health insurers, though costs are minimal. The Board and DOBI staff are responsible for implementing any legislative changes to New Jersey insurance regulation that impact the SEHBP.

Prior to the small group reform, DOBI had prior-approval authority for premiums charged to small employers. However, this process led to significant delays in bringing new plans to the market. In addition, when DOBI did not approve a rate, the insurer would sometimes initiate litigation. This process was costly and time consuming for both DOBI and insurers. Under the SEHBP, neither DOBI nor the Board regulates premiums charged by insurers in the market, though carriers are required to file rates with DOBI prior to using them.

To insure that premiums charged to small group enrollees are not exorbitant, insurance carriers are required to have a minimum loss ratio of 75%, so that at least 75 cents of every premium dollar is paid out as claims for health services. If this minimum loss ratio is not met then carriers must pay that portion back to policyholders. In 2006, the overall loss ratio for the SEHBP was 81.8% after three insurers made premium refunds to policyholders.[22] Overall loss ratios in New Jersey's small group market in 2005 were similar to the fully insured large group market, but lower than in the IHCP.[23] Legislation introduced in March 2008 would increase the minimum loss requirement to 80%.

Most regulators felt that the SEHBP was not difficult for the state to manage. However, insurance carriers did feel that it was at least somewhat administratively burdensome. The biggest management issue cited by stakeholders was the use of the standardized plans in the SEHBP. Insurers in the SEHBP must submit several forms in order to describe an insurance product that they would like to introduce. They submit a form to describe the new product as a standard plan and then rider forms describing the benefits they are adding and/or taking away. Instead, insurers would like to submit one set of paperwork that describes the plan as it is, as is done in other states. This administrative process means that insurers have to submit and maintain additional paperwork to operate in New Jersey's SEHBP and some argue that these costs are passed on to consumers in their premiums.

In addition, some feel that the standard plans in the SEHBP are obsolete and should be updated to include products commonly sold in today's health insurance markets. The process for changing standard plans in the SEHBP is somewhat cumbersome for the Board, DOBI, and insurers. Changes to the SEHBP market are difficult because the market was created through a lengthy rule-making process required by legislation. So, altering rules that are no longer ideal may require months to be implemented. Some have suggested that a reduced standard benefit package should be permitted so that carriers can offer lower cost options in the SEHBP. However, regulators fear that offering a less rich standard plan will reduce benefits below what is acceptable and enrollees may not realize that the benefits are limited until they try to file a claim.

New legislation introduced in March 2008 would continue the use of standard plans (though the number of standard plans would be reduced from five to three) and allow insurance carriers to use riders to modify those standard plans. In addition, to improve price transparency in this market, the legislation would require that the price for the standard plan be listed separately from the price adjustment(s) for riders to the standard plan. In this way, employers can compare the cost of different policies within and across carriers and better understand how the price was derived. Similarly, agents and brokers would be required to disclose their fees and commissions to employers.

Another concern raised about small group market regulations is that employers are permitted to offer an unlimited number of plans. This allows employees to choose plans to meet their health care needs, which may result in adverse selection. Carriers contend that adverse selection into richer plans is raising premiums in those plans and making them unstable. In addition, enrollment in multiple plans is complex and costly for carriers to administer. A legislative bill introduced in March 2008 would still allow employers to offer multiple plans, but would require that the employer only offer policies from one insurance carrier. This may help insurance carriers to limit adverse selection across plans. Until recently, employees in the SEHBP could also switch plans as frequently as they wanted. However, after much discussion, the Board agreed to allow a plan change only once in twelve months at renewal. This change reduced the ability of enrollees to move into richer benefit plans when they need medical care, and to return to less rich plans when they are healthy.

Finally, over the past few years, the SEHBP Board has been considering the choice of fee schedule for out-of-network claims. The SEHBP currently requires insurers to reimburse out-of-network claims at 80% of Ingenix's Prevailing Healthcare Charges System (PHCS) commercial pricing data. However, insurers argue that these fees are inflated because they are based on whatever a physician chooses to bill major insurers for their services. Insurers contend that this fee schedule results in higher premiums for plans with out-of-network benefits and that changing this fee schedule would lower premiums for popular insurance products.

The alternative to the current fee schedule is the Medicare Resource Based Relative Value Scale (RBRVS) physician payment schedule and then reimburse at 150% to 200% of these rates. However, Medicare rates are routinely criticized by providers for being too low. Some products sold in New Jersey's large group market already use the RBRVS fee schedule and insurance carriers would like this fee schedule to apply to the small group as well.

Program Effectiveness

Most stakeholders and regulators consider the SEHBP a success. In 2005, almost two-thirds of small firm establishments offer health insurance and over 80% of full-time employees of small businesses are at firms that offer insurance (Figures 4 and 5). Enrollment in the SEHBP market grew from 1994 when the program was first implemented to 1999 and then leveled off and has remained stable since (Figure 8). Ten different insurance carriers participate in the SEHBP, and competition is considered adequate. Horizon BCBSNJ, Aetna, and United Healthcare/Oxford insure the greatest proportion of the small group market (Horizon 44%, Aetna 25%, and United Healthcare/Oxford 17% in the third quarter of 2007).[24]

Stakeholders also agree that the SEHBP reform has achieved intended objectives for the market. The main objective of the reform was to guarantee accessibility to health insurance coverage for employees of small businesses, especially those with significant health problems. Guaranteed issue and guaranteed renewability (now required in all small employer markets as per federal Health Insurance Portability and Accountability Act legislation) ensure access to the market and portability of coverage. In addition, keeping the employer contribution requirement low, using modified community rating to keep premiums reasonable, and including family coverage

resulted in more small businesses offering coverage through the SEHBP. Many more employees of small businesses in New Jersey have access to coverage than in the nation as a whole (Figures 4 and 5). The reform also sought to reduce coverage restrictions based on pre-existing conditions, which it did.

The greatest challenge to the SEHBP, as in other New Jersey markets, is that some may not be able to access coverage because of unaffordable premiums. The impact of medical inflation on premiums affects all New Jersey health insurance products, not just the SEHBP. However, average premiums in the SEHBP remain higher than the average for large groups (Figures 6 and 7). This trend is more acute in New Jersey than in the nation as a whole where premiums for single coverage among small firms was less than $200 more than large firms and premiums for family coverage in small firms were actually less than in the large firms.[25]

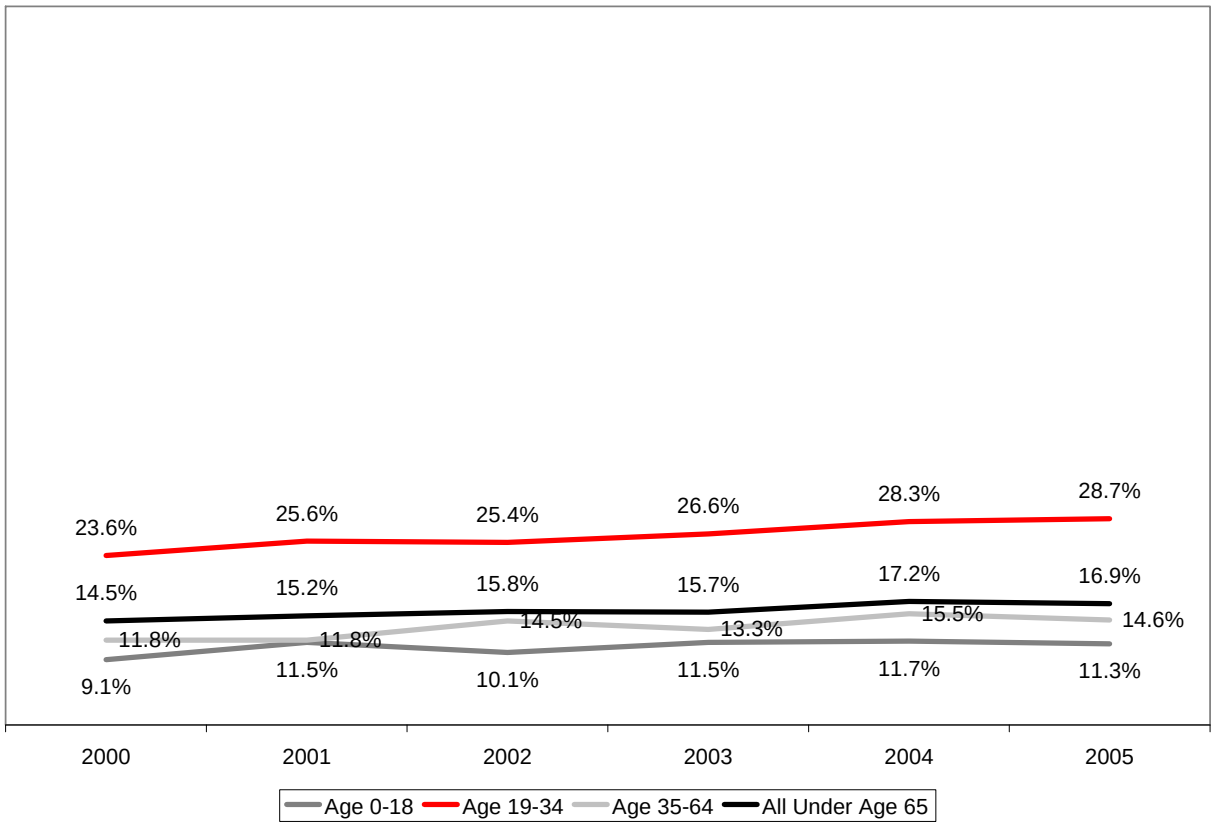
Stakeholders point to one factor in particular that contributed to the successful implementation of the SEHBP reform and that is the creation of a diverse Board of Directors. High level representatives of all the key stakeholders in the market were able to share their expertise and perspectives early on and have a say in how the legislation was implemented. As a consequence, these stakeholders supported the final market regulations. Since then, the Board's impact has diminished as it now makes fewer decisions about the market's structure, but is instead focused on enforcing SEHBP rules and maintaining gains in health insurance coverage accomplished through these initial reforms.

CASE STUDY STAKEHOLDER INTERVIEWS

NAME	TITLE AND ORGANIZATION*
Ellen DeRosa	Executive Director NJ Individual and Small Employer Health Benefits Program Boards
Ward Sanders	President NJ Association of Health Plans
Gale Simon	Assistant Commissioner NJ Department of Banking and Insurance – Life and Health
Christine Stearns	Vice President of Health and Legal Affairs NJ Business and Industry Association
Jim Stenger	Principal NAS Financial Services Small Employer Health Benefits Program Board Chairperson
Lilton (Tony) Taliaferro	Vice President AmeriHealth Small Employer Health Benefits Program Board Vice Chairperson
Neil Vance	Managing Actuary NJ Department of Banking and Insurance – Life and Health

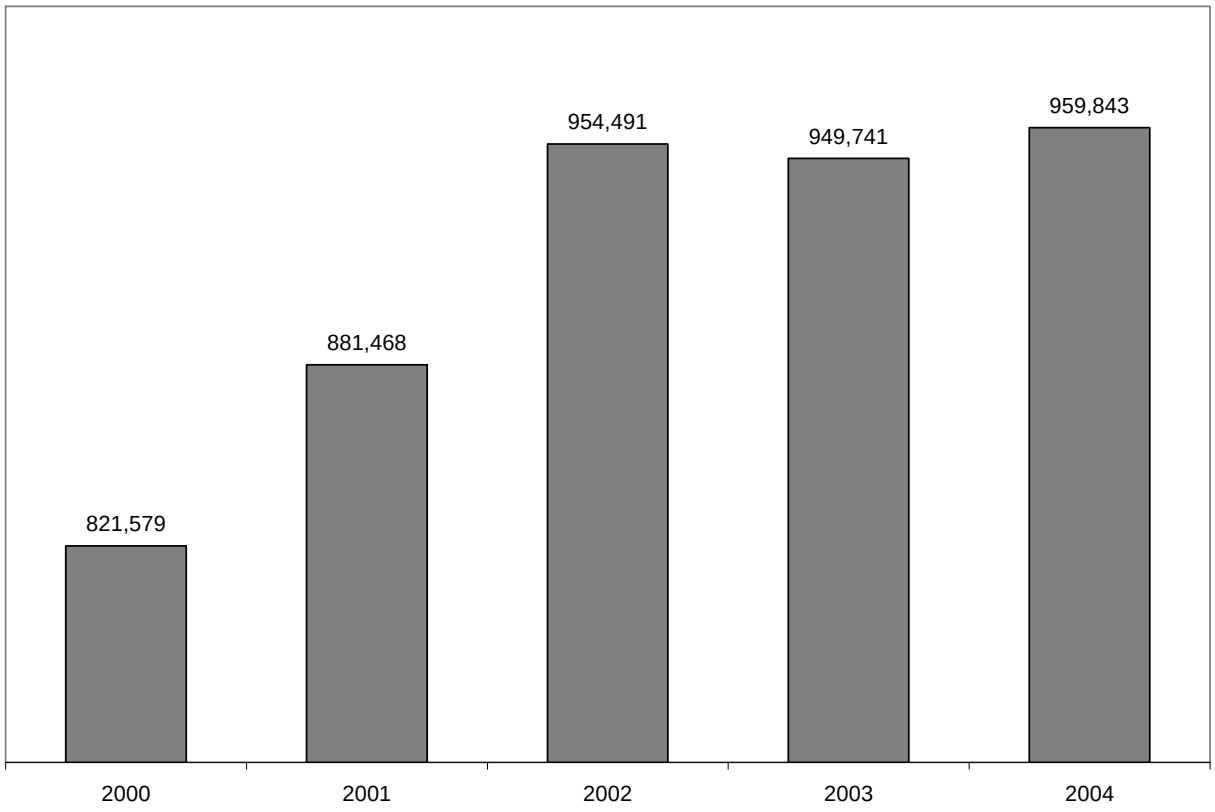
* Opinions expressed by case study interviewees are their own and not the opinions of their organization or the Small Employer Health Benefits Program Board.
Note: Stakeholder interviews were conducted in February 2008.

Figure 1: New Jersey's Percent Uninsured by Age, 2000-2005



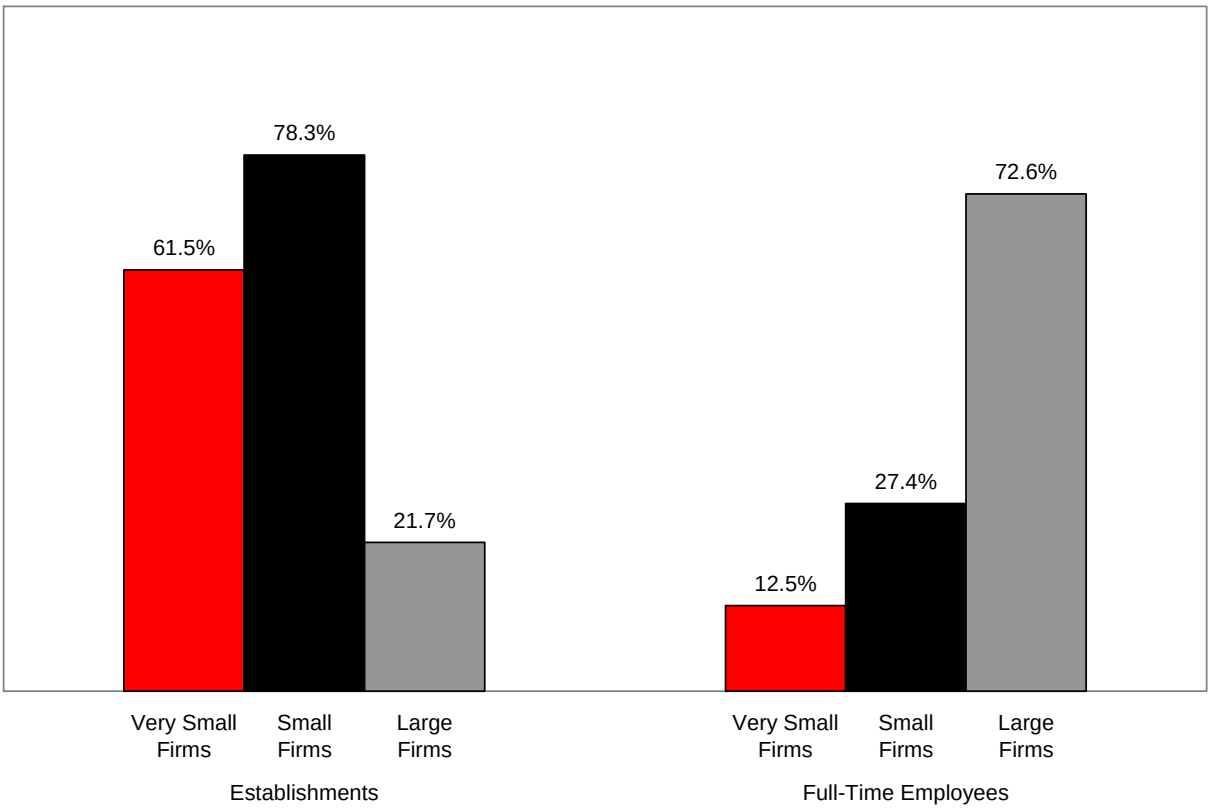
Source: Current Population Survey, Annual Demographic File, Bureau of the Census. Data analyzed by The Center for Health Statistics, NJ Department of Health and Senior Services. Accessed on 1/14/08 at http://www.state.nj.us/health/chs/hic.shtml.

Figure 2: New Jersey Medicaid and SCHIP Beneficiaries, 2000-2004



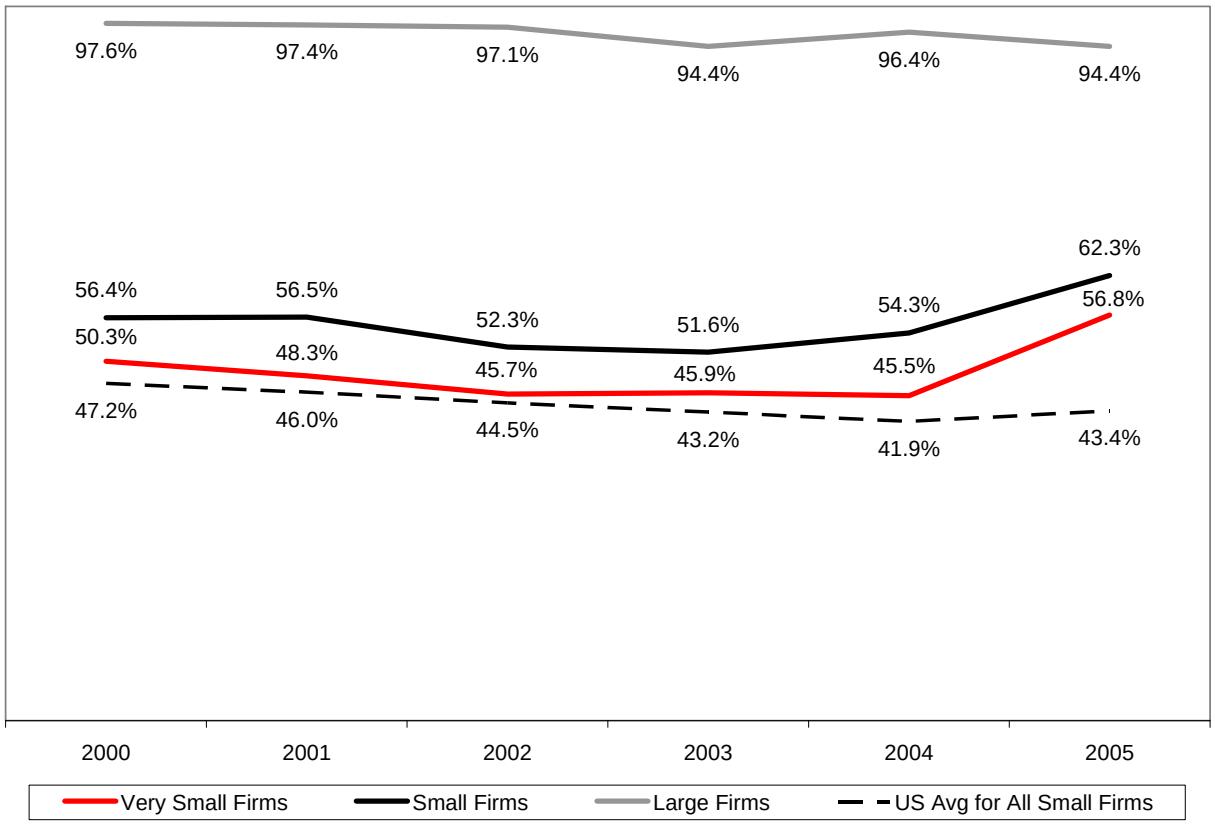
Source: U.S. Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations, National MSIS State Summary Tables, Revised 6/22/2007. Accessed on 1/15/2008 at www.cms.hhs.gov/MedicaidDataSourcesGenInfo/02_MSISData.asp#TopOfPage.

Figure 3: New Jersey Businesses and Full-Time Employees by Firm Size, 2005



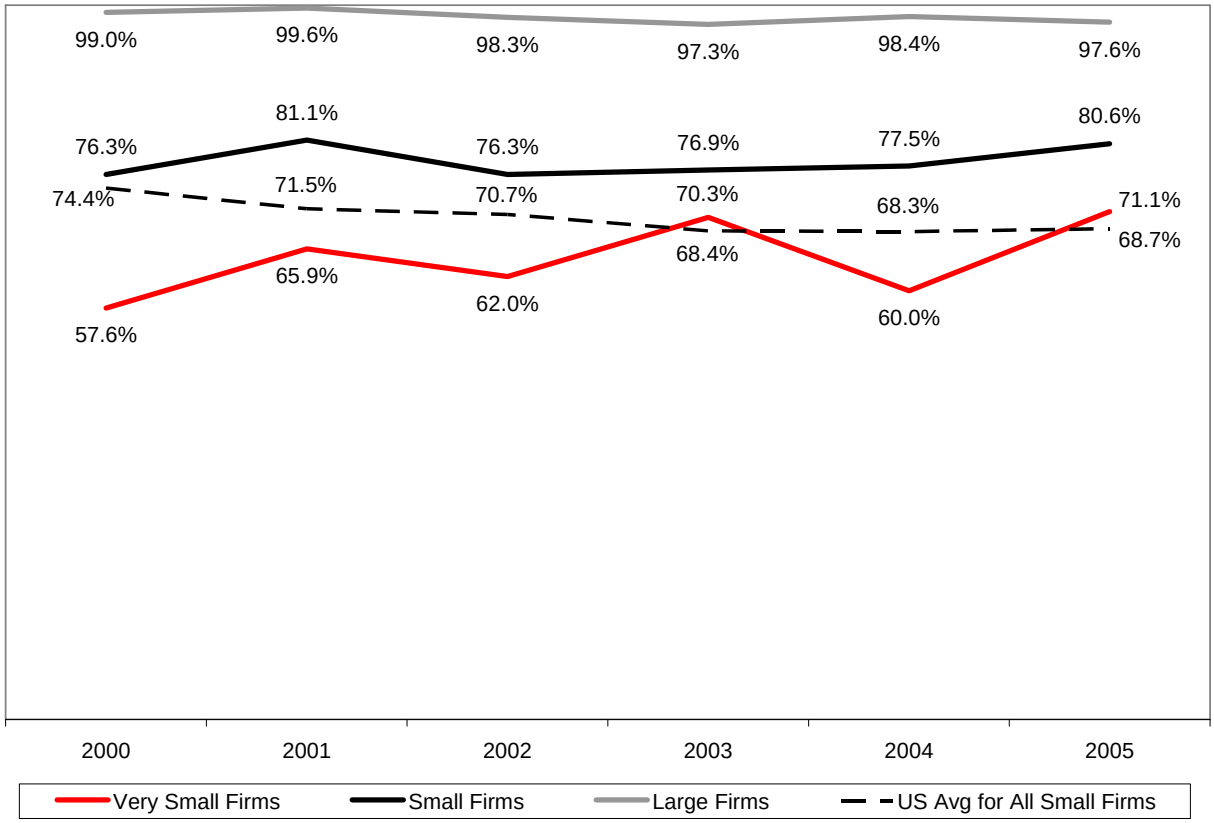
Note: The designation of 'Very Small Firms' corresponds to the MEPS-IC category of 2-9 employees. 'Small Firms' corresponds to the MEPS-IC category of 2-49 employees. 'Large Firms' corresponds to the MEPS-IC category of 50+ employees. The MEPS-IC firm size categories do not exactly match NJ small group health insurance market sizes, which include firms with 2-50 employees.
Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Medical Expenditure Panel Survey – Insurance Component. Accessed on 1/17/2008 at http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2.

