

# MPA

## Master of Public Administration Capstone Applied Research Project

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### Health Insurance Exchanges: A Multi-State Analysis and Recommendations for Oregon

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## Executive Summary

The United States' health care sector is increasingly overwhelmed by the high number of uninsured Americans combined with the ever-rising cost of service provision. Over the last thirty years both federal and state budgets have felt the strain, forcing policymakers and legislators to develop new methods to address the market failure. The Patient Protection and Affordable Care Act (PPACA) of 2010 is one such method. As a groundbreaking piece of health care reform, PPACA strives to increase health care affordability and accessibility for all Americans in both the short and long-term. PPACA has enabled the federal government to institute regulations for states, insurance carriers, businesses and the uninsured as way to increase coverage and control costs.

PPACA includes a program for insurance provision called a health insurance exchange (HIX), which all states are required to implement by 2014. The purpose of an HIX is to create an insurance market for individuals and small businesses by grouping them into combined risk pools, and to increase accessibility and coverage to the uninsured population. Given these reforms, the Congressional Budget Office and the Joint Committee on Taxation predict that nearly 32 million people will gain coverage in the non-group market by 2016. Of those, they expect that 23 million will obtain insurance through an HIX (Congressional Budget Office, 2010).

Health care reform is not a new phenomenon; in fact, it gained considerable national attention in the early 1990s. Eight states created and implemented health purchasing cooperatives (HPC), the predecessors to current day HIXs, in an attempt to control for the same problems faced today. While deemed largely unsuccessful when evaluated on factors such as market share, new products, price, competitive effect on the market and reduction in the uninsured, HPCs did increase price competition and coverage options for small businesses. However, little research exists that highlights the necessary components for state success based on historical and current reform programs; even less exists on the strategies states should undertake to ensure long-term sustainability and participation.

This report analyzes the structural design and methods of implementing an HIX on Oregon's small business health insurance market from the perspective of insurance carriers. To do so, this research conducts an in-depth study of five state health insurance pooling programs to identify best practices and better understand important features and characteristics that should be considered in the development of Oregon's HIX. The historical case studies of HPCs in California, Connecticut and Florida are compared with current examples of health insurance exchanges in Massachusetts and Utah. The successes and challenges of HPCs, and the preliminary outcomes of current HIXs, provide valuable lessons for design and implementation strategies.

Six indicators for carrier participation guided the analysis: risk adjustment; affordability; accessibility; implementation and administration; agent and broker participation; and marketing strategies. State-specific findings are filtered through the six indicators and

then compared with PPACA regulations that mitigate many of the hurdles they faced. The report concludes with practical recommendations for Oregon as it continues planning the implementation of an HIX. Special consideration is given to demographic and market trends in Oregon such as recent unemployment rates and coverage demographics. Additionally, Oregon's health care reform history as well as Senate Bill 99, which outlines the state's first steps in HIX development, help inform the likelihood of implementation and political feasibility.

After a careful analysis of existing literature, historic and current case studies, and pertinent legislation the authors recommend that Oregon: 1) Establish standard measures for risk assessment amongst insurance carriers inside and outside the HIX; 2) Limit the authorization of young adult plans to the HIX only; 3) Define the role of agents and brokers; and 4) Establish a marketing plan for HIX implementation.

This report contributes to the discussion of HIX development by analyzing case studies using an insurance carrier lens and identifying features of success and failure to support effective implementation. Should policymakers utilize this report in the development of organizational structures and strategies for implementation, the authors expect greater long-run sustainability and carrier participation.

## I. Introduction

Insurance in the United States is designed to help people spread their financial risk over a larger group, not all of whom will experience a loss or need at the same time. Individuals, or their employers, pay into an insurance plan and in return are assured that their medical costs will be paid, up to an agreed amount, should anything happen to them (Gruber, 2007). Unfortunately, people who are relatively less healthy tend to use greater amounts of medical care while more healthy people use less. This creates uneven participation and can result in healthy individuals choosing to forego insurance in order to save money, while less healthy individuals continue to pay high premiums in order to guarantee their coverage.

Today, the U.S. health care system faces two major problems: spending and costs. Over the last thirty years, health care spending has increased about two percentage points faster than per capita income, while insurance costs have grown by 120 percent in the last decade (Holtz-Eakin, 2011). These rising figures have put immense strain on both state and federal budgets and have forced policymakers and legislators to find alternative approaches to solve the current health care crisis.

The Patient Protection and Affordable Care Act (PPACA) of 2010, enacted by Congress and signed into federal law by President Obama, is a groundbreaking step in federal health care reform, and has important implications for state regulation of health insurance. PPACA establishes that health insurance exchanges (HIX) will operate in all states by 2014. An HIX organizes the market for health insurance by connecting small businesses and individuals into larger pools that spread the risk for insurance companies, while facilitating the availability, choice, and purchase of private health insurance for the uninsured (Jost, 2010). The government (state or federal level) or a nonprofit entity must administer the HIX under current PPACA legislation.

Many states are designing and constructing their own HIX framework, knowing that they must offer services by 2014. Any state that does not establish an HIX by the deadline will relinquish their control to a federally designed HIX. In this case, the federal government will likely establish the exchange without significant input or assistance from the state (OHA, 2010a). In Oregon, the Legislature began setting the foundation for an HIX before PPACA was passed. In 2009 they directed the newly minted Oregon Health Authority (OHA) and the Department of Consumer and Business Services (DCBS) to develop an HIX plan authorized under House Bill 2009.

In the past, states have attempted to create exchanges or “purchasing cooperatives” similar to the HIX proposed by PPACA. In the early 1990s a handful of states started using various exchange programs, some of which shut down soon after, but including at least one that still operates today. Research exists on the primary outcome-based factors of success and failure for these exchanges. However, there is very little research that outlines what states can do differently to set themselves up for success. Findings geared toward the insurance carriers are essentially nonexistent.

The purpose of this capstone project is to analyze state health insurance exchanges and health purchasing cooperatives in order to identify recommendations for Oregon's HIX from the perspective of insurance carriers. It determines best practices for an exchange by reviewing five state small-group programs and comparing their outcomes across six indicators, which were identified to encourage insurance carrier participation. The findings are then filtered through the regulations established by PPACA that control for many of the challenges of historical programs. It will then consider the implications for Oregon by reviewing demographic characteristics and previous health care reforms. The result is a set of four recommendations that contribute a new perspective to the research on best practices for the implementation of an HIX in Oregon.

## **II. Literature Review**

This section reviews available research in order to establish an understanding of health insurance exchanges in the United States. It will focus on the structure of an HIX as it is outlined in PPACA, describe the mechanics of implementing an HIX, and conclude with the history of health insurance exchanges over the last few decades.

### **Organizational Considerations**

Federal regulations define clear requirements for an HIX, but lack best practices and leave states with many vital unknowns, such as implementation strategies, how best to market the HIX or tactics for working with agents/brokers. PPACA, along with the amendments found in the Health Care and Education Reconciliation Act, laid the foundation for a transformation of the health care system in the United States. According to Harrington (2010), these Acts will lead to "the most significant social legislation in the United States since the enactment of Medicare and Medicaid in 1965" (p.703). Though the legislation spells out many aspects of an HIX, individual states will oversee the specific structure and implementation. Organizational considerations include subsidies granted to individuals who qualify according to income level, tax credits for certain small businesses, and an expansion of Medicaid to include a wider income base as well as non-disabled, non-elderly adults without dependent children.

In order to maintain autonomy of their HIX, states must have established their frameworks before 2014. If they do not, the federal government will begin its own implementation. As a result, many state governments have recently initiated their planning phases. Expert consensus has articulated that the following structural issues should be considered in the design of an HIX, in order to address both the needs of their respective population as well as fulfillment of PPACA mandates. Structural components include: the value of a state versus federally implemented HIX; the HIX market structure; administration and governance issues; qualifying health plans; and who will be served by the HIX.

### **The Value of a State vs. Federally Implemented HIX**

It is important for states to understand the difference between state and federal implementation. Understanding the nuances of a state HIX versus a federal HIX helps policymakers determine their level of planning and development inputs. Carey (2010) posits the following three advantages of state implementation: **1)** the promotion of individual state health reform priorities and strategies; **2)** the enabling of states to maintain regulatory authority over most of the insurance market and; **3)** the allowance for more state coordination of benefits and eligibility rules across health coverage programs (e.g., Medicaid, CHIP and policies sold through the HIX).



For insurance carriers, this means individual states can create plan levels that best suit the demographic characteristics and needs of their constituents.

Along with these benefits, states must ponder the following challenges of choosing to establish their own HIX: the difficulty of initiating a new program, particularly during a budget crisis; the mandate that the HIX be self-sustaining by 2015; and the challenging task of keeping the administrative costs minimal while achieving high quality customer service (Carey, 2010). To address the issue of funding, Dorn (2010) offers three strategies that may assist in doing this: surcharging insurance premiums; assessing health plans, employers, or individuals (e.g. imposing some sort of tax structure); or appropriating state General Fund dollars.

#### Advantages of State HIX Implementation

- Individual state health priorities and strategies highlighted
- State will maintain authority over most of the insurance market
- Easier coordination of benefits and eligibility rules across health coverage programs

### **HIX Market Structure – Single, Dual & Modified Dual**

When developing an HIX, states must consider their market options. PPACA fails to clearly define what an HIX market structure should look like, thus leaving states to decide. Policy experts have devised three market approaches for states to implement an HIX: a Single Market approach, a Dual Market approach, or a Modified Dual Market approach. Moreover, PPACA establishes the following uniform rules that pertain to all markets: insurers must not deny coverage to eligible individuals; products must cover the same risk pool and have similar rate design; and programs should include reinsurance, risk adjustment, and/or risk corridor programs that reduce the impact of differences in enrollee health (Etherton, McNeely & Russo, 2010). Additionally, each organizational approach has operational restrictions that ensure all citizens have an equal opportunity to obtain health insurance and are guaranteed issue.

The first two approaches, the single and dual market, create strict regulations whereby states either replace all current methods of insurance provision (single market), or allow current methods for insurance delivery to continue alongside an HIX (dual market). The single market eliminates all competition and increases regulations, while the dual market increases competition yet holds the potential that a private market undermines the HIX, decreasing its chances of success. These approaches concern policymakers and insurance carriers alike because they are extreme responses to health care reform.

The third approach, a modified dual market, is expected to be the most common for state programs. Under this structure the HIX market exists in addition to the private market, with government regulations spanning all insurance plans inside and outside the exchange (Etherton et al., 2010). The modified dual market structure involves an increased level of administration and monitoring, making it the most complicated of the three, but Blumberg and Pollitz (2009) highlight that having these regulations will help increase standards for all health insurance provision instead of just that which falls under the HIX.

A nuanced understanding of the single and dual market further complicates the issue of market structure *within* the HIX. Under the assumption that the majority of states will choose to operate under the modified dual market, policymakers often refer to the single and dual market structures

as organizational options for an HIX. This means that they may refer to a “single-market” as an HIX that combines both individual and small business health option program (SHOP) plans into one market scheme, and a “dual market” as an HIX that separates individual and SHOP plans into two distinct HIXs. Hereafter we refer to the single and dual markets as structural elements within an HIX.

### **Administration and Governance Issues**

Much like the market structure, states must design administrative and governance policies when creating a new program. PPACA requires that a governmental agency or non-profit entity, established by the state, administer the HIX. This provides some flexibility for states to decide whether to house the HIX within an existing governmental agency, a new agency, a quasi-public authority, or a non-profit entity. An entity that is accountable to the public, yet separated from executive and legislative influence, may suitably address the range of responsibilities necessary to oversee an HIX (Carey, 2010).

An HIX’s authority may be characterized in a few possible ways. The first form of governance includes one Executive and an advisory board. This approach allows a selected Executive or Secretary (advised by and provided with input from an advisory board) the responsibility to oversee and manage the HIX. Therefore the final decision-making authority would rest with the Executive or Secretary (Carey, 2010). The other approach suggests that states institute a governing body, separate and insulated from state agencies, to serve as the policy-making authority for the HIX. Massachusetts uses this model. The governing bodies can be volunteer-based, elected members, or a combination of the two. Using this model can help establish the independence of the HIX, provide greater stability in the event of a change in state government administration, and include individuals with relevant business and insurance expertise, as well as representatives from across the political spectrum (Carey, 2010).

Routine functions of the HIX will need to be carried out by a professional, experienced, and reliable staff. The individuals should be able to implement and efficiently operate a health insurance marketplace, assist potential enrollees to make informed choices, and provide an equitable environment where insurance carriers can compete. Placing the operations of the HIX within an existing state agency should be carefully evaluated before a state opts for this choice because of the inherently commercial nature and arduous planning needed to establish a successfully functioning PPACA-mandated HIX (Carey, 2010).

In Oregon, SB 99 concludes that the Oregon health exchange be governed by a board of directors and serve as a public corporation. Under this structure, the HIX will be considered a governmental entity, focused on state level needs, but not connected to any particular municipality or state agency. Ex officio members including the director of the Oregon Health Authority, the director of the Department of Consumer and Business Services, and the chairperson of the Oregon Health Policy Board, as well as individuals appointed by the Governor, will make up the board of the HIX. They will perform the tasks of the board and carry out all necessary decision-making (SB 99, 2011).

## Qualifying Health Plans

Mandated coverage must ensure the following:

1. Active and continual review of plans;
2. Availability of essential health benefits in each plan (emergency services, hospitalization, prescription drugs, etc.);
3. Equal premium charges whether offered in or out of the HIX;
4. No discriminatory risk selection;
5. Strong participation from insurance carriers;
6. The existence of transparent consumer information and enrollment procedures; and
7. The reduction of racial and ethnic disparities within the HIX (Dorn, 2010).

State HIX planners must also consider how to regulate the number of plans available through the HIX. PPACA Section 1302 mandates that insurance coverage plans use actuarial value (AV) for both individuals and small business/group enrollees. AV is determined by calculating the percentage of health care costs paid by the plan for an average population (Dorn, 2010). Many combinations of covered benefits and cost-sharing requirements can yield the same AV. AV is a single number that indicates a general level of comprehensiveness while still leaving room for considerable variation in the details of coverage (Dorn, 2010). PPACA Section 1302 requires that state HIXs calculate these values and decipher their four levels of actuarial coverage – bronze, silver, gold and platinum.

Insurance carriers will need to take special note of these requirements in order to compete in the new HIX market, as they may require a slight change in their current plan offerings. Sandra Shewry, the former executive director of California's exchange program, suggests that the implementation of PPACA requirements will generally expand the market as a whole, and benefit all carriers. Large cross-state insurance carriers used to depend on segregated markets as their major profit source. In an HIX, this practice will be limited. Small local/regional carriers focus on their reputations and networking relationships with local health care providers, and on providing better services. These small carriers may be more capable of creating inventive insurance plans that suit community needs (S. Shewry, personal communication, April 21, 2011).

### Who Will Be Served by an HIX?

The population served by the HIX is another administrative factor policymakers need to consider. Section 1304 of PPACA temporarily allows states to decide whether companies using the HIX may have a maximum of 50 or 100 full-time employees. Then, beginning in 2016, all firms with 100 or fewer workers may use the HIX. Starting in 2017, states have the option of opening the HIX to larger companies (Dorn 2010; PPACA, 2010).

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) predict that about 32 million people will obtain coverage in the non-group market by 2016. This projection includes approximately 23 million who would obtain coverage through an HIX and 9 million who would purchase coverage outside (Congressional Budget Office, 2010). In Oregon, the Oregon Health Authority (OHA) estimates that the number of individuals obtaining coverage through the HIX will rise to 232,500 by 2016 (OHA, 2010).

