NEW YORK STATE
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# From Access to Affordability

# A Summary of State Strategies to Provide Private Health Insurance Coverage to Small Groups

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## About the Paper and the Intended Audience

This paper is intended to serve as an overview of state strategies to increase insurance access in the small group market. It reviews actions of states to increase access and affordability of private health insurance for small groups rather than focusing on public health insurance program expansions. The content is targeted primarily at state legislators and health policymakers interested in learning about options for increasing private insurance coverage in the small group market.

## About the Rockefeller Institute and the 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.

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## Executive Summary

Many state governments have been attempting to reform their health care systems to ensure that more people have or can obtain health insurance. Individuals may obtain health insurance in three ways: through their employer, directly from an insurance carrier, or through a public insurance program such as Medicaid or Medicare.

One challenge for states wanting to ensure better health care coverage is that small employers, i.e., businesses with fewer than 50 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 insurance often are higher for both employers and employees.

There are a range of strategies that states use to influence coverage in the small group market. Such strategies include regulation, pooling risk, or subsidies. In the late 1980s and early 1990s, when employer based health coverage was declining, states primarily used regulation to ensure access to insurance. These regulations govern under what conditions insurance companies can offer coverage. Regulations range from guaranteed issue and portability protections to modified community rating and setting rate bands. More recently, states have focused their efforts on making insurance affordable.

This paper summarizes methods states have used to try to improve insurance coverage in the small group market; outlines the features of these options; reviews the literature regarding the success of different policies; and concludes based on existing literature, which policies hold promise for increasing insurance coverage in the small group market.

In reviewing the literature, we found that states' regulatory actions such as guaranteed issue and community rating may have helped ensure access to insurance for high risk/high cost groups, but that such regulations have not been highly successful in decreasing the overall rate of uninsured in the small group market. In examining the literature regarding other strategies to increase coverage such as tax credits, premium subsidies, and group purchasing arrangements (GPAs), we found that such techniques likely have helped select groups maintain coverage, but that most such initiatives have been too small to make a significant impact on the overall number of uninsured working for small employers.

We conclude that both access and financial accessibility (i.e., affordability) must be considered when formulating policy strategies. Newer reform strategies such as creating larger risk pools and establishing statewide insurance exchanges hold promise for reducing the number of uninsured not only in the small group market, but overall, if done on a large scale. We also conclude that even if some policies are effective at reducing the rate of uninsured, the biggest challenge for governments may be sustaining financing for coverage initiatives. Any strategies that hold promise for increasing coverage rates are likely to require financial support. This support becomes increasingly more difficult as health care costs rise. A final conclusion of the paper is that efficiency strategies that reduce costs or ensure better value for what care is purchased must be part of health reform if coverage gains are to be sustained.

# I: Introduction and Overview

## Challenges to Small Group Insurance Coverage

The U.S. health system relies on employers to provide health insurance. For those individuals that had health insurance in 2006, 59.7 percent received coverage through their employer, down from 70.4 percent in 1994.[1] The decrease in employer sponsored insurance (ESI) means that people must find insurance from another source. If a person loses employer based coverage and enters the individual insurance market, it is usually more expensive and often unaffordable – so they either may go without insurance or attempt to qualify for publicly sponsored insurance. In states that highly regulate insurance, it may be more accessible by law, but because these regulations may make insurance more expensive, it may not be as financially accessible.

The challenge of providing employer sponsored insurance is difficult particularly for smaller businesses, in part because they are subject to different regulatory rules than the large group market. This different regulatory market, which has its origins in federal legislation commonly referred to as ERISA (Employment Retirement Income Security Act), applies only to individuals purchasing directly from an insurer (nongroup plan), small businesses (small group plans) and a small portion of larger businesses. ERISA allows businesses that bear financial risk for losses from health care costs (i.e., self funded plans) to be exempt from state regulations, while smaller businesses and individuals who cannot bear the risk of financial losses are subject to more state regulation such as mandated benefits and state premium taxes.

In addition to the rules imposed by ERISA, smaller employers are less likely to offer private health insurance, and workers in smaller firms are less likely to buy health insurance for the following reasons: First, small firms employ more lower wage workers on average than larger companies, so the cost of health insurance is often too high for many of these workers. Second, it is harder for small employers to spread the risk of adverse events among their employees, and the higher risk associated with insuring a smaller pool of people may cause insurers to either avoid providing coverage or price health insurance products higher. Finally, 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. 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 employees under 25 have employment based coverage.[2]

For many years, state governments have attempted to bolster employer based health insurance. The good news for states as they attempt to cover more uninsured is that they have significant regulatory

[1] In addition, 27 percent of the population received coverage through public programs – Medicaid (12.9%), Medicare (13.6%), and Military (3.6%), and 9.1 percent purchased the coverage directly. DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica Smith. "Income, Poverty, and Health Insurance Coverage in the United States: 2006." Edited by U.S. Census Bureau. Washington, DC: U.S. Government Printing Office, 2007. The numbers add up to more than 100 percent because some individuals have insurance from more than one source. There has been a general downward trend in employer sponsored insurance, with some slight increases during economic booms. See Reschovsky, James D., Bradley C. Strunk, and Paul Ginsburg. "Trends: Why Employer-Sponsored Insurance Coverage Changed, 1997-2003." *Health Affairs* 25, no. 3 (2006): 774-82.

[2] P. Fronstin, *Sources of Coverage and Characteristics of the Uninsured: Analysis of the March 2005 Current Population Survey,* EBRI Issue Brief no. 287 (Washington, D.C.: Employee Benefit Research Institute, 2005); P. Fronstin, *Union Status and Employment-Based Health Benefits,* EBRI Notes 26(5) (Washington, D.C.: Employee Benefit Research Institute, 2005); and author estimates of the March 2005 Current Population Survey.

power over the private insurance market. The bad news for states is that employees who work in smaller firms, which constitute a significant part of the economy, have proved particularly difficult to cover.[3]

## Overview of State Strategies to Increase Small Group Insurance Coverage

State governments play a large role not only in providing health insurance through public programs like Medicaid and Medicare but also through a complex structure of regulations that affect the availability, characteristics, and affordability of private insurance products in the small group market. To maintain and improve the rate at which individuals working for small employers receive coverage, states have implemented a wide array of policies that attempt to cover more of the uninsured who might be eligible for small group coverage by either increasing the rate at which employers offer coverage or the rate at which employees use (i.e., take-up) employer based coverage.

### *Regulating the Supply of Insurance Products*

In the 1980s and early 1990s, most states attempted to address the problem of rising uninsured rates in the small group market by regulating the supply and features of insurance products. State health insurance regulations 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). Similar regulatory mechanisms also are used in the individual market to affect the supply of insurance products.