Figure 4: Percent of New Jersey Establishments that Offer Health Insurance, 2000-2005



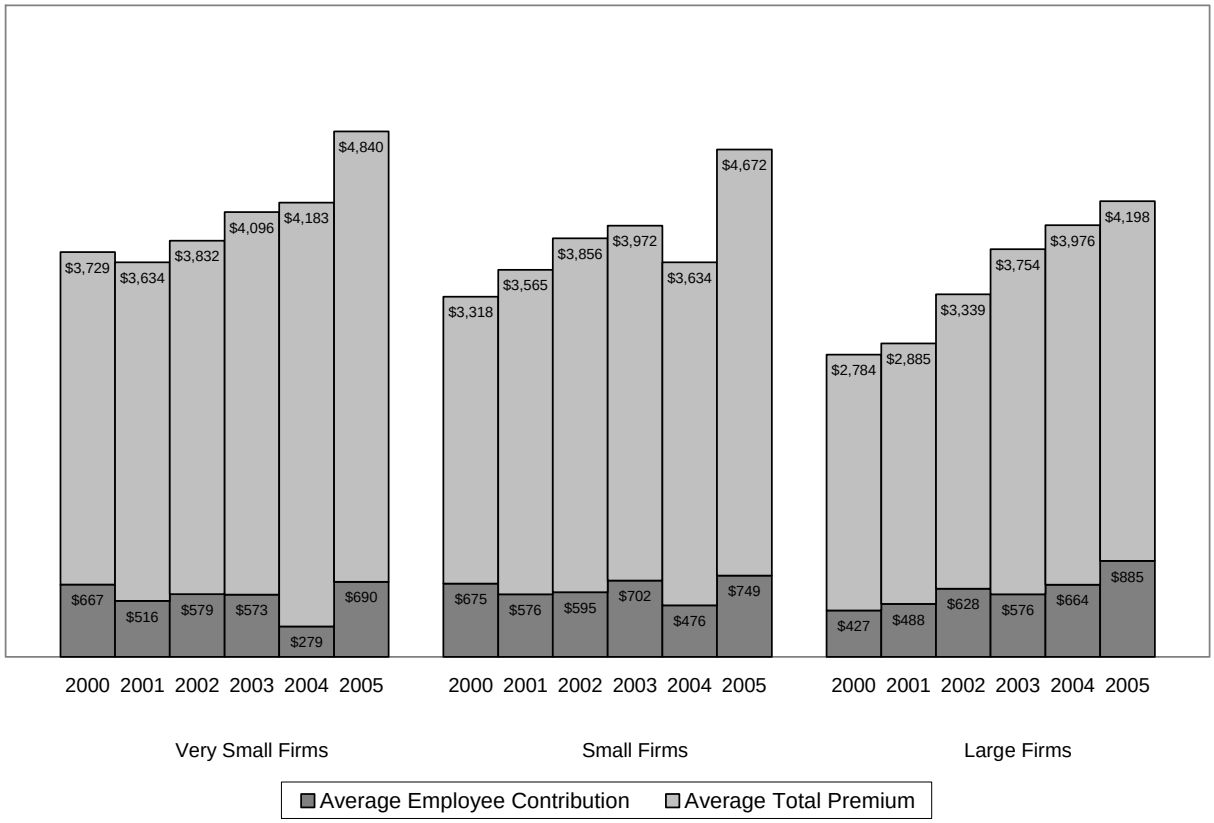
Note: The designation of 'Very Small Firms' corresponds to the MEPS-IC category of 2-9 employees. 'Small Firms' corresponds to the MEPS-IC category of 2-49 employees. 'Large Firms' corresponds to the MEPS-IC category of 50+ employees. The MEPS-IC firm size categories do not exactly match NJ small group health insurance market sizes, which include firms with 2-50 employees.
Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Medical Expenditure Panel Survey – Insurance Component. Accessed on 1/17/2008 at http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2.

Figure 5: Percent of New Jersey Full-Time Employees at Establishments that Offer Health Insurance, 2000-2005



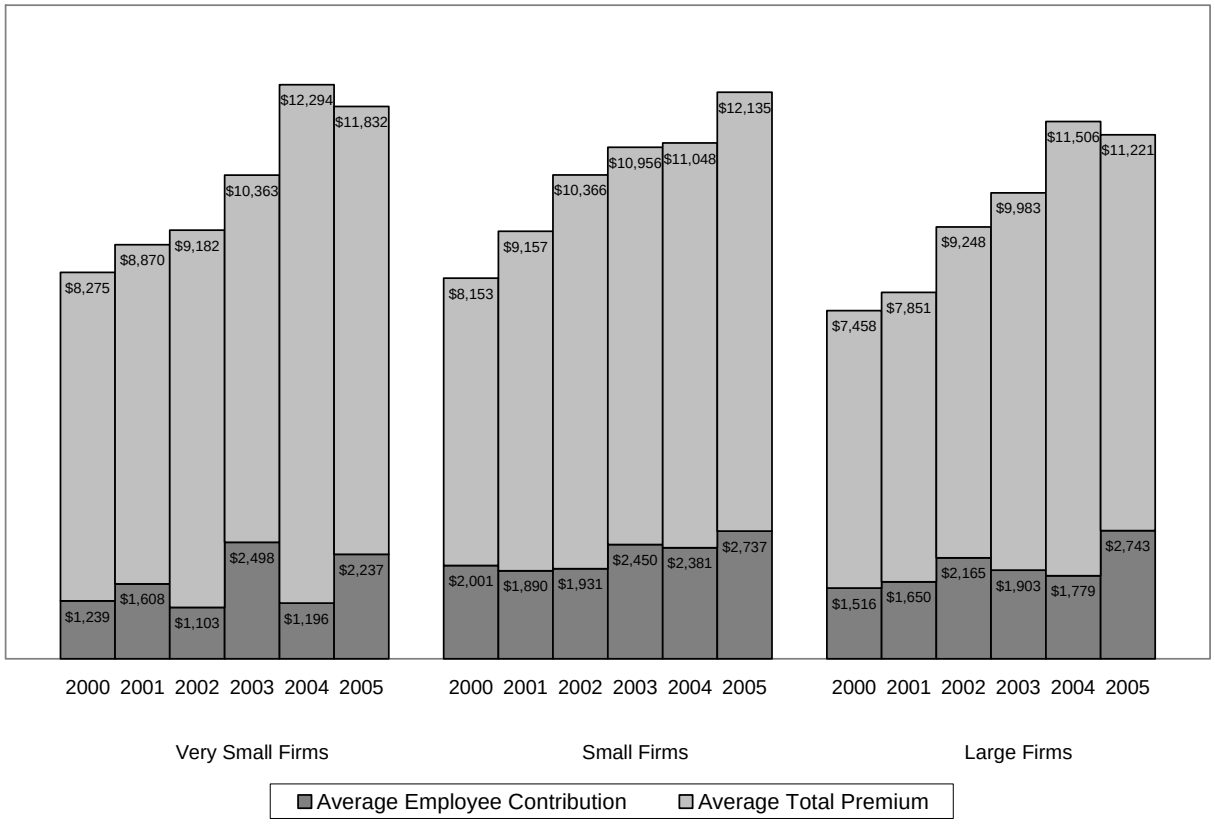
Note: The designation of 'Very Small Firms' corresponds to the MEPS-IC category of 2-9 employees. 'Small Firms' corresponds to the MEPS-IC category of 2-49 employees. 'Large Firms' corresponds to the MEPS-IC category of 50+ employees. The MEPS-IC firm size categories do not exactly match NJ small group health insurance market sizes, which include firms with 2-50 employees.
Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Medical Expenditure Panel Survey – Insurance Component. Accessed on 1/17/2008 at http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2.

Figure 6: Average Total Premium and Employee Contribution for Single Coverage in New Jersey, 2000-2005



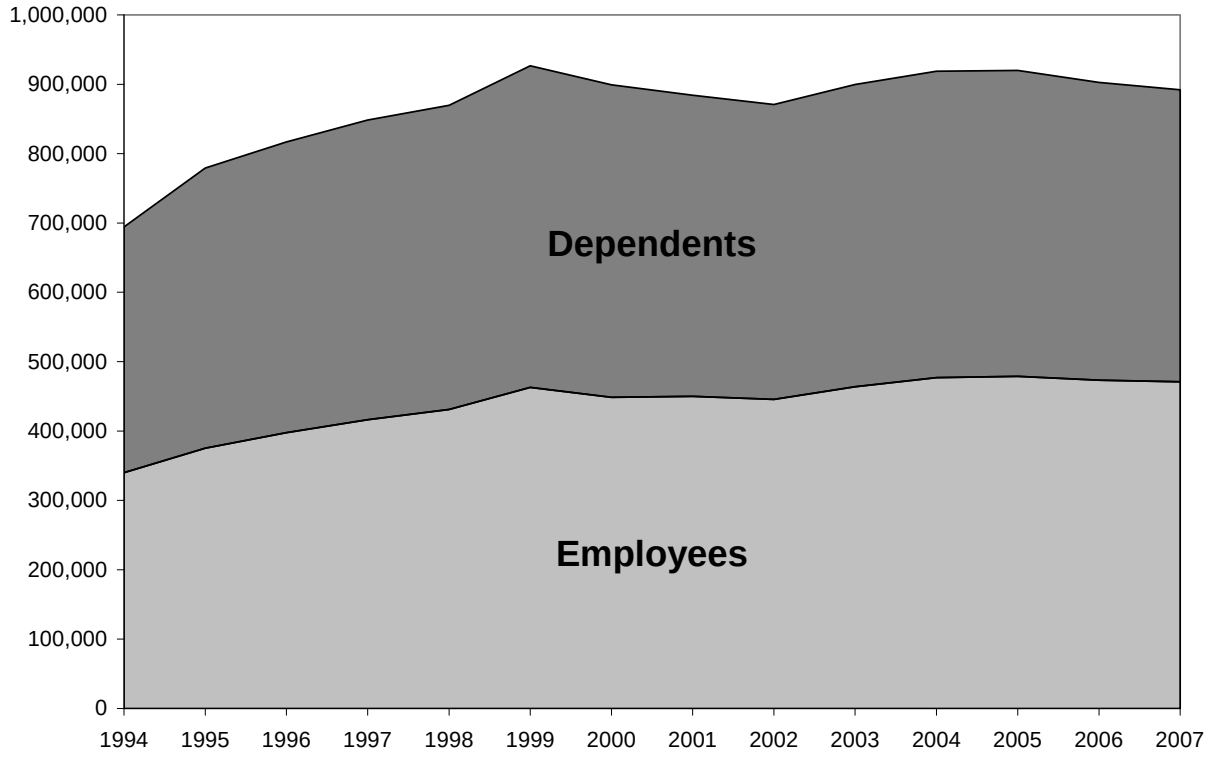
Note: The designation of 'Very Small Firms' corresponds to the MEPS-IC category of 2-9 employees. 'Small Firms' corresponds to the MEPS-IC category of 2-49 employees. 'Large Firms' corresponds to the MEPS-IC category of 50+ employees. The MEPS-IC firm size categories do not exactly match NJ small group health insurance market sizes, which include firms with 2-50 employees.
Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Medical Expenditure Panel Survey – Insurance Component. Accessed on 1/17/2008 at http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2.

Figure 7: Average Total Premium and Employee Contribution for Family Coverage in New Jersey, 2000-2005



Note: The designation of 'Very Small Firms' corresponds to the MEPS-IC category of 2-9 employees. 'Small Firms' corresponds to the MEPS-IC category of 2-49 employees. 'Large Firms' corresponds to the MEPS-IC category of 50+ employees. The MEPS-IC firm size categories do not exactly match NJ small group health insurance market sizes, which include firms with 2-50 employees.
Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Medical Expenditure Panel Survey – Insurance Component. Accessed on 1/17/2008 at http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2.

Figure 8: Historical Enrollment in New Jersey's Small Employer Health Benefits Program, 1994-2007



Note: Note: Data for 1993-2006 are from the fourth quarter. Data for 2007 are from the third quarter.
Source: NJ Department of Banking and Insurance, Insurance Division. Historical Comparison of Enrollment Data 3rd Quarter – 2007. Accessed on 1/15/2008 at www.nj.gov/dobi/reform.htm.

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[20] The only exception to this is for late enrollees who were uninsured before enrolling in the SEHBP.
[21] New Jersey Department of Banking and Insurance, "What Is New Jersey Health Insurance Reform?" Accessed on 1/7/2008 at www.nj.gov/dobi/ihc_seh.htm.

[22] NJ Department of Banking and Insurance Memo from R. Neil Vance, FSA, Managing Actuary, Life & Health Actuarial and Avnee Parekh, ASA, Actuarial Analyst, Life & Health Actuarial to Ellen DeRosa, Executive Director, SHE/IHC Boards, dated February 15, 2008, re: SEH Loss Ratio and Refund Reports for 2006.
[23] In 2005, the loss ratio for the small group market was 81.4%, the loss ratio for the individual market was 85.1%, and the loss ratio in the large group market was 81.7%. NJ Department of Banking and Insurance, Life and Health. New Jersey Commercial Health Market – 2005 Preliminary Report. Complete data for 2006 were not available.
[24] NJ Department of Banking and Insurance, Insurance Division. Historical Comparison of Enrollment Data 3rd Quarter – 2007. Accessed on 1/15/2008 at www.nj.gov/dobi/reform.htm.
[25] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2005 Medical Expenditure Panel Survey – Insurance Component. Accessed on 1/17/2008 at http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2.

APPENDIX C. Field Research Report — Minnesota

Minnesota Comprehensive Health Association (MCHA):

Field Research Report

Prepared for:
Rockefeller Institute of Government and New York State Health Foundation

By:
Donna L. Spencer, M.A. and Lynn Blewett, Ph.D.
University of Minnesota

May 1, 2008

Introduction

This report was prepared as part of a state health policy research project led by the Rockefeller Institute of Government's New York State Health Policy Research Center (HPRC) and funded by the New York State Health Foundation. The purpose of the project, "Small Group Market Reforms in the States," is to inform legislative efforts in New York State to increase health insurance coverage in the state's individual and small group markets. HPRC contracted with researchers to generate in-depth information about the small group market contexts in three other states (Maine, Minnesota, and New Jersey) and select policy approaches used by these states to broaden access to health insurance coverage. This report's focus is the state of Minnesota. The report provides information on Minnesota's small group market and one particular program in place within the state to expand coverage to the uninsured: the state's high risk pool, the Minnesota Comprehensive Health Association (MCHA). Implemented in 1977, MCHA is one of the longest-running state high risk pools, and, with current enrollment just

under 30,000 and a total funding level above $235 million, it is also among the largest and most expensive state high risk pools in the nation.

Report Approach

In preparing this report, we obtained information from several sources. First, we compiled readily available data, reports, and other information on health insurance coverage in Minneosta, the small group market in the state, and Minnesota's high risk pool. Regarding the latter, we relied on MCHA, the Minnesota Department of Commerce, the Research Department of the Minnesota House of Representatives, and key resources on state high risk pools such as the *Comprehensive Health Insurance for High Risk Individuals: A State-by-State Analysis*, the most recent version (2007/2008) of which was published by the National Association of State Comprehensive Health Insurance Plans (NASCHIP).[1]

In March and April 2008, we also spoke with key informants about MCHA. These included representatives from MCHA, the Minnesota Department of Commerce, Research Department of the Minnesota House of Representatives, and the Health Economics Program housed within the Minnesota Department of Health. All of the individuals have long-term familiarity with MCHA. Finally, we obtained additional reports and data on MCHA from these individuals, including monthly carrier reports to MCHA and MCHA reports to the Department of Commerce.

Organization of Report

The balance of this report is organized into three sections. First, we provide important contextual information for Minnesota: We present an overview of health insurance coverage and health care financing in Minnesota, introduce the small group market in the state, and summarize

key state legislation related to the regulation of the state's small group market. The next section of the report provides an in-depth summary of Minnesota's high risk pool, including its legislative history, organization and management, plan and benefit options, eligibility criteria, and financing. Finally, we highlight some of the key challenges, successes, and issues associated with MCHA.

Minnesota Context

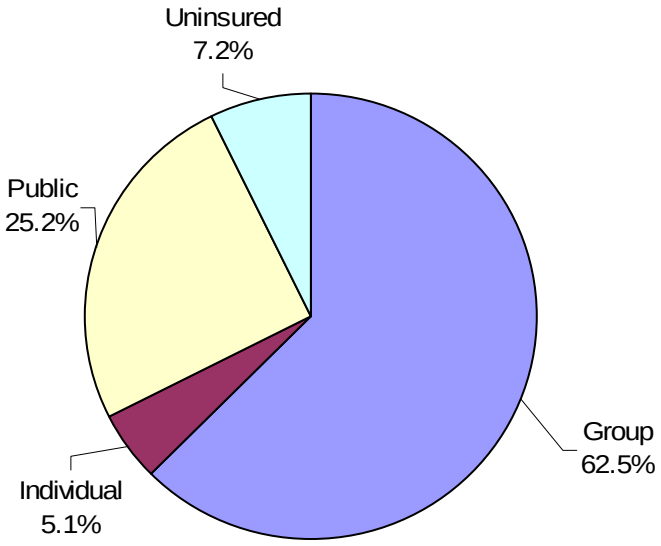
Overview of Health Care Financing and Health Insurance Coverage in Minnesota

According to data from the March Supplement of the Current Population Survey, Minnesota's rate of uninsurance was 8.6% for 2005/2006, lower than the national uninsurance rate of 15.5%. (During the same time, New York's uninsurance rate fell in between at 13.5%.)[2] A very recent state survey on health insurance coverage in Minnesota found that the uninsurance rate in 2007 was 7.2% (see Figure 1 on following page), which remained statistically unchanged from 2004 (7.7%), when the state survey was last conducted. According to the 2007 survey, 71.3% of uninsured Minnesotans are employed[3], and the percentage of these working for small businesses is 44.1%.[4]

Public programs provide health insurance coverage to 25.2% of Minnesota's total population (Figure 1). As shown in Figure 2, Medicare and Medicaid combined were the source of coverage for approximately 85.0% of those enrolled in public programs in 2005 (representing 21.2% of Minnesota's total population, data not shown[5]). MinnesotaCare, a reduced-cost program for low-income uninsured residents including adults without children, makes up 10.4% of those with public coverage, followed by Minnesota's General Assistance Medical Care (GAMC, a free state health care program for very low-income adults and children who are not eligible for other programs), and the state's high risk pool (MCHA), both of which make up less

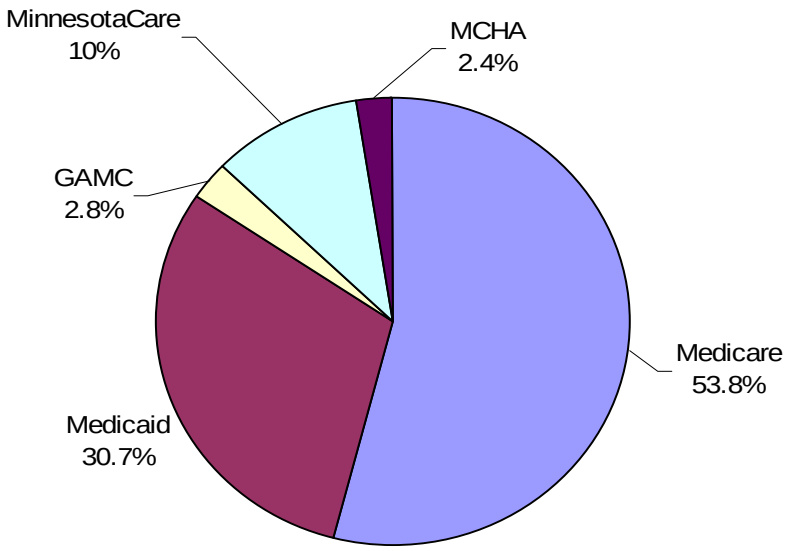
than 3.0% of public health plan enrollees. Taking into consideration the entire state population, MCHA supports less than 1% of the population overall (data not shown).[6]

Figure 1. Sources of Insurance Coverage in Minnesota (2007)



Source: Minnesota Department of Health and University of Minnesota School of Public Health (2008). Based on the state's total population.

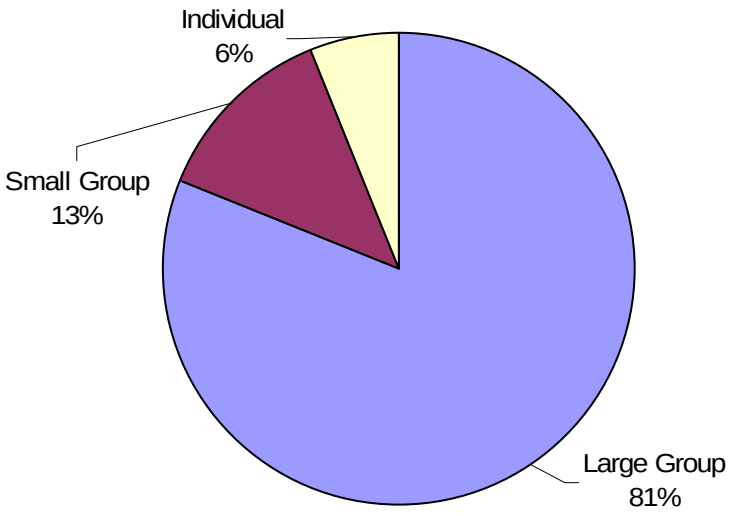
Figure 2. Composition of Public Health Insurance Coverage in Minnesota (2005)



Source: Minnesota Department of Health, Health Economics Program (2007).

The majority of Minnesotans get their health insurance coverage in the private market (67.6% in 2007, see Figure 1 above). Of those privately insured, the overwhelming majority (94%) are insured in the group market, with only 6% having coverage from the individual market (see Figure 3). In Minnesota, 81.0% of the private market is enrolled have large group health plans (plans with greater than 50 employees), and 13% have coverage through a small group plan (2-50 employees). In 2005, an estimated 40.4% of the private market was fully-insured (that is, employers pay insurers to bear the risk associated with employees' health care costs), and 59.6% were self-insured (usually large companies that elect to bear the risks themselves but may have an insurance company manage the plan).[7]

Figure 3. Composition of Private Health Insurance Market in Minnesota (2005)



Source: Minnesota Department of Health, Health Economics Program (2007a).