### The Evolution of Health Insurance Exchanges

Health insurance exchanges, as they are known today, have only recently come into focus; however, the idea of small employers pooling to purchase health insurance as a collective has been around for a few decades. Health purchasing cooperatives (HPCs), also known as alliances, became popular in the early 1990s, when the idea of comprehensive health care reform took a front seat in national deliberation among policymakers and stakeholders in the medical and business communities. In particular, small employers often had difficulty obtaining health coverage and a noticeable percentage of uninsured individuals worked for small firms, making small business employers a focus in the debate (Yegian, Buchmueller, Smith & Monroe, 2000). A handful of states initiated a reform aimed at alleviating these problems in the small-group market. The newly designed HPCs targeted firms with 50 or fewer employees, and offered at least two independent health plans (Wicks, Hall, Meyer, & ESRI, 2000).

Wicks et al. (2000) studied the various states that implemented HPCs, eight in all, and evaluated their success based on five factors: market share, new product, price, competitive effect on the market, and reduction in uninsured workers. Overall, Wicks et al. (2000) conclude that the HPCs were largely unsuccessful. In six of the eight states, they garnered less than 5% of the small-group health insurance market, and the remaining two did not do much better. Data from California, Connecticut, and Florida, the three largest small-group HPCs, shows that between 1993 and 1997, none of the programs increased coverage or reduced insurance premiums (Long & Marquis, 2001).

On a more positive note, HPCs did offer greater choice in coverage plans for small-group employees, who were found to take advantage of that opportunity (Long & Marquis, 2001).

#### Health Purchasing Cooperative (HPC):

An entity that purchases health insurance for individuals and small businesses and provides services so that they may pool their resources. An HPC enables businesses to aggregate purchasing in order to afford better plans at lower costs. These programs generally go beyond just contracting with health insurance carriers and include other direct services (Stahl, 2004).

#### Health Insurance Exchange (HIX):

An organized marketplace for the purchase of health insurance. It is set up as a governmental or quasi-governmental entity to help carriers comply with consumer protections, compete in cost-efficient ways, and to facilitate the expansion of insurance coverage to more people (Urban Institute, 2010).

Additionally, they were credited as achieving increases in price competition and coverage options, which was attributed to greater transparency and ease of comparing plans and rates. While insurance carriers did not admit to changing plan options because of HPCs, the variety of plans increased for small-firm employees during that time (Wicks et al., 2000). These programs served as excellent trials for out-of-the-box insurance pools, and provided valuable lessons.

The first lesson was of concept and structure. HPC administrators needed buy-in from insurance carriers and agents, but they did nothing to convince them of the HPCs' value in advance (Wicks et al., 2000). Long & Marquis (2001) also recognize the critical importance of agents/brokers, but identify marketing and administration as two additional significant issues. Many people did not know the HPCs existed, pointing to a lack of marketing. In California, only about 40% of small businesses that offered insurance said they knew about the alliance. In contrast, 75% of small businesses in Connecticut knew about their state's alliance. Although this is a large difference, it did not greatly affect percentages of market share. In no state did HPCs ever gain more than 10% of market share (Long & Marquis, 2001). Administration of the HPCs was also lacking. They had the intention of handling paperwork offsite in order to cut administrative costs. However, research shows that the HPC, carriers, and agents/brokers often duplicated organizational efforts (Wicks et al., 2000; Long & Marquis, 2001).

Regardless of the specific details of the states' HPCs, administrators agreed that the programs succeeded in acting as a catalyst for change. States that implemented HPCs showed that this type of reform in the insurance market was possible. Their shortcomings have more to do with usage rates than anything else. Since PPACA mandates both insurance and HIXs, much of this problem will be mitigated automatically.

The spirit of the recommendations from Wicks et al. (2000) can be seen in today's PPACA. They recommend the mandate that all small-group plans provided by insurance carriers be offered within the HIX, or possibly offered *only* through the HIX; that the government offer subsidies for employers buying coverage through an HIX; and that the government mandate that all small employers offer employees several different health plans to choose from (Wicks et al., 2000). Long and Marquis (2001) also suggest that large subsidies are necessary to greatly expand coverage by HIXs.

As a leader in more recent health care reform, Massachusetts' experiences and legislation have shaped much of the current reforms in the PPACA, including: mandating individual coverage, subsidizing insurance for families with income at a certain percentage of the poverty line, establishing a marketplace for coverage comparison, penalties for non-compliance, and expanding coverage for Medicaid-equivalent eligible persons and children (Gruber, 2011). The insights from these historical alliances and current HIXs may help policymakers, insurance carriers, and the general public understand the impact of health insurance exchanges.

The literature review provides the groundwork for defining an HIX, understanding how it will be implemented and various historical shifts that have taken place in the health insurance market over the years. The following research questions will highlight particular holes in the research that have yet to be answered with regard to HIX implementation today. Those questions will be addressed through case studies that identify best practices as well as causes of failure, and will

shed some light on recommendations for Oregon moving forward. Furthermore, we anticipate that our analysis will help to express implications for health insurance carriers in Oregon.

### III. Research Questions

Oregon currently has the opportunity to choose how to run its state HIX, and thus the chance to determine the quality of and accessibility to health care for its residents. The federal government has set aside funds to finance the development, implementation and operating costs of Oregon's exchange for 2014 (OHA, 2010). Additionally, Oregon received one of only seven "Early Innovator" federal grants to begin designing its information technology infrastructure (U.S. Department of Health and Human Services, 2011). This moment is the perfect occasion to spend time researching best practices, forecasting possible outcomes, and analyzing available data to determine the most efficient and effective design for Oregon's HIX. As such, this research will review historical and current case studies to determine indicators of success and failure among health insurance exchanges that serve small businesses. We focus our research on the following questions:

- What can Oregon learn from historical health purchasing cooperatives (also known as alliances) and current health insurance exchange programs?
  - What are the shared characteristics of programs in each state (i.e. implementation and administration strategies, risk mitigation measures to avoid adverse selection, the use of agents and brokers, etc.)?
  - Are there specific features that lead to the increase or decrease of small business participation within state programs?
- What are some necessary considerations for the establishment of a successful HIX in Oregon? And how can insurance carriers use these findings to successfully participate in Oregon's HIX?

### IV. Data Sources

In order to address these questions, we compare and contrast outcomes and strategies from selected historical HPC and current HIX programs. Information on market structure, policy details and outcomes are derived from existing academic research and government resources. Interviews with selected administrators of the case study programs provide an inside view of successes and challenges, to fill gaps in the research. Finally, data from the Oregon Department of Consumer and Business Services (DCBS) and Employment Department afford baseline market and demographic information to provide recommendations specific to Oregon's population.

### V. Methodology

There are many lessons that can be applied to future development of HIX programs so as to avoid repetition of past mistakes. For example, a lack of market share and buy-in from insurance carriers highlights the importance of including carriers early on in the process, and guides this study to focus on carrier needs and expectations around HIX development. This research aims to do an in-depth study of five state small-group health insurance exchanges (historically named



“health purchasing cooperatives” or “alliances”) to better understand important features and characteristics that should be considered in the development of Oregon’s HIX.

### Identifying Historical and Current HIX Models

First, we review the Health Insurance Plan of California (HIPC), Florida Community Health Purchasing Alliances (CHPA), and the Connecticut Business and Industry Association (CBIA) because they each offer a different look at historical efforts to create health insurance alliances (Long and Marquis, 2001). Implemented in the late 1990s, these alliances played a significant role in the development of current PPACA requirements. Despite their reputation for failure, we study these programs to identify policy deficiencies and participation holes to improve current organizational development. It is important to draw connections between the organizational structure and the unintended consequences of these alliances for purposes of planning the strategic direction for Oregon’s HIX. Specific information about each of these state programs is listed below:

- **California:** The HIPC began in 1993 after the California legislature made plans with Assembly Bill (A.B.) 1672 for it to be the first state to enact a broad reform package. The primary goals of HIPC were to increase insurance coverage for small firms by improving affordability and enhancing consumer choice (Yegian et al., 2000). The focus on small firms derives from the belief that bigger firms are typically afforded greater selection powers, risk spreading and market share. Organizers tried to replicate the large-employer model by negotiating and selectively contracting with health carriers in exchange for a large group of enrollees. Unfortunately, the HIPC never gained the momentum needed to gather a strong contingent of participants, which led to insurance carriers’ refusal to participate (Terry, 2009).
- **Florida:** The early 1990s were marked by high uninsurance and skyrocketing health care costs in Florida. In response, the Florida legislature passed the Health Care Reform and Insurance Reform Act of 1993. The Community Health Purchasing Alliances (CHPA) were a key component of that legislation. They were state-chartered, nonprofit organizations governed by a volunteer board that appointed an executive director to oversee operations. CHPAs anticipated an increase in access to coverage for the state’s uninsured, and a reduction in health insurance costs by acting as brokers for small-group members through the initiation of a managed competition model between carriers. Like California’s HIPC, the 11 CHPAs throughout Florida never gained high rates of participation, thus increasing costs and leaving small business employers with few competitive options (Feldheim, 2000).
- **Connecticut:** Established in 1995, the CBIA Health Connections is one of the first private sector purchasing alliances that spans statewide health insurance carriers (Chollet, Liu, Steward, Wellington & Barret, 2008). They are the only program out of the five case studies that identifies two levels of small-group size: small groups ranging from 3-49 employees and medium size groups ranging from 50-100 employees. Additionally, the alliance offers a range of benefits to

participating employers for increased employee choice. This incentive has helped lead to their longevity. CBIA is one of the last remaining small-group health purchasing alliances that emerged in the early 1990s (Chollet et al., 2008).

Next, Massachusetts represents a leading example of a health insurance exchange that most closely matches PPACA requirements. Open for business in April of 2006 (Kaiser Foundation, 2008), the “Massachusetts Connector” provides an inside look at the successes and challenges of implementing a statewide HIX. An immense amount of literature and data is available both before and after implementation, as well as consistent monitoring of involvement among early participants. Specific information about the Massachusetts Connector is below:

- **Massachusetts:** The Connector is a quasi-governmental agency created by Massachusetts’ legislation, and focuses on providing insurance options to small businesses and individuals who otherwise would not have access to employer-sponsored plans (Lischko, Bachman & Vangeli, 2009). A board of directors meets monthly to discuss issues, create policy, and make regulatory and programmatic decisions. This is the first single-market health insurance exchange enacted in the United States.

Finally, the Utah Health Exchange provides a case study of a state program that is a few steps ahead of Oregon in planning and implementing an HIX. The state began researching HIXs in 2007, and released a limited launch of their plan in 2009 (Girvan, 2010). Utah is creating a final structure for their HIX from the results of these pilot programs. The pilot serves as a model of program configurations that also include knowledge of PPACA requirements. This case study offers an in-depth look at the pilot program literature justifying the decisions made for the final HIX structure, expected to begin in 2012.

- **Utah:** The Utah Health Exchange began planning in 2007 and was officially established in 2009. The Exchange started after two house bills directed the Office of Consumer Health Services to create an internet-based information portal to connect consumers with health insurance information (Lischko, 2009). They began by identifying their target groups and have created pilot programs to help with the process of developing their HIX.

Having identified the key HIX and HPC models for research, the next section will outline the methods employed for performing the analysis.

## Research Design

A holistic, multiple-case study analysis offers a large understanding of small-group insurance in state HPC and HIX programs nationally. This research reviews policy design structures of each state’s program. More specifically, it identifies common or unique indicators of each state’s organization and implementation of their program. The identified indicators include:



- **Risk adjustment**, including mechanisms for risk assessment and transferring funds.
- **Affordability** for small-group purchasers (e.g. premium rates, range of selections).
- **Accessibility** for purchasers (e.g. eligibility, information availability).
- **Implementation and administration** (e.g. leadership, start-up and long term costs).
- **Agents' and brokers' participation**.
- **Marketing strategies**.

Thorough analysis of relevant research provides information about program characteristics (see [Table 1](#) in the Appendix). A case-by-case analysis and multi-case comparisons highlight strengths and weaknesses in each state HPC or HIX.

Historical case studies show how and why the health insurance exchange mechanism would work, and what specific objectives the programs have met. On the other hand, these cases also demonstrate where the pooled small-group markets found challenges for successful implementation and sustainability of practice. By examining the indicators, this research is able to compare and contrast the initial assumptions regarding the risks of an HPC in each state, whether those efforts were effective, and what unexpected outcomes may have influenced decisions to discontinue service.

More recent HIX models point to lessons learned from the historical experiences of HPCs. Through the indicators, we identify how approaches to HIX development have changed in the last ten years, highlight initial success with participation levels, and gauge whether they meet current PPACA requirements.

The case studies provide the foundation for what has been done nationally with regard to health insurance reform. However, it is important to identify ways that PPACA has already worked to mitigate some initial failures of insurance pooling programs, and this research does just that. Finally, a depiction of state legislation and demographics in Oregon inform the current status of Oregon's preparedness for implementing an HIX. Together, these analyses support the formulation of recommendations for the most effective structure and implementation strategy for Oregon's HIX.

The next section will review the guiding indicators for research and the way in which they are utilized in this study.

### **Guiding Indicators for Research**

There are numerous possible characteristics to consider when researching HPCs and HIXs. Therefore the scope of this research is focused on three different aspects of HPC and HIX implementation – the insurance carrier perspective, the insurance purchaser perspective, and long-term participation. The six indicators previously mentioned were divided among these categories, and are more fully detailed below.

- **Insurance Carrier Perspective:** Do states provide sufficient protection for health insurance carriers against adverse selection within an HIX?

If an HIX were disproportionately made up of high-risk clients, insurance carriers would find the market unattractive. Without support from insurance carriers, coverage within the HIX may become unaffordable for small businesses (Jost, 2010). Furthermore, if the pricing control mechanism prohibits carriers from maintaining profit margins, the market would collapse. States need to consider the proper strategy for mitigating this market failure.

- **Indicator 1. Risk Adjustment:** The purpose of a risk adjustment system is to offset losses when adverse selection occurs in plans, “thereby reducing incentives for plans to avoid higher-risk groups and focusing competition on price and quality” (Wicks et al., 2000, p.40). Risk adjustment includes mechanisms of detecting biased selection, determination of funds to be transferred between plans and carriers, and other related regulations.
- **Insurance Purchaser Perspective:** Do states have provisions that adequately support small businesses in enrolling employees in “qualified” health plans?

The advantage for small-group members to purchase coverage in an HIX is for employers to offer increased choice for their employees, and for the pooled market to have more power to negotiate prices (Wicks et al., 2000; Long & Marquis, 2001). Possible indicators that states need to consider are: how to adapt the current system of employment-based health insurance for an HIX; the existence of employer “cafeteria plans”; tax subsidy structures; and the ability of employers to purchase insurance outside the HIX market.

- **Indicator 2. Affordability:** State authorities need to define affordability for the intended audience, and design pricing regulations accordingly (Muller & Desmarais, 2010). Related structures include: review mechanisms for premium rates, price control of the outside market, range of choices for employers and employees, and premium subsidies for purchasers.
- **Indicator 3. Accessibility:** To assure that market participants have access to plans and understand their choices (Muller & Desmarais, 2010), accessibility of HIXs were examined through: carriers’ participation, methods and convenience of enrollment, and education or availability of information.
- **Long-Term Participation of Carriers:** Do state provisions encourage participation for competing insurance carriers in the long run?