The federal government eventually intervened and through passage of the Health Insurance Portability and Accountability Act (HIPAA) in 1996, minimum standards for insurance portability and issue were required for small groups in all states, and the definition of small group was standardized to be employers with 2-50 employees or in certain instances "groups of one." Currently, 13 states allow their small group market to include "groups of one." Typically, these groups include sole proprietors, but not individuals without labor force engagement.[4] [5]

In addition to regulations requiring that employees have access to insurance and that they are able to carry it with them from job to job, states also put regulatory policies into place during the 1990s to govern how insurance rates are set. States can affect rating policies by determining how "communities" or groups are defined. One state (New York) has what is known as pure community rating – meaning that premiums are set by putting everyone enrolling in a given insurance plan into a single risk pool. 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 in 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, they typically set bands (i.e., limits) regarding how much the premiums can vary.

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[3] It is estimated that small businesses employ about half of U.S. workers. "Of 115.1 million nonfarm private sector workers in 2004, small firms with fewer than 500 workers employed 58.6 million and large firms employed 56.5 million. Firms with fewer than 20 employees employed 21.2 million, and firms with 100 employees, 41.8 million. Although small firms create 60 to 80 percent of net new jobs, their share of employment remains steady since some firms grow into large firms as they create new jobs." Source: U.S. Dept. of Commerce, U.S. Bureau of the Census. Accessed on 8/4/08 at www.sba.gov/advo/stats/sbfaq.pdf (2007).

[4] Kaiser Commission on Medicaid and the Uninsured, State Health Facts online, Managed Care and Health Insurance, Accessed on 6/25/08 at www.statehealthfacts.kff.org/comparetable.jsp?ind=350&cat=7.

[5] The Kaiser Commission on Medicaid and the Uninsured's State Health Facts online is an excellent resource for learning how states define groups of one. (See www.statehealthfacts.org/comparetable.jsp?ind=350&cat=7). The Kaiser Family Foundation website also provides similar Information about restrictions for pre-existing condition exclusion rules at www.statehealthfacts.org/comparetable.jsp?ind=352&cat=7.

States also can restrict medical underwriting, which allows medical or health status information to be considered in the evaluation of an applicant for health insurance coverage. At least ten states ban medical underwriting. For those states that regulate medical underwriting in the small group market, they generally define criteria for how insurers may determine the health status of individuals. For example, some states regulate what insurers can ask on health questionnaires or what information may be used in examining past claims experiences when calculating the premium for a group of individuals in the small group market.

Allowing employers to offer 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. States also are encouraging insurers to offer products with wellness incentives or insurance riders. Riders may either exclude specific pre-existing conditions 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 that were largely implemented in the 1980s and early 1990s are outlined in the first set of strategies in Table 1.

*Pooling Mechanisms and Administrative Simplification*

The second set of strategies outlined in Table 1 that states or employers have used to improve insurance coverage in the small group market are pooling or other mechanisms that may simplify the administration of purchasing insurance. Pooling brings together groups or individuals to make a larger group. The four pooling strategies outlined include group purchasing arrangements (GPAs), merging of the individual and small group markets, insurance exchanges, 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 potentially enhancing purchasing power. GPAs allow groups to band together, with the intent of decreasing the administrative burden of providing insurance, spreading risk among a larger group and therefore potentially lowering costs. There are several types of GPAs, which are explained in more detail later in this paper.

Insurance exchanges are another form of pooling that allows individuals to benefit from the existence of an administrative mechanism for purchasing insurance. Only Massachusetts has a fully operational, large-scale statewide insurance exchange, although a number of states have considered creating exchanges.[6]

Also within the "pooling" set of strategies is merging the small group and individual markets, which has only recently been done in Massachusetts. In the case of Massachusetts, merging the markets is estimated to reduce the cost of insurance premiums in the individual market more than in the small group market. The effect of merging markets will vary depending on the characteristics of the markets in a given state.

Another approach is to require insurers to allow enrollment of dependents. These individuals are allowed to remain on their parents' insurance policy after reaching adulthood (e.g., until age 25 or 26 as

[6] 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.

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, as well as ensure better access to insurance for this target population. The number of states extending coverage to dependents and the precise effects of this strategy has not been thoroughly studied.[7]

*Subsidies to Increase Affordability*

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 subsidies include premium assistance 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 approach designed to make insurance more affordable, differs from premium subsidies and tax credits in that it is an indirect subsidy targeted to help finance care of high cost individuals or groups. Under reinsurance, anyone within a defined group whose health insurance costs are within or above 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 it applies. 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.

*Applicability of Strategies*

It is worth noting that in almost all instances the strategies used in the small group market are also used in the individual market, although differing rules may apply. For instance, the individual market also has regulatory requirements, such as guaranteed issue, portability, modified community rating, and flexible benefits. The individual market may also benefit from an insurance exchange, merged markets, limited benefit plans, and dependent coverage extensions. Group purchasing is the one strategy outlined in this paper that is unique to the small group market; however, even this can be used by groups larger than what is defined as a small group. Similarly, strategies designed to increase affordability of insurance through subsidies such as premium subsidies, tax credits and reinsurance may be available to both the individual and small group markets.[8] The strategies outlined in the Table 1 are those as they apply to the small group market.

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

[8] The Robert Wood Johnson Foundation's State Coverage Initiatives program provides an informative overview of which states are using tax credits, premium subsidies, reinsurance, or purchasing pools to increase coverage, while The Kaiser Commission on Medicaid and the Uninsured provides an overview of states policies related to guaranteed issue and portability requirements for small group and individual markets. See http://statecoverage.net/matrix/index.htm and www.statehealthfacts.org/comparetable.jsp?ind=350&cat=7.

## 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 |
|---|---|---|
| **Regulating Supply of Insurance Products** | | |
| 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 |
| 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+ |
| 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: Kaiser Commission on Medicaid and the Uninsured and the Robert Wood Johnson Foundation's State Coverage Initiatives.

## II: Closer Examination of Select Strategies

### Rating Policies

Although all states now have guaranteed issue and portability in the small group market, there are notable differences in their use of community rating. Most states have some form of modified community rating that prevents insurers from using health status in developing and pricing insurance products, but which allows insurers to make distinctions regarding age, gender, geography, and other factors. As stated previously, this means that modifications or adjustments may be made to premiums based on factors such as age, industry of employment, or geographic location of a certain small group. Table 2 provides an overview of states' rating policies. New York has what is known as pure community rating. Everyone in the small group insurance market in the state is considered part of the same rating pool. That is, insurers may charge only one price for any given insurance product, regardless of the characteristics of the purchaser. Other states use rating bands (i.e., set variation allowances) that allow health status to be taken into account, but most specify how much premiums are allowed to vary for a group's health status.