Small Group Health Insurance Market in Minnesota

In line with the Health Insurance Portability and Affordability Act (HIPAA) of 1996, Minnesota defines "small group" as employers with 2 to 50 employees.[8] Although, as noted above, only 13% of the private health insurance market in Minnesota was enrolled in small group health plans in 2005, approximately 91% of private-sector employers in Minnesota during the same year had fewer than 50 employees. Enrollment in fully-insured small group health plans consistently increased in Minnesota between the mid 1990s and early 2000s and amounted to over 438,644 people in 2006.[9]

Small Employer-Sponsored Health Insurance Offer and Take-Up Rates.[10] Similar to private employers in the U.S. overall, 54.3% of private firms in Minnesota offered health insurance to their employees in 2005. The majority (99.0%) of all private establishments in the state with at least 50 employees offered insurance, compared to only 41.3% of private firms with fewer than 50 employees. This pattern is similar to that found at a national level, where 95.7% of large private firms and 43.4% of small private firms provided insurance coverage. For very

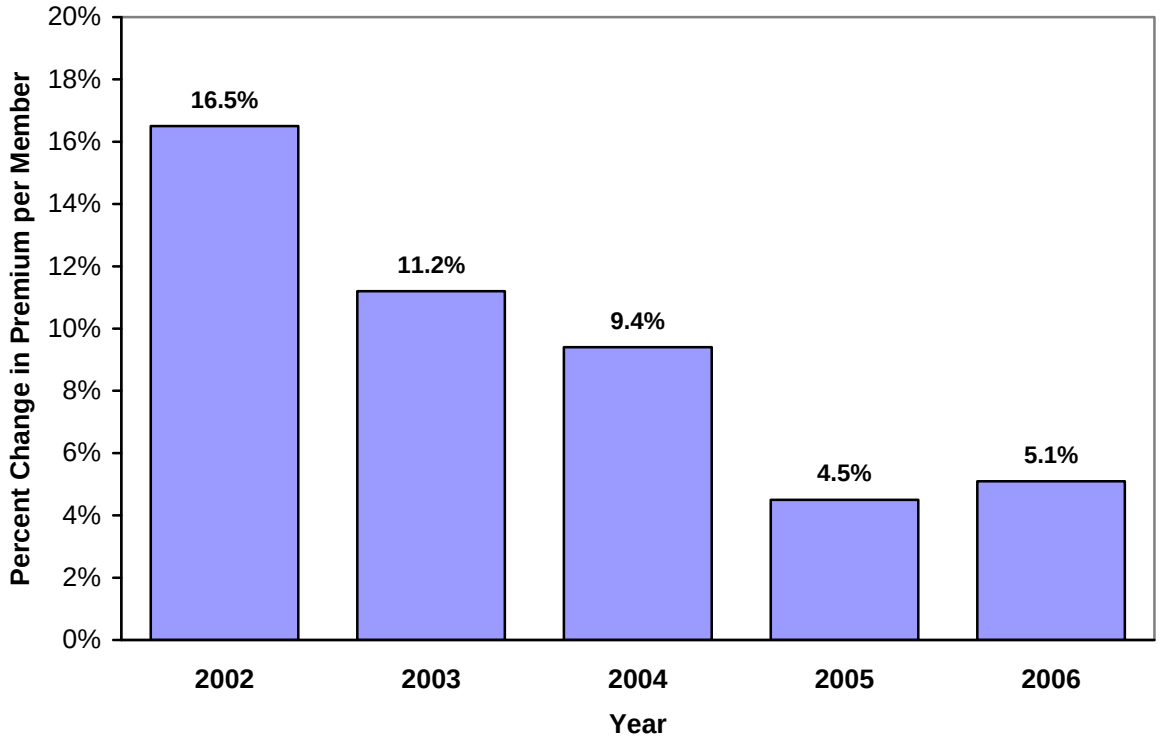
small-sized private establishments in Minnesota (i.e., those with fewer than 10 employees), the offer rate in 2005 was particularly low at 31.8%.

In terms of employee take-up of employer-sponsored insurance (ESI), 78.3% of Minnesota's private-sector employees who were eligible for coverage from their employer enrolled in coverage in 2005, which is similar to the national private ESI take-up rate of 79.6%. For private firms in Minnesota with fewer than 50 employees, the take-up rate was 80.2%. For the state's larger private establishments, the rate was 77.9%.

Premiums. Health plans in Minnesota's fully-insured small group market generated $1.5 billion in total premium volume in 2006.[11] It is important to highlight the concentrated nature of the state's small group market: Three providers in the state comprise over 90% of the small group market shares and include Blue Cross and Blue Shield (BCBS) of Minnesota (44.3%), Medica (30.7%), and HealthPartners (17.5%).[12] Minnesota is not alone in terms of its small group market: other states have highly consolidated small group markets as well.[13]

In 2006, the average small market monthly premium in Minnesota was $324 (for single coverage) and $849 (for coverage for a family of four), both of which fell higher than the national average.[14] Not surprisingly, small group market premiums in Minnesota have increased consistently in recent years (see Figure 4). The percent change in premium amount per member was particularly high in 2002, 2003 and 2004 (ranging from 9.4% to 16.5%). In 2005 and 2006, the percent increase in small group market premiums was about 5.0%.

Figure 4. Premium Increases in Minnesota's Small Group Market (2002-2006)



Source: Minnesota Department of Health, Health Economics Program (2007a).

Small Group Regulation in Minnesota

Federal laws – including the Employee Retirement Income Security Act (ERISA) of 1974 and three amendments to ERISA, the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986, the Mental Health Parity Act (MPHA) of 1996, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 – provide a foundation for more recent health insurance regulation at the state level. States' small group markets typically are "fully-insured"[15] – that is, the employer pays an insurance company to bear the financial risk. While most group health insurance plans must meet certain federal standards, fully-insured group health plans also are subject to state benefit regulation and rating rules.[16] In line with HIPAA on

the federal level, Minnesota defines "small group" as employers with 2 to 50 employees.[17] Minnesota does not have special rules for groups of one (i.e., self-employed individuals).[18]

Here, we discuss guaranteed issue and renewal requirements, pre-existing condition exclusion rules, service coverage requirements, rating approaches, continuation and conversion coverage, and other efforts to regulate small group health insurance in Minnesota. As summarized in Table 1 below, in some cases, the state does not regulate its small group market beyond what is required by federal law; in others, Minnesota augments federal law to reach the small group health insurance market.

Table 1. Summary of Small Group Health Insurance Market Regulation in Minnesota

Area of Regulation	Meets Federal Standard	Exceeds/Augments Federal Standard	MN Additions
Definition of Small Group (2-50 individuals)	X		
Guaranteed Issue	X		
Guaranteed Renewal	X		
Pre-Existing Condition Exclusion Rules	X		
Service Coverage Requirements		X	Additional mandated benefits
Mental Health Parity		X	Required parity goes beyond annual/lifetime limits
State Continuation Coverage		X	Expands COBRA to smaller businesses
Conversion Coverage		X	Mandates coverage for fully-insured and limits rates

Guaranteed Issue and Renewal. In compliance with HIPAA, Minnesota requires guaranteed issue for all small group market products. That is, an employer with 2-50 employees cannot be turned down for a small group insurance plan by an insurer due to the characteristics (e.g., health status) of the employers' workers. Likewise, an insurer may not refuse to renew coverage for a small group due to group characteristics.

Pre-Existing Condition Exclusion Rules. HIPAA limits the pre-existing conditions that can be excluded from coverage by a group plan. Minnesota's laws do not exceed this federal standard.[19] Per HIPAA, the maximum look-back period is 6 months in Minnesota, and the maximum exclusion period under the new coverage is 12 months. Group plans are required to give credit for prior "creditable" coverage, and in calculating this coverage, the maximum lapse period in coverage allowed is 63 days.

Service Coverage Requirements. Federal law does not require that health insurance plans cover a minimum set of services. Instead, mandates are implemented at a state level for fully-insured plans, and all states have mandated at least some benefits.[20] Mandated benefits in Minnesota include maternity care, preventive well-baby care, emergency care, cancer screening, hearing aids for children younger than 18 years, certain diabetes-related services, mental health parity (more below) and many other health care services.[21] In addition to traditional plans, all insurers participating in the small group market in Minnesota must offer at least two types of plans (a deductible-type plan and a copayment-type plan) covering a list of minimal benefits prescribed by state statute. As of 2005, small employers in Minnesota may also offer "flexible benefits" plans. These benefit plans must include maternity benefits and meet federal requirements, but do not have to include the otherwise mandated benefits.[22]

Regarding mental health coverage, group health plans that offer mental health benefits are not allowed to have lower annual or lifetime limits for mental health benefits (not including substance abuse or chemical dependency) than limits for medical/surgical benefits. This requirement is in accordance with the federal MPHA of 1996.[23] Additionally, Minnesota exceeds this federal law by also mandating that managed care organizations give parity to both mental

illness and substance abuse in terms of other coverage limits such as deductibles, co-payments, and maximum number of office visits.[24] This law only pertains to fully-insured plans.

Rating Restrictions. Minnesota places limits on rating for the small group market and uses premium rate bands to restrict rates in the state.[25] Minnesota Statute 62L.07, Subdivision 2 states that "each health carrier must offer premium rates to small employers that are no more than 25 percent above and no more than 25 percent below the index rate charged to small employers for the same or similar coverage." Further, the percent increase in a small employer plan rate for a new period is restricted. As of 2002, the state allows carriers to charge new rates upon filing to the Minnesota Department of Commerce as opposed to waiting until the Commissioner's approval.[26]

Continuation and Conversion Coverage. Continuation coverage refers to a short-term extension of group coverage for an individual whose eligibility for that coverage has ended (e.g., termination of employment). In 1986, the U.S. passed COBRA requiring many group health plans to provide access to such continuation coverage. Should a policy holder elect to continue coverage, s/he is responsible for the entire premium amount (including the employer's share) during the extension period. The federal law only impacts group plans offered by employers with at least 20 employees. As of 2007, 40 states (including Minnesota) have legislation in place requiring access to continuation coverage for group plans held by employers with fewer than 20 employees.[27] COBRA typically provides continuation coverage for up to 18 months (although it can be extended to a total of 36 months for individuals who qualify), and COBRA costs are capped to 102% of the existing group plan premium plus an additional 2% for administrative costs.[28] Minnesota's continuation coverage for small businesses protects policy holders up to 36 months and, as with COBRA, caps the premium rate at 102% of the original group coverage.[29]

Following termination of either COBRA or state continuation coverage, fully-insured group plans are mandated to offer a conversion policy (from group to individual) in Minnesota. The conversion policy may cover standard health benefits similar to the state's high risk pool or be a reduced-premium policy covering fewer benefits. Minnesota law limits the rates insurers may charge for a conversion policy: Premiums for a standard conversion policy may not exceed 90% of the premiums charged by the MCHA for similar coverage.[30]

Minnesota Comprehensive Health Association (MCHA)

MCHA was created by the Minnesota Legislature in 1976 to make health insurance available to state residents who are considered medically uninsurable. These residents have reached the lifetime maximums of their group or other insurance benefits or do not have access to a group insurance plan and have been denied private individual coverage, can only obtain limited coverage, or are assessed higher premiums due to pre-existing medical conditions. MCHA is a not-for-profit organization regulated by the Minnesota Department of Commerce and became operational in 1977. The mission of MCHA is:

> "…to offer health coverage, through a statewide nonprofit Minnesota corporation, to Minnesota residents who cannot obtain coverage in the private market due to existing health conditions; to offer our members educational healthcare resources, and to develop initiatives to help our members manage their chronic diseases and achieve optimum health."[31]

MCHA Plans and Benefits

MCHA offers six non-Medicare individual plans and a Medicare supplement plan.[32] Table 2 summarizes the various non-Medicare deductible plan options.

Table 2. MCHA Individual Deductible Plan Offerings

Plan Type	Medical Deductible	Prescription Drug Deductible	Out of Pocket Maximum	Co-Insurance Rate (for in-network)
$500 deductible	$400	$100	$3,000	80/20%
$1,000 deductible	$800	$200	$3,000	80/20%
$2,000 deductible	$1,600	$400	$3,000	80/20%
$5,000 deductible	$4,000	$1,000	$5,000	80/20%
$10,000 deductible	$8,000	$2,000	$10,000	80/20%
High-Deductible Health Plan (health savings account)	Individual deductible= $3,000 Family deductible = $6,000		Same as deductible	100%

Source: MCHA (2007a). Note: Once out of pocket maximum is met, $500-$10,000 deductible plans pay 100% of expenses.

MCHA benefit plans are comprehensive major medical plans and generally cover the services listed in Table 3. The lifetime maximum amount payable per covered person is $5 million. MCHA does not cover vision or dental services.[33] Additionally, although MCHA does not cover all preventive services, the pool does provide cancer screening, pediatric preventive services, child immunizations, and flu vaccinations for adults. Additionally, routine adult physicals will be a covered service as of July 2008.[34]

Table 3. Services Covered under MCHA Individual Deductible Plans

Hospital/Inpatient Care
Physician Services
Chiropractor Services
Routine Cancer Screening Procedures
Prescription Drugs (except Basic Medicare Supplement plan)
Skilled Nursing Facility
Hospice Care
Home Health
Outpatient Rehabilitation Services
Mental Health and Substance Abuse Services
Reconstructive and Restorative Services
Ambulance
Infertility Services
Transplant Services
Durable Medical Equipment and Prosthetics

Source: MCHA (2007a).

The MCHA Basic Medicare Supplement Plan provides limited coverage for Medicare Part A and B co-payments but covers neither Part A and B deductibles nor coverage for prescription drugs. For Medicare Part A (hospitalization and skilled nursing), the Basic Medicare Supplement Plan pays for the Part A coinsurance and all eligible hospitalization expenses not covered by Medicare. For Medicare Part B (physician and other services), the MCHA Plan pays for the share of Medicare's approved amount for covered services that is not paid for by Medicare. Through optional riders, the Basic Medicare Supplement Plan may be extended to cover Part A and B deductibles as well as 80% of usual and customary charges exceeding Medicare-approved costs for Part B services. The Medicare Supplement Plan also provides coverage for substance abuse, outpatient mental health, cancer screening, immunizations, reconstructive and restorative surgery, and other services/devices.

MCHA Eligibility

To be eligible for participation in MCHA, state residency is required. There are several eligibility avenues for state residents in applying for MCHA coverage. The five eligibility categories include loss of group coverage, federal Health Coverage Tax Credit (HCTC) program eligibility, ineligibility for the federal Medicare program, health-related rejection, and the existence of a presumptive condition. Table 4 below summarizes the requirements under each of these eligibility categories.

For all eligible persons, MCHA provides dependent coverage for spouses up to age 65 years, unmarried children through the age of 25 years, children for whom the applicant or spouse is a legal guardian or has a Qualified Medical Support Order, dependents with a disability or mental illness or disorder, and newborn grandchildren who are financially dependent on the applicant.[35]

Table 4. Eligibility Categories for MCHA

1. Loss of Group Coverage - State resident as of date of application - Lost group coverage - Eligible individual under HIPAA	**4. Health Related Rejection** - State resident for at least 6 months prior to date of application - Due to health reason(s), rejected for individual health coverage from MN carrier or rejected from health insurance agent in last 6 months
2. Health Coverage Tax Credit (HCTC) Program - State resident as of date of application - Deemed eligible by federal HCTC program	**5. Presumptive Condition(s)** - State resident for at least 6 months prior to date of application - Treated within last 3 years for a special medical presumptive condition (e.g., AIDS/HIV, chemical dependency, and others)
3. Ineligible for Medicare Program - State resident for at least 6 months prior to date of application - 65 years of age or older - Deemed ineligible by federal Medicare program	

Source: MCHA Website, available at: http://www.mchamn.com/html/eligibility.html

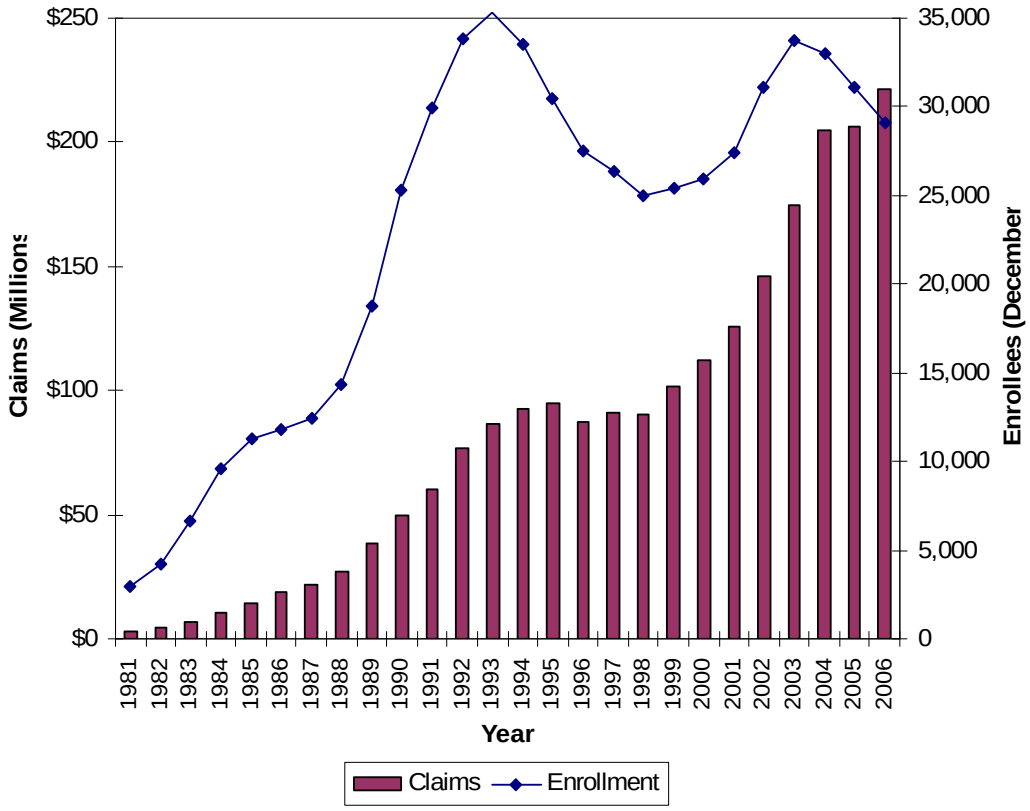
In the fall of 2004, MCHA conducted a survey of a random sample of its enrollees.[36] The majority (68.7%) of respondents (1,640 Medicare and deductible plan members) indicated that being turned down for an individual policy due to a pre-existing condition was a reason for their applying to MCHA. Approximately 23.0% reported that they applied to MCHA because their COBRA benefits had terminated, they could not afford COBRA, or COBRA was not available to them at the time of job termination. Approximately 8.0% indicated that a reason for applying was that their employer did not offer health insurance. A much smaller percentage, 3.3%, reported that they qualified for MCHA under HIPAA.

Those who applied to MCHA because of a pre-existing condition were asked about the condition that prevented them from obtaining health insurance. Weight condition (13.6%), cardiovascular condition (12.5%), diabetes or other endocrine disorder (12.4%), hypertension (11.4%), and mental health (9.0%) were the top five conditions reported.

Enrollment and Claims

With approximately 30,000 enrollees participating at the end of 2006, Minnesota's MCHA program is the largest state high risk pool in the country.[37] Of course, plan enrollment has not always been this high (see Figure 5). Enrollment in MCHA grew consistently between 1981 (2,918 plan participants) and 1993 (35,296 participants). Between 1994 and 1998, enrollment decreased by 25.5% to 24,954 members in 1998. Since then, enrollment has fluctuated but overall has increased by 16.6% to 29,089 participants in 2006. At the end of 2006, 4.8% of participants were enrolled in the Basic Medicare Supplement Plan, with 95.2% of the enrollees spread across the six deductible plans as follows: $500 (18.7%); $1,000 (27.5%); $2,000 (28.9%); $5,000 (9.2%); $10,000 (5.1%); and high deductible health plan (5.8%).

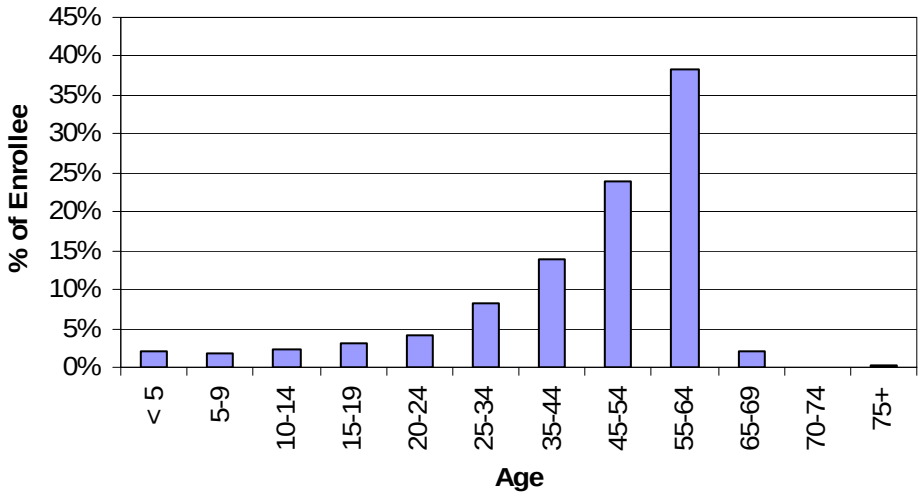
Figure 5. MCHA Claims and Enrollment (1981-2006)



Sources: Communicating for Agriculture and the Self-Employed (2005) and NASCHIP (2007).

Figure 6 below shows enrollment by age group for MCHA participants enrolled in the individual deductible plans. In 2006, the majority (62.0%) of these enrollees were between 45 and 64 years of age, and another quarter (26.4%) were 20-44 years. Fewer enrollees were below 20 years of age (9.2%) or 65 and above (2.3%). Overall, just over half (53.8%) of the enrollees were female.

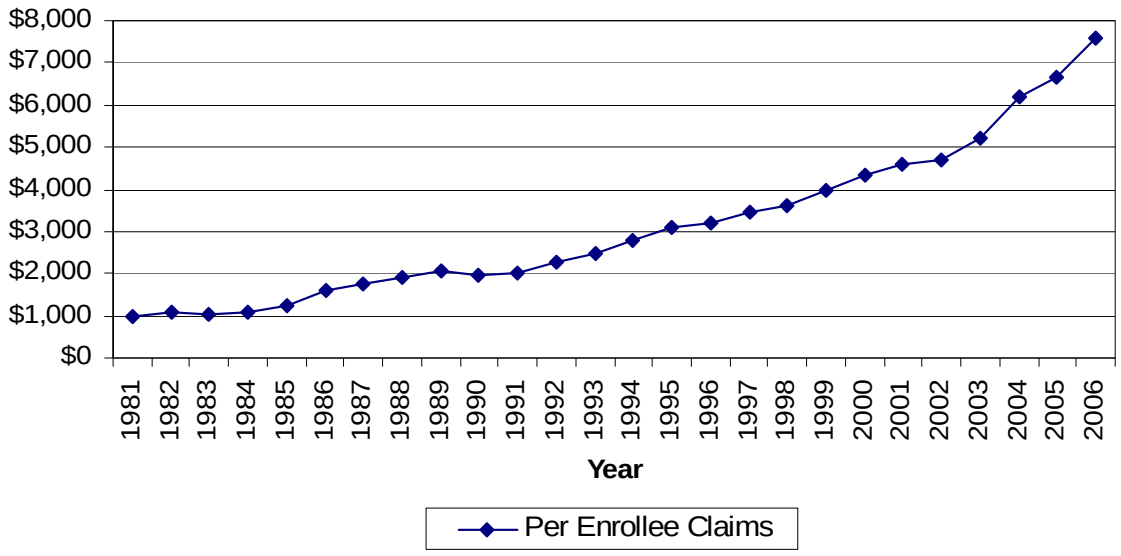
Figure 6. Age Distribution of MCHA Deductible Plan Enrollees (2006)



Source: Gruber (2008).

In addition to showing trends in enrollment, Figure 5 on the prior page presents total claims for all MCHA (both deductible and Medicare supplement) enrollees from 1981 to 2006. With the exception of the late 1990s, when total claims decreased slightly, total claims increased consistently between 1981 ($2.9 million) and 2006 ($221.2 million). Figure 7 below presents medical expenditures expressed as total claims per enrollee at the end of each year, revealing similar steady growth in claims. In 1981, total claims per enrollee amounted to under $1,000; in 2006, that amount was $7,605. (Note: Data in graphs were not adjusted for inflation.)