It is important that initial HIX structures be sustainable. One measure of sustainability is the number of carriers that participate in the exchange. Looking back on outcomes of HPCs, there are three indicators for carrier dropout: 1) excessive implementation cost and administration efforts; 2) a lack of involvement or buy-in from related market participants (e.g. insurance brokers and agents); and 3) inadequate marketing strategies (Wicks et al., 2000).

- **Indicator 4. Implementation and Administration:** To examine an HIX’s operational stability, the following factors are reviewed: leadership and

- administration entities; start-up costs for government and insurance carriers; long-term operational costs; duplication of administration efforts.
- **Indicator 5. Agent and Broker Participation:** Historically, high commission rates for agents and brokers burdened small and large businesses alike (Wicks et al., 2000). Therefore, initial strategies of HPCs included bypassing agents and brokers in order to eliminate their commissions (Yegian et al., 2000). However, researchers caution that the support from agents and brokers may be crucial for an HIX's success. Factors reviewed include: whether agents and brokers are included and/or encouraged to participate in an HIX and enrollment processes.
  - **Indicator 6. Marketing Strategies:** HPCs found marketing difficult when market participants did not support the cooperative (Wicks et al., 2000). The review of marketing strategies included: administration of marketing efforts, marketing materials, information distribution techniques, collaborations and partnerships with agencies or non-governmental organizations, and technology used to increase information accessibility.

Before delving into further examination, however, it is important to mention the limitations of this study, along with the assumptions made in order to produce this report.

### **Limitations**

As a result of the methodology and the timely subject matter, this project faced certain constraints. Although case studies can be very useful in recognizing best practices and projecting outcomes, they also face certain inherent limitations. These are described below.

A primary concern of this project is that long-term impacts of an HIX are not available for consideration. Given this uncharted territory, it is difficult to identify flawless best practices for a long-term sustainable structure of Oregon's HIX. Where historical case studies may have filled this gap, privatization of programs led to a decrease in public reporting; this resulted in a lack of research available for some states' final outcomes. Additionally, should state HIXs become privatized in the future, this lack of transparency could contribute to inefficient practices or public resentment of reforms.

While the five states included in this analysis were chosen because they exhibit distinct characteristics and can be considered early policy laboratories, their particular results and experiences may, in fact, prove to be anomalies. The outcomes may have resulted from unique state-specific characteristics, such as their various population numbers, demographics and health care systems. This variation could lead to a skewed analysis when formulating comparisons to Oregon's particular HIX strategies. Additionally, economic or employment changes in Oregon that cannot be predicted could limit the reliability of the recommendations for the structure and implementation of Oregon's HIX.

The selected indicators, which provide the foundation for the outcome-based analysis, may also prove insufficient to gauge changes in affordability, accessibility and carrier participation with the implementation of an HIX in Oregon. Moreover, recommendations for Oregon may be imperfect due to given changes in policy or small-group behavior over the course of the research

timeframe. Because of the politically sensitive nature of health care reform, both locally and nationally, the conclusions and suggested next steps are presented under the assumption that current funding models and policy reforms will remain in place, and that the national policy will be upheld.

Despite these limitations, the recommendations generated from this project are consistent with findings from all five case studies, and have taken Oregon’s specific characteristics into consideration. With the established research design and methodology, the following sections will begin the in-depth analysis of each case study. Cases are broken up by their status as either historical or current, and analyzed according to the guiding indicators for research. A cross-case synthesis will then provide further analysis of lessons learned and commonalities between both historical HPCs and current HIXs.

## VI. Historical Case Studies: California, Florida, and Connecticut

When building programs for the future, it is wise to look to the past for examples. The intention of reviewing these historical cases is to learn from their mistakes and achievements by comparing and contrasting the six indicators listed above within each program.

### Risk Adjustment

Risk adjustment is a crucial element to any health care reform. Without it there is a danger of one carrier bearing a disproportionate number of people with higher medical costs, while other carriers gain the advantage of low-cost members. There are various methods of controlling risk; California, Florida and Connecticut each established different solutions outlined below.

CA	FL	CT
<ul style="list-style-type: none"> <li>• Standard benefit design and annual open enrollment</li> <li>• Distribution of funds between plans according to "risk assessment values" (RAVs)</li> </ul>	<ul style="list-style-type: none"> <li>• Modified community rating system, which adjusts rates for specific case characteristics</li> </ul>	<ul style="list-style-type: none"> <li>• Modified community rating system, which prohibits varying rates based on health factors</li> <li>• Non-subsidized reinsurance (insurance for insurance carriers)</li> </ul>

### California

Initially, the Health Insurance Plan of California (HIPC) had limited risk adjustment strategies. However, certain statutes within A.B. 1672 did create lower risk pools for insurance carriers. These statutes prohibited insurance carriers from denying health insurance coverage to firms with 3 – 50 full-time employees, disallowed cancelation of coverage, and barred carriers from declining coverage for more than six months on the basis of preexisting medical conditions (Buchmueller, 1997). In addition to legislation, the HIPC also incorporated structural measures for risk adjustment. These included the use of a standard benefit design and annual open enrollment periods in which employees could change insurance carriers and health plans (Shewry, et al., 1996). However, the statutes in A.B. 1672 and the structural components of HIPC were ineffective at minimizing adverse risk selection (Buchmueller, 1997).

In 1996, the third year of operation, HIPC launched an innovative process for assessing the distribution of risk among insurance carriers and their plans. In short, risk-adjustment funds were transferred between plans if selection bias was detected (Shewry et al., 1996). First, participating plans identified high-risk enrollees. High-risk enrollees are defined as individuals who were hospitalized in the prior year with one of a predetermined set of costly conditions (\$15,000 or more) classified as “marker diagnoses.” This measurement relied exclusively on inpatient data (Yegian et al., 2000). Second, a “risk assessment value” (RAV) was calculated for insurance carriers and their plans. The RAV was based on the health plan’s enrollee mix as compared with the enrollee mix of the HIPC as a whole. It focused specifically on three components: gender, diagnosis, and the number of children per contract. The RAV of the HIPC as a whole is always 1.0. Whether or not the risk adjustment process was engaged, each health plan’s RAV is calculated (Shewry et al., 1996). Lastly, if any plan had an RAV 5% above or below the average for the entire pool (a value that is less than 0.95 or greater than 1.05), risk-adjustment payments were made to the carrier of that plan. Transfers of payment were adjusted and made by an ongoing process that continued until all plans had an adequate RAV range (Yegian et al., 2000). This risk adjustment process remained in place until the HIPC shut down in 2006. However, the “marker diagnoses” had been replaced by Medicare diagnostic cost groups, which employs a more streamlined method of data collection (Yegian et al., 2000).

### **Florida**

In 1994, Florida legislation required guaranteed issue of health insurance for all defined small-groups. However, the rating rules were relatively restrictive, allowing rating variations for only age, gender, family status, geographic location, and tobacco usage (Wicks et al., 2000). Adjustment was no longer permitted for health status, pre-existing conditions or claims experience.

This type of rating system is known as modified community rating. It develops a ‘community rate’ then adjusts it for specific case characteristics. But, if participating Community Health Purchasing Alliance (CHPA) insurance carriers have a combined insurance pool of approximately 2,000 lives, that insurance pool can be separately rated by state regulators (Wicks et al., 2000).

### **Connecticut**

Health Connections uses the same rating rules to mitigate the potential for adverse selection (age, gender, geographic area, family tiers) as those in the small-group market of Connecticut. It includes a baseline of benefits which each of the three participating carriers must meet. As a condition of group enrollment, at least 75 percent of eligible full-time employees must participate (Chollet et al., 2008). Additionally, Health Connections restricts the number of plan options to 30 across all carriers.

Connecticut legislative policies take risk management into account, though they are not defined as such. For example, Connecticut law requires insurers to use modified community rating for small employer groups, defined as groups of 1 – 50 employees. Thus, carriers are prohibited from issuing insurance policies with varying rates based on health factors (Kaminiski, 2005).

The state of Connecticut also operates a non-subsidized reinsurance (insurance for insurance carriers) pool for the small group market. Any carrier may purchase reinsurance from the pool

for individuals, dependents, or small-groups with a \$5,000 deductible per covered life. Individual carriers make the choice to reinsure or not. State officials credit the Connecticut reinsurance pool with keeping the small-group market competitive (State Coverage Initiatives, 2010).

### Affordability

The purpose of offering affordable plans is to increase the number of people with health insurance. Affordability is a large issue that HPCs addressed through various approaches such as the range of premiums, choice between plans, and the availability of subsidies.

CA	FL	CT
<ul style="list-style-type: none"> <li>•HIPC had power to negotiate premium rates and exclude carriers</li> <li>•Employee choice of carrier and plan</li> <li>•Requirement for employers to contribute at least 50% of least costly plan</li> <li>•Contracts prohibiting underpricing in the outside market</li> </ul>	<ul style="list-style-type: none"> <li>•Employee choice of carrier and plan</li> <li>•Requirement for employers to contribute at least 50% of least costly plan</li> </ul>	<ul style="list-style-type: none"> <li>•Requirement for employers to contribute at least 50% of least costly plan</li> <li>•Employees may "buy up" or "buy down" for alternative benefits; similar to defined-contribution plans</li> </ul>

### California

The HIPC had the power to negotiate premium rates with potential health plans. Additionally, it could choose to exclude insurance carriers that offered unsatisfactory prices or failed to meet other minimum standards. Employers were required to contribute at least 50% of the least costly plan available to their employees, and needed 70% participation rate among their employees (Wicks et al., 2000). The program then allowed for employee choice of insurance carrier and plan, a choice between two relatively comprehensive standardized benefit plans. Premium rates charged to HIPC participants varied based on age, geographic region, and family size. Premiums could not vary based on an enrollee’s sex or health status (Shewry et al., 1996).

There were additional rules affecting overall premium rates for participants. HIPC contracts prohibited carriers from under-pricing their plans in the outside market. Moreover, premiums were initially required to fall between 80% and 120% of a standard age-rated premium for a given benefit design. This rule was tightened to +/-10% in 1996 (Buchmueller, 1997). Dowell and Oliver (1994) reported that the HIPC’s initial premiums were 10% - 15% lower than those outside the HIPC in 1994. However, a report of five HMOs offered by the HIPC in 1997 showed that four of them had overall benefit-adjusted premiums 7% – 8% higher than those outside the HIPC (Shore & Bertko, 1999). This revealed a gradual rise in premium rates throughout the progression of the HIPC’s lifespan.

### Florida

Employers were required to give employees the option of choosing from a minimum of two health plans offered through the CHPA; a “basic” health benefits plan and a “standard” health benefits plan. Both plans had premium prices established by a modified community rating system. Additionally, employers were required to contribute at least 50% of the premium of the least expensive plan (Wicks et al., 2000). CHPA soon added a more comprehensive “Plus”



benefits plan in response to employers' dissatisfaction with the basic and standard plans (Wicks et al., 2000).

Employers and employees both had the flexibility to choose the carrier and plan that best met their personal needs within CHPA. Under this system, a company could have three or four different carriers and plans but only pay one bill (Feldheim, 2000). Carriers began exiting the CHPA fearing a disproportionate share of bad risks with the employee-choice provision and no underwriting (Wicks et al., 2000).

CHPAs did not negotiate and contract with insurance carriers for premium prices. Instead, the contract was between the insurance carrier and the employer (Wicks et al., 2000). Unfortunately premium prices continued to increase year after year, and with no intervention mechanism to negotiate lower prices, the CHPA was unable to continue.

### Connecticut

Employers must select one of two “suites” of plan designs for their employees. Each employer must establish a minimum premium contribution level, equal to at least 50 percent of the premium for the lowest cost plan in the suite. Typically, employers identify a “benchmark” plan within the suite, which becomes the basis for their premium contribution and monthly premium budget. Employees may enroll in the “benchmark” plan or opt to ‘buy up’ or “buy down” to an alternative level of benefits offered within the suite. This model allows employers to establish their premium budget while providing employees the opportunity to choose a plan that best meets their needs (Chollet et al., 2008).

### Accessibility

A crucial aspect of health care reform is the ability to reach more people. When looking at accessibility, key factors include the structure, the number of competitors in the market, and any education or outreach available to support the HPC.

CA	FL	CT
<ul style="list-style-type: none"><li>•Major innovation: made it practical for small employers to give employees choice in plans</li><li>•Began with 20 carriers, but many dropped out over time</li><li>•Purchasers preferred PPOs, but those dropped out due to cheaper HMOs</li></ul>	<ul style="list-style-type: none"><li>•45+ carriers at the beginning; only 5 remained in 2000</li><li>•Standardized all plans to streamline statewide data system and produced "comparison sheets"</li></ul>	<ul style="list-style-type: none"><li>•Only available to small business employers, their employees and employee dependents</li><li>•Online portal for product and service information</li></ul>

### California

California was divided into six regions for premium setting to account for regional differences and their population characteristics. Participating carriers were required to offer insurance plans throughout their entire licensed service area (Buchmueller, 1997). Furthermore, the HIPC's major innovation was making it practical for small employers to allow their employees to choose from multiple health plans. Previously, employers could not deal with the administrative complexities of having contracts with multiple health plans (Wicks et al., 2000).

The HIPC began offering coverage statewide in July 1993 with 20 insurance carriers. It grew rapidly and attracted firms with an average group size of about 10 employees (Wicks et al., 2000). However, as time progressed carriers began dropping out of the HIPC, diminishing the range of choices. From 1998-1999 the HIPC offered plans from 11-15 health maintenance organizations (HMOs) and one to two point of service (POS) plans. Choice was dependent on the region. In those same years, six of the nineteen plans accounted for 80 percent of enrollment (Yegian et al., 2000).

Employees favored preferred provider organizations (PPOs). However, PPO plans dropped out due to the price competition with HMO's and the resulting adverse selection (Yegian et al., 2000). There were fifteen HMOs, four POSs and no PPOs left when HIPC privatized and became Pac Advantage. Through Pac Advantage, additional vision, chiropractic, and dental coverage could be purchased (Yegian et al., 2000). Before it ended in 2006, only three major state-wide carriers were left in the program; Blue Shield of California, Health Net of California, and Kaiser Permanente (Colliver, 2006).

Unfortunately, the HIPC's share of the small-group market remained below 5 percent (Yegian et al., 2000). Although there were small changes in characteristics of the market in California, there is little evidence that the HIPC had broader effects on the small-group market. Moreover, the HIPC did not increase the availability of insurance to workers in small businesses. It also did not lead to increased price competition in California (Long & Marquis, 2001).

## Florida

State regulation limited competition by mandating that CHPA accept every insurance carrier that met state certification requirements. More than 45 carriers sought and were awarded certification during the early years. However, only about 35 carriers actually sold products through the CHPAs (Wicks et al., 2000). By the year 2000, only 5 carriers remained in the CHPAs and none of these were available statewide, leaving many counties without a small-group insurance carrier. Consumer enrollment peaked in 1998 with 92,000 lives covered, accounting for 5% of the market, but by February 2000 enrollment was down to 45,000 lives covered (Wicks et al., 2000).

Another accessibility challenge focused on streamlining information about insurance plans so consumers could easily compare their options. In response, the Florida legislature standardized all plans allowing for "apples to apples" comparison of prices and increasing consumer information (Feldheim, 2000). Additionally, Florida's Agency for Health Care Administration developed a statewide data system for CHPA participants that provided comparative information on provider prices, utilization, patient outcomes, quality, and patient satisfaction (Florida Legislature Report, 1996). This information was then compiled into "comparison sheets" giving both consumers and insurance agents information necessary to make informed decisions (Feldheim, 2000).