**Table 2. Overview of States' Small Group Health Insurance Rating Policies for Small Groups**

| Rating Restriction | States |
|---|---|
| Pure Community Rating | NY |
| Modified Community Rating Based on Demographic Factors | CT, ME, MD, MA, NH, NJ, OR, VT, WA |
| Rating Bands for Health Status Only | AL, AK, AZ, AR, CA, CO, DE, GA, FL, ID, IL, IN, IA, KS, KY, LA, MI, MN, MS, MO, MT, NE, NV, NM, NC,** ND, OH, OK, RI, SC, SD, TN, TX, UT, WV, WI, WY |
| No Rating Restriction | DC, HI, PA,* VA |
| * In Pennsylvania, Blue Cross Blue Shield and HMOs are required to use modified community rating.<br>** North Carolina allows +/-20 percent variation for age, gender, family composition, geography, claims experience, and administrative costs. The health status will be considered at the renewal process. | |

Sources: Kaiser Foundation Managed Care & Health Insurance: www.statehealthfacts.org/comparetable.jsp?ind=351&cat=7; The National Association of Health Underwriters (2007). Hearing on H.R. 493, http://energycommerce.house.gov/cmte_mtgs/110-he-hrg.030807.Trautwein-Testimony.pdf; Kofman, Mila, and Karen Pollitz. "Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change." Washington, DC: Georgetown University Health Policy Institute, 2006.

### Group Purchasing Arrangements

Group purchasing arrangements (sometimes called alliances) are intended to serve several purposes: spread and minimize the risk of adverse health events; provide administrative economies of scale to participants (such as marketing, enrollment, or claims administration); allow participants to gain price advantages by increasing negotiating power; and provide an infrastructure to promote managed competition.[9] Group purchasing arrangements are not a new concept. One of the oldest GPAs has been in existence since 1973.[10]

[9] "Encouraging Purchasing Pool Options." Submitted to Washington State Planning Grant on Access to Health Insurance, funded by U.S. Department of Health and Human Services, Health Resources and Services Administration, Grant # 1 P09 OA00002-01, April 2002. Also, Hall, Mark A., Elliot K. Wicks, and Janice S. Lawlor. "Healthmarts, HIPCs, MEWAs, and AHPs: A Guide for the Perplexed." *Health Affairs* 20, no. 1 (2001): 12.
[10] Ibid, page 512. Also see Kofman, M. "Group Purchasing Arrangements: Issues for States," State Coverage Initiatives *Issue Brief*, State AcademyHealth, Robert Wood Johnson Foundation, April 2003, at www.statecoverage.net/pdf/issuebrief403.pdf.

In this paper, two types of group purchasing alliances are reviewed: health insurance purchasing coalitions (HIPCs), and Association Health Plans (AHPs). HIPCs are nonprofit or government entities that are willing to accept all small employers and offer individual employees a choice of several independent health plans.[11] Association health plans are group purchasing arrangements that typically are initiated by private sector entities and are not subject to the same regulatory requirements as HIPCs. Not reviewed in this paper are multiple employer welfare arrangements (MEWAs). MEWAs are a form of group purchasing in which multiple employers, including employers from different states, join together to administer health benefits.[12] Both AHPs and HIPCs can be considered MEWAs under certain circumstances.

The features of current and disbanded GPAs are outlined in Table 3. MEWAs are not included in this table because accurate data on the several hundred that exist around the country are hard to obtain, and it is difficult to determine when they are serving small businesses. Included in the table are five major purchasing alliances that have been disbanded and five that are known to be operational. Among the five disbanded HIPCs, California's PacAdvantage is the only HIPC that imposed a minimum participation requirement (that at least 70 percent of eligible employees were signed up for the plan).The reasons for the disbandment of the various alliances include a lack of capital for marketing and adverse selection issues.[13] Most disbanded HIPCs could not garner enough purchasing power because using a third party administrator hindered their ability to determine the characteristics of enrollees.

Ohio's Council of Smaller Enterprises of Cleveland (COSE) program is one of the oldest GPAs. COSE imposes rigid participation requirements (100 percent) for firms with fewer than five employees, and in contrast to the other GPAs it allows employers with over 50 employees to participate. Unlike some of the disbanded group purchasing arrangements, COSE has kept a stable relationship with one dominant insurer and provided participating employers with a limited choice of benefit plans. New York's HealthPass, which grew out of a grant to the Business Group on Health from the New York City Mayor's office, requires that 75 percent of eligible employees participate in the GPA.[14]

[11] Wicks, Elliot K., Mark A. Hall, and Jack A. Meyer. "Barriers to Small-Group Purchasing Cooperatives: Purchasing Health Coverage for Small Employers." Economic and Social Research Institute, 2000.
[12] An employer welfare plan is technically defined in Section 3(1) of ERISA, 29 U.S.C. Section 1002(1).
[13] Wicks et al., 2000.
[14] The authors note that other GPAs for small employers may be in existence, but all those that could be identified are outlined in Table 4.

**Table 3. Examples of Group Purchasing Arrangements**

| State and Name of Arrangement/Alliance | Date Enrollment Began |
|---|---|
| **Purchasing Alliances In Operation** | |
| Connecticut – CBIA Health Connections | 1995 |
| Ohio – Council of Smaller Enterprises of Cleveland Ohio (COSE) | 1973 |
| New York – HealthPass | 1999 |
| New York – LIA Health Alliance | 1994 |
| Texas – 42 small employer purchasing cooperatives | 1994 |
| Wisconsin – Co-op Care: Division of Wisconsin Federation of Cooperatives | 2003 |
| **Disbanded Purchasing Arrangements** | |
| California – Pacific Health Advantage (PAC) | 1993-2006 |
| Florida – Community Health Purchasing Alliance (CHPAs) | 1994-2000 |
| North Carolina Purchasing Alliance | 1995-2000 |
| Texas Health Care Purchasing Alliance | 1995-1999 |

Sources: Purchasing alliances in operation obtained from the Robert Wood Johnson Foundation State Coverage Initiatives. Disbanded purchasing arrangements obtained from multiple sources.

## Premium Subsidies

As of 2007, six states had premium subsidy programs in which the purchase of private employer-sponsored health insurance was publicly subsidized. Premium subsidies generally target low income employees of small firms, although they also can be provided to small employers more generally (e.g., Massachusetts's Insurance Partnership). Table 4 outlines states' premium contribution requirements. This table demonstrates that minimum employer contribution requirements are a common feature of all premium subsidy programs, but that the contribution and eligibility criteria and range of the subsidy vary. The purposes of mandatory employer contributions are to lower costs for low income working individuals, prevent employers from reducing their contribution, and leverage employers' resources as a contributor to the cost of insurance.