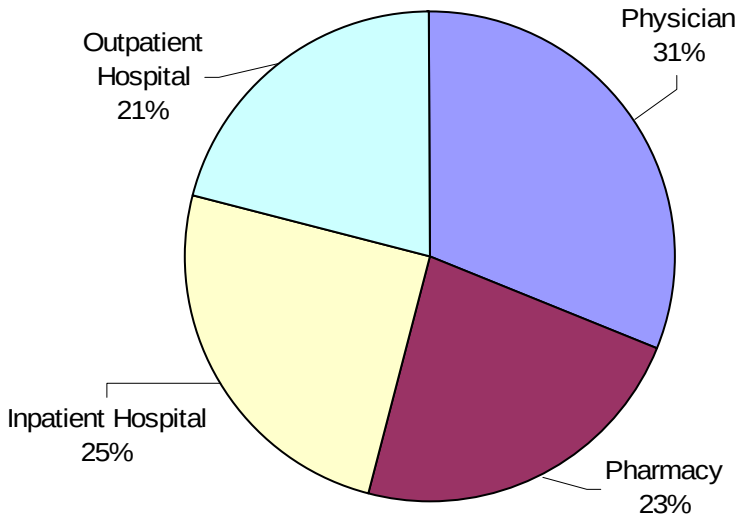
Figure 7. MCHA: Per Enrollee Claims (1981-2006)



Sources: Communicating for Agriculture and the Self-Employed (2005) and NASCHIP (2007). Value represents total claims divided by number of enrollees at end of year.

MCHA's 2004 Annual Report[38] provides information on service utilization and expenditures. Figure 8 summarizes the distribution of expenditures for both individual deductible and Medicare supplement plan enrollees combined by type of service for claims during calendar year 2004. A third of all costs were attributable to physician services, followed by inpatient hospital, pharmacy, and outpatient hospital services. For the individual deductible plan enrollees, the top diagnostic categories in terms of costs were cardiovascular, neoplasms, and musculoskeletal (together representing 39.1% of costs). For the Medicare supplement enrollees, the top two diagnostic categories, comprising 31.7% of costs, were cardiovascular and genitourinary. While only representing 2.1% of total MCHA enrollment, catastrophic cases (cases in which claim payments exceeded $50,000 in a year) contributed 34% to total expenditures during 2004.

Figure 8. MCHA Expenditures by Type of Service (2004)



Source: MCHA (2005).

MCHA Organization

The Minnesota Legislature established MCHA as a non-profit corporation in 1976. Chapter 317A of Minnesota law provides the organizing framework for the MCHA as a nonprofit corporation. Chapter 62E of the state law outlines the operations and administration of MCHA, qualified plans, as well as member eligibility, benefits, and premiums. Per Chapter 297I (Section 15, Subdivision 7), MCHA is exempt from the state insurance taxes imposed under this Chapter. In accordance with its originating legislation, the Minnesota Department of Commerce regulates MCHA, and the association is governed by a Board of Directors. The Commissioner of Commerce is responsible for creating policies related to the pool, approving the carrier to administer the pool, selecting or approving board members, and responding to appeals from plan enrollees.

Board. Historically, MCHA was governed by a nine-member Board of Directors, including five members representing industry and four public members selected by the Commissioner of the Department of Commerce. Under the original arrangement, at least two of the public members were required to be MCHA plan enrollees.

In 2004, the Minnesota Legislature revised the required board composition to include 11 board members. Six members are now selected from contributing health plan carriers. One of these members must be a health actuary, and all private members must be approved by the Commissioner. The other five members are public members and are selected by the Commissioner. Of the five public directors, at least two must be MCHA plan enrollees (as was the case originally), two must represent employers whose insurance premiums are included in the MCHA rate assessment base, one is required to be a licensed insurance agent, and at least two must reside outside the seven-county metropolitan area in the state. As of 2008, the board members are as follows[39]:

1. **Tim Luy (Chair):** Industry Board Member, General Manager Commercial Health, Federated Mutual Insurance Company
2. **Kathy Mock (Vice Chair):** Industry Board Member, Vice President, Public Policy and Legislative Affairs, Blue Cross and Blue Shield of Minnesota
3. **Rich Sykora (Treasurer):** Industry Board Member, Vice President and General Manager, Medica
4. **Dave Dziuk:** Industry Board Member, Senior Vice President of Finance and Controller, Health Partners
5. **Dorothy Petersen:** Industry Board Member, Corporate Actuary, Health Partners
6. **Mary Vollkommer:** Industry Board Member, Vice President and Product Actuary, Assurant Health
7. **Sheryl Radle (Secretary):** Public Board Member, Licensed Insurance Broker

8. **Kristin Flaten,** Public Board Member, Mental Health Advocate, MCHA Policyholder

9. **Bernard Reisberg,** Public Board Member, Retired Businessman

10. **Harlan Johnson:** Public Board Member, Licensed Health Insurance Agent

11. **Rolf Halstensen,** Public Board Member, MCHA Policyholder

In addition, as MCHA President, Lynn Gruber of the MCHA Executive Office, participates in the board meetings.

MCHA Operations

MCHA's every day insurance operations (including enrollment, premium billing, claims payments, and customer support) are handled by a carrier in the state. Minnesota law allows MCHA to accept bids from state carriers to administer the plan as the writing carrier. Selection must be based on Board-established and Commissioner-approved criteria. Since 2003, Medica Health Plans has fulfilled the administrative function. The history of MCHA administration (which includes three writing carriers since 1977) is summarized in Table 5.

Table 5. History of MCHA Administration

Years	Writing Carrier
1977 – 1982	Northwestern National Life Insurance Company
1983 – 2003	Blue Cross and Blue Shield of Minnesota
2003 – present	Medica Health Plans

Sources: MCHA (2000) and Communicating for Agriculture and the Self-Employed, Inc. (2005).

MCHA Financing

Since its inception, MCHA has been supported by two main sources of funding: enrollee premiums and annual assessments on insurers selling in the individual and group health insurance markets within the state of Minnesota. (Due to ERISA, self-insured employer plans are

protected from these assessments.) In addition, state General Fund appropriations have helped to support the pool at a few points in time in MCHA's history.[40]

Typically about half of the program's total funding has come from enrollee premiums.[41] In 2005, premiums totaled $113.3 million, about 51% of total funds. State law requires MCHA premiums to fall between 101 to 125% of the average premium for a comparable individual plan in the commercial market. Currently, MCHA's premium rates, which are set by the Commissioner, are at approximately 119% of the market.[42] Since 2004, there have been two premium rates: a tobacco user premium rate and a standard premium rate (for nonusers). Table 6 shows the standard and tobacco user rates currently in effect for the six deductible plans.

Table 6. MCHA Standard and Tobacco-User Monthly Premium Rates (July 2007 – June 2008)

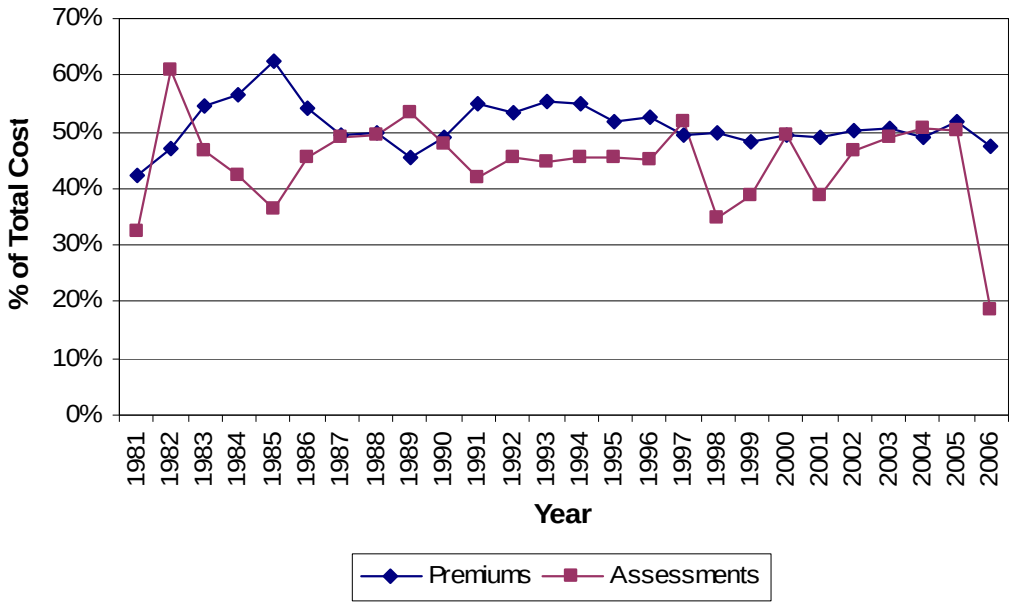
Age	$500 Deductible		$1,000 Deductible		$,2000 Deductible		High Deductible		$5,000 Deductible		$10,000 Deductible	
	S	T	S	T	S	T	S	T	S	T	S	T
< 15	$252	$315	$187	$234	$153	$191	$148	$184	$113	$142	$77	$96
15-29	$260	$325	$191	$239	$157	$196	$152	$190	$117	$147	$80	$100
30-34	$288	$360	$210	$263	$172	$215	$165	$206	$130	$163	$89	$111
35-39	$303	$378	$222	$278	$183	$229	$175	$219	$135	$169	$92	$115
40-44	$338	$422	$249	$311	$205	$256	$197	$246	$150	$188	$103	$129
45-49	$413	$517	$305	$381	$250	$313	$242	$303	$186	$232	$127	$159
50-54	$539	$674	$397	$496	$326	$407	$312	$389	$242	$303	$166	$208
55-59	$685	$857	$510	$637	$409	$512	$389	$486	$306	$383	$209	$261
60-64	$755	$944	$559	$698	$456	$570	$439	$549	$340	$425	$230	$288
65+	$756	$944	$560	$699	$457	$572	$441	$551	$340	$425	$230	$288
1 Child	$222	$222	$156	$156	$117	$117	$111	$111	$94	$94	$68	$68
2 Children	$443	$443	$312	$312	$235	$235	$221	$221	$188	$188	$136	$136

Source: MCHA (2007c). S= Standard; T= Tobacco-user. Rates are rounded to nearest dollar.

The annual insurer assessments are determined by MCHA, approved by the Commissioner of Commerce, and are based on the proportion of each insurer's volume of premium revenue to the total premium revenue generated by all relevant insurers in Minnesota. In 2005, insurer assessments totaled $102.9 million (or 49% of total pool funds). It has been estimated that the assessments result in a 2% increase in commercial health insurance premiums.[43] Exhibit 9 shows the relative role of enrollee premiums and insurer assessments in

MCHA funding each year between 1981 and 2006. The drop observed in 2006 insurer assessments pertains to another source of funds (tobacco settlement funds) secured during that year (discussed more below).

Figure 9. Role of Enrollee Premiums and Insurer Assessment in Financing MCHA (1981-2006)



Source: Calculations based on information from Communicating for Agriculture and the Self- Employed (2005) and NASCHIP (2007). Value represents total premiums (or total insurer assessments) divided by total costs. Premium and assessment contributions may not total 100% in a given year. In some years, state appropriations or tobacco settlement funds supplemented premiums and insurer assessments.

As mentioned above, state funds have been leveraged to subsidize MCHA costs and offset losses at several points in time during the program's history.[44] First, until 1987, the state subsidized contributing insurers by granting them a 100% income and premium tax offset against the MCHA assessments. This part of the law was repealed in 1987, and the tax offset has since been discontinued. Then, during its 1997 session, the Minnesota Legislature appropriated $30 million to MCHA for a two-year period (1998 and 1999) from the state's Health Care Access Fund (HCAF). Because the HCAF is funded by a hospital and provider tax, which is allowed to be passed-through to payers including self-funded purchasers, self-funded plans indirectly

contributed to MCHA during these two years. Later, $15 million were appropriated to cover MCHA's losses in 2001. These monies came out of a surplus from the Minnesota's Workers Compensation assigned risk plan.[45]

Finally, one other source of revenue has supported MCHA: 1998 tobacco settlement funds paid to Blue Cross and Blue Shield of Minnesota. Approximately $73.9 million were disbursed to MCHA to offset losses/insurer assessments in 2006.[46]

Key Issues and Insights

MCHA is a stable, mature, and well-managed high risk pool that has been viewed as a relatively small but important component of our state's health care system and safety net option for the uninsured. There are several issues and insights from MCHA for New York (and other states) to take into account when considering the inclusion and design of a high risk pool.

Implementation and Organization. Overall, the private/non-profit health plan arrangement with public oversight and a liberal policyholder appeal process has resulted in a strong, flexible, and efficient design. Inherent in this approach is the involvement of and a "balance of power" among key stakeholders, including the Department of Commerce, insurance companies, board members, and plan enrollees. In 1989, policyholders also established a nonprofit "to represent the interests of MCHA policyholders before the MCHA governing board, the Minnesota Legislature, public officials, and the public at large."[47]

One related success associated with the implementation of MCHA is the involvement of multiple stakeholder perspectives. While the Department of Commerce oversees and regulates the pool, it established committees early on to give opportunities for stakeholders (health care providers, hospitals, carriers) to provide input and participate in the implementation of the pool, particularly the development of the operating rules. The statute creating the pool provided

parameters in the design and implementation of the pool, but there was flexibility built into the language, allowing space for Department of Commerce and stakeholder input.

Administration/Management. Because there is no employer or agency to push for change or better managed or preventative care, there has been a lack of incentive to innovate or to be a market leader. Indeed, MCHA is one of the few fee-for-service health plans left in Minnesota. With its current writing carrier, MCHA uses Medica's disease management services covering approximately 60 different conditions. Also, it has started an incentive-based health and wellness program for all members, available via the Internet.[48] Otherwise, MCHA enrollee service utilization is managed largely through co-payments and deductibles similar to the private sector.

Market Issues. By directing residents with serious (and costly) health problems to MCHA, the high risk pool has helped to stabilize the private individual market in the state. Further, MCHA eligibility rules, underwriting practices, and dependent/spouse inclusions also have stabilized the high risk pool by allowing the entrance of relatively healthy individuals into the pool as well. The average cost per enrollee has been relatively low due to the number of relatively healthy individuals.

In 2004, the Department of Commerce, in collaboration with MCHA, studied the eligibility criteria used for preemptive conditions.[49] The study compared MCHA with other state high risk pools and examined the underwriting practices of the health care market. MCHA, along with a subset of other state pools, automatically accepts an applicant into the pool if the applicant has one of the preemptive conditions (even if the applicant does not have proof of insurance rejection). Some believe that there is little oversight of the underwriting practices in the individual market and that some people are underwritten too easily. This study found that the underwriting practices of carriers would not likely insure anyone with one of the major health

conditions but concluded that additional market regulations would render the market more vulnerable and there should be no changes to MCHA.

Related to underwriting in the state, a House bill (HF3991) was recently proposed during the 2008 legislative session for the Department of Commerce to convene a risk adjustment advisory council (comprised of representatives from the insurance industry, MCHA Board, safety net providers, and consumers). The bill proposes that the council conduct a study of MCHA financing and review "whether the affordability needs of persons with health problems can be addressed through guaranteed issue, with no premium penalty for health history and not allowing pre-existing condition limitations." If the bill passes, Council recommendations would be due to the legislature in November 2009.

Expenses and Cost Control. A prominent concern with MCHA pertains to growth in costs, and this concern is of course not unique to Minnesota's pool. "The actual need for additional revenue by a high-risk pool is dependent on its level of enrollment, eligibility requirements, premium levels, plan designs, provider reimbursement levels, cost containment efforts, and program management."[50]

Historically, enrollment caps have not been used to control costs in Minnesota; instead, other mechanisms have been considered. For example, MCHA involves a large network of providers and enrollees are generally satisfied with MCHA benefits. However, in order to make MCHA more affordable in future, some consideration has been given to limiting the provider network or establishing network tiers to reduce costs.

Financing. "All state risk pools inherently lose money and need to be subsidized."[51] As already mentioned, MCHA has been primarily supported through enrollee premiums and insurer assessments, with occasional support from the state. Minnesota's high risk pool premium rate

level (up to 125% of the standard risk rate) falls on the lower end of rate limits used in other states. In most states, the maximum is at least 150% and, in a handful of states, it is 200%.[52] Legislators have considered increasing the premium range used for MCHA.

Given that MCHA helps to address both fully-insured and self-insured market failures, some believe that the MCHA insurer assessment financing mechanism should be broader, with insurer assessments based on not just fully-insured plans (consisting of many small businesses and individuals) but also self-insured plans (typically large employers). ERISA legislation currently prohibits assessments on the self-insured plans. Compounding this concern is recent growth in self-funded plans (representing 59.6% in the state's private market in 2005) and the ramifications for the overall size of MCHA's assessment base. Some legislators and policy analysts have considered alternative mechanisms to building health care resources, such as third party administrator assessments similar to those implemented in Maine and provider taxes.

Finally, regarding public subsidies, state appropriations have been used irregularly to offset MCHA losses during the pool's 31 years of existence. During the first few years of MCHA, tax write-offs were used to subsidize insurer assessments. Since then, the state appropriated funds to offset pool losses during three years, for a total of $45 million. Some believe that there is a need for more regular state funding for MCHA. A concern related to state funding, however, is its consistency and stability. Some believe that relying on annual state budgets may make pool funding more uncertain. In this context, insurer assessments have been viewed by some as more predictable.

Affordability. While premiums are relatively low (again capped at 125% of private individual market average), still many enrollees cannot afford the premiums (and may not reach the deductible especially in the case of the high-deductible plans). One feature MCHA has used

to enhance its affordability for enrollees is a split deductible – one for medical services and a separate deductible for pharmaceutical drugs. Excluding preventive care from the required deductible is another example of an affordability option that has been considered.

Additionally, subsidies for low-income MCHA enrollees have been available four times in the pool's history: 1998, 2005, 2006, and 2007.[53] Federal TIAAA grant funds supported these subsidies. In 2007, 2,422 MCHA beneficiaries below the 200% of the federal poverty level received subsidy checks.

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[3] For uninsured children, the employment characteristic refers to a parent.
[4] Minnesota Department of Health and University of Minnesota School of Public Health (2008).
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[7] Data not shown. Derived from data presented in Minnesota Department of Health, Health Economics Program (2007).
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[39] A list of the current board members are available at http://www.mchamn.com/html/board.html
[40] Communicating for Agriculture and the Self-Employed (2005) and NASCHIP (2007).
[41] MCHA (2005).
[42] MCHA (2007b).
[43] MCHA (2007b).
[44] See, for example, MCHA (2005), Communicating for Agriculture and the Self-Employed (2005), and NASCHIP (2007).
[45] Communicating for Agriculture and the Self-Employed (2005).
[46] NASCHIP (2007).
[47] Association of MCHA Policyholders (2008).
[48] NASCHIP (2007).
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[50] NASCHIP (2007), p. 11.
[51] Minnesota Department of Commerce and MCHA (2005).
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Field Report:
Maine's Dirigo Reform Law

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Executive Summary

In 2004, following a half decade of unprecedented premium increases in the small group insurance market, the Maine legislature authorized a comprehensive health reform effort that included measures to: 1) expand affordable access to coverage for small businesses, sole proprietors, and individuals; 2) slow the growth of health cost inflation; and 3) improve health service quality. The DirigoChoice Plan, the linchpin of the access expansion effort, began operations in January 2005 and after 2 ½ years had over 15,000 individuals enrolled, representing over 700 small businesses, over 4,000 sole proprietors, and over 7,000 individual enrollees.

The DirigoChoice Program is administered by a newly created state agency, the Dirigo Agency, in partnership with a private insurer. Discounts on the premium costs ranging from 20 percent to 80 percent are available on a sliding scale, based on household income, to low and moderate income program participants. Individuals and business owners whose income exceeds 300 percent of the federal poverty level may participate in the program at full premium cost. Employers must contribute a minimum of 60 percent of employees' premiums and the discounts apply to the employee share, including the full cost of dependent coverage. To hold employer costs down and conform to the current small group market conditions in Maine, the insurance products offered through the Dirigo Agency have relatively high deductibles (ranging from $1,250 to $2,500 per individual and $1,750 to $3,500 per family). Program participants who are eligible for discounts also have reduced out-of-pocket requirements in the form of lower deductibles and lower annual maximum payment limits.

The DirigoChoice Plan was launched with $53 million in seed funding from the state general fund. The legislature approved an assessment on insurers' and third party administrators' claims volume, capped at 4 percent, to cover ongoing program costs. The assessment was contingent upon a demonstration, by the Dirigo Agency and its Board of Directors, of system health savings of equal value deriving from the cost containment measures of the reform legislation. This funding mechanism proved to be politically contentious and administratively cumbersome, as agency administrators and affected payers clashed over definitions of savings, measurement strategies and, ultimately, the amount of the assessment. In addition, by the third year of the program, the revenues generated by the assessment were insufficient to sustain program growth and, in September, 2007, enrollment was frozen for all except those ineligible for discounts.

The 2008 Maine legislature approved a supplementary health reform bill that establishes a fixed assessment of 1.8 percent on health insurance claims volume and dedicates revenues from increased taxes on alcoholic beverages and soft drinks to the DirigoChoice program and a newly created reinsurance fund for insurers in the non-group insurance market. This new legislation will allow the DirigoChoice program to reopen enrollment for discount-eligible enrollees. The impact of the legislation on the affordability of individual insurance coverage and rates of uninsurance in the state is not yet known.

Table of Contents

Maine Field Report

I. Background and Context for Maine Small Group Insurance Market

Overview

The Economy

Maine is a rural state with vast, sparsely populated areas and concentrated populations in its southern third and along the Route 1 corridor that runs the length of Maine's coastline. The state is developing, both politically and economically, a "two-state" character. In the rural areas, the economy is anemic. Traditional manufacturing employers such as paper and lumber mills have downsized their operations or moved to other areas of the country. Declines in harvest threaten ocean fishing. Coastal regions and towns around lakes and mountains are becoming increasingly dependent on a seasonal tourist economy. Emblematic of the increasing dependency on low paying service jobs is the fact that Hannaford Brothers, a chain of supermarkets, is the largest private sector employer in the state, followed by Walmart. Twenty-four percent of Maine's workforce is employed in either retail (with an average hourly wage of $10.82) or foodservice and accommodations (average wage, $9.40). Overall, the average wage across Maine's workforce is $15.95.[1] Unemployment is high and the young Mainers are migrating out of rural areas (and out of the State). Between 1990 and 2000, Maine's geographically largest and most northern county saw a decline in population of 15 percent. [2]

Maine's southern economy and growth, by contrast, is relatively robust. At the end of 2007, for example, while statewide unemployment was 5.1 percent and unemployment in Maine's most rural counties stood at 8 percent, in Cumberland County the rate was 3.5 percent.[3] Here, the City of Portland serves as the center of Maine's banking and insurance industry and hosts divisions of a number of national companies such as National Semiconductor and Unum Provident. Portland is also home to the state's largest hospital and a substantial industry of medical specialty care. Located seventy-

five miles north of Boston, the Portland metropolitan area and the county to the south, York County, are growth areas with strong housing markets.

Demographics and Socio-economic Status

Overall, although 35 percent of Maine's population lives around or south of Portland, the state's rural regions drive population demographics and place stresses on the state's capacity to provide safety net services. Due to out-migration of younger persons, Maine's median population age is the highest in the country.[4] The median household income of $45,040, is below the national median and ranks Maine as the 19th poorest state. However, Maine is characterized more by large numbers of working poor than by concentrated populations of extreme poverty. With 14 percent of the population below the federal poverty level, Maine has a smaller proportion of citizens in poverty than 31 other states.[5]

Health Coverage

The decline in employment opportunities associated with sectors that have traditionally provided good health benefits has inevitably produced an associated decline in employer-based health coverage in Maine. Between 2002 and 2006, the proportion of the adult, working age population with employer health benefits declined 4 percentage points, from 66.3 percent to 62 percent.[6] Employer-based coverage for children fell from about 60 percent to 57 percent. The current rates of employer coverage are similar to national average rates, but low for New England.