## Connecticut

Health Connections is administered by the Connecticut Business and Industry Association (CBIA), a private not-for-profit organization, and is only available to small business employers, their employees, and employee dependents. In 2007 there were more than 6,000 businesses with 88,000 covered lives in Health Connections. Be that as it may, Health Connections only has a small-employer market penetration of a little more than 10% (Altarum Institute, 2011).



Currently Health Connections is an online portal where information about products and services is disseminated to employers, employees, and brokers. Transactions are primarily made online. By 2011 there were three participating insurance carriers; ConnectiCare, CIGNA Corps, and Oxford Health Plans.

### Implementation and Administration

Big questions about these programs remain. What are the costs? Are programs cost-effective and sustainable for carriers and the government? How will the program manage in the short term versus the long term? Finally, the question of efficiency; can carriers and managers be sure that administration efforts are not duplicated?

CA	FL	CT
<ul style="list-style-type: none"> <li>• Run by government agency, but mandated to be privatized by 1996</li> <li>• Initially financed by government loan; hoped to reduce costs by lowering agent commissions, allowing direct purchase, and realizing economies of scale</li> </ul>	<ul style="list-style-type: none"> <li>• Primarily run by state agency; some tasks done by third-party administrators</li> <li>• Initially subsidized by state government; had to self-finance operations by 1997</li> </ul>	<ul style="list-style-type: none"> <li>• Private trade nonprofit organization</li> <li>• Membership organization with sliding-scale dues; not subsidized by government</li> <li>• Reduces administrative burden for small employers by offering human resources</li> </ul>

### California

The HIPC was the first entity of its kind. It was initially financed by a state government loan of \$5.5 million. The Managed Risk Medical Insurance Board (MRMIB), a government agency in the Health and Welfare Agency that also managed several other government health insurance programs, governed and staffed the HIPC (Wicks et al., 2000). However, state law mandated that the HIPC be privatized by July 1996. No private organizations were willing to take over until 1998 when the Pacific Business Group on Health (PBGH) won a bid to operate the HIPC. It renamed the program Pacific Health Advantage (Pac Advantage for short) and began operations on July 1, 1999 (Wicks et al., 2000).

Administratively, the HIPC hoped to reduce costs through several methods of operation: by paying agents lower commissions, by offering direct purchase from the HIPC, and by realizing economies of scale through centralization of enrollment, collection of premiums, and marketing functions (Wicks et al., 2000). In reality, the HIPC did pay lower commissions, creating great hostility toward the program among agents. To improve relations, the HIPC ultimately raised its commission rate to compete with commissions in the small-group market (Wicks et al., 2000).

The decision to allow direct purchase also proved to be less successful than was hoped. About 70-75% of employers used agents from the beginning and thus continued to pay the commission (Wicks et al., 2000). Also, groups that did enroll directly required more time and staff resources than did those enrolling through brokers. The costs of those resources were comparable to the commission rates (Yegian et al., 2000). The HIPC subsequently changed its policy to offering direct sales with a fee equal to the agents' commission. This resulted in no cost difference between direct purchase and purchasing through a broker (Wicks et al., 2000).

Lastly, there is little evidence that shows a reduction in administrative costs for insurance carriers. Some carriers claimed savings in costs from the centralization of enrollment, bill collection and marketing, and yet carrier premium rates remained comparable or higher to those outside of the HIPC (Wicks et al., 2000). However, the amended risk assessment tool that used Medicare diagnostic cost groups did prove to reduce the duplication of data gathering efforts, and thus costs (Yegian et al., 2000).

### **Florida**

The state government subsidized CHPAs in the initial years of operation. From fiscal years (FY) 1993/1994 to 1995/1996, the state provided approximately \$8.1 million in general funds and grants to the CHPAs (Office of Program Policy Analysis & Government Accountability, 1996). This may point to CHPA rates nearly 6% lower than the outside market competitors. However, price reduction and efficiency reversed in FY 1995/1996 when CHPAs had to finance their operations, passing fees on to employers (Wicks et al., 2000).

The state's Agency for Health Care Administration oversaw some of CHPA's administrative activities and provided technical assistance. This included annually certifying that each CHPA complied with applicable statutes and rules, conducting annual reviews of the performance of each alliance, and reviewing appeals from CHPA members whose grievances were not resolved by the alliance (Florida Legislature Report, 1996). Beginning in 1997, CHPAs had to finance their operations entirely from fees they added to the premium and passed on to employers (Wicks et al., 2000).

The Agency for Health Care Administration was not the only agency involved with CHPA. Other functions were carried out by a third-party administrator, including tasks of enrollment, premium collection and distribution, enforcing premium contribution and employee participation requirements, and some aspects of marketing (Wicks et al., 2000). The expectation was that the carriers would experience lower administrative costs as a result, and participants would see lower premiums. However, with such a small market share, this expectation was not met in Florida.

Most carriers continued to duplicate the administrative functions of the third-party administrator. This was largely because most administrative costs were fixed, meaning CHPAs' administrator produced little, if any, savings (Wicks et al., 2000). Feldheim (2000) claims this was a major reason why premium costs rose significantly within CHPAs over time. For example, the average cost per covered individual in 1994 was \$100.70. In 1998, the cost per individual was \$126.35, an increase of about 25%. However, it is difficult to make a truly accurate comparison between 1994 and 1998 since the averages are spread over different types of plans; the basic and standard plans from 1994, and the basic, standard and plus plans from 1998 (Feldheim, 2000).

### **Connecticut**

The CBIA is a private trade non-profit organization providing services to member businesses. Thus, its main source of revenue comes from membership dues, which collected are on a sliding scale. Health Connections carries out their own administration and does not receive subsidization from the government. Additionally, the Health Connections Alliance has been particularly successful at reducing the administrative burden for small employers by offering them full-service human resources amenities (State Health Access Data Assistance Center, 2010).

## Agents and Brokers

Agents and brokers comprise a group of highly talented and connected individuals with an established understanding of health insurance systems. Therefore, utilizing them as a resource would seem wise for HPC administrators. However, they are also a source of additional fees. Examining the role of agents and brokers throughout the progression of the health insurance alliances is important to understand how to proceed with current structures of the HIX.

CA	FL	CT
<ul style="list-style-type: none"><li>• Initial broker policy: employers could bypass brokers; brokers' fees itemized rather than rolled into premium; brokers' fees lower within HIPC than outside</li><li>• Altered in 1998: direct sales now included fee equal to broker cost; brokers' fees upped to be comparable with outside</li></ul>	<ul style="list-style-type: none"><li>• Law mandates all transactions be made through agents</li><li>• Role of "general agent" was impacted, no longer a need for these middle, administrative agents</li></ul>	<ul style="list-style-type: none"><li>• Policies are sold and distributed through independent agents and brokers</li></ul>

### California

Initial policies regarding brokers took a middle ground, neither eliminating their role nor mandating their involvement. Without state funding, HIPC could lower costs for small employers by reducing or eliminating broker fees (Yegian et al., 2000). The initial policy is summarized as follows: employers could enroll directly and bypass brokers and fees; brokers' fees were itemized on the employer's bill rather than being rolled into the premium; and brokers' fees paid by HIPC were to be lower than commissions outside the HIPC (Yegian et al., 2000). Unfortunately these policies created animosity in the broker community.

### Florida

Florida law mandated that all CHPA transactions go through agents. Nevertheless, anti-agent advocates supported CHPAs direct marketing plan during developmental stages. This caused initial agent hostility toward the CHPA program (Wicks et al., 2000). In the end, agents were not entirely eliminated from the process, though the hostility remained since the role of a "general agent" was impacted so dramatically. A general agent was someone who recruited and trained agents for the carriers they represented. This was often the only way an agent could get access to a carrier (Wicks et al., 2000). The general agents would then get part of the commission for serving as an intermediate. For CHPA transactions, third party administrators served in the role traditionally held by general agents. This meant that agents no longer needed to go through the general agent because the law required that carriers allow agents to sell directly through the CHPAs (Wicks et al., 2000).

Throughout the course of the CHPA, agents remained skeptical of the micro-groups (employers with 1-2 employees), which produced lower than usual commissions. Because the average CHPA group size was between 3-5 employees, commissions were often lowered around 1 percentage point for micro-group agents (R. Sailors, personal communication, May 6, 2011). On the other hand, agents claimed that their work was made easier by the insurance carrier comparison information, produced and made readily available by the CHPAs (Wicks et al., 2000). As a leader in the development of a previous alliance in Florida, Ree Sailors stated that

the shopping guide was one large success of the CHPAs as it was one of the first times that type of comparison was done and done well (R. Sailors, personal communication, May 6, 2011). Moreover, larger groups may have created work because the agent often had to individually counsel employees about the range of plans that were suddenly available to them. If agents sold coverage outside the CHPAs, all employees were on the same plan, so no counseling was required (Wicks et al., 2000).

### Connecticut

From its inception to the present, Health Connections’ policies are sold and distributed through independent insurance agents/brokers. Health Connection executives report that developing and maintaining a role for agents/brokers was essential in order to gain market share (Chollet et al., 2008). However, there is little further literature that discusses the impact of agents and brokers in the exchange.

### Marketing

As with any new product or program, a large portion of the success or failure can be attributed to the marketing campaign. Vast differences exist between states regarding working with partners and the amount of resources devoted to the cause.

CA	FL	CT
<ul style="list-style-type: none"> <li>• Fewer than 1/3 of small employers knew about the HIPC</li> <li>• Strained relationship with agents/brokers hurt marketing efforts</li> <li>• Marketed through direct mail, telemarketing, follow-ups by sales reps, and radio ads</li> </ul>	<ul style="list-style-type: none"> <li>• Marketing funds came from administrative company, CHPAs, and even carriers (for a time)</li> <li>• 11 separate CHPAs caused inconsistent strategies, duplicated efforts, non-targeted plans</li> </ul>	<ul style="list-style-type: none"> <li>• Agents/brokers do bulk of marketing</li> <li>• Information distributed online and in print</li> </ul>

### California

Despite a substantial surge in enrollment during the first two years, survey results showed that less than one-third of small employers had heard of the HIPC (Yegian, Buchmueller & Robinson, 1998). Strained relationships with brokers may have hindered sales, since most employers bought health insurance through brokers.

Marketing was the responsibility of the HIPC administrator. As a result, two times a year there were direct mail campaigns, as well as a telemarketing campaign to advertise the HIPC. There were sales representatives who followed up on any leads developed during campaigns. In turn, interested employers were referred to a broker. The HIPC also effectively used radio advertising to get the word out (Wicks et al., 2000). However, the HIPC staff estimated that an effective job of marketing would have taken at least three times the budgeted \$400,000 in FY 1997-98 (Wicks et al., 2000).

### Florida

The third-party administrative company and the CHPAs were both responsible for allocating marketing funds. In addition, Governor Chiles pressured insurance carriers to contribute to

marketing efforts. Governmental pressure disappeared once Governor Bush took office and with it, so did carrier support and marketing contributions (Wicks et al., 2000).

Furthermore, each of the 11 state-subsidized CHPAs had their own marketing budgets and developed separate marketing plans. This meant that money for marketing was not concentrated in the areas with the most population where the potential for enrollment was greatest. It also created division between CHPAs, producing duplication of efforts and inconsistent strategies (Wicks et al., 2000).

### Connecticut

Marketing of the Health Connections program is largely done through agents and brokers. Their main focus is to recruit new employer groups (Schilling, 2010). Information about Health Connections is distributed to those agents and brokers (and subsequently their customers), both online and in print.

The historical case studies provide a glimpse at health insurance reform of the early 1990's. The next section will review more current versions of health insurance exchanges as they have been implemented in Massachusetts and Utah.

## VII. Current Case Studies: Massachusetts and Utah

Equally important as looking to past programs for lessons learned, it is prudent to consider the current climate for health insurance exchanges by studying present day programs for their successes and challenges. The intention of reviewing these current case studies is to learn how the six indicators listed above play a role in modern program development and implementation.

### Risk Adjustment

As mentioned previously, this indicator is reviewed to understand how current programs are attempting to mitigate adverse selection for insurance carriers participating in the HIX.

MA	UT
<ul style="list-style-type: none"><li>• Limit rate variation</li><li>• Aggregate risk-sharing for carriers</li></ul>	<ul style="list-style-type: none"><li>• Different rating system for each employer participation method (defined-contribution vs defined-benefit)</li><li>• Adjusts risk before and after an individual joins market</li></ul>

### Massachusetts

It is said that the best defense is a strong offense, advice the Massachusetts' Connector took to heart when considering risk assessment. The more options there are for rate variation, the more risky the insurance pools. There is less need for risk adjustment when there are tighter programs on community rating. Thus, the Connector tries to limit the number of plans available to reduce risk for carriers (Haislmaier & Owcharenko, 2006). Massachusetts has also created an aggregate risk-sharing program, whereby the Connector attempts to balance the costs and benefits to participating carriers. If Carrier A ends up paying more than expected in medical costs, and

Carrier B saves more, Carrier B must give the surplus back to the Connector, which will reimburse Carrier A (Lischko et al., 2009). The purpose of this mechanism is largely to increase incentives for participation by decreasing risk to insurance carriers and the state.

### Utah

Utah recognized the concerns about adverse selection, but took an alternate approach. They researched uninsurance demographics ahead of time, and were able to assure the industry and business leaders that the primary targets of the Exchange were young, healthy people. Unfortunately, the limited defined contribution launch in 2009 resulted in irregular premium rates that suggested adverse selection (Girvan, 2010). Another problem was discovered for employers switching from traditional health insurance packages to the Exchange – they were often treated as new customers. They would have received better risk ratings if they had been considered renewing groups. Additionally, risk ratings were assigned differently to defined-contribution plans in the Exchange, when compared to defined-benefit plans in the regular market (Girvan, 2010).

Having identified these various issues, state lawmakers looked to experts, such as insurance regulators and actuaries, for advice. Being well versed with the health status of Utahns and the balance of persons of risk between insurance carriers provided policymakers with a unique perspective. In the current model, the Exchange adjusts risk by assessing the potential risk of each carrier’s pool before and after an individual joins the market. The Exchange then compensates the carrier accordingly (Haislmaier, 2010). For small businesses, the Exchange collects limited health histories from all employees, then creates a risk premium for the employer and applies it when determining the employee’s final premium (Lischko, 2009).

### Affordability

This indicator identifies the current definition of affordability, and reviews the range of premiums, choice between plans, and the availability of subsidies.

MA	UT
<ul style="list-style-type: none"> <li>• Assessment of affordability yearly by Connector board</li> <li>• Plans based on income level</li> <li>• Young adult (18-26) plans available</li> <li>• Separate risk pool for those receiving subsidies</li> <li>• Cafeteria plans required for employers with 11 or more employees</li> </ul>	<ul style="list-style-type: none"> <li>• Pushes defined-contribution plan for improved budgeting</li> <li>• Allows for contribution combining between family members to increase insurance choices</li> </ul>

### Massachusetts

The term affordability implies lofty goals of getting as many people covered by health insurance as possible. In order to consistently align itself with that goal, the Connector creates a plan each year that determines levels of affordability. Those levels are then brought to statewide hearings for approval. They offer numerous plans in an attempt to accommodate the most MA residents possible. For individuals, the Initial Commonwealth Care program had five options of increasing premiums, based entirely on income level (Lischko et al., 2009). There also is a product



provision for young adults, which offers mandate-light plans (Haislmaier & Owcharenko, 2006), and a separate risk pool for the population receiving subsidies (Lischko, 2009).