The amount that small employers are required to contribute to their employees' premium varies by state, ranging from 25 percent in Montana and Oklahoma to 60 percent in Maine. States generally use three approaches to determine the value of a premium subsidy: a flat rate (e.g., Idaho); a sliding scale according to an applicant's family income (e.g., Maine, Massachusetts, and Oregon), or a fixed percentage rate (e.g., Oklahoma). A few states couple their premium subsidy programs with a state administered plan, such as Montana's state purchasing pool and Maine's DirigoChoice program. Maine provides small employers with assistance solely through DirigoChoice, whereas Montana offers premium subsidies not only to those in one of two Blue Cross Blue Shield of Montana plans through the new State Health Insurance Purchasing Pool, but also through a qualified association plan.

Most states have directed premium subsidies to previously uninsured individuals. These provisions are intended to prevent the "crowd out" of coverage that formerly had been paid for by small businesses without subsidies. Maine does not have a crowd out provision in the small group market since its target population includes individuals who have been uninsured as well as underinsured.

### Table 4: Examples of State Premium Subsidy Programs for Small Employers/Employees

| | Income Eligibility % of Federal Poverty Level (FPL) | Employer Contribution (% of Premium) | Range of Subsidy |
|---|---|---|---|
| Idaho (Access to Health Insurance) | 185% | 50% | Maximum of up to $100 per month per person, and $500 per month, per family. |
| Maine* (DirigoChoice) | Under 300% | 60% | Program subsidizes deductibles. Sliding scale subsidies from 80% of employee share for under 150% FPL to 20% between 250% and 299% FPL. |
| Massachusetts (The Insurance Partnership) | Below 300% | 50% | Monthly premium assistance for employer share and employee share (e.g., $30 for individuals and $83 for families). |
| Montana (Insure Montana) | No employee is paid more than $75,000 per year (owner excluded) | 25% of employee premium, after premium incentive | The monthly premium assistance for each employee ranges from 20-90% of the premium depending on family annual income. |
| Oklahoma (Oklahoma Employer / Employee Partnership for Insurance Coverage: O-EPIC) | At or below 185% | 25% of employee premium | Premium assistance pays 60% of the premium while the employee and employer split the remaining amount at 15% and 25%, respectively. |
| Oregon (Family Health Insurance Assistance Program) | At or below 185% | No | Subsidies on a sliding scale according to annual gross household income. |

Note: * At the time this table was completed, subsidized coverage to new members was not being provided to new members of DirigoChoice.
Sources: Figures for Massachusetts are archived from the Insurance Partnership, www.insurancepartnership.org/index-html.asp. Figures for Idaho are archived from Idaho Department of Health & Welfare, www.healthandwelfare.idaho.gov/portal/alias__Rainbow/lang__en-US/tabID__3580/DesktopDefault.aspx. Figures for Maine are adopted from Tarren Bragdon, "Command and Control: Maine's DirigoHealth Care program." The Heritage Foundation, 2005, at www.heartland.org/pdf/17988.pdf.

## Subsidies: Refundable Tax Credits for Small Employers Offering Health Insurance

As of 2006, eight states had authorized tax credits for small employers offering health insurance to their employees. The designs of state authorized tax credits vary, as shown in Table 5. States provide health care tax credits in three different forms: a fixed dollar credit, percent credit, or a combination of both approaches. Three states (Idaho, Montana, and Oklahoma) provide small group employers with a fixed dollar credit. Kentucky, Maine, and Massachusetts offer a percentage credit that covers a proportion of premiums paid by employers. Kansas and Arizona employ a combination of both approaches in determining the value of a credit, but offer whichever is less costly. With a flat tax credit, small employers may be more sensitive to the cost of premiums and therefore more likely to purchase limited benefit plans.

Arizona's and Kansas' tax credits include anti crowd out provisions to help ensure that the credit is directed to small employers that previously were unable to offer coverage.

A few states target their tax credits to very small groups. For instance, Montana's tax credits are directed to groups ranging from 2-9 employees, while Arizona's tax credits target small groups with 2-25 employees. Of the eight states that offer tax credits, Arizona is the only state that offers the credits to both the small business employee and employer. State authorized tax credits for small employers offering health insurance can be tenuous. In many instances tax credits are provided on a temporary basis (e.g., Kansas, Kentucky, and Massachusetts) or the credits may be reduced over time.

### Table 5. Examples of Refundable State Tax Credit Amounts for Small Employers

| State | Tax Credit (Per Employee, $) |
|---|---|
| Arizona* | |
| Employee | Single person: $1,000<br>Per dependent child: $500<br>Family coverage: $3,000<br>- OR -<br>50% of the annual health insurance premium |
| Employer | $1,000 for each employee electing single coverage<br>$3,000 for each employee electing family coverage<br>- OR -<br>50% of the annual health insurance program |
| Idaho | $1,000<br>$500 |
| Kansas | 1st year: $70 per month<br>2nd year: $50 per month<br>3rd year: $35 per month |
| Kentucky | 1st year: 20 percent of the premium<br>2nd year: 15 percent of the premium<br>3rd year: 5 percent of the premium |
| Maine | Limited to 20 percent of qualified expenses, not to exceed $125 per employee with covered dependents |
| Massachusetts | 1st year: 20 percent of the premium<br>2nd year: 10 percent |
| Montana | Per employee: $100 per month<br>Per employee's spouse: $100 per month<br>Per employee's dependents: $40 per month |
| Oklahoma | $15 per month ($180 per yr) |

Note: * Arizona has a $5 million credit limit. Montana's program is targeted at businesses of 2-9 employees.
Sources: Foundation for Managed Care & Health Insurance, Kaiser Commission on Medicaid and the Insured – www.statehealthfacts.org/comparetable.jsp?ind=379&cat=7; and State Coverage Initiatives, www.statecoverage.net/matrix/index.htm.

## Subsidies: Reinsurance

Another strategy to improve the affordability of private insurance in both the small group and individual market is reinsurance. States with reinsurance programs include Arizona, Connecticut, Idaho, Massachusetts, New York, and New Mexico.[15] In these states, reinsurance is used to remove the burden of high cost claims from the insurer with the aim of stabilizing markets and lowering premiums. Reinsurance provides an indirect subsidy for the purchase of health care coverage and removes some of the volatility of medical costs in nongroup and small group markets.