Maine has traditionally maintained generous eligibility standards for its Medicaid program and, particularly in recent years, has taken advantage of optional eligibility categories and waivers to expand public coverage. The combination of a lower than average income in the state and generous eligibility criteria result in a relatively high proportion of state residents with public coverage. Thirty percent of Maine's children are enrolled in Medicaid or the SCHIP program, compared to a national average of 27 percent. Sixteen percent of Maine adults have Medicaid coverage, compared to 8 percent nationally.[7] As of July 2005, Maine had 272,790 enrollees in Medicaid and related programs (excluding drug coverage only program participants) - about a 14

percent growth over enrollment in 2003. Maine's 1115 Waiver Program extending coverage to low-income, non-categorically eligible adults had its first full year of operation in 2004 and served approximately 26,000 during that year. This new eligibility category explained much of the enrollment increase during this period.[8]

Maine's high enrollment in public programs, consistently, has kept the state's uninsured rate below national averages. As of 2006, the uninsured rate among Maine working age adults was 13 percent compared to a national average of 20 percent and the disparity is entirely explained by the higher levels of Medicaid and other public coverage.[9] Rates of coverage by employers and self-purchased insurance are very similar in Maine to the rest of the country. Among children, the uninsured rate was 7 percent compared to a national rate of 12 percent. Like the adults, the rate of private coverage for children mirrors national patterns, but the higher rate of Medicaid coverage in Maine reduces the number of uninsured.

Health Care Costs

Although Maine appears to be holding its own in terms of maintaining relatively high coverage rates, both the public and the private sector are straining under Maine's unusually high health care costs. Maine currently has the second highest rate of per capita personal health care spending of any state in the nation (following Massachusetts). Its current per capita rate, $6,540, is 24 percent higher than the national average rate. In 1990, at the start of the "managed care revolution," Maine's spending was 7 percent below the national average. Health care spending in Maine rose at an annual rate of 7 percent – faster than any other state – in the period between 1991 and 1998, and at 8.9 percent between 1998 and 2004, second only to Vermont.[10] There is no consensus on the reasons for the atypical rate of growth in Maine. Contributing factors probably include: the abandonment of regulatory constraints on hospital revenues in the early 1990s, the inability of managed care plans to force savings through selective contracting in a state without excess capacity and geographically dispersed providers, and the lack of economies of scale and technology proliferation to many small, rural hospitals with small patient loads. Rurality certainly seems a contributing factor. States with consistently higher than average growth rates in per capita spending

across the past fifteen years include: Maine, Vermont, South Carolina, Kentucky, Wyoming, and West Virginia.

In Maine, there is evidence that high spending is driven both by high utilization rates and by high service prices. Maine's Association of Health Plans sponsored an analysis by Milliman Associates of allowed claims of the major insurers conducting business in Maine, New Hampshire and Massachusetts. This analysis revealed that average negotiated payments per ICD-9 code in Maine were consistently higher than either New Hampshire or Massachusetts payments for all services except primary care office visits. Differences in negotiated rates ranged from 12 percent to 100 percent. CAT scans reimbursed by commercial insurers in Maine, for example, cost twice as much as the insurers were paying in Massachusetts.[11] A separate analysis, examining per capita cost trends for privately insured persons in Maine over a six year period from 1995 to 2001, showed an increase in the per capita rate of use of Cat scans of 143 percent between 1995 and 2001 and, for MRIs, of 149 percent in this same period. This analysis, based on claims data from Maine employers (encompassing about 100,000 covered lives) revealed that per member per month outpatient costs for this privately insured population increased from $34 in 1997 to $57 in 2001. At this time (2001), the national average per member per month cost for privately insured outpatient services was $36 – an excess in Maine of $252 per covered life per year. [12]

Maine's high health care costs are reflected in insurance premiums, where on average, across all employers, premiums are 7 percent above the national average for employer premiums.[13] The greatest differential between national averages and Maine premiums can be found among businesses of more than 100 employees where, for those between 100 and 999 employees, Maine's total employee premium average in 2005 was 12 percent higher than the national average. The smaller disparity in the small group market may be a reflection of a trend among Maine small businesses to reduce benefit levels as a response to price increases, while larger employers are more reluctant to do so or face union resistance to such a move.

The Insurance Market

Maine's insurance market is dominated by three national insurance companies – Anthem Blue Cross and Blue Shield, Aetna and Cigna, and one regional managed care company – Harvard/Pilgrim. The state has no staff model HMOs and, although HMO products have a 27 percent share of the market, these products differ from PPO and POS products only in that they require enrollees to select a primary care provider and require that provider to pre-authorize referrals to specialists and other services.[*] Provider networks generally include almost all providers in the state and primary care physicians in the state are disinclined toward stringent gate-keeping, so while HMO enrollees face additional hurdles, their limitations on desired services are ultimately few.

Maine's insurance market, like many regional markets, experienced significant turmoil in the late 1990s. Up until the early '90s, the market had been dominated by the local, not-for-profit Blue Cross and Blue Shield plan, which held the largest share of the large group market, the small group market and the individual coverage market. HealthSource, a small regional HMO with roots in New Hampshire, struggled at this time to build a provider network based on provider capitation payments and shared risk pools, and to build market share with Maine employers. In the late 1990s, as large national companies developed managed care products and aggressively competed for market share across the country, a number of companies entered Maine's market including Aetna, NYLCare, Cigna, Harvard/Pilgrim and Tufts. Competition was fierce and for a period, premium increases were held to a minimum in both the large group and small group markets. In a reflection of national trends, where the market went through significant consolidation, Maine's market was quickly winnowed down to a few large players. Anthem Blue Cross and Blue Shield, a for profit plan based in Indianapolis, purchased Maine's Blue Cross Plan. Cigna purchased Healthsource, Aetna purchased NYLcare, Tufts left the Maine market, and Harvard/Pilgrim froze operations as it worked to resolve financial difficulties in its base operations in Massachusetts. In

[*] PPO plans also differ from HMO plans in that they are required to cover out-of-network services (albeit with greater subscriber cost sharing). HMO point-of-service plans also provide some out-of-network coverage but are not subject to mandatory minimum benefit levels for these services. In Maine, because networks tend to be so extensive, these differences have less impact on consumers than they might in other states.

the past five years, Anthem has continued to grow and consolidate its hold in all market segments. As of 2006, Anthem had over 66 percent of the large group market, over 68 percent of the small group market, and 83 percent of the individual market. Aetna, which sells in both the large and small group markets, had about a 16 percent share overall and Cigna, which no longer offers products in the small group market, had a 9 percent share. Harvard Pilgrim has resumed competition in the small group market and has close to a 4 percent share and Mega Life & Health Insurance, which tends to sell policies with more benefit limitations than the other carriers (e.g., no maternity coverage) in Maine's individual market, has grown its share of the non-group market to 22 percent (less than 3 percent of the market, overall).[14] The consolidation seen in Maine mirrored a country-wide pattern. Nationally, between 1993 and 1995, there were 31 major acquisitions among publicly traded managed care companies. By 1997, twenty-five companies controlled about two thirds of enrollment, nationwide.[15]

Small Group Market

The small business sector in Maine comprises a very significant portion of the state economy. Slightly more than a third of the Maine workforce is in firms of fewer than 25 workers, and 24 percent is in businesses of less than ten. With its reliance on natural resource-based businesses and tourism, Maine also has a large part of the workforce – 40 percent – in part-time and seasonal occupations. These workers are even more likely to be in small businesses, with 41 percent in businesses of under 25 and 30 percent in businesses of less than 10 (Table 1).

Table 1: Distribution of Maine Workers by Business Size and Full-time/ Part-time Employment

Size of Business	FT All Year	Distribution of FT	PT/ Seasonal	Distribution of PT/ Seasonal	Total	Distribution of Total
< 10	273,260	20.5%	261,231	30.0%	534,491	24.3%
10-24	111,931	8.4	97,307	11.2	209,239	9.5
25-99	183,507	13.8	131,973	15.1	315,480	14.3
100-999	306,206	23.0	144,737	16.6	450,943	20.5
1000 +	457,648	34.3	236,201	27.1	693,849	31.5
Total	**1,332,552**	**100.0**	**871,450**	**100.0**	**2,204,002**	**100.0**
Row Percent	60.5%		39.5%			

Source: Current Population Survey pooled data from surveys for 2004-2006.

Maine's uninsured population reflects the state's disproportionate reliance on small business and part-time and seasonal work. Eighty-seven percent of uninsured Mainers are in working families, compared to 82 percent nationally. However, more of Maine's uninsured work part-time (19 percent) than is the case nationally (12 percent). Strikingly, more than half (54.6 percent) of uninsured workers in Maine are in businesses of fewer than 25 workers compared to 33 percent nationally. Only 26 percent of Maine's uninsured workers are in larger firms (25 employees up to 1,000) compared to half of workers, nationally. The disparity in the proportion of uninsured workers in small businesses in Maine is a by-product of the dominance of Maine's economy by small business – not a reflection of a lower offer rate than is found in other states. The percent of employees in firms under 10 that offer coverage in Maine is the same as the national rate (43.7 percent nationally vs. 42.8 percent in Maine), and the offer rate among Maine firms of 10 to 24 is almost ten percent higher than the national average (77 percent vs. 68 percent).[16] Overall, the insurance coverage rate for small business workers in Maine is higher than on average across the country (23 percent uninsured compared to the national rate of 33 percent).[17]

After 2000, following significant insurance market consolidation in Maine, health plans rapidly raised premiums to recoup losses or increase their margins (Table 2). The impact in the small group market was substantial. In 2001, the average premium increase in Maine's small group market was 33 percent (actuarially adjusted to control for changes in benefits). The next year saw an average 29 percent increase and following that, a 16 percent increase. Between 2001 and 2004, the number of covered lives in Maine's small group market declined by 23 percent, from 148,000 to less than 114,000.[18] In 2004, the Dirigo Reform Act was debated and passed. That year saw a moderating trend in premium growth, perhaps due to the threat of greater regulation and government involvement in the market. Small group market enrollment stabilized in 2005 and has shown marginal increases since, but the total number of persons covered remains well below 2001 levels (Table 2).

Table 2: Maine Small Group Market Trends, 1999-2006

Year	Covered Lives	Percent Change in Covered Lives	Average Small Group Rate Increase	Aggregate Small Grp Market Loss ratio
1999	N.A.			86.1%
2000	N.A.			90.25
2001	147,784		33%	86.2
2002	131,138	-11.3%	29	76.6
2003	118,277	-9.8	16	72.1
2004	113,694	-3.9	6	73.9
2005	114,466	+0.7	13	77.4
2006	115,141	+0.6	8	81.0
2007	117,140	+1.7	14	N.A.

Source: Maine Bureau of Insurance Reports

The relatively high proportion of small business workers in firms that offer coverage in the small group market (compared to national rates) suggests that the decline in enrollment may derive more from individuals declining offers or dropping dependent coverage than from employers dropping coverage, altogether. Although no trend data are available, there is some indication that small employers have responded to premium increases by shifting more costs to their employees through benefit changes and/or premium cost sharing.[19] However, unlike the individual market in Maine, the small group market has not made a wholesale shift to catastrophic coverage policies. It is difficult to determine broad trends because there are approximately 250 products sold in the small group market (with 90 products with enrollments of greater than 100).[20] A 2007 actuarial analysis of Maine's small group and individual markets determined that the average actuarial value for small group products in Maine is about 25 percent above the average value in the individual market. The small group market's average deductible is about $1,000, substantially below the dominant products in the individual market (where the average deductible is over $7,000 and the highest sales are currently for products with a minimum of a $10,000 deductible).[21] However, substantial variation in plan design is found among small groups**.** Among the top selling plans in the small group market are those with no deductible and a maximum annual coinsurance amount of $1,500 (6.4% share of the market) and plans with a $250 deductible and $1,000 coinsurance maximum (5.1% share). The top selling plan has a $500 deductible and $2000 coinsurance maximum (7% share). All these plans offer a three-tiered pharmacy benefit with a $10 copayment for generic and other designated 1st tier drugs.[22]

Relationship between the Small Group and Individual Markets

The individual insurance market in Maine is a little more than one-third the size of the small group market in terms of covered lives. As elsewhere, the individual market serves as a market of last resort and declines in employer-based coverage generate some growth in the individual market. Between 2001 and 2004, during the period when the small group market in Maine declined by 24 percent, the individual market grew by 28 percent. The largest growth was in 2004, the year the DirigoChoice plan was enacted when overall enrollment in the non-group market jumped by over 5,000.[23]

Maine's individual market has experienced substantial adverse risk selection and deteriorated over the past decade. The actuarial analysis of the two markets conducted in 2007 determined that the age factor in the individual market is 15 percent higher than in the small group market. In addition, the claims trend in the individual market in recent years has been much higher resulting in a current differential in average per member per month allowed claims costs of $357 in the individual market compared to $312 in the small group market (based on 2006 claims).[24] These differences were due to a small group of high claims cases. The individual market had a higher proportion of persons with $0 claims than the small group market. But the number of catastrophic cases in the individual market was proportionately higher than the small group market, and the cost per case in this group was higher.

Both Maine's small group and individual markets are highly regulated (see discussion below), limiting insurers' strategies for segmenting the market and offering low cost products. Because of the deterioration in the individual market, insurers that offer both individual and group products have tried to maintain a bright line between these lines of business and (until 2008) have not allowed "groups of one" – or self-employed individuals – to purchase in the small group market. Companies that do not offer individual products have to offer groups of one. Association plans have also been available to self-employed individuals in some lines of business but these products tend to be high priced and have low actuarial value. The DirigoChoice Plan was the first plan in Maine to enroll both individuals and small groups (although the contracting insurance carrier rates the two groups separately). In 2007, the Chamber of Commerce

successfully negotiated with Anthem Blue Cross and Blue Shield to offer a range of benefit options (cafeteria plan) as a Chamber sponsored plan, and to allow, for the first time, self-employed individuals to participate (although a number of the professional association plans, for example the Maine State Bar Association and the Maine Medical Association were already doing so). At least one insurance industry representative with knowledge of the Maine market speculated that the Chamber's interest in including the self-employed and Anthem's willingness to do so may have been stimulated by the favorable DirigoChoice experience with this population.

Insurance Regime

Regulatory Framework in Maine's Small Group Market

In the early 1990s, Maine's legislature enacted a package of regulatory constraints affecting both the small group and individual insurance markets. Both markets have requirements of guaranteed issue and guaranteed renewal, limits on waiting periods for pre-existing conditions, and requirements to honor waiting periods met under prior policies. In addition, Maine has a modified community-rating law that limits the factors for which insurers may adjust premiums to age, geography, and (in the case of the small group market only) industry, and that limits the allowable variance to no more than 20 percent from a base premium for the combination of these factors. However, Maine law does not currently limit the extent that insurers may make adjustments for group size. Thus, premiums for different sized businesses can reflect differences both in the morbidity within the different sized business groups and differences in administrative costs to the insurer. In 2006, the band width for the group size adjustment applied by insurers in the small group market was approximately 1.34 – meaning that groups of 1 to 2 employees paid premium rates about 34 percent higher than the rates of groups of from 26 to 50 employees, all other factors being equal. The effect of the group size adjustment, in combination with the 20 percent variance allowed for age and industry, is a sizeable difference in premiums for (as an example) a 50 year old individual in a business of two compared to a 25 year old individual in a business of 30.

Similarly to many other states, Maine legislators in the 1970s and 1980s were receptive to interest group pressure to add mandated benefits to the insurance regulatory code. In the late 1980s, with rising premium costs and counter pressure from groups such as the National Federation of Independent Businesses, policymakers enacted a provision requiring a cost benefit analysis of proposed new mandates, and began to scrutinize requests against this standard. The increased sensitivity of the legislature to cost issues has almost halted the addition of new mandates, but not entirely. Two mandates that have been added since the new standard of review are requirements for coverage of screening mammography for women over age 45, and a mental health parity law. Maine currently has about 40 benefit mandates – about mid-range for states. It is one of 23 states with a mental health parity law.

Small Market Reforms Considered Prior to the Dirigo Reform Act

Maine stakeholders, legislators, and small business owners are divided in their views on the wisdom of maintaining the current regulatory structure in the small group market. There is a widely held conviction among the public, at large, and small business owners, in particular, that the lack of competitiveness in the insurance market has allowed the insurance industry to charge excessively high premiums and net unnecessarily fat profits. Some business owners see the remedy for the situation as deregulation, which they believe will attract more insurance companies to the state and stimulate corrective competition in the market. Others take the opposite view and believe that a stronger government hand is necessary to assure the affordability of insurance coverage.[25]

In 2002 these concerns were pushed to the front of the legislative agenda by the steep premium increases of the last few years and are reflected in legislative proposals that predate the Dirigo Reform Act. The Democratic and Republican leadership of the legislature put forward two competing proposals intended to address cost barriers in the small group market. The Republicans proposed a purchasing pool for small employers and a change in regulation to allow insurers to offer plans that did not meet state mandated benefit requirements. Democrats proposed a plan to allow small employers to purchase coverage for their low income workers through the state Medicaid program. Maine's Department of Human Services secured a grant from the federal HRSA State

Planning Program to undertake a study of both of these proposals as well as other options. However, the election of a new Governor with his own agenda for health reform changed the direction of both policy analysis and policy debate, and within the first year of the new administration, the Dirigo Health Reform initiative was passed (discussed below).

II. The Dirigo Health Reform Act

Political Origins

Governor Baldacci was elected in 2002, taking office in January, 2003. His campaign for office came upon the heels of a period in which insurance premiums in the small group market had risen, cumulatively, 78 percent over three years (see Table 2) and his political agenda was shaped by the level of concern he encountered from constituents in all parts of the state regarding the cost of health insurance. He came into office determined to make health system reform a priority and, in his first act as governor, created an executive office of Health Policy and Finance charged with developing and securing political support for a comprehensive reform plan. The Governor appointed a stakeholder group – the Health Action Team (HAT) – to advise the proposal development process. Included in the group were legislators of both parties, representatives from the hospital and physician associations, representatives from the insurance industry, employers, consumer advocates, and union representatives.

Because of the high level of frustration over rising health care costs, both influential large businesses and small businesses, as represented by the Chamber of Commerce, were more receptive to government action in the health services arena than is usual. The Governor enjoyed a majority control by his party of both houses in the legislature. Insurers, while wary of the intent of the administration, knew they had to come to the table because of the significant possibility of a reform measure succeeding in the legislature.

The particular structure of the reform initiative was not preconceived, but developed through analysis and interaction with stakeholders over the first six months of the administration. The governor specified only that he wanted an initiative that would address access, costs, and quality simultaneously, and that the plan should have the capacity to attain universal coverage. A statewide household survey carried out the prior year under the state's HRSA state planning grant confirmed the impressions gathered during the campaign, that the most significant barriers to coverage were in the small business sector. Initially, the governor's staff explored with the HAT the concept of a reinsurance program for the small group market, similar to the HealthyNY plan recently implemented in New York. At that time, HealthyNY had an attachment point for the state's reinsurance contribution of $75,000. Policymakers in New York, at a later date, finding that the reinsurance program as structured had an insufficient impact on premium costs to reduce cost barriers to enrollment, changed the HealthyNY reinsurance to cover claims between $5000 and $75,000. Maine policymakers debated a program with a high attachment point similar to the original HealthyNY design. The spokesperson for the insurance industry serving on the HAT argued strongly against such a program, stating that actuarial analyses showed that it would make little difference to the cost of premiums and pointing out that, if Maine's small group market needed reinsurance, the national companies with which Maine insurers were affiliated had "deeper pockets" than Maine's state government. When the Administration's own analyses concurred with the industry on the impact on premium of such an approach, the reinsurance proposal was abandoned.

The DirigoChoice coverage model that was next proposed and ultimately approved by the legislature grew from a proposed strategy to maximize coverage of the working poor through Medicaid developed by a team of in-state and out-of-state policy experts on the Medicaid program. The proposal hinged on the concept of a state-sponsored and state agency-administered health benefit plan offered as group coverage to employers with Medicaid eligible workers. While federal Medicaid rules prohibit states from using employer contributions to health benefit plans to draw down federal matching dollars, they allow as match state revenues obtained by state agencies (through licensure fees, for example). Maine proposed the creation of a state agency, the Dirigo Agency, which

would administer the new state health benefit plan, collecting program participation fees from participating employers and employees. Some portion of the agency's revenues would be transferred to the State Medicaid agency to cover the state share of Medicaid wrap-around services for program participants who were determined to be Medicaid eligible.

With a view toward making coverage affordable for non-Medicaid eligible low and moderate income workers in the targeted small businesses, the Administration proposed sliding scale premium subsidies for enrollees with incomes up to 300 percent of the federal poverty level. This basic proposal – expanded Medicaid coverage and sliding scale subsidies offered through a small group and individual insurance product administered by a new state agency – was put forward as part of a comprehensive reform bill that included significant cost control mechanisms and quality enhancement strategies. The bill included a proposal for the development of a state health plan to be updated on a biennial basis that would, among other things, establish a global cap on hospital spending. A council of hospital representatives was proposed that would allow hospitals, themselves, to negotiate allocation of revenues within the cap – a "cap and trade" model. In addition, the bill proposed strengthening the Certificate of Need (CON) review process and new regulations governing insurers and providers (details discussed page 30). The proposal called for the creation of a Maine Quality Forum, housed within the Dirigo Agency, with a dedicated funding line of $1 million per year, that would have responsibility for developing quality measurement tools, educating the public on variations in quality among providers and service areas and, in partnership with providers and payers, undertaking initiatives to enhance the quality of care in the state.

To cover program costs, the administration proposal initially included a funding formula based on an assessment of insurance premiums, with a provision that the assessment could not be passed through as an increase in premium costs to insurance purchasers. This funding strategy was premised on the concept that savings from the spending caps and other cost containment measures and from averted bad debt and charity care as the pool of uninsured was diminished would offset the insurers'

assessment cost, allowing the program subsidies for the low income to essentially derive from system savings.

Substantial negotiations with stakeholder groups took place after the bill was introduced, particularly with regard to the cost containment and funding measures. The hospitals, in particular, were successful in rallying significant public support and blocking legislative action on the global spending cap provision. Ultimately, the bill sent out of legislative committee had abandoned the global spending caps in favor of several voluntary cost containment targets for hospitals and a commission to study hospital costs. The provision barring insurers from reflecting the costs of the assessment in their premiums was also removed and replaced with a provision that the Dirigo Agency could levy an assessment of up to 4 percent of health insurance and third party administrator claims volume if the Agency could show system savings of equal or greater value that would offset the assessment (commonly referred to as the Savings Offset Payment, or SOP).

The ultimate bill reflecting these compromises was developed through negotiation with the affected stakeholder groups and in exchange for the modifications they agreed not to oppose the compromise bill. At a public hearing, the State Chamber of Commerce testified in support of the bill, as did a small association representing "progressive" small businesses. The hospital association, medical association, and insurers testified neither for nor against, in each case, speaking favorably about the access initiative and quality measures contained within the bill and saying that specific (relatively narrow) provisions prevented them from offering unqualified support. The bill passed out of the bipartisan legislative committee with a unanimous vote of "ought to pass" and was approved in both houses of the legislature.

Dirigo Reform Program Description

H.P. 1187, An Act To Provide Affordable Health Insurance to Small Businesses and Individuals and To Control Health Care Costs (known as the Dirigo Health Reform Act) includes four initiatives designed to expand access to health coverage:

- An expansion of eligibility under MaineCare (Maine's Medicaid and SCHIP programs) for parents of eligible children from 150 percent of the federal poverty level up to 200 percent of FPL;
- An expansion of eligibility under Maine's HIFA waiver for non-categorical adults from the federal poverty level up to 125 percent of the federal poverty level;
- Authorization of a state-sponsored health coverage program with subsidies on a sliding scale for non-MaineCare eligible individuals and families with incomes up to 300 percent FPL who meet program eligibility criteria (discussed below); and
- Authorization for a premium assistance program for uninsured persons with incomes below 300 percent of FPL working in large businesses to encourage the purchase of coverage in their employer's qualified health benefits plan.

To date, although authorized by the reform legislation, Maine has not implemented a premium assistance program. In addition, the expansion of the non-categorical adult waiver program eligibility from 100 percent of the federal poverty level to 125 percent of the federal poverty level has not been implemented. The conditions of a HIFA waiver require that federal Medicaid spending not exceed what would have been spent in the absence of the waiver program. Maine's coverage of non-categorical enrolled adults exhausted available federal cost sharing while enrollment was limited to those with incomes below the poverty level. As a consequence, no expansion in eligibility to this program is contemplated in the short-term.