Moreover, Massachusetts requires that employers with 11 or more employees provide their workers with Section 125 Cafeteria plans (Lischko et al., 2009). Cafeteria plans offer employees the choice of having pretax salary-reductions taken out of their pay to apply toward health benefits. The money taken out for health benefits can be applied toward the premium that workers would otherwise pay out of pocket, meaning it is possible that all insurance payments be made using pretax funds (Haislmaier & Owcharenko, 2006).

### Utah

Utah's Health Exchange is pushing defined-contribution plans. These plans let employers decide how much money they want to pay toward an employee's health insurance, and then the Exchange lets the individuals choose the plan that is best for them (State of Utah, 2011). The employee has 66 options of plans to choose from after all the administration is dealt with (Lischko, 2009). According to Girvan (2010), these types of plans will not only increase the number of insured individuals with assistance from employers, but will also improve the quality of medical care by strengthening the relationship between doctors and patients, and will improve plan portability. Additionally, a defined-contribution plan allows both spouses to receive contributions from employers to put toward their family's health insurance, rather than having to choose just one employers' plan.

### Accessibility

This indicator is guided by the HIX's goal to increase access to health insurance. As identified in the historical case study, it includes structure, competition and education efforts of the HIX.

MA	UT
<ul style="list-style-type: none"><li>• Web-based registration</li><li>• Includes all <i>qualified</i> plans</li></ul>	<ul style="list-style-type: none"><li>• Entirely online program</li><li>• HIX is the only place for employer defined-contribution plans</li><li>• 4 carriers at present; more expected</li></ul>

### Massachusetts

The Connector relies heavily on web-based registration, which drives many people to contact insurance carriers directly in order to get support with the set-up (Lischko, 2009). Currently, the Connector offers employees plans from nine different insurance carriers (Health Connector, 2011). Furthermore, the Connector must include all qualified plans that are approved by the state's insurance regulator (Haislmaier & Owcharenko, 2006). There are, however, strict guidelines the plan must follow, which ends up limiting the number of options.

### Utah

Utah's Health Exchange is entirely online. The web-based system allows administrators to quickly expand services as the need arises. The Exchange is the *only* outlet for employers to institute defined-contribution plans. This system was created for small businesses, and it allows potential customers to compare plans, enroll, determine their premiums, and manage their billing

and collection (Lischko, 2009). Initially, the universal health form was found to be too complicated for many users, but has since been updated (Girvan, 2010). According to the state’s website, there are currently four carriers who together offer 66 plans, but they anticipate even more carriers joining soon. Lischko (2009) attests that other carriers wanted to participate earlier, but could not join due to their own internal technology challenges.

### Implementation and Administration

This section reviews the costs of operation and structures employed for start-up efforts. Additionally, it examines administration techniques in each HIX program.

MA	UT
<ul style="list-style-type: none"> <li>•Independent, quasi-governmental entity</li> <li>•Received start-up costs</li> <li>•Administers both state insurance programs</li> </ul>	<ul style="list-style-type: none"> <li>•Defined-contribution simplifies management and administration</li> <li>•Run by two government employees but operations done largely by contracting private entities</li> </ul>

#### Massachusetts

Massachusetts’ Connector is “an independent, quasi-governmental entity that is self-governing and a separate legal entity from state government” (Lischko, 2009). It did receive \$25 million for start-up costs, but is expected to be self-sustaining through administrative fees on all health plans combined with the receipt of a percentage of capitation payments. The Connector administers both of the state insurance programs, Commonwealth Care and Commonwealth Choice; this streamlines administrative efforts (Lischko et al., 2009).

#### Utah

For Utah, the use of defined-contribution plans greatly simplifies the management of a company’s health benefit options. Defined contribution is an insurance funding strategy where an employer pays a fixed, tax-free dollar amount towards health care coverage for each employee. The employer then provides employees with multiple health care plans to choose from. It is up to the employee to decide which plan will best suit his or her needs (Girvan, 2010 & Christianson et al., 2002). The employer pays a portion of the premium, directly to the health care provider, but, if the plan costs more than the employer's defined contribution, the employee must pay the difference. This model reduces the administrative burden by managing both member and carrier details, as well as making the annual cost of providing insurance more predictable.

Two employees within the Governor’s Office of Economic Development oversee administration of the exchange. Their mission is to promote the growth of Utah’s business community. Much of the operational work is done by private entities with 1-year contracts. They look to existing entities and technology frameworks in order to save costs, and convene often with business leaders for advice (Lischko, 2009).



## Agents and Brokers

As we saw in the historical programs, agents and brokers played an important role in the communications of the HIX. This indicator is studied to understand how current HIX programs are using the resources and connections of people who are already in the business of health care.

MA	UT
<ul style="list-style-type: none"><li>• Little success getting agents/brokers on board due to lower commissions for services</li></ul>	<ul style="list-style-type: none"><li>• Incorporated agents/brokers from the beginning developing strong relationships</li><li>• Serve as primary marketing tool</li><li>• Website offers support for participants to find an agent/broker to work with</li></ul>

### Massachusetts

There are a couple of reasons Massachusetts has had little success in getting agents and brokers on board with the Connector, especially for the small-group market. Namely, brokers make more money if they do not have to share their fees with the Connector and can take an employer directly to an insurance carrier. Additionally, they receive more commission by bringing higher volumes to a single carrier, rather than working through the Connector where employers can choose from a range of carriers (Lischko, 2009).

### Utah

The Utah Exchange, unlike Massachusetts, has worked with agents from the beginning, and has developed strong relationships while designing and implementing the health insurance reform. These ties have contributed to the enthusiastic response the Exchange has received. In fact, the Exchange relies on brokers and businesses as primary marketers, and when the trial run began, the 100 test slots were quickly filled and another 150+ organizations were on the waiting list (Lischko, 2009). To further support these relationships, the state encourages website users to work with an insurance agent who has defined-contribution experience, and offers an Agent Search on the website (State of Utah, 2011).

## Marketing

This indicator will help to uncover the efforts being made to share information with the public about the HIX and ways to participate.

MA	UT
<ul style="list-style-type: none"><li>• Heavily marketed</li><li>• Direct mail campaign</li><li>• Collaboration with Bay Transportation Authority</li><li>• Partnered with well known stores and organizations</li></ul>	<ul style="list-style-type: none"><li>• Small marketing budget</li><li>• Partnered with business community</li></ul>

### Massachusetts

Massachusetts focused heavily on promotion of the Connector, and developed a Public Information Unit (PIU) to answer people's questions about the structure and the process.

Additionally, they collaborated with state agencies, community organizations, and corporate and civic organizations on public education and outreach campaigns, and were widely supported by commercial carriers (Lischko, 2009). Some of their efforts included:

- Statewide “Connect-to-Health” forums (30 events in 20 communities)
- Direct mail effort to nearly 3 million MA taxpayers, providing information about the new law and how they could purchase insurance through the Connector
- Collaboration with the Massachusetts Bay Transportation Authority (MBTA) to display information and offer contact cards in all MBTA cars
- Partnered with CVS stores and the Boston Red Sox to share information about health reform with all MA residents

### **Utah**

Utah’s scheme was far smaller, and their marketing budget for outreach and education was just \$10,000. However, they did mimic Massachusetts by establishing a cooperative relationship with the business community, and they relied heavily on unpaid guidance on the subject from the private sector (Lischko, 2009).

In the next section, the case studies are combined through an analysis of common lessons and important take-aways that will help inform future recommendations for the Oregon HIX. The guiding indicators for research continue to drive the analysis.

## **VIII. Cross-Case Synthesis**

The case studies show that there are multiple ways to address each aspect of implementing health insurance reform. In these examples, each state did things slightly differently, which leads to various outcomes and mixed results. The six indicators for research guide the review of the case studies below, in order to draw out comparisons and contradictions between alliances and exchanges, and to recognize what worked and what did not.

### **Insurance Carriers**

#### **Risk Adjustment**

Beginning from the perspective of the insurance carrier, the subject of risk assessment is of utmost importance. Carrier drop out is cited as a primary reason that Florida’s HPC eventually shut down, and adverse selection was a key motivator for that exodus. Regulations within the HPC were more stringent than those outside the market, and left little protection for carriers from adverse selection and more expensive medical claims. Additionally, Florida’s HPC made special efforts to serve micro-groups (1-2 employees) to address the social problem of small-employer underinsurance, thus drawing a disproportionate number of employers in this size category; this was perhaps their most detrimental factor. Carriers believed that these were higher-risk groups with higher claims experience, and they saw little incentive in covering these dominant micro-groups in the HPC. Carriers were not permitted to respond to this situation by raising their rates, and many dropped out for fear of adverse selection.

California took a different route. After functioning for a couple of years, the HIPC started a process of determining a risk assessment value for a carrier's policy-holders, and then granting payments to carriers who were identified as covering an unequal portion of high risk enrollees. This seemed like a legitimate way to handle the issue within the HIPC, and it remained in place until the HIPC shut down. However, the HIPC suffered from adverse selection in terms of the health insurance market outside the exchange. Overall, higher-risk groups found they could save money (roughly 10%) by purchasing through the HIPC, whereas lower-risk groups could realize similar savings by buying outside the HIPC (Wicks et al., 2000).

Connecticut uses yet another approach, where one of the primary risk adjustment tools is their reinsurance pool for the small-group market. It allows carriers to share their policy-holders' risk with a third party, and is said to be keeping their small-group market viable.

Having recognized adverse selection as an issue, Massachusetts worked hard to establish protections against it when building the Connector. For starters, they limited the number of available plans by enforcing strict regulations. This forces the insured into fewer, larger groups, thus reducing the possibility of an outlier group holding all the risk. Additionally and more proactively, they have established an aggregate risk-sharing program to balance the costs for all carriers. Utah has a similar plan in place, and compensates carriers according to pool assessments before and after new members join. These structures bode well in that the exchanges are attempting to control for potentially unequal distributions of risk. However, new HIXs will need to keep in mind the importance of remaining competitive with the private market as well, to avoid adverse selection on a larger scale as happened in California, which leads to the next indicator.

## **Insurance Purchasers**

### **Affordability and Accessibility**

The price of premiums within the HPC/HIX compared to the outside market is an important aspect of affordability. Beginning again with Florida, the HPC faced the challenge of having to allow any willing and qualified health plan to participate, without being able to negotiate and maintain contracts with the insurance carriers. This inability to discuss premium options was extremely harmful to the CHPA program, as the rising prices were out of their control (Wicks et al., 2000).

This was not the case in California, where the HIPC independently rated carriers' insurance plans, negotiated premium prices, contracted with employers, and could exclude health plans as they saw fit. The downside to this was that they attracted people with high medical costs, because their pricing policies were more favorable than those in the external small-group market. Although HIPC contracts expressly prohibited carriers from offering their plans in the external market at a lower cost, technicalities in the labeling system still made it possible. Once the prices were fully adjusted for their benefits, four of five plans offered within the HIPC had higher premiums than those outside (Shore & Bertko, 1999).

In the current programs, both states deal with affordability in different ways. Massachusetts renegotiates plan prices every year through state hearings, and they offer plans at multiple premium levels to cover as many people as possible. Additionally, they offer mandate-light plans

to young adults, which include fewer health benefits and thus can be offered at a lower price. These plans help to draw in this younger, healthier population. In Utah they focus on defined-contribution plans, which allow for contributions to be made from various employers (i.e. spouse's, second job) to a single, employee-chosen health care plan. These plans allow employers to more accurately budget their health care costs, as they pay the same set amount for every employee. This is different from the more traditional defined-benefit plans, in which employers agree to pay whatever it costs to get their employees certain specified benefits.

In terms of accessibility, much of the historical data is linked to carrier participation. As mentioned, carrier drop-out was a large, negative factor in the demise of both California and Florida's HPCs. Florida's exchange viewed carriers as adversaries rather than partners due to their inability to barter. California started out with 20 carriers, but that number decreased over time. Also, data shows that the HIPC did not increase availability of insurance to small business employees (Long & Marquis, 2001). However, it is not only the number of carriers that is important; Connecticut is the only historical HPC still operating, and they currently have just three insurance carriers. Perhaps stability, over quantity, matters more. Plans appear stable in Massachusetts, where nine carriers are solidly participating in the Connector. Utah's pilot programs had four carriers involved with more clamoring to join the Health Exchange. One hurdle Utah carriers face is technology, which they must update to be compatible in the HIX.

## **Long Term Participation of Carriers**

### **Administration**

The first of the three indicators used to determine the sustainability of exchanges pertains primarily to structure, an aspect outside of the control of carriers and purchasers alike since the state will decide on the governance of the HIX. Looking to the historical case studies, the two entities initiated purely by the government eventually collapsed, while Connecticut's HPC is run by a private nonprofit entity and is still operating. Initially, government backing was a good thing, as it gave many of the first HPCs some credibility and start-up funding. However, association with the government began to hurt more than it helped because small businesses and insurance agents tended to be suspicious of government after the primary stages of many of the HPCs. Furthermore, a positive attribute of being privately run is that the HIX is not entirely dependent on state law to define its role, thus it can more easily change policies and redefine itself when need be (Wicks et al., 2000). Looking at the present, both cases seem fairly well established for success. The HIX in Massachusetts is a quasi-governmental entity, and is separate from the state government. Two state employees run Utah's program, but they work out of the Office of Economic Development so they focus on promoting business growth, hiring private entities for their operations, and working closely with business leaders for guidance.

Outside of the governance structure, the administration of the HPC/HIX is another concern. In Florida and California, officials hoped to centralize administrative duties as means to reduce costs. In actuality, carriers and the HPC administrators ended up duplicating responsibilities. Additionally, potential savings from the elimination of brokers was not realized because many of the people who attempted to sign-up without a broker often needed more administrative staff resources (Yegian et al., 2000).

Increasing the portability of the plans is one way that carriers have avoided some of the unnecessary paperwork. That is, if people lose their jobs in Massachusetts or Utah they do not automatically lose their insurance, because both individual and small-group plans are available through the exchanges. Rather, they can keep their current carrier and switch into the individual market until they find a new job, at which time that employer would begin paying and the individual would move back into the small-group pool. The HIX works directly with the individual and manages all aspects of these transitions.

### **Agents and Brokers**

The role of insurance agents/brokers is cause for debate. While historical cases determine that using agents/brokers can make all the difference in terms of success, Massachusetts may disprove that theory. Connecticut attained the highest market share in HPC history at 10%, in part because of a mandate requiring all insurance-related transactions be made through agents or brokers (Tuerck et al., 2005). This is a stark contrast to California and Florida, where agents and brokers were initially considered barriers to lower premiums. Utah seems to have sided with Connecticut, and has worked with agents/brokers from the beginning of their research; the HIX needs their marketing support, and in return administrators promote agents' expertise on the Health Exchange website. On the other hand, Massachusetts does not have widespread buy-in from agents/brokers, as they can make more money working outside of the Connector.

### **Marketing**

Marketing is another area with wide variances in technique and disparate results from actions. California spent roughly \$400,000 in FY 1997-98 on a marketing scheme that included direct mail, telemarketing, and radio advertising. Even with all this, less than a third of small employers had heard of the HIPC. Florida also put a lot of emphasis on marketing, and funding came from the private administration organization, the CHPAs, and even insurance carriers. However, because there were 11 separate CHPAs coordinating different versions of the plan, the overall result was inconsistent and scattered. Both paid attention to marketing, but it did not pay off for either group. Meanwhile, Connecticut simply worked through agents and brokers to recruit new employer groups and to disseminate information about Health Connections. They did not emphasize advertising, and yet their health insurance market share is the highest, and they are the sole survivors of the HPCs.