As shown in Table 6, states structure their reinsurance programs differently. Most notable is that in Arizona and New York the reinsurance program is administered by the government and in New York it is also subsidized by the government. The other states listed in the table provide reinsurance to the existing market without creating a separate insurance program. In these states, all participating carriers in the small business health insurance market are required to decide which enrollees they want to

[15] At least 21 states have reinsurance programs, but it has been reported that many of them are inactive or have low enrollment. Arizona, Connecticut, Idaho, Massachusetts, New York, and New Mexico have actively provided reinsurance. Rhode Island and New Hampshire are excluded since their reinsurance programs are under development. Source: Chollet, Deborah. "The Role of Reinsurance in State Efforts to Expand Coverage." State Coverage Initiatives *Issue Brief*, State AcademyHealth, Robert Wood Johnson Foundation, October 2004.

reinsure. These conventional reinsurance programs are created by state law and are operated by a governing body.[16] All carriers that issue insurance to the small employer market are automatically part of the reinsurance program. They do not provide indirect subsidies through reinsurance; instead, the nonprofit entity that operates the reinsurance program functions as an administrator, withholding a certain percentage of earned premium revenue by carriers to cover losses.[17]

There are two ways to reinsure: aggregate stop loss and excess of loss. Aggregate stop loss reinsurance is designed to protect insurers from high aggregate losses relative to the premiums by establishing a stop loss above a certain threshold. The threshold is usually defined as the ratio of claims paid to premiums collected. Currently, two states — Arizona and New Mexico — have aggregate stop loss reinsurance programs. Arizona's Healthcare Group (HCG) reimburses participating insurers' aggregate losses above 86 percent of premium revenues. New Mexico Health Insurance Alliance (HIA) covers medical losses accrued by participating insurers that exceed 75 percent of premium revenues. Excess of loss reinsurance is designed to protect insurers from high losses on a per enrollee basis, so once an individual's medical costs reach a certain threshold, reinsurance applies.

The target population for reinsurance programs also varies by state. Some states use reinsurance as a reform strategy exclusively for the small group insurance market, whereas others target individuals as well as small businesses. In New York and New Mexico, sole proprietors and individuals are also eligible for the reinsurance program. However, these two states' approaches differ from Massachusetts and Idaho. Massachusetts and Idaho have a separate reinsurance program for their small group and nongroup markets and apply different threshold levels for the activation of reinsurance. In New York and New Mexico, all small employers, including sole proprietors as well as individuals, participate in a single reinsurance program.

The eligibility rules of reinsurance programs also vary. New York, New Mexico, and Arizona impose minimum participation requirements for employers to participate in the reinsurance program. In Arizona, firms with fewer than five employees are required to enroll all eligible employees. Healthcare Group Arizona (HCG) requires that 80 percent of eligible employees in firms with six or more employees participate. Compared to Arizona, New York and New Mexico's reinsurance programs have a relatively flexible minimum participation requirement of 50 percent of eligible employees, regardless of firm size.

The amount of medical costs that are reinsured varies among the states. Massachusetts, Connecticut, and New York set the minimum target point for reinsurance activation at $5,000. In the case of Healthy New York, 90 percent of enrollees' claims between $5,000 and $75,000 are reinsured. Using this corridor — which also has a maximum amount of $75,000 — encourages better management of care for persons whose medical costs are within this range, so that they do not exceed the top amount and fall out of the reinsurance program. All participating insurers in Massachusetts' small group reinsurance plan are reimbursed for 90 percent of annual losses between $5,000 and $55,000. Idaho's small group reinsurance plans have much higher deductibles, set at a different levels corresponding to the benefit plans (basic, standard, and catastrophic), while Connecticut's reinsurance program pays all enrollees' claims in full above $5,000.

[16] The New Mexico Health Insurance Alliance (NMHIA) was created by the New Mexico State Legislature and provides coverage to small businesses, self-employed, and qualified individuals. Individuals who are signed up for the plan offered by NMHIA are reinsured. This makes the NMHIA look similar to the state sponsored reinsurance programs in New York and Arizona.

[17] O'Connor, James T., John Dante, and Karl Ideman. "The Use of Small-Employer Health Reinsurance Programs." no. 2 (1997), Retrieved from www.soa.org/library/proceedings/record-of-the-society-of-actuaries/1990-99/1996/january/rsa96v22n281pd.pdf.

## Table 6. Overview of Reinsurance Programs

| State & Name of Reinsurance Program | Minimum Participation Requirement for Firms With 6 or More Employees | Employer Contribution Requirement | Income Criteria | Range of Expenses Covered/Stop Loss Amount |
|---|---|---|---|---|
| **Government Administered or Publicly Subsidized Reinsurance Programs** | | | | |
| Arizona<br>HealthCare Group of Arizona (HCG) | For employers with 6 or more employees, 80% of their employees are required to participate.<br><br>For employers with 1-5 employees, 100% of their employees are required to participate | No | No | Aggregate stop loss that exceeds 86% |
| New York<br>Healthy New York (HNY) | At least 50% of employees | At least 50% of premium | At least 30% of employees earn $35,500 or less in annual wages | 90% of enrollee's claim between $5,000 and $75,000 |
| **Privately Subsidized and Administered Reinsurance Programs** | | | | |
| New Mexico<br>Health Insurance Alliance (HIA): Alliance of Independent Health Insurers | At least 50% of eligible employees | No | No | Reinsurance premiums |
| Massachusetts*,[1, 2]<br>Small Group Plan | 75% of their eligible employees | No | No | Excess of loss covered for 90% of claims between $5,000 and $55,000 and 100% of claims over $55,000 |
| Idaho*<br>Small Group Reinsurance Pool | At least 75% of eligible employees; if the employer pays 100% of the premium, then 100% of the eligible employees | At least 50% of premium | No | Excess of loss covered varies[18] |
| Connecticut*<br>Small Employer Health Reinsurance Pool | No | No | No | Excess of loss covers claims over $5,000 |

Notes: * Insurance carriers may reinsure covered workers, dependents, or entire small groups in the reinsurance pool within 60 days of issuing coverage.
Reinsurance programs may apply to more than the group market (such as individuals and sole proprietors. Information on those groups is NOT included in this table.

1. In Massachusetts, self employed individuals are guaranteed for an issuance of small group plans. In contrast, the nongroup plans are not offered on the basis of guaranteed issue. Nongroup reinsurance plans are designed to support guaranteed issues of individual coverage regardless of health status.
2. In Massachusetts, HMOs do not participate in small group reinsurance plans, but are included in nongroup reinsurance plans

Sources: Chollet, Deborah. "The Role of Reinsurance in State Efforts to Expand Coverage." State Coverage Initiatives *Issue Brief*, State AcademyHealth, Robert Wood Johnson Foundation, October 2004; and Silow-Carrol, Sharon, and Tanya Alteras. "Stretching State Health Care Dollars: Building on Employer-Based Coverage." The Commonwealth Fund, 2004.