Maine implemented the expansion of eligibility for SCHIP parents to 200 percent of the FPL and enrolled an additional 5000 people in the MaineCare program.

Detailed below, is a description of Maine's new coverage initiative targeted to the small business community and the working uninsured, a program called DirigoChoice. Also of direct relevance to small group coverage in Maine, are other components of the Dirigo Reform act targeted to containing health care costs and placing greater regulatory constraints on insurer profit margins in the small group market. These features of the Dirigo Reform are detailed following the description of the DirigoChoice plan.

Overview of DirigoChoice Program Structure

The DirigoChoice Program is a public/private collaborative enterprise that is jointly administered by the Dirigo Agency – a public agency created by the Dirigo Reform Act – and a private insurance carrier under contract. Policy for the program, within the parameters set by the legislature, is determined by a nine-member Board of Trustees appointed by the Governor. The Director of the Governor's Office of Health Policy and Finance, the Commissioners of the Departments of Professional and Financial Regulation, and Administrative and Financial Services and the State Treasurer (or their designees) serve as ex-officio, non-voting members of the Board.[*] The Board, with advice from Agency staff, makes decisions regarding the scope of coverage and number of products that will be offered through the DirigoChoice Program and program eligibility specifications within the parameters of the statute. It approves contracts with the insurance carrier and determines, annually, the level of assessment for the program's subsidy funding, within the limits established by law.

The DirigoChoice insurance products are fully insured by the participating insurance carrier. Premiums are negotiated by the Dirigo Agency staff and Board with the carrier, while subsidy levels are determined by the Board. The carrier is responsible for premium billing, claims processing and payment, and parts of the enrollment process. The selection of the insurance partner is determined through a competitive bid process. For the first three years of program operation, 2005 through 2007, Anthem Blue Cross and Blue Shield of Maine served as the insurance partner for the program. As of January, 2008, the Harvard Pilgrim Health Plan became the insurance partner.

The Dirigo Agency maintains responsibility for program oversight, contract management, determining subsidy eligibility of enrollees, administering the subsidy program, program marketing, member services, and public education. The agency is required to report to the legislature on an annual basis with information on program enrollment levels, program cost, prior insurance status of members, and the impact of the reforms on the uninsurance rate in the state.

[*] The Dirigo Act created a five member Board which was increased to nine by legislative amendment in 2007.

Program Eligibility

The DirigoChoice Program is targeted to small businesses, the self-employed and some individuals who meet specified eligibility criteria. Specifically, businesses with 50 or fewer full-time employees are eligible to purchase an employee health benefits plan through DirigoChoice. Consistent with Maine small group market requirements, at least 75 percent of employees working 30 hours or more per week and who do not have other credible coverage must participate. Sole proprietors are considered businesses of one and are eligible to enroll. For enrolling businesses, the program does not have a crowd-out provision. Currently insured businesses are not precluded from switching to the DirigoChoice Plan. Although the lack of a crowd-out provision has generated controversy in the State as the DirigoChoice enrollment of previously insured self-employed individuals and small businesses has grown (see discussion, page 33), the choice by policymakers was deliberate. They were concerned with three issues which they felt outweighed the crowd-out hazard. First, a number of policymakers were strongly concerned about equity. They felt that small employers who had possibly suffered financial stress in order to provide health benefits in the past should not be precluded from benefiting from a government program that was available to their competitors who had chosen, previously, not to provide benefits. Second, the rate of increase in premiums had been so substantial in the years prior to the implementation of the DirigoChoice plan that some policymakers were concerned about continued volatility and involuntary loss of coverage due to unaffordable premiums. Finally, policymakers wanted to reach individual employees who could not afford coverage despite the fact that their employer offered a health benefit plan.

Maine residents may purchase non-group coverage through DirigoChoice if they work 20 or fewer hours per week for any one employer, if they work for a business of fewer than 50 that does not offer health insurance coverage, if they are retired but not yet eligible for Medicare benefits and their employer does not contribute to retirement health coverage, or if they are an employer of a small business who tried to purchase DirigoChoice group policy but was unable to secure 75 percent participation from eligible employees. Employees working for employers who do not provide employer-

sponsored health benefits are not eligible until they have been without employer-sponsored coverage for 12 months.

During the first three years of program operations, the DirigoChoice program linked with Maine's Medicaid Program, MaineCare, to provide seamless coverage for Medicaid-eligible workers within participating small businesses. To operationalize this link, the Dirigo Agency negotiated a Medicaid managed care contract with the DirigoChoice insurer, Anthem, to provide coverage for MaineCare recipients enrolled through the DirigoChoice program. These individuals received benefits through the DirigoChoice Plan carrier in a manner similar to other Dirigo enrollees and, additionally, received wrap-around benefits administered by MaineCare to the extent of their entitlement under the MaineCare program. The intent in using the DirigoChoice program for Medicaid-eligible workers was twofold. First, policymakers felt that the program might successfully reach and extend coverage to eligible individuals who have opted not to enroll in Medicaid because of the perceived stigma (or who may not realize that they are eligible). Second, with the required employer contribution toward premium costs, the DirigoChoice program was seen as a less costly way for the State to provide coverage than traditional Medicaid coverage.

Employers of DirigoChoice enrollees are not provided with subsidy information on their employees and contribute equally to all employee premium payments (discussed below), including employees dually eligible for MaineCare. The employee share of the premium for Dirigo MaineCare enrollees was 100 percent subsidized by the MaineCare Program.

In 2008, the MaineCare cross-over enrollment was terminated and the maximum discount available through the DirigoChoice Program, regardless of income, is 80 percent. Take-up of the Medicaid option had been consistently very low (80 members at the time the option was terminated). Although many enrollees have family incomes below the threshold of eligibility for MaineCare, many applicants were unwilling to apply for MaineCare or to submit the more comprehensive financial information required for eligibility determination, and many had assets that put them over the eligibility threshold for MaineCare, but not DirigoChoice discounts. Further, federal

regulators challenged Maine's application of employer contributions toward the premium costs of Dirigo/MaineCare enrollees and other regulatory hurdles (ERISA and state insurance regulations) made seamless integration very problematic.

Subsidy Program

For groups enrolled in the DirigoChoice program, the employer is required to contribute a minimum of 60 percent of each employee's premium (but is not required to contribute toward the coverage cost of dependents). The employer share of the premium is not subsidized. In these groups, enrolled individuals and their dependents whose household income is below 300 percent of the federal poverty level are eligible for state funded subsidies for their share of program costs (their contribution to their own premium costs as well as 100 percent of dependent coverage). There are four tiers of subsidy: an 80 percent discount, 60 percent, 40 percent, and 20 percent (Table 3). Employees and employers whose incomes exceed 300 percent of FPL may enroll in DirigoChoice at full membership cost.

Sole proprietors and employers with personal incomes below 300 percent of the federal poverty level are eligible for discounts only on 40 percent of the full premium (the enrollee "share"). Their business is expected to pay the employer's (60 percent) share of the premium. Non-group enrollees with incomes below 300 percent of poverty and not otherwise eligible for MaineCare receive discounts against the entire premium. Thus, while an employee of a business might be eligible for a 20 percent reduction in his/her *share* of the membership costs, a similarly situated individual would receive a 20 percent reduction in the full premium costs.

Table 3: DirigoChoice Subsidy Structure (Based on coverage options with $1250 deductible)

- Employer/self-employed pay 60% of employee premium
- Employee/self-employed discount based on 40% employee share and 100% of dependents
- Individual discount based on 100% of premium

Discount Groups based on Income	<149% FPL	150-199%	200-249%	250-299%	+300%
Discount	80%	60%	40%	20%	None
Deductible					
Single	$250	$500	$750	$1000	$1250
Family	$500	$1000	$1500	$2000	$2500

Deductibles within the DirigoChoice program are also tiered according to subscriber household income (Table 3). *

The Dirigo Board decided to offer health plans with relatively high deductibles and to dedicate a portion of the subsidy dollars for discounting the deductible as well as the premium as a means of reducing the total premium cost and reducing, thereby, the 60 percent share required of employers. The small group market in Maine is moving toward high deductible policies in response to the general rate of increase in health care costs and insurance premiums. Because the DirigoChoice products have deductibles comparable to many other products in the market, the unsubsidized premiums (and employers' share) are within a range to stay competitive with other choices available to small groups.

The administration of the discount program is complex for the Agency in order to reduce complexity for participating employers and to protect the confidentiality of enrollees. Program enrollment forms are submitted through the employer to the Dirigo Agency. However, applicants individually and confidentially submit paperwork related to eligibility for discounts and Agency staff make determinations of eligibility. Employers do not receive information related to employee discounts and make uniform

* Three plan choices are available with (non-subsidized) deductibles of $1250, $1750, and $2500 for a single person, respectively. Premiums for higher deductible plans are correspondingly lower. Equivalent discounts are available for any of the three plans. The overwhelming majority of enrollees have selected the lowest deductible plan.

payroll deductions for all participating employees. Those participants who have been determined to qualify for a discount are reimbursed by the Dirigo Agency, electronically, on the same day that the payroll deduction for premium payment is made. Initially, the Agency used an Electronic Benefits Transfer (EBT) card, similar to those used for food stamp recipients, as a mechanism for transferring reimbursements to enrollees. These cards generated many complaints from participants both for inconvenience (some banks would not accept them) and for generating social discomfort when store clerks would associate them with state income assistance programs and sometimes try to prevent the users from purchasing items disallowed by the food stamp program. In response to these complaints, the Agency has instituted an arrangement where, after 90 days of enrollment, a participant can apply for and receive electronic transfer of the refund directly to his or her bank account. In addition, the Agency has developed arrangements with the insurance carrier to avoid the need for reimbursements altogether for self-employed and individual enrollees. These participants are billed by the insurance carrier the discounted amount owed from them, and the Dirigo Agency makes direct payments to the carrier of the difference between the discounted premium payments and the full premium due.

Although the Dirigo Agency tries to maintain an administrative process that minimizes complexity for participating employers and subscribers, the actual pricing of the DirigoChoice product and ultimate subsidization scheme is very complex. The Dirigo Agency negotiates the program's base premium. But the actual premium the insurer establishes for a given enrollee will be adjusted from this base rate by the subscriber's age, geographic location, type of business and group size. For groups, the insurer calculates the individual rates based on the enrollees' age profile and other allowed factors and develops an amalgamated, average premium rate for the group. The employer pays a minimum of 60 percent of the amalgamated rate for each employee and deducts the balance of the premium due from each participating employee's paycheck.

But the DirigoChoice program faces an additional complication in premium pricing beyond the normal variance of the small group market pricing. Because each subsidy tier of the DirigoChoice Program has a different deductible, the benefits of each subsidy

tier have a different actuarial value. This difference is driven not just by the value of the deductible, itself, but by the constraining effect that higher cost-sharing is assumed to have on utilization of health services. DirigoChoice's insurance partner treats each subsidy tier as a separate insurance product and prices each tier separately. The Dirigo Agency compensates the insurer for the premium differentials associated with the different subsidy tiers, making this variance in premium invisible to participating employers and subscribers. For example, if a group's individual, amalgamated premium were $300, the employer would pay 60 percent, or $180 and employees would pay 40 percent – the full employee share ($120). If one employee had been deemed eligible for an 80 percent discount, the employee's deductible would be $250, rather than the unsubsidized deductible of $1250. The insurer's price for her coverage might actually be $340 rather than $300. The Dirigo Agency, in this case, reimburses the enrollee 80 percent of her premium payment ($96) and, additionally, reimburses the insurer the additional premium owed ($40).

Program Marketing and Outreach

The Dirigo Agency maintains primary responsibility for DirigoChoice program marketing and outreach while, at the same time, cooperating with brokers or producers. The Agency periodically sponsors marketing campaigns using multiple media including radio spots, mailers, and television. In addition, the program periodically receives news coverage through the newspapers and television. Initially, the agency relied on the producer network of its contract insurer to provide more detailed information to interested prospects and to assist individuals and groups with the enrollment process. This strategy produced frustrations for both the producers and the Dirigo Agency. Producers found the DirigoChoice product much more difficult to explain than the products they were used to and the process of reaching out to currently uninsured businesses time consuming and minimally productive. The Agency, in turn, found that the producers spent their time trying to win businesses from competitors rather than bringing in uninsured businesses, and that many were uncommitted to selling the DirigoChoice products. The Agency (and its insurance partner) received many direct inquiries and the vast majority of program enrollment derived from direct inquires and requests (see Table 4).

Table 4: Source of Enrollment for DirigoChoice Groups and Individuals[26]

	Small Group	Sole Proprietors	Individuals
Producers	66%	20%	17%
Direct	34%	80%	83%

In 2007, the Dirigo Agency negotiated with the insurance partner an arrangement where unexpended money set aside for producer commissions (part of the administrative costs loaded into the Dirigo product premiums) were provided to the Dirigo Agency to fund staff positions within the Dirigo Agency. The Agency established a five person call center, staffed with trained individuals who could explain knowledgably the enrollment options, the discount program, and the application process and then refer individuals to producers to complete the paperwork.

DirigoChoice Program Funding

The DirigoChoice Program is funded through a combination of payments by participating employers and subscribers and public funds. In the program's first year, the Governor committed and the legislature approved a one-time general fund allocation of $53 million to "jump-start" the program. Continuing public funds necessary to support the program's discount program and the operations of the Maine Quality Forum have come from a Savings Offset Payment derived from an assessment on insurers, third party administrators, and reinsurers based on their paid claims volume. The Dirigo Agency administrative costs, to date, have been funded through the initial $53 million in state seed funding. In April 2008, the legislature passed a law that allows revenues derived from the Savings Offset Payment assessment to cover agency costs going forward.

The Dirigo Act is unspecific as to how savings should be measured, but procedurally requires the Dirigo Board to recommend an assessment amount based on its measurement of savings and the Superintendent of Insurance to rule on reasonableness of the Board's recommendations. The procedure involves an adjudicatory hearing in which interested parties can testify and present written evidence in support of or in opposition to the Dirigo Board's recommendations. In 2005, 2006 and 2007, the Superintendent of Insurance ruled that the Board had reasonably produced evidence of

$43.7 million in savings in Year 1 of the program, $34.3 million in Year 2, and $32.8 million in Year 3 . These savings levels resulted in assessments of 2.4 percent of claims volume in Year 1 and 1.85 percent in Year 2.[27] The demonstrated savings derived from savings in hospital costs based on Maine hospitals' compliance with the voluntary cost reduction measures, and savings in bad debt and charity care resulting from the comprehensive coverage provided through the DirigoChoice Program to previously uninsured and underinsured Maine residents.

The savings allowed by the Superintendent were about half of those claimed by the Dirigo Agency in Year 1, about 80 percent of those claimed in Year 2, and about 42 percent of the amount claimed in Year 3. The measurement of savings as presented by the Dirigo Board and the counter arguments by consultants for Maine payers were highly technical.[28] The largest component of allowed savings in each year derived from reductions in hospital costs in relation to the trend line prior to the implementation of the Dirigo reforms. As the time since the reform was implemented has increased, the certainty regarding likely trends in the absence of the Dirigo reform has decreased, accounting for the Superintendent's proportionately lower ruling of allowed savings in Year 3. Other components of allowed savings include measurements of decreased bad debt and charity care associated with the enrollment of previously uninsured in the DirigoChoice program and in the Medicaid expansions passed as part of the Dirigo Reform Act.

DirigoChoice Program Experience, to Date

Enrollment

The DirigoChoice program began offering coverage on January 1, 2005. Because of the partner insurer's concern for the potential for adverse selection among non-group enrollees, the program was open only to small businesses and sole proprietors for the first operational quarter. In April, the program opened to individuals. The program ended the first twelve months with an enrollment of 8,682. By the end of the second year, it had grown to 13,292. In the third year (2007), because the assessments that supported program subsidy costs were inadequate to support continued program

growth, new enrollment was suspended in September except to non-subsidized enrollees and to new employees and or dependents of currently participating small businesses. At the time enrollment was closed, a total of 15,123 members were enrolled. The program ended the year with 14,405 enrollees (see Figure 1 at end of report).

The rate of enrollment growth was fastest for individuals, slightly less among sole proprietors, and slower for small business groups. As of December, 2007, individuals made of 49 percent of total enrollment, sole proprietors and their dependents, 28 percent, and small group enrollees, 23 percent (see Figure 2 at end of report). The small group enrollment includes 720 small businesses (exclusive of sole proprietors).

Enrollees eligible for the deepest level of discount (80 percent) have consistently been over-represented among the DirigoChoice membership. As of December 2007, 51 percent of the membership was in Group B – the deepest discount group. Eighteen percent of the membership has incomes above the eligibility for subsidies (above 300 percent of the federal poverty level). Among the other income tiers, numbers of enrollees decline as the level of subsidy declines: 15 percent of members in the 60 percent discount group; 10 percent in the 40 percent discount group; and 4 percent in the 20 percent discount group (see Figure 3 at end of report). The non-subsidized DirigoChoice enrollees are fairly evenly divided among individuals, sole proprietors and small business enrollees. Proportionately, a larger percentage of the small business enrollees are non-subsidized segment than is the case among sole proprietors or individual enrollees (see Figure 3). This may be indicative of participation by relatively high income employers in small businesses with low-wage employees.

The take-up rate in the DirigoChoice plan has been politically controversial in the State. There were approximately 49,000 working uninsured (and their dependents) in businesses of fewer than 50 at the time the program was implemented.[29] DirigoChoice's enrollment of between 5 and 6,000 uninsured employers, employees and dependents represents a take-up rate of about 11 percent of that pool of uninsured small business workers. An additional 4,400 of DirigoChoice enrollees were underinsured at the time of enrollment or had COBRA coverage indicating a risk of future uninsured status. Prior

experience in other states has shown that in individual insurance programs, substantial subsidies are necessary to stimulate a significant response from the uninsured. Overall, the experience has been that every 10 percent decrease in price leads to an increase in the number purchasing coverage of between 3 and 7 percent.[30] Prior experience with the response from non-insuring small businesses to subsidy opportunities targeted to small groups has also been disappointing.[31] The DirigoChoice take-up rate for the first three years has been in the upper range of experience when compared to similar state initiatives. However, the DirigoChoice program was presented to the legislature as the linchpin in an effort to attain universal insurance coverage in Maine. An enrollment of 30,000 in the first year was suggested as a goal to policymakers. By the standards of public expectations, then, the take-up rate of the DirigoChoice program has been a disappointment.

DirigoChoice Expenditure Trends

Over the three years of DirigoChoice program experience, public expenditures more than doubled between years 1 and 2, and increased by 41 percent between years 2 and 3. Increase in public spending for this program is a function of three factors: overall growth in program enrollment; a change in the mix of enrollment trending more toward individuals than small groups and toward more heavily discounted enrollees than less subsidized ones; and premium increases negotiated by the insurance carrier. The most pronounced cost driver is program growth. Member months increased 190 percent between years 1 and 2 and by 34 percent between years 2 and 3. Individual enrollees absorb substantially more subsidy dollars at each subsidy tier than do small group enrollees because there is no employer contribution toward program costs for these individuals. Over the life of the program, individual enrollment has grown faster than small group enrollment, increasing the state average costs on a per enrollee basis.

Overall, the claims experience of the program has not been dissimilar to Maine's small group market. In 2005, the first year of operations, premiums were built around an

assumption of an 80 percent loss ratio.* Across total enrollment in this year, the DirigoChoice loss ratio was 79.1 percent. However, the average experience masks substantial differences by enrollee type. The loss ratio for small group enrollees was 64 percent (substantially better than Anthem's norm), for sole proprietors the ratio was 72.7 percent, and for individuals, the ratio was 101.3 percent (indicating the insurer paid out more for this group than was collected in premiums).[32]

Table 5: DirigoChoice Cost Trends

	2005			2006			2007		
	Dollar Amount	PMPM	% Dist.	Dollar Amount	PMPM	% Dist.	Dollar Amount	PMPM	% Dist.
Member Contributions	$12,104,746	$179	51%	$23,330,519	$188	47%	$33,069,002	$229	46%
Subsidy	11,493,893	170	49%	27,260,836	212	53%	39,475,326	192	54%
Total	**23,598,639**	348		**51,458,378**	400		**72,544,328**	421	
Total Member Months			67,728			128,754			172,350

Overall, Maine has seen some deterioration in risk distribution in the individual insurance market. DirigoChoice – probably because of its comprehensive benefit coverage in relation to products otherwise available in the non-group market – appears to have experienced adverse selection among non-group enrollees even in relation to Maine's individual market. Among DirigoChoice individuals and sole proprietors, the age factor is 25 percent above Maine's small group market, compared to the overall individual market age factor of plus 15 percent.[33] Nevertheless, the better than average experience among small group enrollees kept overall DirigoChoice Program experience for the first two years within norms, as established by Anthem Blue Cross. In 2006, for example, among all DirigoChoice enrollees, the top 1 percent in terms of claims costs drove, overall, 29.1 percent of the group's total claims experience. Anthem's norm is 30

* The loss ratio refers to the proportion of premium collected that is used to pay for enrollees' medical costs. An 80 percent loss ratio indicates that 80 percent of premium is used for medical expenses and that 20 percent is retained by the insurer for administrative costs and profit. In the first two years of DirigoChoice program operations, because the likely claims experience of enrollees was unknown, the Dirigo Agency negotiated an Experience Modification Provision with the insurer, where moneys were prospectively escrowed to cover excess claims costs if claims exceeded an 80 percent loss ratio, but returned to the agency if claims remained at or below an 80 percent loss ratio.

percent. Among DirigoChoice enrollees who filed a claim, the average cost, in 2006 was $2,875, not dissimilar to the Anthem norm of $2,786.[34] *

Based on the aggregate claims experience of the DirigoChoice Program, Anthem reported $3.6 million in underwriting gain on the DirigoChoice Program in Year 1. Nevertheless, because of losses among individuals, the trend toward proportionately greater individual enrollment, and overall market trends of increasing per member per month costs, premiums have increased each year for the DirigoChoice program – adding a third driver to increased public costs for the program.

Dirigo Agency Administrative and Operational Costs

The Dirigo Agency functions with a small staff of 15. The agency Executive Director is supported by three management positions, the Director of the Maine Quality Forum, a Deputy Director who oversees information systems, finance, and contracts, and a Director of Operations who oversees eligibility determination, enrollment support, the call center and marketing. The Quality Forum is supported by two planning/research support positions. The Agency's operations are supported by five additional professional staff positions and two clerical workers. In 2005, Agency operating costs were a little below $3.3 million and in 2006, about $4.2 million, or a little under 6 percent of program costs. The insurance partner's administrative costs associated with the DirigoChoice Program are built into the program's premium. As indicated above, approximately 20 percent of premium revenues collected is allocated for administrative costs and profit.

Because of the controversy around the Savings Offset Payment funding mechanism for the DirigoChoice program, stakeholder groups have been publicly critical of DirigoChoice costs, suggesting that the program is a very inefficient strategy for extending coverage to the uninsured. Dirigo Program advocates, on the other hand, have suggested that the program has not received the credit it is due for efficient

* Because the norms used by Anthem for reporting DirigoChoice experience derived from their large group enrollment where the opportunities for adverse selection are minimal, the DirigoChoice experience in relation to these norms was particularly reassuring.

operations. A portion of the $53 million in public funding that was originally intended to cover year 1 costs was still unspent and available to supplement other revenues in year 3 of the program. In addition, they point out, the medical claims costs of the DirigoChoice program are in line with the general population health cost experience in Maine. DirigoChoice, these advocates assert, is expensive to the same extent that health care costs in Maine, in general, are expensive. This argument has been used to try to generate greater support from stakeholder groups for the Dirigo Act cost containment measures.

