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State Case Studies

Product Standardization in Small Group and Individual Insurance Markets

State Sample Selection (Maryland, New Jersey, Massachusetts, New York)

Product standardization in Maryland, New Jersey, and Massachusetts was examined in the brief "Gold, Silver, and Bronze: The Important Role of Product Standardization in Health Insurance Reform" because their insurance markets and political ideologies about the role of government in regulating insurance companies are closer to New York's than most other states — and New York policymakers are a primary audience for this research. In addition, Massachusetts was chosen because proposed national reforms appear to build on what the state has done with product standardization.

State Snapshot: Maryland

Written by Courtney Burke, director, New York State Health Policy Research Center, The Nelson A. Rockefeller Institute of Government. Comments provided by Enrique Martinez-Vidal, vice president at AcademyHealth and director of the Robert Wood Johnson Foundation's State Coverage Initiatives program

Maryland initially introduced reforms to its small group market in the early 1990s. Among other things, the reforms allowed for development of a statewide standard benefit package by the Maryland Health Care Commission (MHCC), an independent state agency.[1] This required that no insurers in the small group market offer anything less than the "Comprehensive Standard Health Benefit Plan (CSHBP)." The law required the benefits to be no less than the actuarial equivalent of a federally qualified HMO. In addition, at the time of enactment, the average premiums for

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the standard benefit were limited to 12 percent of Maryland's average annual wage (currently, the cap is 10 percent of the average annual wage).[2] These actions essentially created a minimum benefit floor and premium ceiling, helping to protect consumers. The state allows differences in rating for age and geography only. These factors are limited by "rate bands" in how much premiums can vary.

In the first few years after the reforms were enacted, enrollment rose by over 20 percent, to 489,473, and nearly 54,016 employers participated by 1999; however, the enrollment declined in the following years.[3] Although much of the initial increase in enrollment was attributed to a tight labor market, the standard benefit package was seen as another factor contributing to enrollment growth because it prevented adverse risk selection. The cap on premiums also was viewed as a factor that contributed to lower cost growth.[4]

After a decade in operation, few employers were still purchasing the base or "standard" plan that was used in the early and mid-1990s, and a high percent of employers purchased riders to reduce the cost-sharing requirements or increase available benefits. The proliferation of riders was in part due to sizeable increases in premium costs.[5] The problem with the 10 percent cap was that there was no incentive to cut actual services, so the Maryland Commission kept raising the cost-sharing amounts to keep the premiums below the cap. This, in turn, made policyholders purchase riders to buy down the cost-sharing amounts, ultimately making it a shell game.

More employers also started shifting to point of services plans (POS), which allowed more flexibility in where people could receive care. Overall, insurers in the small group market decreased dramatically over the decade, from 37 insurers in 1995 to 8 by 2007.[6]

Because of the extensive use of riders, a dramatic drop in the number of insurers, and lagging enrollment, the legislature passed the Small Employer Affordability Act in 2003. The goals of the Act were to stop a gradual decrease in enrollment and plan competition and re-evaluate whether there was a need for a new basic benefit, since at least 90 percent of employers that offered coverage bought riders at a higher premium than the standard plan rate to reduce cost sharing.[7]

Changes in Maryland's small group market also led the legislature in 2007 to require the MHCC to examine "potential opportunities for change that would encourage employer and employee participation both through new participants and retention of existing participants" in the small group market. That commission hired an actuarial firm to examine changes that could create a more flexible environment for plan design and pricing. Specifically, the firm was asked to assess what would happen under each of the following:

- Retaining the existing approach of using the actuarial equivalency of a federally qualified HMO as the baseline for benefits;
- Defining a minimum set of core benefits and allowing health insurers to offer defined wraparound benefits;
- Making available health saving accounts compatible with high deductible health plans;
- Maintaining the existing core benefits and allowing employers to rider up and down;
- Requiring health plans to offer at least two plan choices; and
- Specifying a separate in-network deductible, out-of-network deductible, in-network out-of-pocket maximum and out-of-network out-of-pocket maximum.

In assessing the experience of Maryland, it appears that standardization of benefits and capping cost sharing initially helped stabilize and grow the marketplace; however, as the marketplace was altered, costs rose and consumer preferences changed, and legislative intervention was necessary to examine the merits of plan standardization. One of the commission's conclusions was that "the need to define any basic plan based on a federally qualified HMO is no longer as relevant as it may have been in the early 1990s and restricts creative plan design and pricing." This suggests that some states may want to keep their markets flexible enough to allow the introduction of new plan types that better meet consumers' needs.

State Snapshot: New Jersey

By Dina Belloff, senior research analyst, and Margaret Koller, senior associate director for planning and operations, Rutgers Center for State Health Policy

In 1992, New Jersey enacted health insurance market reforms for the individual and small group markets to improve accessibility to health insurance coverage and services in the state. The small group component of this legislation created the Small Employer Health Benefits Program (SEHBP), which was implemented in 1994.

SEHBP regulations require guaranteed issue for coverage of owners and employees of small businesses and their families. Small businesses must have two — but not more than fifty — employees that work 25 or more hours per week in order to qualify for coverage in this market. In addition, 75 percent of these "full-time" employees must enroll in some kind of group coverage, which includes Medicare, Medicaid, or NJ FamilyCare. Premiums are set using modified community rating with 2-to-1 rate bands based on age, gender, and location of the business. Employers are required to contribute a minimum of 10 percent toward the cost of the premium.