[18] "The reinsurance benefit limits mirror the benefit designs of the small-employer plans established by Idaho's Small Employer Health Insurance Availability Act. The small-group carrier is responsible for the first $12,000 of claims for each reinsured employee or dependent each calendar year, and 10 percent of the next $13,000 (basic), $88,000 (standard), or $120,000 (catastrophic). As of April 2004, Idaho reinsured eligible employees and dependents in 44 small-group plans." Source: Chollet, 2004.

## III: What Works and Might Work to Improve Coverage in the Small Group Market?

### What the Literature Says About the Effects of Different Coverage Strategies

The effectiveness of state efforts to increase the health insurance coverage of people in small groups could be defined as increasing the rate at which employers offer insurance; increasing the percent of employees that enroll in the insurance plans offered by their employers; or decreasing the overall rate of uninsured persons in the state. Unfortunately, few studies have estimated the precise effects of policies affecting small groups on these outcomes, a task that is difficult to do without a controlled experiment.

Several nonexperimental studies have been conducted on these policies, however, and although they cannot be definitive about impacts, they do provide considerable insight regarding the challenges to increasing insurance coverage for people in small groups. Most research seems to show that any effects from the various strategies for increasing small group market insurance coverage have been modest. A study by Long and Marquis showed that subsidies had only a modest effect on insurance participation.[19] Helms, Gauthier, and Campion concluded that premium reductions alone could not ensure a higher offer rate for health insurance by employers[20] (although one might hypothesize that a combination of strategies may have a larger impact). Chollet, Kirk, and Simon conclude that state regulation of insurance issue, renewal, and rating in general either reduces health insurance coverage or has no impact on coverage.[21] In perhaps one of the most comprehensive reviews of the literature on the effects of small group market regulatory reforms, Kosali Simon found 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.[22]

In examining specific actions designed to increase affordability, the success of different approaches varies. Much of the literature regarding the effectiveness of tax credits at increasing insurance affordability shows that the amount of most existing credits is not sufficient to ease financial barriers that small employers face when offering coverage to their employees.[23] Large tax credits may be needed to induce insurance purchases. [24]

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.[25] However, the success of premium subsidies seems partially dependent on how eligibility for the subsidy is structured – regardless of whether the subsidy is for purchase of public or private insurance. If eligibility for the subsidy is confusing, fewer people are likely

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[19] Long, S. H., and M. S. Marquis. "Participation in a Public Insurance Program: Subsidies, Crowd-out, and Adverse Selection." *Inquiry* 39, no. 3 (2002): 243-57.
[20] Helms, David W., Anne Gauthier, and Daniel M. Campion. "Mending the Flaws in the Small Group Market." *Health Affairs* (1992).
[21] Chollet, Deborah, Adele M. Kirk, and Kosali Ilayperuma Simon. "The Impact of Access Regulation on Health Insurance Market Structure." Report for the Office of the Assistant Secretary for Planning and Evaluation Us Department of Health and Human Services, October 20, 2000.
[22] Simon, Kosali I. "What have we learned from research on small-group insurance reform?" In *State Health Insurance Market Reform: Toward Inclusive and Sustainable Health Insurance Market*, edited by Alan Monheit and Joel Cantor. New York: NY: Routledge, 2004.
[23] Butler, Stuart, "Health Care Tax Credits and the Uninsured" Heritage Foundation, testimony dated February 13, 2002.
[24] Meyer, Jack A., Sharon Silow-Carrol, and Elliot Wicks. "Assessing Tax Subsidies to Cover the Uninsured." Washington, DC: Economic and Social Research Institute, 2000.
[25] "Why Premium Assistance Strategies Can Succeed in Connecticut." State of Connecticut, Office of Health Care Access (OHCA), March 2005, at www.ct.gov/ohca/lib/ohca/publications/premium_assistancebrief.pdf.

to use it because it is difficult to understand. Belloff and Fox's study for the state of New Jersey concluded that very few people who were eligible for premium subsidies actually "took-up" the assistance. They attributed the lower enrollment to the administrative complexity of the program as well as restrictive program design rules."[26] 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.[27] 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."[28]

Group purchasing arrangements also have experienced mixed success, with many going out of business. The major barriers that group purchasing arrangements have faced include rising health care costs that outweigh the estimated savings of participating in an alliance versus not offering coverage, adverse selection of people or groups into the purchasing pool, and lack of capital for marketing. Purchasing arrangements also require start-up funds, which are not always readily available.[29] The downside of purchasing alliances are that they are limited in who they serve and thus most have not had a large scale impact on the small group market. But a larger arrangement could have a more notable impact on coverage.

### What Strategies Hold Potential But Have Yet to be Fully Examined?

If regulations have had only a modest impact on access to insurance, pooling and administrative simplification have had limited success, and subsidy strategies have been too small to make a significant change in uninsured rates in the small group market, then what potentially are the best solutions? Len Nichols suggests that "there may be a better way to increase coverage at lower net economic cost by spreading the risk of higher risk individuals over a broader pool than their copurchasers in a community rating context, while allowing the majority for whom actuarial prices are relatively low to continue to purchase insurance in a relatively unregulated environment."[30]

Nichols' idea of broader pooling is now being implemented in Massachusetts, where the small group and individual markets have been merged to create a much larger risk pool, although the effects of this merger may differ if implemented in other states. His suggestion of targeted subsidies is also being implemented in Massachusetts through the state's insurance connector agency, which, among other functions, serves as a statewide insurance exchange and helps determine at what amount insurance is considered affordable so that assistance may be effectively targeted.

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[26] Belloff, Dina and Kimberley 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.
[27] Alker, Joan C., "Premium Assistance Programs: Do They Work for Low-Income Families?" Center for Children and Families, Georgetown University Health Policy Institute, 2007.
[28] Ibid.
[29] State Planning Grant Consultant Team, University of Washington Health Policy Analysis Program, Rutgers University Center for State Health Policy, RAND for the Washington State Planning Grant on Access to Health Insurance funded by the U.S. Department of Health and Human Services, "Encouraging Purchasing Pool Options, April 2002. Also see Kofman, Mila, Kevin Lucia, Eliza Bangit, and Karen Pollitz. "Association Health Plans: What's All the Fuss About?" *Health Affairs* 25, no. 6 (2006): 1591-602; and Wicks, Elliot K., and Mark A. Hall. "Purchasing Cooperatives for Small Employers: Performance and Prospects." *The Milbank Quarterly* 78, no. 4 (2000): 511-46
[30] Nichols, Len M. "Improving State Insurance Market Reform: What's Left to Try?' In *State Health Insurance Market Reform: Toward Inclusive and Sustainable Health Insurance Market*, edited by Alan Monheit and Joel Cantor. New York: NY: Routledge, 2004.