Massachusetts focused quite a bit of resources into their marketing plan, which included heavy collaboration with big agencies, education and outreach efforts, and Public Information Units to address questions about the Connector. It has been a success through and through. Utah, on the other hand, has devoted only \$10,000 to their marketing and education campaign, relying instead on cooperative relationships with the business community as well as with agents/brokers. It remains to be seen exactly how successful Utah's tactics are, but they are on the right track in terms of carrier buy-in, as there are currently carriers lined up to join the Health Exchange.

Based on these six indicators and the various methods used by each of the examined states, there are multiple possibilities of ways to run a health insurance exchange. In mandating a health insurance reform for the nation, PPACA controls for some of the negative factors and prescribes the methods it recognizes as most successful. With other details, it turns control over to individual states, that that they may best serve their particular populations. The next section describes the decisions made by the national reform that address the historical shortcomings and

define PPACA’s proposed solutions. This will be followed by an analysis of Oregon’s current situation as it pertains to the forthcoming HIX. With this foundational understanding of where Oregon stands today, along with PPACA’s methods of addressing some of the early issues of pooling health insurance, this report will conclude with recommendations on how to further support the successful implementation of an HIX.

## IX. PPACA Controls for Failure

The HPC failures in the late 1990s and early 2000s provide valuable insight for the organizational and marketing structures of current and future exchanges. Historically, many carriers were reluctant to join due to the high risk of adverse selection. This was in part due to limited participation, conflicting rating regulations, and/or the tendency of HPCs to attract high-risk micro-groups. Additionally, small-group market reforms and political turnover in the 1990s changed the environment in which HPCs operated, creating increased selection biases (Wicks & Hall, 2000).

Wicks & Hall (2000) note a variety of factors that led carriers, even those who were championing for the success of HPCs, to leave. First, regulations within the HPC were more stringent than those outside the market and provided little protection for carriers from adverse selection or costly medical claims. Second, at their inception, proponents claimed that HPCs would be able to gain a majority of the market share for small-groups. When this did not happen, many carriers moved their attention back toward the outside market. Third, most carriers faced increased competition in the HPC, forcing them to drop plans that were not producing necessary profits.

Adverse selection has arguably been one of the greatest threats to HPC and HIX markets. Therefore PPACA includes key provisions that mitigate, but do not entirely eliminate, the risk of adverse selection. The first provision is Section 1501 of PPACA that requires individuals to have “minimum essential coverage” or pay a monetary penalty (PPACA, 2010). This is designed to discourage individuals from choosing to forego insurance entirely. In particular, it encourages

### PPACA Controls for HIX Failure

- Minimum essential coverage
- Combined risk pools
- Premium rate design is the same for comparable plans inside and outside HIX
- Reinsurance required for insurance carriers
- Tax credits and subsidies are available for participants

healthy individuals to purchase coverage rather than take the chance that they will remain healthy. Second, individual and small-group plans in both markets must cover the same defined “essential health benefits.” Moreover, out-of-pocket limits are required to be the same inside and outside the exchange (Jost, 2010). This measure supports the HIX by decreasing opportunities for outside competition. Third, PPACA Section 1302 mandates that health insurance carriers place all individual enrollees in one risk pool and all small-group enrollees in another risk pool. Alternately, the state

may elect to combine members of both pools into a single risk pool (PPACA, 2010 & Jost, 2010). Lastly, Section 1301 mandates that health insurance carriers “charge the same premium rate for each qualified health plan of the [carrier] without regard to whether the plan is offered



through an [HIX] or whether the plan is offered directly from the [carrier] or through an agent” (PPACA, 2010, p. 45).

Complementary to these provisions, PPACA Section 1341 requires the spread of risk amongst carriers within the HIX through reinsurance (PPACA, 2010). Acting as insurance for insurance carriers, reinsurance decreases the risk for carriers who incur a disproportionate number of high risk customers and compensates the losses to help increase equity for carriers participating in the HIX. This is true across the inside and outside markets. In other words, if carriers outside the exchange attract a significantly healthier population than carriers in the HIX, a reinsurance plan will compensate the carriers within the exchange (Jost, 2010). PPACA includes funds for a state regulated entity. It is important to note that the state-regulated reinsurance pool is only available to qualified health plans *within* the HIX. This is designed to attract more carriers to participate in the HIX.

Additionally, tax credits will only be offered to small businesses insured through the HIX (Jost, 2010). This is another way to induce participation in the HIX. PPACA also provides premium tax credits and cost sharing reduction payments to eligible individuals who are insured through the HIX.

PPACA does not require individuals or employees to purchase insurance through the exchange. It also does not prohibit states from imposing additional regulations on the outside market to encourage participation in the HIX (Jost, 2010). “[PPACA] only preempts state laws that would ‘prevent the application’ of the [PPACA], and state laws prohibiting or tightly regulating the sale of insurance outside the exchange would not violate that principle. The only constraint on state regulation of the health insurance market is that states cannot, because of [the Employee Retirement Income Security Act], directly regulate self-insured plans” (Jost, 2010, p.9-10). Thus, it is up to the state to enforce the applicability of PPACA both inside and outside the HIX market.

Having identified the major controls put in place by PPACA legislation, we now look to the specific situation in Oregon. In particular, the next section will review specific demographic and market trends in Oregon. It will also provide an overview of current HIX plans as outlined by Oregon Senate Bill 99.

## **X. Implications for Oregon**

This section reviews data specific to Oregon’s population and health insurance market trends as well as information about the state’s health care reforms. The purpose of this section is to set the context for Oregon’s position as it continues to plan for implementation of the state HIX.

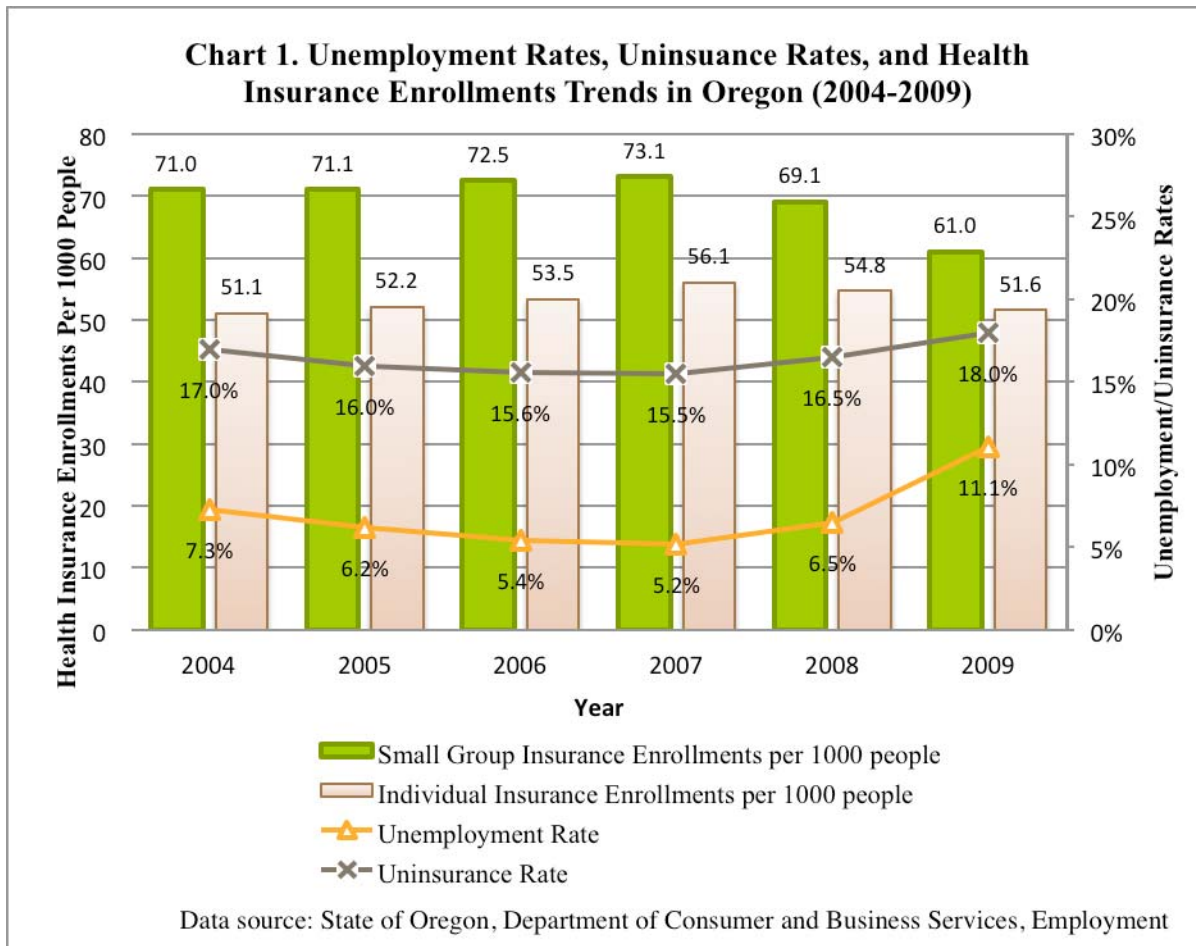
### **Oregon’s Insurance Market Trend**

Oregon’s statewide population has grown approximately 2% on average each year since 1990. One sub-group that has experienced constant growth is individuals aged 55-74 (OHPR, 2009). Oregon’s aging population suggests two future issues for the insurance market. First, this growing age group may represent an increase in self-employed and small business owners relative to the younger working population (Stangler, 2009). Second, as Oregonians age into the 65-74 age group, the state will be forced to increase public spending on Medicare.

Unemployment rates in Oregon also substantially impact trends in the insurance market. Traditionally, high percentages of individuals get insurance from their employer. However, in Oregon, employer-sponsored health insurance rates are low in correlation with increased unemployment rates. The economic downturn over the last few years pushed Oregon's annual unemployment rate to 11.1% in 2009, one of highest levels in recent history, nearly 2 percentage points higher than the national level (Oregon Employment Department, 2011). Monthly unemployment rates peaked at 12% in January 2010, and have steadied between 10 and 10.5% in the past year (Oregon Employment Department, 2011). The Oregon Population Survey in 2006 shows that the state faced an uninsurance rate of 15.6% of the total population (OHP, 2009). A report conducted by Families USA (2009) highlighted the connection between employment and insurance coverage. The study calculated that Oregon's unemployment rose by 5.2 percentage points from the end of 2008 through the first eight months of 2009, and resulted in a 3.1 percentage point increase in the uninsured rate (as cited in DCBS, 2010). In fact, over 57% of uninsured working-age adults in Oregon reported that they are currently employed for pay or self-employed in a business or farm (OHP, 2009).

These recent trends denote the instability of Oregon's employment rates and insurance provision. They also signify the importance of policies regulating small-group health insurance and portability issues. DCBS's (2011) quarterly database shows small group and individual health insurance enrollments from 2004 to 2009. Chart 1 depicts these recent trends with enrollments per 1000 Oregonians to control for population growth. Small group insurance enrollment slowly increased from 2004 to 2007 (0.2% quarterly increase on average) and had a drastic average decrease of 2.2% since the fourth quarter of 2007. Individual insurance enrollments had 0.8% average quarterly growth from 2004 to 2007, and started decreasing rapidly by 1.6% quarterly since the fourth quarter of 2007. On the other hand, both unemployment rates and uninsurance rates had adverse trends in relation to insurance enrollments.





We calculated Pearson Correlations and regression models to examine possible relations between quarterly health insurance enrollments and unemployment rates. The results indicate that both small group and individual health insurance enrollments have significant and strong negative correlations with unemployment rates. In particular, the regression model shows that a one percentage point increase in the unemployment rate is associated with a decrease in small group health insurance of 1.89 per 1000 people enrolled (P value = 0.000; R-square = 0.904).

In addition to changes in demographic composition and uninsurance rates, recent reports from OHP (2009) and DCBS (2010) suggest three major trends in Oregon’s health insurance market: growth in health care spending, skyrocketing premium rates, and decreasing employer-sponsored health insurance provision in small firms and cost shifting to employees. For purposes of this report, the third trend is most pressing, and will be examined further.

- Decreasing employer-sponsored health insurance provision in small firms and cost shifting to employees:** Larger businesses are far more likely to offer health insurance than smaller businesses (DCBS, 2010). In 2008, virtually all businesses with 100 or

more employees offered health insurance; however, only about 31% of businesses with fewer than 10 employees offered health insurance to their full-time employees (DCBS, 2010). The recent recession also caused many employees to move to lower-paying jobs, which are often less likely to offer coverage. As employers struggle with rising premium rates, one solution is to shift costs to employees or, in some cases, to eliminate health insurance benefits altogether (DCBS, 2010). Employee contributions to employer-sponsored insurance in the single coverage category increased from 11.5% in 2004 to 14% in 2008 (DCBS, 2010). A similar increase was also witnessed in the family coverage category, with employee contribution growing from 23.9% to 26.2% (DCBS, 2010).

In general, the rise in Oregon's uninsured population contributes to rapidly rising medical spending and premium rates (OHPR, 2009). This creates additional challenges for the health insurance market. This situation is especially severe in the small-group market. A nationwide study on the social cost from the uninsured population suggests that a 6-9% "hidden health tax" is borne by people who purchase health care coverage (Families USA, 2009). The current climate indicates that Oregon is facing a pivotal policy moment. The following section outlines the history of health care reforms in Oregon and the recent steps being taken to address the ever-growing uninsured rate among the small-group population.

### **Overview of Oregon Health Care Reforms**

For the last two decades the state of Oregon has initiated reforms to improve health care for its citizens. Significant reforms began with the creation of the Oregon Health Plan (OHP) in 1987. The goal of OHP was to provide access to high-quality health care for all Oregonians at affordable rates (OHPR, 2009). The four major components of OHP were: Medicaid reform, insurance for small businesses, high risk medical insurance pools, and employer mandates for health insurance (OHPR, 2009). In the context of future HIXs, three of the four components are most applicable.

First, the Office of Private Health Partnerships works to increase coverage of Oregon businesses and "encourage private-sector group health insurance market growth with a limited expenditure of public-sector funds" (OHPR, 2009, p.24). Second, the Oregon Medical Insurance Pool (OMIP) was Oregon's first attempt at pooling high-risk persons, or those with pre-existing medical conditions, in order to keep rates low. OMIP presents a way to provide coverage for people who are denied in the individual market, who are not able to receive employer-sponsored coverage, or who have run out of COBRA benefits (OHPR, 2009). The third component, the employer mandate, attempted to cover the additional Oregonians who would not be impacted by the other sections of OHP. Recognizing that the majority of them were from working families, OHP sought to "require all employers to offer full-time permanent workers and their dependents insurance via a 'play or pay option'" (OHPR, 2009, p.25).

Although it was ultimately unsuccessful due to legislative grounding, the efforts put forth through OHP demonstrate an interest within the state of Oregon to increase coverage for all citizens. In an attempt to aid struggling families, especially after the failure of the employer mandate, the Family Health Insurance Assistance Program began in 1997. The program provides subsidies to families to aid them in paying for private health insurance (OHPR, 2009).

It was expanded in 2002 to provide more coverage with a focus on employer-sponsored insurance.

More recently there have been notable changes to Oregon's health insurance and care. House Bill 2002, which took effect in January 2008, redefined Oregon's small-group market to align with federal regulations. Increasing small-group size to include businesses with 50 or fewer employees was intended to spread risk in a larger pool and to stabilize rates for small employers over the long-term (OHPR, 2009). In 2009, the Oregon Legislature established the Oregon Health Authority (OHA) and Oregon Health Policy Board. The agency seeks to maximize its purchasing power by "tackling issues with costs, quality, lack of preventive care and health care access" by streamlining and consolidating health care oversight in Oregon (OHA, 2010b).