In addition, the reforms established five standardized plans and an HMO. Plan "A" is the most basic plan, covering hospitalization only. 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 percent coinsurance rate, plan "C" 70 percent, "D" 80 percent, and plan "E" 90 percent. Carriers are permitted flexibility in how they structure care delivery in these plans. For example, they may offer Preferred Provider Organization (PPO) or Point of Service (POS) plans, as long as either the in-network or out-of-network coinsurance rate conforms to one of the standard plans. A standard HMO plan is also available. In addition, the 2008 New Jersey Health Care Reform Act reduced the number of standard plans that a carrier must offer from five plans to three. Insurers are permitted to submit riders to the standardized plans that either increase or decrease the standard benefits. Therefore, in practice, many commercial plan variations are available to small businesses in New Jersey. Those familiar with the program estimate that there are something in the order of 30,000 riders in existence, though clearly some riders are far more attractive to employers and consumers than others. SEHBP policies vary greatly by coverage, premium, and network of providers, so small groups can find a policy to meet their needs.

Insurance carriers express some frustration with regard to the administrative burden of filing riders, since carriers must first issue the plan as a standard plan and then attach a rider. It is not permissible for the carriers to introduce the rider language directly into the standard plan text. From a regulatory perspective, the advantage of attaching riders separately is that it makes it easier to distinguish between the benefits that are mandatory in the standard plan and those that are offered through a rider.

Changes to the SEHBP market are difficult because the market was created through a lengthy rule-making process required by legislation. As a consequence, 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.

Among other goals, the New Jersey Health Care Reform Act[8] sought to improve price transparency in this market. The legislation required 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, the Act requires that agents and brokers disclose their fees and commissions to employers.

Stakeholders in the SEHBP, including regulators, insurers, and brokers, report that this market is stable though, following the national trend, many small group employers in New Jersey have struggled to continue offering coverage through the steep recession. Enrollment in the SEHBP market grew from 1994, when the program was first implemented, to 1999, and then leveled off and has remained stable at around 900,000, with some recent fluctuation.[9] Offer rates for small firms are high in NJ compared to the US and other states, and more full-time employees are offered coverage.[10] Eleven insurance carriers participate in the SEHBP,[11] and competition is considered adequate.

State Snapshot: Massachusetts

By Courtney Burke

In an effort to increase the rate of insured, Massachusetts passed legislation in 2006 that initiated several changes to the state's health insurance markets. Among these were reforms requiring that individuals purchase insurance, merging the small group and individual markets, and establishing an insurance exchange.

The exchange was designed to act as a market organizer and payment aggregator through which small groups and individuals could purchase insurance. Existing statutory coverage requirements continue to apply to insurance policies available through the exchange.[12] There are two exchanges in Massachusetts: Commonwealth Care (CommCare), which is a subsidized program for people below 300 percent of the federal poverty level (FPL), and Commonwealth Choice (CommChoice), which is unsubsidized, for persons above 300 percent FPL. CommChoice offers a choice of six carriers and three benefit levels (gold, silver, bronze) and a special set of policies for young adults ages 18-29 who lack employer coverage.[13]

The remaining plans offered through the exchange within one category have equivalent benefits but varying levels of cost sharing or different provider networks. The products are overseen by a group of officials appointed by the governor and attorney general, known as the Connector Board, established as part of the reform in Massachusetts. The board is composed of insurance experts with varying viewpoints. They meet regularly to debate policy issues affecting functioning of the marketplace, including reviewing and approving the benefits offered by insurance plans.[14]

The advantages and disadvantages of the standardized products offered through Massachusetts's newly merged market and insurance exchange have not had as much time for assessment as states like New Jersey and Maryland. But so far, the system seems to be working well at helping to decrease the number of uninsured in the state. The percent of uninsured has dropped below 3 percent from a high near 10 percent since reforms were enacted.

Endnotes

1 Thomas R. Oliver, "Holding Back the Tide: Policies to Preserve and Reconstruct Health Insurance Coverage in Maryland," *Journal of Health Policy, Politics and Law* 29, 2 (April 2004): 203-36.

2 Ibid.

3 Enrollment numbers are from the Oliver article. They were 402,411 in 1995; 489,473 in 1998; and 448,080 in 2003. Calculations are by the authors. Enrollment was relatively stable in 2005 and 2006, although there were notable declines in dependent coverage.

4 Ibid, p. 212.

5 "Options Available to Reform the Comprehensive Standard Health Benefit Plan (CSHBP) As Required Under BH 579 (2007)," (Baltimore, MD: Maryland Health Care Commission, December 20, 2007).

6 Ibid.

7 Enrique Martinez-Vidal, "Maryland HRSA State Planning Grant: Maryland's Small Employer Health Insurance Market" (Baltimore, MD: Maryland Health Care Commission, November 10, 2003).

8 A summary of the Health Care Reform Act and links to related work can be found at: http://www.cshp.rutgers.edu/announcements.htm?a=145#children .

9 "Historical Comparison of Enrollment Data 3rd Quarter, 2007" (Trenton, NJ: New Jersey Department of Banking and Insurance, Insurance Division, 2007).

10 "Medical Expenditure Panel Survey – Insurance Component" (Rockville, MD: Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends, 2008).

11 New Jersey Department of Banking and Insurance, Insurance Division website: http://www.state.nj.us/dobi/division_insurance/ihcseh/sehcos.htm, accessed June 2009.

12 Edmund F. Haislmaeier and Nina Owcharenko, "The Massachusetts Approach: A New Way to Restructure State Health Insurance Markets and Public Programs," *Health Affairs* 25, 6 (November/December 2006): 1580-90.

13 Mark Merlis, "A Health Insurance Exchange: Prototypes and Design Issues" Issue Brief 832 (Washington, DC: National Health Policy Forum, June 5, 2009).

14 For more information on the Connector, see Amy M. Lischko, Sara S. Bachman, and Alyssa Vangeli, "The Massachusetts Commonwealth Health Insurance Connector: Structure and Functions" (New York, NY: Commonwealth Fund, May 2009).