Dirigo Act Provisions Affecting the Small Group Market in Maine

The Dirigo Reform Act is a comprehensive reform initiative that includes a number of provisions, beyond the creation of the DirigoChoice Plan, that affect the small group market. Principal among these provisions are new cost containment measures targeted to the health care delivery system and new regulations imposed on insurers in the small group market. The Dirigo Act strengthened Maine's Certificate of Need law to extend its reach to non-hospital providers and sites of care and to establish an annual dollar cap on new capital projects requiring CON review. The effect of the cap is to make the CON review process a competitive process, where proposed projects are evaluated against each other and prioritized in terms of the health system needs of the state. Maine's Department of Human Services has established a review procedure with two review cycles per year, one for large capital projects and one for small capital projects. The Dirigo Act also established several benchmarks for hospital cost performance – standards which were negotiated with the hospital industry. Compliance with the standards is voluntary, not mandatory, but the benchmarks provide a means of publicly evaluating each hospital's performance against norms agreed to by the industry as reasonable. The standards include a limit of 3.5 percent growth in average cost per case-mix adjusted discharge per year and a limit of 3 percent in total operating margin per year. Insurers in the small group market are now held to a minimum loss ratio of 78 percent, calculated as a three year, rolling average. Premiums collected in excess of the 22 percent allowed to be retained for administrative costs and profits must be returned to policy holders in the form of rebates. Additional requirements imposed by the law on

the insurance industry include annual reporting to the Bureau of Insurance (and hence, to the public domain), of total small group enrollment, premium collected, claims paid out, loss ratios, administrative costs, and profit margins.

There is tentative evidence that the combination of cost containment measures and restrictions on insurer administrative costs and profits may have had some moderating influence on subscriber costs in the small group market. Table 2 shows that premiums in the small group market in Maine increased, on average, 26 percent per year in the three years prior to the enactment of the Dirigo Reform law and have increased, on average, 10.25 percent a year in the four years since enactment. In addition, the average loss ratio across the small group market in Maine in the two years prior to enactment were 72 and 74 percent, respectively, while in the first two years post enactment, the averages were 77 and 81 percent. In addition, the minimum loss ratio requirements have resulted in at least one instance of premium rebates to small group employers (see Appendix).

It is too soon to tell whether the moderating trends in the small group market are simply a result of the usual insurance pricing cycle, a temporary chilling effect from the focus of legislative attention on the problems of the small group market, or a long term trend resulting from the state reforms. Opinion in the business community is divided on whether the new minimum loss ratio regulations and Dirigo cost containment measures have had any effect. However, apparent changes in the trend line of hospital costs in Maine point to a good faith effort by Maine hospitals to meet the benchmarks established by the Dirigo Reform Act and may be contributing to a reduction in cost pressures driving premium increases. In the year following the enactment of the Dirigo Reform, average hospital costs were projected to increase 5.7 percent based on the experience of the prior four years and national hospital trends. Instead, Maine hospital costs in this year increased by 2.3 percent (see Figure 4 at end of report).

III. Assessment of Major Management and Implementation Issues and Program Effectiveness

Strengths and Weaknesses of DirigoChoice Program Structure

Subsidy Program

The structure of the DirigoChoice subsidy program is designed to bridge the gap between what low income and moderate income individuals and families can realistically be expected to pay for health coverage and what adequate and comprehensive health care costs. By scaling the subsidies according to household income, the program conforms to an equity principal that individual contributions should be proportionate to income and an efficiency principal that public dollars should be targeted where most needed and matched, to the extent possible, with contributions from beneficiaries according to their ability. By requiring employer and employee contributions toward the coverage cost in the DirigoChoice program, the state has been able to extend coverage to a greater number of individuals at the program's current funding level than would have been possible with a totally state funded program. In addition, by tailoring subsidies to income and requiring participant contributions, the program ostensibly avoids "free riders" – individuals who could afford coverage without assistance from the state.

The structure of the subsidy program is, however, controversial. Many small employers have expressed disappointment that subsidies are targeted exclusively to employees and that they, as employers, are not given "a break." There has been resistance to the required 60 percent employer contribution despite the fact that many small business employers that offer private coverage currently contribute a higher proportion. These complaints may be coming from employers who currently do not offer coverage and whose point of reference is having no health benefit costs. However, these are precisely the employers that the DirigoChoice program hoped to attract.

There is no political consensus on how much low to moderate income individuals and families "should" be willing to pay for health coverage and scant economic research on price sensitivity of this population in a voluntary market. Thus, a tiered subsidy

structure is subject to many challenges. The skewing of the DirigoChoice membership to the lowest income category and deepest discount has raised questions about the current subsidy structure. Some have suggested that the decline in subsidy is too steep, making the program less affordable for families with incomes between 200 and 300 percent of the federal poverty level than those with incomes just above the poverty threshold. The average household income of subsidized enrollees in the DirigoChoice Program in 2006 was $15,144 – about 150 percent of the federal poverty level.* The median household income in Maine in 2006 was $45,040, about 270 percent of the federal poverty level† and the largest segment of Maine's uninsured have incomes between 200 and 300 percent of poverty (23 percent compared to 13.6 percent with incomes between 100 and 200 percent of poverty).[35] These statistics suggest that the DirigoChoice Program is successfully targeting those who arguably have the greatest need – individuals and families with incomes just above eligibility for other public programs such as MaineCare – but that the program has not penetrated significantly a broad swath of near-poor and moderate income Mainers who are currently uninsured or at risk of uninsurance.

The combination of the subsidized premium structure and the lack of a crowd-out provision for small businesses is another source of controversy. Spokespersons for the Chamber of Commerce and the insurance industry have raised concerns about the ratio of previously insured businesses to previously uninsured businesses participating in the DirigoChoice product. This issue is sensitive for two reasons. First, initial support for the Dirigo Reform, particularly from the business community was premised on the concept that the program would significantly reduce the number of uninsured and decrease medical bad debt and charity care, thus providing some relief to price pressures for all purchasers of insurance in the Maine market. In addition, the Savings Offset Payment (SOP) was justified partially by expected reductions in bad debt and charity care. The smaller than expected proportion of participants in the DirigoChoice program drawn from the uninsured is seen as evidence of providing insufficient relief in this regard. The second concern is the traditional crowd-out dynamic. Small business

* Relation to FPL calculated based on the average household size among subsidized DirigoChoice families of just under 2.
† Relation to FPL calculated based on Maine's average household size in 2000, of 2.9.

groups that were previously in the private market presumably were able to afford commercially available products. Their transfer to the DirigoChoice program is seen as a raid on the private market and an unnecessary expenditure of public funds. These transfer employers are not viewed as free riders because, generally, they are paying higher premiums than they were for their prior coverage. (The DirigoChoice product is a rich benefit package by the standards of the small market in Maine and the inclusion of individuals as well as small groups skews the risk profile, raising the program's community rate.) Many of the DirigoChoice participating employers state that they transferred to the plan so that a larger proportion of their workers, taking advantage of the subsidies, would be able to afford coverage. When they offered insurance in the past, without subsidies, many of their employees declined. This piecemeal increase in insured lives from within already insuring businesses, however, is viewed as insufficient by spokespersons within the business community and insurance industry to quell their concerns about the crowd-out dynamic.

A further point of disagreement between program advocates[†] and critics is the significance of the problem of under-insurance and the impact of the DirigoChoice Program on bad debt deriving from under-insurance. Close to a third of program members were under-insured prior to enrolling in DirigoChoice – meaning that their household income was below 200 percent of the federal poverty level and their insurance policy deductible was greater than 5 percent of household income.[*] A telephone survey of DirigoChoice Program enrollees in the first year of the program indicated that among those with prior coverage, the lowest income families were the most likely to have had policies with very high deductibles. Specifically, among the program participants with the highest level of discount (incomes below 150 percent of the federal poverty level) who had prior coverage, 55 percent had policies with deductibles above $2,500. Among the participants ineligible for subsidies (income above 300 percent of the federal poverty level), only 27 percent of those with prior

[†] Among the organizations supporting the DirigoChoice program at a public hearing of the Legislature in the 2008 session were: Consumers for Affordable Health Care, Maine Equal Justice Program, Catholic Archdiocese of Portland, Maine People's Alliance, Heart Association, Lung Association, and the Maine Medical Association.

[*] The definition of under-insurance adopted by the Dirigo Board of Directors

coverage had policies with deductibles at this level.[36] For the program's advocates, this evidence of front-end cost-sharing faced by low-income families indicated both barriers to appropriate access to care and a high risk of bad debt for providers. In the business community, however, there is strong interest in high deductible policies and Health Savings Accounts as mechanisms for discouraging inappropriate utilization and for encouraging improved healthy lifestyle behaviors. Thus, high deductible policies tend not to be viewed as under-insurance so much as giving employees "skin in the game."

DirigoChoice Program Funding

The most significant political vulnerability of the DirigoChoice Program has been the legislatively created structure of program financing. Rather than creating a dedicated revenue source either through a new tax or a specified assessment on providers or insurers, the Dirigo Health Reform Act created a *contingent* revenue source available only when and in amounts approved by the Superintendent of Insurance based on annually measured system savings derived from the cost containment measures of the Dirigo Reform Act. This structure came about as a political compromise to mollify the concerns of employers and insurers about shouldering another health system cost when costs were already perceived as too high. The assessment would be offset by savings, thus holding payers harmless. In addition, policymakers hoped that the use of captured savings to expand coverage to the uninsured would realign incentives, making cost containment a higher priority for providers, payers, and consumers, alike.

The contingent nature of the funding mechanism has two major drawbacks. First, it makes financial forecasting difficult for insurers and self-funded employers, since they do not have a sufficient lead time before the final determination of the level of the assessment. (Equally importantly, it makes forecasting and program management difficult for the Dirigo Agency, which has no way of knowing what the program budget will be in each succeeding calendar year.) In addition, the funding formula has proven sufficiently vague that it has been a source of endless challenge and litigation. As indicated earlier, the Legislature did not specify in law a methodology for measuring savings. Expectations and assumptions by payers were very different from the Administration and its representatives. Employers apparently expected savings to be

measured in terms of actual reductions in their claims or premium expenditures so that their costs, following the assessment would be flat from one year to the next. The Administration and the Dirigo Board considered a reduction in the trend line of health care spending as savings in relation to what would have been spent in the absence of the cost savings measures put in place by the Dirigo reforms. Large sums (a million dollars, in the case of the Dirigo Agency) have been spent annually by both payers and the Administration on economic, actuarial, and legal consultants to make a case demonstrating savings or the lack thereof. Hearings before the Superintendent of Insurance have been adversarial with legal representation on both sides, and the Superintendent's rulings have been contested in court on both procedural and substantive grounds and appealed up to the state's highest court (where the Administration prevailed).

Political and legal pushback against the assessment by payers may have been particularly pronounced because of the steep increases in spending on health care benefits in Maine in the past decade (see discussion, page 3). In addition, large employers subject to the assessment perceive that the social burden of health care costs for medically indigent populations is unfairly concentrated on them. Maine, with a high average age, low median household income, and generous Medicaid eligibility criteria has an unusually high proportion of its population covered through public programs. The Medicare DRG funding formula, which adjusts Maine hospital payments down in relation to most states due to Maine's generally low-wage economy, disadvantages Maine hospitals which compete in a national labor market for physicians, nurses and trained technicians and which frequently have to pay a premium to attract and keep highly trained personnel in rural areas. Medicaid, too, pays lower rates than private payers. The net effect of low reimbursement by the public programs is a substantial mark-up for private payers for hospital services – a "cost-shift" about which employers in Maine are acutely sensitive. The assessment on claims volume for insurers and third party administrators as a funding mechanism for the DirigoChoice Program is seen as another instance of a "hidden tax" to meet the needs of public programs. Further, national companies, whose insurance contracts are arranged through the home office in a different state are beyond the reach of Maine legislators for the purpose of

assessments like the SOP. Thus, Walmart, the second largest employer in the state, provides health benefits that are not subject to the Savings Offset Payment assessment. The net effect is, as one large employer representative said, "You are asking a smaller and smaller footprint to pay a larger and larger share of the costs. That's what cost shifting is all about."

Strengths and Weaknesses of DirigoChoice Program Administration

Subsidy Program

The DirigoChoice premium subsidy structure is administratively complex. Private insurers' administrative and billing systems are not designed to accommodate variable pricing based on household income or to match funding streams from two sources (public and private) for premium payments. Further, the need to protect employee confidentiality with regard to household income and eligibility for discounts creates additional administrative hurdles for the Dirigo Agency.

The Dirigo Agency has developed procedures that successfully maintain confidentiality and which minimize the complexities of the subsidy program for employers and employees. Their success in doing so has required the development of a customized management information system within the Dirigo Agency and collaboration of the partnering insurance company in developing specialized administrative procedures for the DirigoChoice program. Although the internal systems for managing the complexity of information flow and funding flow within the Dirigo Agency are highly sophisticated and function well, the drawback to this customized organizational structure is that the structures for streaming information back and forth with the partner insurance company have to be built anew, with each new partner. This limits the state in the number of potential contract partners and could impede the process of bringing the program to scale. It is also a feature that may limit the transferability of the program to other states. Further, because of the lack of political consensus on appropriate payment requirements at different income levels, all subsidy structures, regardless of how well-tuned, are likely to generate controversy. The administrative complexity and lack of clarity around appropriate targeting of public funds may suggest that simpler cost reduction strategies are the better choice for states.

Program Marketing

As a voluntary enrollment program, targeting an elusive niche in the market populated by businesses and individuals ineligible for entitlement programs but priced out the commercial insurance market, the DirigoChoice program faced a number of marketing challenges. The first challenge was public education. Not only was the DirigoChoice product new to the market, but it was different in kind from anything previously available to small businesses. Small business owners with prior health benefit experience may be accustomed to variable premiums based on insurance underwriting criteria such as age, but the concept of variable premiums based on income is foreign and requires an adjustment in frame of reference from "actuarial fairness" to one of social justice.[*] The second challenge was political. The DirigoChoice Program never had a honeymoon period with local political "pundits" or the press. From the first, political organizations opposed to increased government spending and an increased government presence in the health sector decried the strategy as the wrong approach and tried to build political support for market deregulation and program repeal. Even those who supported the program as an appropriate strategy for combating medical indigence held the program to very high performance standards with regard to short-term success in reducing the number of uninsured in the state and began to second guess the program's rate of enrollment and spending within the first year of operations. Because state administrators' and policymakers' prior experience with access initiatives was with Medicaid expansions where increased enrollment was rapid and substantial, little thought was given to the greater difficulties inherent in attracting small business owners and employees to a voluntary program which required premium payments. During the legislative debate, a target first year enrollment of 30,000 was routinely used to estimate potential savings from averted bad debt and charity care. When this enrollment (and these savings) did not materialize, it set the program up for charges of failure. From a marketing perspective, the political attacks meant that small groups contemplating participation were very uncertain as to the program's staying power.

[*] Although participating employers are not informed whether their employees apply for or are granted discounts, the program is marketed to employers on the basis that it offers discounts to low income employees and this concept distinguishes DirigoChoice from other insurance products on the market.

Particularly employers who had not offered health benefits in the past had to weigh carefully the prospect of creating expectations among employees and then, should the program lose legislative support, either withdrawing health benefits or transferring to a non-subsidized product. A third challenge stems from the elusiveness of the DirigoChoice target market. Very small businesses are widely dispersed and difficult to reach. New businesses form frequently and others cease operations almost as quickly. Most very small businesses tend not to belong to associations which maintain membership rosters and many of them do not list their services in the Yellow Pages. Small business owners frequently work long hours and perform multiple functions within their operations. They do not necessarily pay close attention to policy developments in the state capital. These factors increase the challenges of getting the word out and lead to a situation where many in the targeted demographic may not be aware of the program, at all.

All of these challenges suggest the need for an aggressive information campaign and dedicated taskforce of producers motivated to make the program a success. However, legislators are not in the habit of thinking of the marketing needs of public programs. The lottery is perhaps the only state sponsored program in most states with its own marketing budget. The DirigoChoice Program had very limited resources that it could put to mounting a marketing campaign. The Dirigo Agency did contract for television spots, radio announcements and periodic mailings, but all on a tightly constrained basis. Insurance brokers, or producers, expect to be paid a commission for the businesses they bring in – another cost to a public program like the DirigoChoice Program. Program administrators could attempt to circumvent this marketing network at their peril – both because brokers are a politically powerful lobby and because they are well connected with the small business community and potentially a valuable resource for marketing a program such as DirigoChoice. Program administrators further learned that enthusiasm for the Dirigo product was far from universal among producers. The amount of time needed to explain the product, particularly to employers who were considering offering benefits for the first time, was large in relation to the number of lives brought in through each group contract (the factor that drove the size of the commission). The DirigoChoice insurance partner for the first three years, Anthem Blue Cross, worked with a dedicated

network of producers which meant both that the loyalty of many marketing the DirigoChoice product may have been to other Anthem products and that the Dirigo Agency was limited in its ability to seek out the community brokers most enthusiastic about DirigoChoice.

As discussed earlier (p. 24), the compromise solution developed between the insurance partner and the Dirigo Agency was to split the public education function and place this directly under Dirigo Agency control through a dedicated call center while sales are still referred to the insurer's producer network.

Dirigo Health Reform Post-Enactment Developments

The contentiousness of the Savings Offset Payment, the continued opposition to the DirigoChoice strategy from conservatives favoring market strategies in health care coverage, and continued concern with the perceived death spiral in the individual insurance market combined to erode the bipartisan support enjoyed by the Dirigo Reform Act at the time of its passage. These dynamics led the Governor to form a Blue Ribbon Commission in 2006 to consider alternative funding mechanisms for the DirigoChoice Program and stimulated a variety of proposals within the legislature in 2006, 2007 and 2008. While modest changes to DirigoChoice were enacted in 2007, the program faced a crisis in 2008. The Savings Offset Payment had generated revenues for over the three years, since enactment, in the range of $43 to $31 million per year. Because of the heavy concentration of membership in the deepest discount group and high proportion of individual enrollees, per enrollee public costs have been higher than originally projected and when membership hit approximately 15,000, the Dirigo Agency had to close the program to new enrollment due to budgetary constraints. The legislature, which had been experiencing substantial pressure from payers to change the Savings Offset Payment mechanism, faced a situation where a new funding strategy had to be enacted or the DirigoChoice Program would face a future as a limited, capped program with no ability to make further inroads into the growing problem of the uninsured. Further, the legislature was deeply divided over a proposal to deregulate the non-group market and establish a high risk pool – a strategy some saw as an alternative

to the DirigoChoice Program. This proposal, developed by Anthem Blue Cross and Blue Shield and supported by the Chamber of Commerce, had been debated 2007 but no action taken. It was introduced again in 2008. Finally, the situation faced by the Dirigo initiative was further threatened by a major state revenue deficit, estimated at $190 million, requiring legislators to seek areas for reduced state spending.

The program has emerged from this crisis with a new, dedicated funding stream which will allow it to reopen enrollment to small businesses and sole proprietors – although enrollment growth will have to remain modest at current funding levels. In addition, the State has enacted a reform strategy for the individual market based on a state-financed reinsurance fund while maintaining regulatory constraints banning medical underwriting and requiring guaranteed issue. These acts by the 2008 legislature mark the beginning of a new phase for the DirigoChoice program and the Dirigo reforms. Summarized below are the major features of the newly enacted legislation and the measures that were considered as alternative legislation and defeated.

Public Law 629, *An Act to Continue Maine's Leadership in Covering the Uninsured*, was introduced by the Democratic Leadership of the Legislature in an effort to be responsive to the multiple concerns regarding the insurance market and the future of the DirigoChoice Program. The law repeals the savings offset assessment of the original Dirigo Reform Act and replaces it with a specified assessment of 1.8 percent on paid claims for all health insurers, third party administrators, and stop-loss reinsurance for health policies. This assessment is estimated to generate approximately $33 million per year. In addition, the law increases taxes on beer and wine, soft drinks and the sugar syrup used to make soft drinks, and dedicates these new revenues to the Dirigo Reform programs. Additional revenues in the amount of $5 million will be allocated from Maine's tobacco settlement fund.[*] These funds will assure the continuation of the DirigoChoice Program and allow it to reopen enrollment. However, the program will not reopen to new individual applicants. New enrollment will be drawn from small businesses and sole proprietors.

[*] Maine already allocates all tobacco settlement dollars to health improvement activities. The $5 million for the Dirigo Programs will an transfer of funds from other health improvement activities to the Dirigo Program activities.

PL 629 also establishes a reinsurance program applicable to insurance products in the individual market that maintain a loss ratio of at least 70 percent. The reinsurance program will cover the cost of 50 percent of claims costs, incurred on an individual basis, between $75,000 and $250,000. The program will be governed by an eleven member Board with 5 members appointed by the Superintendent of Insurance and 6 selected by insurers in the State and will be administered, under contract by a third party administrator or insurer. The revenues from the sources described above will be placed in a Dirigo Health Enterprise Fund and allocated according to a legislatively established formula for either the DirigoChoice Program or for the new reinsurance program.

The new law restricts any resulting changes in a carrier's rating factors such that, in combination with savings from the reinsurance program, the change will not increase rates at the older age tiers. To enhance the impact of the reinsurance premiums in the short term, insurers will be allowed to close their existing book of business in the non-group market and to offer new policies rated based on their anticipated experience. They will have up to three years to merge their existing policy holders into their new non-group products. Other initiatives contained within the law include authorization for pilot insurance products targeted to the under age 30 market (similar to Massachusetts). Finally, the law maintains voluntary cost containment goals for Maine's hospitals and requires hospitals to report to the legislature, annually, on their performance in relation to these standards.

The enactment of PL 629 reflects a reaffirmation by the legislature of the basic health reform strategy it adopted in 2004. The new measures to address barriers in the individual market reflect a continued concern with price barriers and a desire not to allow substantial price increases for individuals with pre-existing conditions, despite the potential for such a move to bring down premium costs for young and healthy individuals. The legislature considered and defeated a competing bill that proposed a very different solution to the individual market problems. LD 1760, "An Act to Restore Competition to Maine's Health Insurance Market," would have established a pooled

mechanism for high risk individuals in the individual market on the model of a program in Idaho. The proposal was similar to other state high risk pools in that carriers would have been allowed to pre-determine whether an applicant is a substandard risk and deny coverage in their mainstream book of business. It differed from high risk pools in that, rather than a single high risk pool program administered by a single insurer or third party administrator, each carrier in the individual market would offer at least one product, established by a Reinsurance Board, for high risk applicants. This high risk population product would be rated separately from other products, and would have purchased reinsurance from the high risk pool. The pool would have reimbursed the plans for 90 percent of claims between $5,000 and $25,000, and paid 100 percent of claims above $25,000. The proposal called for the individual market to be deregulated to the extent of nullifying guaranteed issue requirements and liberalizing the limits on rating bands. Carriers would have been required to guarantee coverage only in their high risk product, not for any of their standard products. Maine's current rating band restrictions allowing variance of 20 percent from the community rate would have been changed to a range of 4 to 1 for the factors of age, occupation and geography. In addition, carriers would have been allowed to rate based on health status (on a ratio of 1.5 to 1 to the community rate) and tobacco use (also with a ratio of 1.5 to one). The pool was to be "partially funded" through a 2 percent assessment on HMOS doing business in the state, on gross premiums collected on all business in the state.

Dirigo Health Reform Political Sustainability

The Dirigo Health Reform offers valuable lessons to states considering responses to the health care crisis. It demonstrates some successes, illustrates a number of administrative and political challenges, and reiterates the experience of other state initiatives in showing greatest political vulnerability around questions of sustained funding. Although not described in detail in this case study, one of the major successes of the reform effort has been the system the state has put in place for more coordinated efforts to improve health quality and to create a more publicly accountable and systematic health planning effort. Almost universally, among stakeholders recently interviewed about the Dirigo Reform effort, the Maine Quality Forum was singled out

for praise. As a small state, and one where the health economy is an engine for economic growth, the political and social relations between health care providers and the business community are, perhaps, unusually cordial. Despite the unrelenting pressure of rising health care costs, employers are reluctant to adopt strategies that are adversarial to the interests of hospitals. This dynamic has resulted in a strong interest in the business community in strategies, such as pay-for-performance, that hold out the hope of ameliorating costs through improvements in quality. The publicly sponsored and administered Maine Quality Forum is playing a major role in getting information to the public on small area variations in utilization and outcomes, is publicizing measurements of quality, and is developing public education campaigns around self-health management and informed use of the health care system.