The OHA and Oregon Health Policy Board are at the forefront of reforms in Oregon and are committed to establishing an HIX that meets the needs of Oregonians. In December 2010, the Oregon Health Policy Board submitted Senate Bill 99, a business plan for Oregon's HIX to the state Legislature based on two overarching goals: (a) develop and implement an exchange that meets the requirements laid out in federal law for an exchange, and (b) ensure that Oregon's exchange is a tool for Oregon's health reform goals, including system delivery reform, access to coverage and care, and improved quality for all Oregonians (OHA, 2011). The Board found that the HIX would increase access for over 350,000 Oregonians who are either currently uninsured or will gain coverage through the small-group market (OHA, 2011). Specifically, the proposed HIX would set up the Oregon Health Insurance Exchange Corporation, an independent public corporation with statewide purposes and a mission to carry out administrative and implementation functions for Oregon (Oregon Health Insurance Exchange, 2011).

### Oregon Health Insurance Exchange Corporation Duties:

- Provide uniform information to consumers of health care regarding costs, benefits, provider networks and other information to assist individuals and small businesses in making informed health care decisions.
- Screen, certify and recertify health plans as qualified health plans according to federal and state guidelines, and ensure that qualified health plans provide meaningful coverage choices.
- Decertify health plans in order to preclude participation in the transaction of insurance through the exchange by health plans that fail to meet federal and state standards.
- Promote fair competition of carriers participating and not participating in the transaction of insurance through the exchange by establishing:
  - Standardized health benefit plan options; and
  - An internet-based clearinghouse and a toll-free telephone hotline for information about carriers, including standardized comparisons of health plan coverage and costs.
- Make qualified health plans available to individuals and employers and assist individual and group enrollment in qualified health plans.
- Grade health plans in accordance with criteria established by the United States Secretary of Health and Human Services and distribute the information through the Internet-based clearinghouse and toll-free telephone hotline.
- Provide information to individuals and employers regarding the eligibility requirements for all publicly funded programs providing medical assistance, and assist individuals in applying for programs.

(Oregon Health Insurance Exchange, 2011)

SB 99 passed through the Oregon State Senate Subcommittee on Health Reform in April 2011. The bill and its amendments contain the final recommendations from the Oregon Health Policy Board and will lay the foundation for the creation of Oregon's HIX. Additionally, OHA was awarded one of only seven "Early Innovator" grants for over \$48 million by the Obama administration in February 2011. The grant aids in the development of information technology infrastructure for the HIX. The U.S. Department of Health and Human Services (2011) stated that, as an Early Innovator, Oregon has committed to "assuring that the technology they develop is reusable and transferable. Using the grants, they will develop the building blocks for Exchange IT systems, providing models for how Exchange IT systems can be created." These policies demonstrate the willingness and readiness of Oregon policymakers to proactively address the health care crisis.

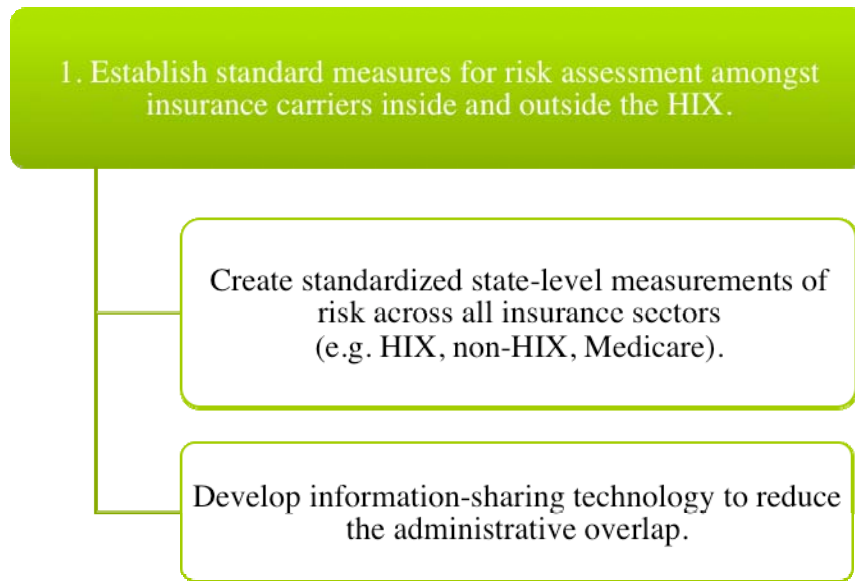
Having reviewed historical HPC's and current HIX's, various lessons from their implementation strategies and structural issues can be gleaned for future planning. With the addition of a clearly outlined Patient Protection and Affordable Care Act, some of those lessons have been mitigated. Finally, with a foundation on the current political and market readiness of Oregon, it is clear that Oregon is prepared to implement this significant change in health insurance provision. The next section will provide recommendations that consider each of these factors and ways that Oregon can successfully become a leader for the nation in health insurance exchange implementation.

## XI. Recommendations

Health insurance exchanges have evolved considerably over the last two decades, shifting from health purchasing cooperatives to a mandated, statewide participation model. It is expected that collaborative efforts and partnerships between the private, public and nonprofit sector will increase as efforts of the Oregon Health Authority continue. Due to the politically sensitive nature of health care reform in the United States, those partnerships are imperative to increase the awareness of and support for the HIX. With this growing support, Oregon can expect a more positive reception of health care reform.

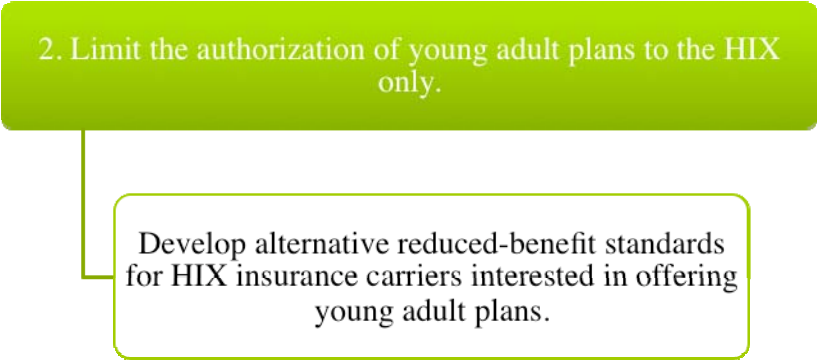
This research reviews the ways in which California, Connecticut, Florida, Massachusetts and Utah have approached health insurance pooling in their states. Additionally, it accounts for ways that PPACA plans to address some initial failures of HPCs. However, there are some remaining factors for Oregon to consider in the development of an HIX. With a lens for long-term carrier participation, the following recommendations provide important insights and some necessary initial steps for a successful HIX in Oregon.

The reinsurance policy, mandated by PPACA, will support long-term fiscal safety for carriers. This sets the stage for the first recommendation by addressing administrative needs under a new system. We learned from California’s Risk Assessment Value (RAV) program that the standardization of information gathering, particularly regarding risk assessment, significantly reduces administrative costs of risk adjustment. The first recommendation is that the HIX in Oregon establish standard measures for risk assessment to help reduce administrative overlaps and aid in risk adjustment processes. Introducing standardization of this level at the onset of program development can reduce future complication as the HIX and other programs grow to include more participants and companies. This step can be done through the development of state-level qualifiers that establish assessment methods and best practices. Through this recommendation, information is more readily available for risk adjustment procedures associated with reinsurance.



Insurance carriers have expressed a concern that the more stringent regulations within an HIX may reduce the competitive nature of the program against the outside insurance market. This recommendation may result in higher risk insurance pools within the HIX, as seen in California and Florida's HPCs. PPACA helps control for some competition by mandating that all insurance plans, inside and outside the HIX, consist of basic features. In conjunction, there is also a concern that young adults (aged 18-26) may choose to forego insurance and pay the penalty if there are no insurance plans that are sufficiently cost effective. Massachusetts offers a young adult option for just this reason and has found that this more affordable option increases the likelihood of young adult participation. PPACA addresses this concern through an allowance for certain young adult plans comprised of fewer health benefit regulations. These plans are similar to current 'catastrophic' plans. The purpose of this allowance would be offer a lower cost option that encourages young adults to obtain insurance rather than pay the penalty for maintaining an uninsured status.

The next recommendation is to limit the authorization of young adult plans to the HIX only. This is intended to increase competition and make the HIX risk pool healthier. Young adult plans are important to insurance carriers because they provide an opportunity to attract individuals who are believed to be in better health. By offering young adult plans through the HIX only, administrators increase the positive benefits for an insurance carrier and thus the likelihood of participation. Another positive outcome of this recommendation is that it works to keep this group of individuals together in one market. In keeping them together, the risk pool is strengthened through the increased concentration of healthy individuals.

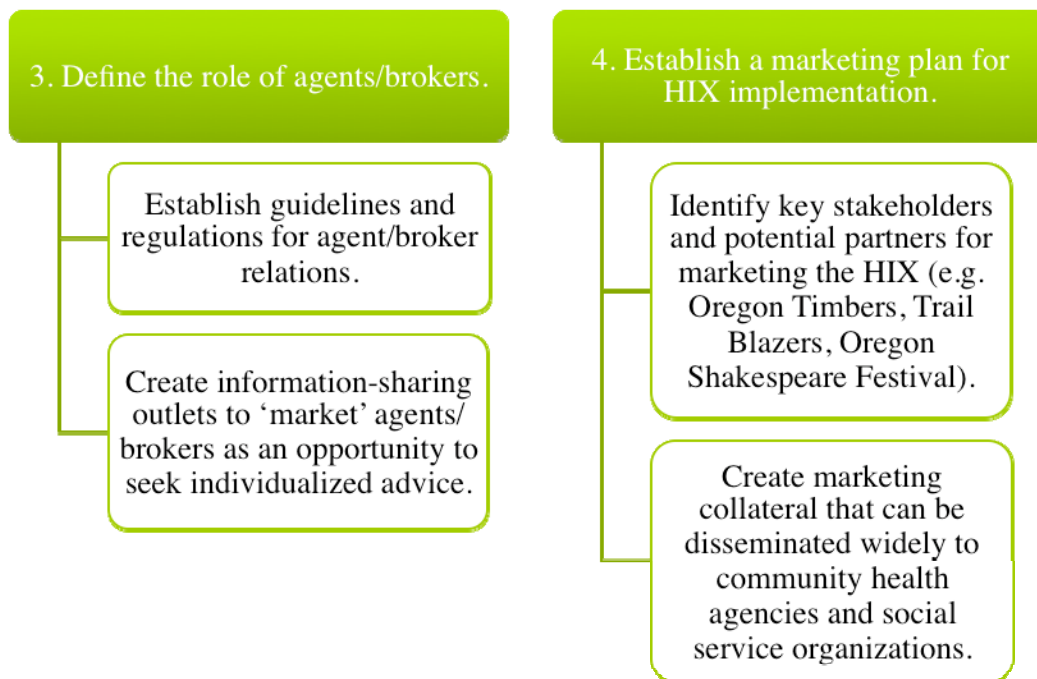


The final two recommendations regard marketing plans and agents/brokers. It is clear from the case studies that dissemination of information and the creation of buy-in among key players are very important for the success of an HIX in both the short and long-term. Massachusetts has seen success from strong, widespread marketing techniques, while Connecticut has gained its market shares by mandating the use of agents/brokers. Furthermore, Utah offers a search option on their website to find information about agents/brokers, a method that has resulted in strong business for the HIX and a waiting list for carriers to join.

The third recommendation is that HIX administrators in Oregon clearly define the role of agents/brokers within their HIX. They should establish a system where agents/brokers can naturally advertise the program by bringing business to participating carriers. It is also recommended that the HIX establish marketing strategies early in the planning and



implementation phases to increase the awareness of the program for Oregonians. Having a combination of marketing and agents/brokers will help reach a wider range of the population. On one hand, agents/brokers cater to individuals and businesses that prefer to talk to a person and ask for advice. On the other, marketing strategies appeal to those who would rather seek out the information on their own and make independent choices. This is especially pertinent for the initial steps of the HIX; however, it is recognized that the role of agents/brokers may change or even be reduced in the long run as technological information is improved.



Having established key recommendations for the state of Oregon, we recognize that there are additional topics beyond the scope of this project that have not been fully addressed. In the next section, we review opportunities for future research and suggest topics to consider in-depth before fully implementing Oregon’s HIX.

## XII. Future Research

This report has identified successful and unsuccessful practices from historical health purchasing cooperatives and current health insurance exchange programs. It has also made recommendations with considerations of PPACA mandates. However, we suggest five related future research opportunities that are beyond the scope of this report:

### Defined-Contribution Plans and Defined-Benefit Plans

Girvan (2010) describes defined-contribution as an insurance funding strategy where an employer pays a fixed, tax-free dollar amount towards health care coverage for each employee. In contrast, the more commonly used defined-benefit model means that the employer determines the benefits available to employees and the premiums they must pay (Girvan, 2010). Defined-contribution plans are the main feature in Utah’s recent HIX program. Studies show that this system may provide more affordability, accessibility and portability among employees, and



allows employers to more accurately predict their annual costs for health insurance coverage. Due to the relatively limited use of this model, we suggest continued research on defined-contribution plans to examine their long-term effects on exchanges, and compare that effectiveness with defined-benefit plans.

### **Health Care Service Provision**

Health care reform and the implementation of an HIX are expected to increase the number of people with health care coverage. By OHA's (2010) projections, 142,500 enrollees are estimated in 2014 alone. This number is expected to grow rapidly in the first three years. This newly insured population may overwhelm the existing health care system, pushing providers to capacity and lowering the quality of service. This may impact HIX market participation, especially for small or local/regional insurance carriers that depend on good reputations and networking with local providers. We suggest further research on the capacity of Oregon's health care providers for such an increase in enrollment.

### **Reinsurance Mechanism**

PPACA mandates a reinsurance system for carriers to help mitigate adverse selection in an HIX. We suggest future research on reinsurance mechanisms, with consideration for carriers' fiscal operations, and performing a cost-benefit analysis to determine strategic use of the platform.

### **Agents and Brokers**

We highlight the importance of including agents/brokers in the design and implementation of the HIX. However, PPACA mandates do not address this issue, and there is limited information on the most effective strategies. We recommend future research to understand agents'/brokers' behavior in a conventional insurance market, to guard against improper use, and to develop sufficient incentives to maintain participation. It is also suggested that a review of the long-term strategies for how the agents'/brokers' role may change with increased reliability of technology and internet-based information gathering be included in this study.

In addition, PPACA section 1311 requires state health insurance exchanges to establish a "navigator" program. The program will help people who are eligible to learn about their new coverage options and purchase coverage through the exchange (PPACA, 2010; Families USA, 2011). States will award grants to entities that provide these services. PPACA lists agents/brokers as among the many types of entities that could receive navigator grants. It will likely take a combination of marketing, agents/brokers and navigators, working together, to inform people of their new coverage options in 2014 and help them enroll (Families USA, 2011).

### **Insurance Portability**

In various interviews and research, it was recommended that insurance carriers be required to participate in both individual and small-group markets within the HIX. However, there is a lack of information regarding individual behavior in an insurance market. Further research is recommended to better understand consumer behavior and to identify whether individuals would choose to remain with the same insurance carrier after a change in employment status, if given the opportunity. A benefit of increased portability is that insurance carriers will have a stronger relationship with their customers. The purpose of this study would be to identify strategies that increase portability of insurance plans and safeguard against an individuals' changing insurance based on employment status.