Katherine Swartz argues that one of the fundamental problems in the insurance market is asymmetry of information between consumers and insurers and the consequent fear of adverse selection.[31] She proposes that if government can reduce the risk of adverse selection for insurers by covering high cost cases through reinsurance, then insurers would be much more likely to provide coverage and costs for purchasing insurance could be reduced. Government sponsored reinsurance programs only exist in two states and have not been in existence as long as some other forms of subsidies. Because this method for improving insurance coverage is newer and conclusions about its effectiveness over the long term have yet to be thoroughly researched, it is difficult to make conclusive remarks about effectiveness. A drawback of reinsurance is that it comes at a price: the cost to the reinsurance agent and the fact that some groups see it as a subsidy to insurance companies rather than a direct subsidy to individuals or employers.

Many states have been passing modest health reforms to affect coverage in the small group market. These reforms include a new law in New Hampshire that requires insurance carriers to offer a standard wellness plan for businesses with up to 50 employees[32] and a law in Florida to provide low cost insurance policies with reduced benefits.[33] These are just two examples of the ways states are continuing to attempt to provide health insurance to more people.

One state — Massachusetts — was already using many of the strategies outlined in this paper, including two not used by other states: a statewide insurance exchange and merging the small group and individual markets. These strategies are essentially another form of administrative simplification and pooling, respectively, but are notable because they are being implemented on a much larger scale. Initial results from Massachusetts indicate that the state experienced considerable success in its first year by significantly decreasing the number of uninsured – but the full effects of the reforms on the small group market have yet to be seen since the program is being implemented in stages.[34]

Although the focus of the Massachusetts plan is much broader than the small group market, its initial success in cutting the state's rate of uninsured in half is worth monitoring. Massachusetts' success in decreasing the overall rates of uninsured may be due to the following factors: the use of **newer coverage strategies** that apply not just to the small group market, such as merging the small group and individual markets and a statewide insurance exchange (i.e., the Connector); **the scale of the reform**, which targets the entire insurance market instead of just the small group market and uses many different strategies; the **individual mandate**, which provides the first ever incentive to motivate individuals, not just employers, to purchase coverage; and that reform efforts addressed both **access to insurance and affordability** of insurance – an important consideration for any state considering the range of reform options. The Massachusetts model has been successful at increasing coverage but the program may face other challenges such as maintaining coverage gains, balancing access and affordability, building capacity to provide health care, and finding sustainable financing mechanisms.

[31] Swartz, Katherine. "Insurance market reform: when, how and why?" In *State Health Insurance Market Reform*: *Toward Inclusive and Sustainable Health Insurance Market,* edited by Alan Monheit and Joel Cantor. New York: NY: Routledge, 2004.
[32] Love, Norma. "Small Business Health Drive Becomes Law." *Concord Monitor*, May 20, 2008.
[33] Sack, Kevin. "New FL law allows Low-Cost Health Policies." *The New York Times*, May 22, 2008.
[34] Long, Sharon K. "On the Road to Universal Coverage: Impacts of Reform in Massachusetts at One Year." *Health Affairs* Web Exclusive, June 3, 2008.

## IV: Lessons and Conclusions

Many of the policies examined in this paper are complicated and still evolving, but few of the approaches have been large enough to have substantial effects on reducing the number of uninsured. In many instances, it appears that the strategies are unguided, without evidence or experiments. For states that are continuing to search for solutions to insurance coverage in the small group market, not all policy decisions can be guided by evidence because systematic evaluations of the effectiveness of the initiatives are limited. Indeed, more systematic assessments of the effects of policies are needed.

As health care reforms are debated at the national level, learning from states' successes and failures is essential. Harnessing state experimentation for learning purposes could lead to better solutions in the future. The small group market is one segment of the population where providing health insurance is challenging and state strategies have evolved to address not only access to insurance, but also access to *affordable* insurance. As shown in this paper, previous and current state efforts to reform the small group market have been minimally successful at maintaining coverage for targeted populations and not necessarily effective at increasing overall insurance coverage rates. The inability to significantly reduce uninsured rates in the small group market is partially due to the complexity of balancing access to insurance with affordable insurance products – and in part due to the incremental size of nearly all states' efforts.

With a downturn in the economy in 2008, several states are shying away from health insurance reforms that may be viewed as too costly or fiscally unsustainable. But while states wait for the economy to rebound, there are several interesting reforms already in place from which states can learn. The ongoing experiments for achieving universal coverage in Maine, Vermont, and Massachusetts hold potentially valuable lessons about successful strategies for increasing insurance coverage, not just in the small group market but in other parts of the market, as well.

Underlying reform efforts in all states and nationally is the larger question of how to restrain health costs, ensure adequate capacity within the system, and sustain financing. Until health costs can be reduced, the price of insurance in the small group market will continue to climb and fewer people will be able to afford coverage regardless of whether they are part of the small group market or another part of the market. In this regard, it is again valuable to look at the experience of states. Cost control efforts in Maine, which were part of its 2004 reform efforts, are receiving renewed attention because of their apparent effectiveness. Maryland is also receiving attention for its efforts in health planning, which are slowing rates of cost growth. Meanwhile, other states such as Florida, Pennsylvania, and New Hampshire are moving forward with incremental reforms to increase the affordability and availability of insurance for small employers. Massachusetts' experience thus far is promising, but the state's shortage of capacity — especially primary care — and the tenuousness of funding demonstrates to other states the importance of considering coverage in tandem with access, cost efficiency, and quality.

## Appendix A: Terminology and Definitions

**Association Health Plans:** Association health plans are group purchasing arrangements that are typically initiated by private sector entities and are not subject to the same regulatory requirements as government initiated Health Insurance Purchasing Cooperatives (HIPCs).

**Community Rating:** A process by which insurance products are based on a price that rates the entire community of risk. In its strictest form (known as pure community rating) premium amounts cannot differ based on the age, gender, and health risks of the population buying the product.