The creation of a Governor appointed Committee of stakeholders and experts to develop a biennial State Health Plan has also been received favorably according to our interview informants. The Plan identifies public health problems and areas for improvement in population health, health system infrastructure needs, and manpower shortage areas. The capped Certificate of Need review is linked to the state health plan so that proposals subject to review and approval are prioritized against the needs of the state as identified in the State Health Plan. Maine has experienced a proliferation of technology, especially diagnostic imaging equipment over the past two decades as competition among small and mid-sized community hospitals has generated a "medical arms race." To the community of Maine payers, the participatory planning process, subject to public review and comment, holds out hope for a strategy to shape the future development of Maine's health care system in ways that meet public needs, while minimizing duplications and excess capacity building.

The DirigoChoice Plan, central to Maine's effort to extend health insurance coverage to all residents of the state, has passionate supporters as well as outspoken detractors. Its major political vulnerability, like all state-sponsored access initiatives outside the federally supported Medicaid and SCHIP programs, is the significant state funding required. Maine is currently experiencing one of the dynamics that chronically plague solo state efforts – counter-cyclical demand. When the local economy falters, states feel

the effect immediately in a decline in government revenues, just at the time when the need and demand for safety net programs is at its highest. The legislature was confronted with a make-or-break decision regarding expanded funding for the DirigoChoice program just as it faced closing a $190 million gap in the state budget. That it chose to dedicate new taxes to the program in the current fiscal climate suggests that the program has weathered its first real political test and offers a tentative indication that the program may have staying power. However, the vote supporting the program fell along party lines in this legislative session, confirming an erosion in the bipartisan support the program enjoyed when first enacted.

As a state with among the highest average per capita health care costs, Maine may also provide a cautionary lesson to other states. In 2004, the strain from health premiums felt both by small employers and large companies created a higher level of private sector interest in government-led reform than is usual from the business community. Most of our business informants told us that the business community was divided, at the outset, between supporters and opponents to the Administration's initiative. But a sufficiently large and influential component of the community favored the effort so that the State Chamber went on record in support at the time the legislation was under consideration. As one business representative said, "It was time to allow experimentation." However, the stress from high health care costs also led to significant resistance to the establishment of any funding source that would result either directly or indirectly in an increased cost to the business community. The administration's effort to link support for program funding directly to cost containment may provide a framework for other states in designing politically palatable strategies to expand coverage. However, in Maine, the reflexively anti-regulatory stance of business stakeholders and the political ties between business and hospitals prevented theoretical support for reining in health care costs from translating into approval of regulatory constraints – limiting the state to negotiating voluntary benchmarks. Many hospitals (including Maine's largest hospital system) met these benchmarks and insurers and self-funded employers have experienced some relief from the relentless double digit cost increases of a few years back. Nevertheless, the largest reduction in the rate of increase in hospital costs was seen in the first year of the reform enactment (see Figure 4) and although the hospital

industry will continue to be held to public scrutiny, there is no guarantee they will continue to hold costs to the voluntary benchmarks. Thus, in Maine, support for the policy framework of the reform effort was contingent upon an expectation that assessments to fund a coverage initiative would be balanced against a substantially reduced the rate of growth in health care spending. But the realization of this trade-off was handicapped by insufficiently potent cost containment mechanisms and lack of clarity around measurement of system-wide cost trends.

Based on interviews with our business community informants, there is also wide-spread belief that the DirigoChoice Program is inefficient and too expensive. The total per capita costs of the DirigoChoice program have been about the same as the per capita costs of most employer benefit plans in Maine ($4,176 compared to an average employer single premium of $4,290 in 2005).[*] And the public costs of the program have been well below this level ($2,304 per capita in 2006). However, both the Administration and payers had expected a substantial portion of DirigoChoice enrollees to be dually eligible for Medicaid and that the federal Medicaid program would share in these costs. Neither of these expectations was realized. In addition, there seems to be a wide-spread belief among payers that the claims costs of the uninsured, once covered, will offset bad debt and charity care costs on a one-to-one basis – an expectation that is unrealistic both because, on average, the uninsured use about 40 percent less health care than the insured, and because hospitals report their charity care costs at their charge rate – a rate no one pays except the uninsured. (DirigoChoice enrollee claims are reimbursed to providers at the negotiated rate of the insurance partner.) Based on expectations, then, the public moneys needed to support the DirigoChoice Program have shocked many in the payer community.

[*] State average figure from the National Medical Expenditure Panel Survey Data for the most recent year available.

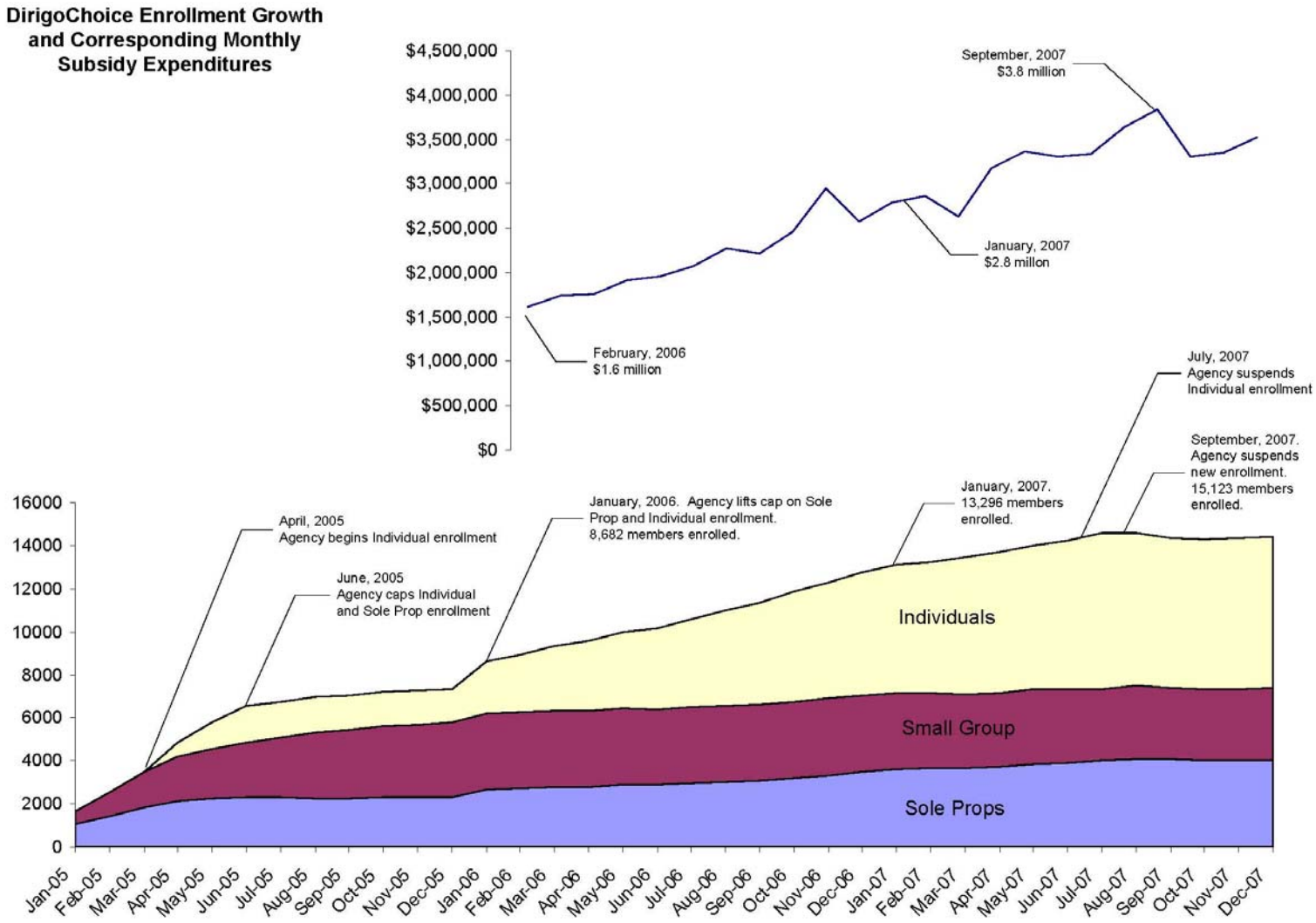
Conclusions

The Dirigo Reform is still very new. Several key aspects of the program have garnered widespread respect and support, particularly the efforts around quality enhancement and rationalized planning. The implementation of the reforms, including the DirigoChoice Program, went very smoothly considering the complexity of the structure and the need to coordinate between public and private entities. The Dirigo Agency which administers DirigoChoice has already shown itself to be responsive to consumer complaints and willing to modify systems to accommodate enrollees (and its insurance partner). The program has withstood its first real challenge and emerged with a guaranteed funding stream. Thus, it may be allowed the time it needs to grow, stabilize, and become an accepted part of the health care delivery system in the State. Despite growing partisanship in the legislature, there is some evidence that a political culture in Maine that places high value on assuring adequate health care to all has not been undermined by the controversy around the DirigoChoice plan. The president of one large enterprise in Maine (subject to the assessment), for example, expressed outrage a year ago over the costs associated with the DirigoChoice plan. In a more recent interview, he shrugged, saying, "Well, I do think it is important that everyone has health insurance. It (DirigoChoice) is expensive, but I have decided to just accept it as a cost of doing business in the state."

State initiatives like the DirigoChoice Program may never be able to resolve all the political tensions that are inherent in programs that try to fill the gaps left by private health insurance without undermining the private system. The private coverage system, itself is unstable. Health care costs continue to rise both in absolute terms and proportionately to wages and the cost of living. As clearly evidenced by the history of the Medicaid program, even if political consensus is reached on a clearly demarcated line between the private market and those entitled to public subsidies, the line has to be frequently redrawn or new "gap" groups emerge. In addition, funding issues will continue to plague the program. Current funding levels for the DirigoChoice program will allow expansion, but not to a point of achieving universal access. Both the debate around eligibility definitions and the funding struggles of the Dirigo experience draw attention, as have so many state efforts at access initiatives, to the need for federal

participation in funding and state flexibility in defining programs attempting to achieve universal coverage. Federal dollars can help smooth regional economic volatility and, as with the Medicaid program, help compensate for differences in state capacity to raise revenues, while state experimentation with different eligibility criteria and subsidy structures can help test a variety strategies for achieving universal access.

Figure 1.


DirigoChoice Enrollment Growth and Corresponding Monthly Subsidy Expenditures
$4,500,000
$4,000,000
$3,500,000
$3,000,000
$2,500,000
$2,000,000
$1,500,000
$1,000,000
$500,000
$0
September, 2007
$3.8 million
January, 2007
$2.8 millon
February, 2006
$1.6 million
July, 2007
Agency suspends
Individual enrollment
September, 2007.
Agency suspends
new enrollment.
15,123 members
enrolled.
January, 2007.
13,296 members
enrolled.
January, 2006. Agency lifts cap on Sole
Prop and Individual enrollment.
8,682 members enrolled.
April, 2005
Agency begins Individual enrollment
June, 2005
Agency caps Individual
and Sole Prop enrollment
16000
14000
12000
10000
8000
6000
4000
2000
0
Individuals
Small Group
Sole Props
Jan-05
Feb-05
Mar-05
Apr-05
May-05
Jun-05
Jul-05
Aug-05
Sep-05
Oct-05
Nov-05
Dec-05
Jan-06
Feb-06
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Jan-07
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Figure 2.

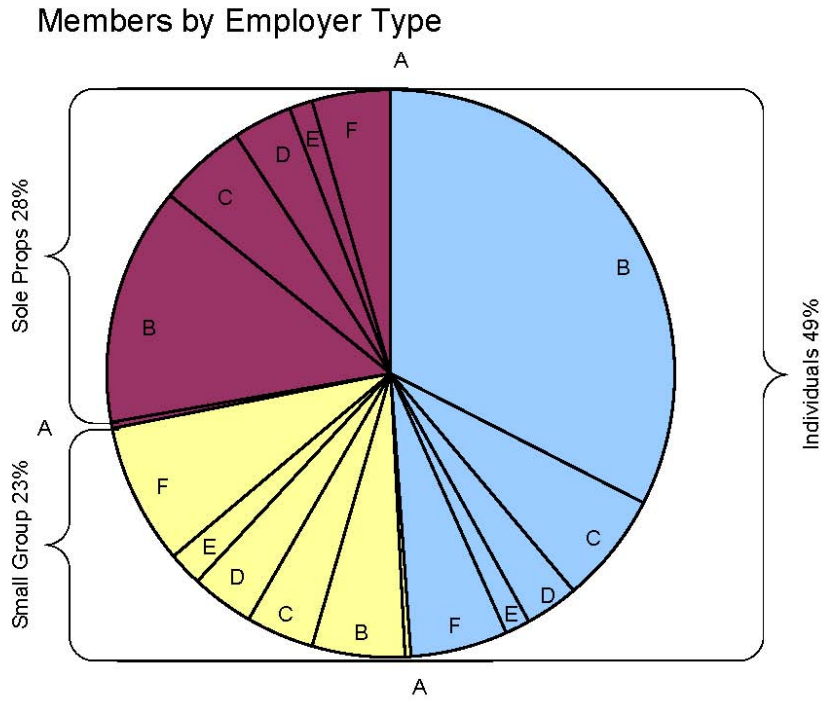


Figure 3.

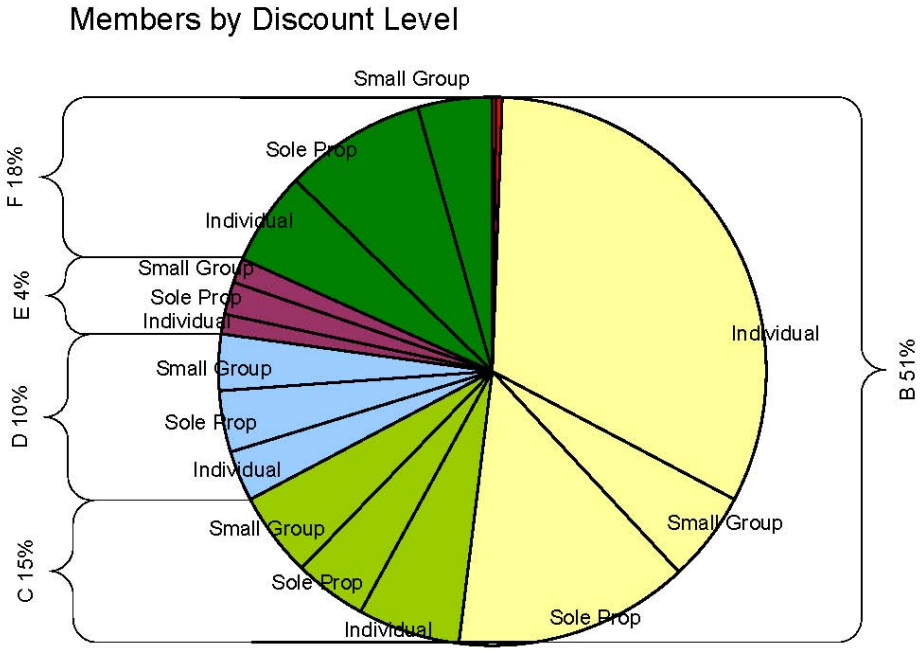
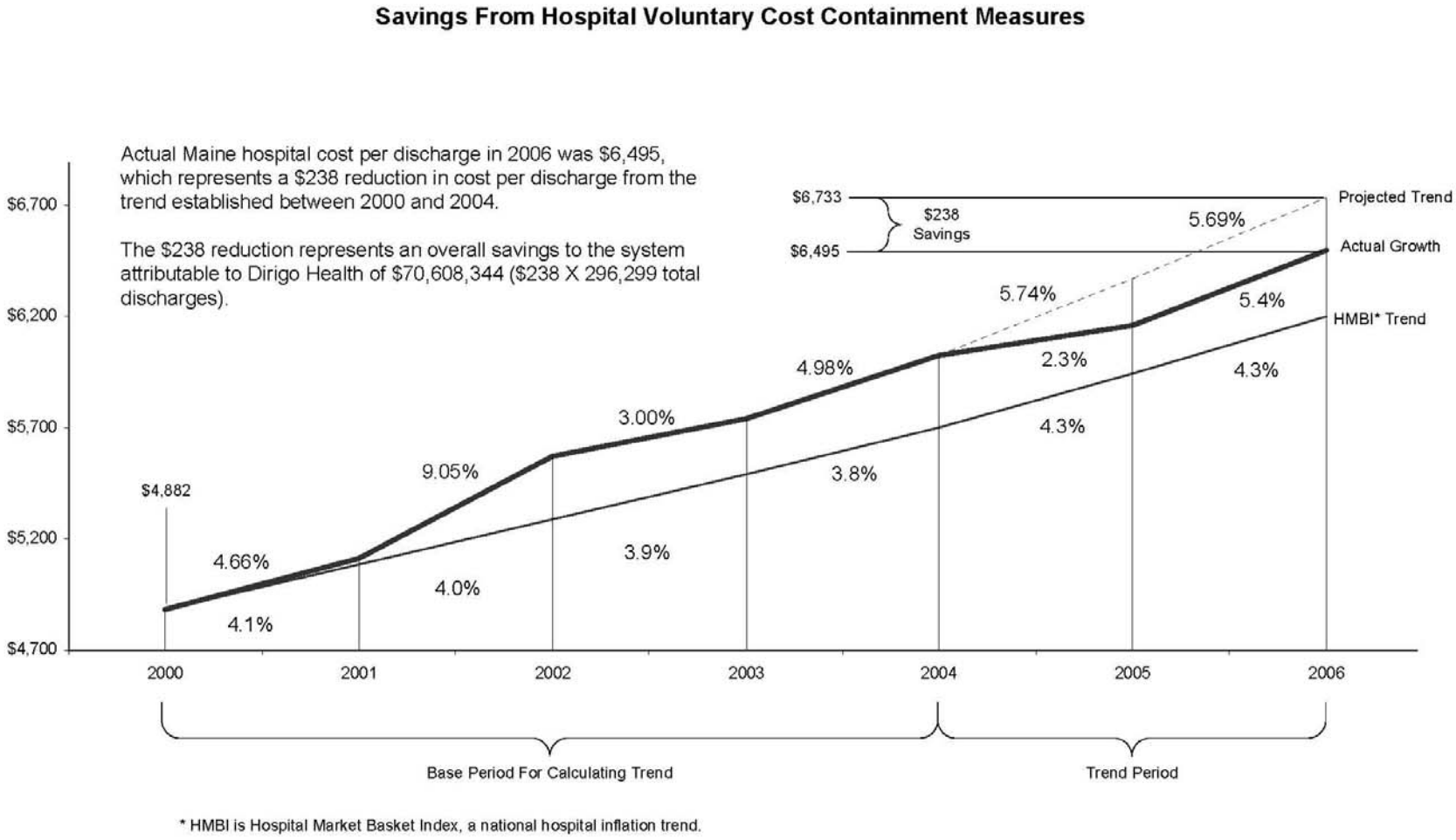


Figure 4.


Savings From Hospital Voluntary Cost Containment Measures
Actual Maine hospital cost per discharge in 2006 was $6,495, which represents a $238 reduction in cost per discharge from the trend established between 2000 and 2004.
The $238 reduction represents an overall savings to the system attributable to Dirigo Health of $70,608,344 ($238 X 296,299 total discharges).
$6,700
$6,200
$5,700
$5,200
$4,700
$6,733
$238 Savings
$6,495
Projected Trend
Actual Growth
HMBI* Trend
$4,882
4.66%
9.05%
3.00%
4.98%
5.74%
5.69%
5.4%
4.1%
4.0%
3.9%
3.8%
4.3%
2.3%
4.3%
2000
2001
2002
2003
2004
2005
2006
Base Period For Calculating Trend
Trend Period
* HMBI is Hospital Market Basket Index, a national hospital inflation trend.

END NOTES

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[4] U.S. Census, 2004.

[5] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau"s March 2006 and 2007 Current Population Survey (CPS: Annual Social and Economic Supplements).

[6] 2002 estimates based on Muskie School Health Policy Institute analysis of Census Bureau Current Population Survey data and a statewide Maine household survey. 2006 estimates based on Urban Institute and Kaiser Commission on Medicaid and the Uninsured analysis of data from the CPS survey for the combined years of 2005 and 2006.

[7] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau"s March 2006 and 2007 Current Population Survey (CPS: Annual Social and Economic Supplements).

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It should be noted that MEPS premium information is not adjusted for differences in actuarial value of benefit plans, so it is not known the extent to which premium differences reflect differences in claims costs versus differences in scope of coverage. In addition, because the sample for the insurance component of the MEPS survey is not very large for states like Maine, results should be interpreted with caution. The MEPS database, for example, the number of business establishments in Maine as 34,243, while Maine's Department of Labor places the figure at 46,334. However, the MEPS data allows a comparison with national averages and across states that is not possible using Maine administrative data sets.

[14] Maine Bureau of Insurance report: Summary of Carriers' Rule 945 filings, 2006. Although the difference in time of measurement suggests the following comparison should be considered with caution, the level of consolidation in Maine's insurance market appears higher than average based on a GAO report from 2002. This report found that the median market share of states' larges carriers was 33 percent. However, like Maine, in 25 of the 37 states that provided information, a Blue Cross Blue Shield Plan had the largest market share and among these plans, the median market share was 34 percent. In more than half of the reporting states, the top five carriers controlled more than 90 percent of market share. Allen, Kathryn. 2002. *State Small Group Health Insurance Markets.* GAO-02-536.

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[22] Gorman and Gorman 2007: 50-51.

[23] Data for years 2000-2004, Governor's Office of Health Policy and Finance and Muskie School of Public Service. 2006. Maine State Planning Grant Continuation: Final Report. Submitted to the HRSA State Planning Grant Program. Data for years 2005-2007, Maine Bureau of Insurance. Market Snapshot. Accessed February 2008 at: http://www.maine.gov/pfr/insurance/employer/snapshot_individual.htm

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[28] The Superintendent's Rulings explaining allowed savings can be found at www.maine.gov/pfr/insurance/laws_rules.htm.

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Katharine N. Begley
President, Northeast Region
Aetna Small Group
One Farr View
Cranbury, NJ 08512

February 26, 2008

Dear Small Employer Plan Sponsor,

As outlined under Maine Insurance Code Title 24-A, Chapter 35, Section 2808-B(2)(C), every January, Aetna is required to review the premium levels and related medical costs associated with its Small Group book of business. This review encompasses a rolling 36-month timeframe, ending the previous June 30th. If medical costs are found to be less than 78% of total premiums over the continuous 36-month period, Aetna must refund a percentage of the premium to current in-force policyholders so that medical costs are no less than 78% of the resulting premium after refunds.

Aetna has completed its review of medical costs and premium levels for the rolling 36-month timeframe of July 1, 2004 through June 30, 2007 for both of its subsidiaries, Aetna Health Inc. and Aetna Life Insurance Company. Reports outlining this data have been submitted to the Maine Bureau of Insurance.

Aetna's review has determined that employers with Small Group health policies currently written by Aetna Life Insurance Company are entitled to a refund of a portion of the premium paid from July 1, 2004 through June 30, 2007. Please be aware that you were charged appropriate premium levels that Aetna had filed with the State of Maine for this time period; it is this retrospective review that has resulted in the refund as attached. We recommend that you return a proportionate share of this refund to employees who have contributed to the cost of this coverage. You may wish to seek legal guidance with respect to this issue.

If you have any questions about this refund, please contact our Plan Sponsor Services department at 1-888-287-4295.

Sincerely,

Katharine N Begley

Katharine N. Begley
President, Northeast Region
Aetna Small Group

APPENDIX E. Bibliography of Reviewed Articles

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