**Connector:** The Connector, as it is called in Massachusetts, is a form of health insurance exchange or marketplace where individuals and employees of small businesses can purchase health care coverage from a variety of competing health insurance plans. A connector is designed as a clearinghouse for insurance plans and payments. In Massachusetts, the Connector has the following functions, some of which are beyond the typical duties of an exchange:

- Runs the Commonwealth Care program for low income residents (up to 300 percent of the poverty level) who do not qualify for MassHealth.
- Offers to purchase health insurance plans for individuals who meet certain criteria.
- Sets premium subsidy levels for Commonwealth Care.
- Defines "affordability" for purchases of the individual mandate.
- Makes health insurance portable by allowing employees to keep the same plan even if they leave an employer.
- Allows employees to aggregate the contributions of multiple employers (for those who have multiple part time jobs, or work for multiple employers) and apply them to one insurance plan.

**Group Purchasing Arrangement (GPA):** Public or private efforts that allow more than one small or large employer and/or individuals to pool together to collectively purchase health insurance. Pools seek to enhance plan choice and service and reduce administrative burden.

**Guaranteed Issue:** A requirement placed upon insurers by government to provide insurance product offerings to all people in the insurance market. Guaranteed issue is required by all states for their small group market. There are also requirements for guaranteed issue in the individual market.

**Guaranteed Renewal:** A requirement placed on insurers by government to renew insurance product offerings to all people in the insurance market.

**Health Insurance Purchasing Cooperatives (HIPCs):** A form of group purchasing where nonprofit or government entities are willing to accept all small employers and offer individual employees a choice of several independent health plans.

**Health Savings Account (HSA):** HSAs allow individuals to put away money in a special, nontaxable account for health related expenses. This can be a strategy to make insurance affordable, but HSAs are not included in this paper because the focus tends to be on individuals.

**High Deductible Plan:** An insurance product option that is typically less costly in terms of monthly premiums, tends to offer limited benefits, but requires the user to pay a high deductible when health services are needed.

**Insurance Exchange:** A health insurance exchange serves as a market clearinghouse, but not as a regulator or purchaser. It functions as a single place where people can go to find out about their health insurance options. It attempts to improve market competition among health plans by providing more complete and understandable access to information about the products and pricing available in the market.

**Medical Loss Ratio:** The percentage of each premium dollar that is spent on the provision of health care services distinct from administration and profit. Health care expenses include physician services, outside referrals to physicians, emergency room and out-of-area services, and costs associated with inpatient care and other health care services.

**Medical Underwriting:** An insurance term referring to the use of medical or health status information in the evaluation of an applicant for health insurance coverage.

**Modified Community Rating (MCR):** A rating process that allows premiums to vary in selected rating dimensions (typically defined by age, industry, gender, and/or geography but not health status or utilization experience).

**Multiple Employer Welfare Arrangements (MEWAs):** A form of group purchasing in which multiple employers, including employers from different states, join together to administer health benefits.

**Pooling:** The concept of bringing groups or individuals together in order to simplify administration of health and/or pool risk.

**Portability:** The ability of an employee to retain benefits when switching employers.

**Premium:** The price paid in advance for an insurance policy. Health insurance premiums are typically paid on a monthly basis.

**Pure Community Rating**: Premiums are set and do not allow for variation by factors that are correlated with health status, such as age.

**Rating Band:** A method for constraining premium variance that allows insurers to vary premiums to a certain maximum amount above and below a midpoint. In most states the amount a company can vary a group's premium rates based on medical underwriting factors is limited to a certain percentage of the average small group insurance rate. Specifics vary by state. Rating bands can be imposed with or without modified community rating.

**Reinsurance:** Reinsurance is a means by which an insurance product, company, or an entire market segment can be protected against the risk of financial losses. In the health care sector, reinsurance is considered a mechanism for sharing the risk of high care claims among health insurance carriers or between carriers and government, in case of publicly sponsored reinsurance. Through reinsurance, a carrier shares or transfers some or all of the claims of one or more covered people with another carrier, a group of carriers, or a public agency. When partially or fully funded by government, reinsurance can be a mechanism for providing public subsidies for high cost cases.

**Rider:** An insurance rider refers to a provision in an insurance policy allowing for amendments to its terms and/or coverage. Usually riders are placed on health insurance companies to exclude specific pre-existing conditions but they also can provide additional coverage for services not specifically covered with a primary policy or increase or decrease cost sharing provisions of a plan. The rider is added to the primary policy and the policyholder pays an extra amount to cover the rider or, in the case of a rider reducing benefits, the policyholder may receive a discount.

**Small Group:** Refers to the number of employees in a given company. It is most often defined as a company with 2-50 employees. In 13 states, the small group can include "groups of one."

**Sole Proprietor:** A sole proprietor is one who manages his/her own business and has no employees. A sole proprietorship is a business entity owned and managed by one person. Some states permit sole proprietors to purchase small group coverage, and others do not.

**Subsidy:** A form of financial assistance paid to an individual, business, or economic sector. This can be used to support businesses that might otherwise fail or to encourage activities that would otherwise not take place. Subsidies also may be used to induce individuals or firms to engage in a specific behavior, such as purchasing health insurance.

**Tax Credit:** A health insurance tax credit is a provision of tax law that permits individuals or businesses to reduce their tax liability by some or the entire amount of health insurance premiums. Tax credits are a form of public subsidy for the purchase of health coverage.

## Appendix B: More Explanation of Variation of Premium Rating Where Health Status Is a Factor in Determining Premium

Table B1: Fourteen states do not permit premiums to vary with health status. Many of these 14 states are located in the Northeast (CT, ME, NH, NY, PA, VT). Seven states permit very little variation in the rating bands (AL, CA, CO, FL, ND, NM, and RI). Fourteen states set a rating band requirement of plus or minus 25 percent. Eleven states allow rates to vary by more than +/- 25 percent of the average premium and four states (MI, ID, KY, AZ) allow variation of +/- 45 percent or more.

**Table B1. Variation of Premium Rating Where Health Status Is a Factor in Determining Premium**

| Variation of Premium Rating (Percent of the Indexed Rate) | States |
|---|---|
| **No Variation** | CT, HI, ME, MA, MD, NC, NH, NJ, NY, OR, PA, VT, VA, WA |
| **Low** (Variation +/- 20%) | AL, CA, CO, FL, ND, NM, RI |
| **Average** (Variation +/- 25%) | AR, GA, IA, IL, KS, MN, MO, MS, MT, NE, OK, SC, SD, TX |
| **Above Average** (Variation +/- 30-35%) | AK, DE, IN, LA, NV, OH, TN, UT, WI, WV, WY |
| **High** (Variation +/- 45% and over) | AZ, ID, KY, MI |

Source: Adopted from Kofman, Mila, and Karen Pollitz. "Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change." Washington D.C: Georgetown University Health Policy Institute, 2006.