### **XIII. Conclusion**

State-level health insurance exchanges have the potential to significantly increase the number of insured people. Increased insurance rates assume movement toward a higher status of health within the population. Through the implementation of an exchange program, people will have increased choice of insurance programs and increased benefits through federal-level mandates. This research has assembled pertinent information for decision-makers and potential participants of Oregon's HIX by reviewing the Patient Protection and Affordable Care Act of 2010 in conjunction with case studies from California, Connecticut, Florida, Massachusetts, and Utah. It highlights lessons learned from historical health purchasing cooperatives and early policy adopters of the health insurance exchange model. Research shows that the number of choices increased for small businesses and individuals as a result of the implementation of these programs. However, some factors within the HPCs specifically prevented insurance carriers from remaining competitive, prompting their departure from the program.

PPACA has created a set of mandates that control for some failures in the early HPC models. Nevertheless, recommendations are provided to further alleviate adverse program outcomes. In particular, regulations around carrier participation are important to consider as incentives for risk mitigation and portability. These recommendations include: establishing standardized measures for risk assessment amongst insurance carriers inside and outside the HIX; limiting the authorization of young adult plans to the HIX only; defining the role of agents/brokers; and establishing a marketing plan for HIX implementation. These recommendations are important because they consider factors beyond PPACA mandates related to insurance carrier participation and retention.

Oregon's decision-makers would be wise to consider all market players (e.g. insurance carriers, agents/brokers, & insurance purchasers) that will be affected by design and implementation of the HIX. In doing so, Oregon's HIX will effectively increase the likelihood of widespread support and positive outcomes for such an overhaul of health insurance provision.

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# Appendix

**Table 1 – Data Gathering Chart**

Indicator	CA	CT	FL	MA	UT
<b>Risk Adjustment</b>	<ul style="list-style-type: none"> <li>High-risk enrollees were identified with costly “marker diagnoses”. Plans were compared with quantitative “risk assessment values” (RAC), and generate transfers if plan had an RAV that was 5 percent above or below average.</li> <li>The “marker diagnoses” indicator has been replaced with Medicare diagnostic cost groups (DCGs) by PBGH.</li> </ul>	<ul style="list-style-type: none"> <li>CT law requires insurers to use modified community rating for small-groups. State Reinsurance Pool (Reinsurance is insurance for insurers.)</li> </ul>	<ul style="list-style-type: none"> <li>Small-group insurers are required to offer basic/standard health plans to all small businesses regardless of employees' health status, preexisting conditions or claims history.</li> </ul>	<ul style="list-style-type: none"> <li>Aggregate risk sharing program: the Connector absorbs some risk by having an agreement with carriers that they share in both excessive costs and savings for any given group of insured.</li> </ul>	<ul style="list-style-type: none"> <li>Exchange collects limited histories of employees &amp; creates separate risk premiums for each employer; determines individuals' premiums.</li> </ul>
<b>Affordability</b>	<ul style="list-style-type: none"> <li>No premium subsidies for purchaser; reducing or eliminating broker fees was one of the strategies to lower the cost for small employers.</li> <li>HIPC prohibits carriers from under-pricing their HIPC products outside the market. Premiums were initially required to fall between 90 and 110 percent of a standard age-rated premium (1996).</li> </ul>	<ul style="list-style-type: none"> <li>Modified Community Rating. Employers that participate must select either of two “suites” of plan design options to make available to their employees. There are 30 plans all together. Each employer must establish a minimum premium contribution level, equal to at least 50 percent of the premium for the lowest cost plan in the suite. “Standard” benefits from the plans are chosen by the employer, but employee can choose more or less benefits from the plans, depending on their need.</li> </ul>	<ul style="list-style-type: none"> <li>Modified Community Rating method: risks spread across a large population to allow for adjustments for specified characteristics. Premiums are established solely on: county of residence, age, gender, family composition and tobacco usage. Little premium savings in CHPAs because insurers are usually unable to gain sufficient market share. 1993 law enacted managed competition model: pooling purchases together to broker best health care available for lowest price, enabling consumers to make informed, cost-conscious selections. Managed competition model hinders competition; most small businesses within CHPA have few employees which pose greater risks.</li> </ul>	<ul style="list-style-type: none"> <li>Offer mandate-light plans for young adults. Section 125 mandated for employers with 11 or more employees to provide pre-tax salary reductions for health care costs.</li> </ul>	<ul style="list-style-type: none"> <li>Defined contribution plans - increases portability; employees have 66 plans to choose from; employer determines their contribution.</li> </ul>
<b>Accessibility</b>	<ul style="list-style-type: none"> <li>A.B. 1672 prohibits insurance carriers from denying small-groups, from canceling, and from</li> </ul>	<ul style="list-style-type: none"> <li>Health Connections is an online portal where information about its products and services are</li> </ul>	<ul style="list-style-type: none"> <li>Agency for Health Care Administration developed statewide system of CHPAs and data system to provide members with provider prices,</li> </ul>	<ul style="list-style-type: none"> <li>Connector uses heavily web-based sign up, driving many people to contact insurance carriers directly</li> </ul>	<ul style="list-style-type: none"> <li>Administration happens entirely within Exchange; individuals can</li> </ul>

	<p>excluding preexisting medical conditions.</p> <ul style="list-style-type: none"> <li>• 11-15 HMOs and 1-2 POS plans were offered in 1998-1999.</li> </ul>	<p>disseminated on its website for employers, employees, and brokers; and transactions are primarily made online. Fully administered by CBIA. 3 insurance providers currently participate.</p>	<p>utilization, patient outcomes, quality and patient satisfaction comparisons. Comparison sheets became tools to create informed consumers. Rating regions are comprised of a large number of geographic areas.</p>	<p>and get help with set up. No limit to the number of plans offered though they must all be approved.</p>	<p>compare/enroll/pay online</p> <ul style="list-style-type: none"> <li>• 4 of 9 insurance providers are involved</li> <li>• ONLY place employers can do defined contribution plans</li> </ul>
<b>Implementation and Administration</b>	<ul style="list-style-type: none"> <li>• Employers receive a single monthly bill regardless of how many plans their workers select.</li> <li>• Initially, firms enrolled directly were able to avoid broker fees. HIPC began charging fees equivalent to broker fees in later years.</li> <li>• Amended risk assessment with DCGS indicator to reduce carrier's data collection efforts.</li> </ul>	<ul style="list-style-type: none"> <li>• CBIA main source of revenue to administer Health Connections comes from membership dues that are based on a sliding scale. CBIA implementation and administration of Health Connections is not subsidized by the gov't. Reduces the administrative burden for small employers by offering full-service human resources services</li> </ul>	<ul style="list-style-type: none"> <li>• All CHPAs contract with one company to provide administrative services (billing and payment distribution). Cost per covered individual: 1994-\$100.70 to 1998-\$126.35 (data reporting makes accurate comparison difficult). Insurance plan costs increased all but the first year due to heavy administrative burdens (not seen in outside market). Initial state funding was over \$8m and state funding was withdrawn in June 1997. Employers let employees chose from a minimum of 2 plans, employers contributed at least 50% of premium of the least expensive plan.</li> </ul>	<ul style="list-style-type: none"> <li>• Due to streamlined effort, both Care and Choice programs go through connector decreasing (de-duplicating) administrative efforts. The Connector received \$25 million for start-up but is expected to be self-sustaining through administrative fee on all health plans and receipt of percentage of capitation payments.</li> </ul>	<ul style="list-style-type: none"> <li>• Health System Reform Task Force creating Task Exchange (includes Legislators)</li> <li>• No board of directors; 2 employees from Gov's Office of Economic Development, ask business leaders for advice</li> <li>• All done online; seemingly no duplication of efforts</li> </ul>
<b>Agents and Brokers</b>	<ul style="list-style-type: none"> <li>• Initially, broker's role was neither eliminated nor mandated, and the fee rate paid through HIPC was lower than commissions outside the HIPC.</li> <li>• Enrollment structure was altered in 1998 to increase broker compensation and involvement.</li> </ul>	<ul style="list-style-type: none"> <li>• Since its inception to 2011, Health Connections' policies have always been sold and distributed through independent insurance agents/brokers.</li> </ul>	<ul style="list-style-type: none"> <li>• Yes. Number of agents and commissions are not set by CHPAs, so they often receive less for selling CHPA-sponsored products. Those agents who do not want to sell CHPA-sponsored insurance severely limit number of and size of businesses in CHPA.</li> </ul>	<ul style="list-style-type: none"> <li>• Little success in getting brokers and agents on board has created some difficulties— particularly in the small-group market.</li> </ul>	<ul style="list-style-type: none"> <li>• Strong relationship established.</li> <li>• Offer Agent Search on website.</li> </ul>
<b>Marketing</b>	<ul style="list-style-type: none"> <li>• HIPC had brochure clearly laid out the premiums which is part of its strategy to eliminate needs for information from brokers.</li> <li>• Utilized direct mailing, telemarketing, and radio advertising.</li> </ul>	<ul style="list-style-type: none"> <li>• To ensure that Health Connections keeps growing, the exchange works through agents/brokers to recruit new employer groups.</li> </ul>	<ul style="list-style-type: none"> <li>• Law mandated all sales to go through agents; CHPA couldn't market directly to small employers. Each CHPA had its own marketing budget and strategy, producing duplication of effort, inconsistent strategies, and majority of funding was not allocated where majority of people were.</li> </ul>	<ul style="list-style-type: none"> <li>• Developed a Public Information Unit (PUI) to field questions that people had about the Connector and the process. Partnered with state agencies, community organizations, corporate and civic organizations for public education and outreach campaigns.</li> </ul>	<ul style="list-style-type: none"> <li>• Marketing budget for outreach &amp; education = \$10,000.</li> <li>• Heavy reliance on unpaid marketing from businesses.</li> </ul>

**Table 2 – California**

Indicator	Health Insurance Plan of California
<p><b>Risk Adjustment</b></p>	<ul style="list-style-type: none"> <li>• In 1996, a process for assessing the distribution of risk among plans was launched. There were risk-adjustment payments to plans if biased selection was detected (Shewry et al., 1996).               <ul style="list-style-type: none"> <li>○ Enrollees who were hospitalized in the prior year with “marker diagnoses” (costly conditions that charges annually \$15,000 or more) were identified as high-risk enrollees. This measurement relies exclusively on inpatient data.</li> <li>○ Plans were compared in terms of quantitative “risk assessment values” (RAV), and funds were reallocated among plans if any plan had an RAV that was 5 percent above or below the average for the entire pool.</li> <li>○ Transfers were determined to by an interactive process that continued until all plans had RAVs falling within the 0.95 to 1.05 range.</li> <li>○ Only 1 percent of total premium dollars in 1995 needs to be transferred by this calculation, ranging from \$0.69 to \$11.80 per member per month.</li> </ul> </li> <li>• The majority of participating plans neither made nor received transfer payments. Even the largest payment of \$46.04 per member per month to one outlier PPO did not keep the plan from leaving HIPC (Yegian et al., 2000).</li> <li>• The risk adjustment process is still in place, but the “marker diagnoses” indicator has been replaced by Medicare diagnostic cost groups (DCGs) which has less additional efforts on data collection (Yegian et al., 2000).</li> </ul>
<p><b>Affordability</b></p>	<ul style="list-style-type: none"> <li>• The HIPC had the power to negotiate premium rates with potential health plans. No premium subsidies for purchaser (Wicks et al., 2000).</li> <li>• Requires that employers contribute at least 50% of the least costly plan available to their employees and that at least 70% of employees participate (Wicks et al., 2000).</li> <li>• Employers receive a single monthly bill regardless of how many different plans their workers select (Yegian et al., 2000).</li> <li>• Premium level:               <ul style="list-style-type: none"> <li>○ HIPC contract prohibits participating plans from under-pricing their HIPC products in the outside market. Premiums were initially required to fall between 80 and 120 percent of a standard age-rated premium for a given benefit design, and was tightened to plus or minus 10 percent in 1996 (Buchmueller, 1997). State report indicates that the initial premiums were 10-15 percent lower than those outside the HIPC in 1994 (Dowell, 1994).</li> </ul> </li> <li>• A report of five HMOs offered by HIPC in 1997, four of them had overall benefit-adjusted premiums higher than premiums outside the HIPC by 7-8 percent (Shore &amp; Bertko, 1999).</li> </ul>
<p><b>Accessibility</b></p>	<ul style="list-style-type: none"> <li>• California Assembly Bill (A.B.) 1672 prohibits insurance carriers from denying health insurance coverage to firms with three to fifty full-time employees, from canceling such coverage, and from excluding preexisting medical conditions for more than six months (Buchmueller, 1997).</li> <li>• The state was divided into six regions for the purpose of setting premiums. Carriers were required to offer coverage insurance plans in their entire licensed service area (Buchmueller, 1997).</li> <li>• Range if choice:               <ul style="list-style-type: none"> <li>○ In 1998-1999 the HIPC offered between eleven and fifteen health maintenance organizations (HMOs) and one or two point of service (POS) plans depending on region. Six of the nineteen plans that participated in HIPC accounted for 80 percent of enrollment in 1998-1999 (Yegian et al., 2000).</li> <li>○ Employees tend to favor preferred provider organizations (PPOs), but due to the higher cost (caused by adverse selection) than competing HMOs, PPO carriers dropped out (Yegian et al., 2000).</li> </ul> </li> <li>• There were fifteen HMOs left in the program after PBGH took over, no PPO available. But four carriers offer POS options. Additional vision, chiropractic, and dental coverage can be purchased separately through Pac Advantage (Yegian et al., 2000).</li> <li>• Only three major state-wide carriers left in the program before Pac Advantage ended in 2006 (Colliver, 2006).</li> <li>• The growth of HIPC enrollment never outstripped the growth in the number of small firms in California, and that the HIPC’s share of the small-group market remained below 5 percent (Yegian et al., 2000).</li> <li>• There is little evidence that the HIPC had broader effects on the small-group market. Although there were small changes in characteristics of the market in California, the purchasing alliance did not increase the availability of insurance to workers in small businesses. Similarly, HIPC also did not lead to increased price competition in California (Long &amp; Marquis, 2001).</li> </ul>
<p><b>Implementation and Administration</b></p>	<ul style="list-style-type: none"> <li>• HIPC was initially financed by a government loan of \$5.5 million (Wicks et al., 2000).</li> <li>• The state law stipulated that the HIPC be privatized by 1996, but the transition occurred in 1999 when PBGH took over control (Wicks et al., 2000).</li> <li>• Initial design to reduce administrative costs (Wicks et al., 2000):               <ul style="list-style-type: none"> <li>○ Paying agents lower commissions than was customary in the small-group market;</li> <li>○ Offering employers the option of avoiding commission fees through direct purchase from the HIPC.</li> <li>○ Realizing economies of scale through centralization of enrollment, collection of premiums, and marketing functions.</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>• In later years, HIPC began charging fees equivalent to broker commissions. “While this policy change may have been partly influenced by a desire to mend relations with the broker community, it also reflects recognition that firms that enrolled directly generated real administrative costs (Yegian et al., 2000, p.161).”</li> <li>• Amended risk assessment using DCGS as indicator helped reducing duplicating data gathering efforts (Yegian et al., 2000).</li> </ul>
<b>Agents and Brokers</b>	<ul style="list-style-type: none"> <li>• Brokers were initially concerned as a middle ground, neither eliminating their role nor mandating their involvement. With no state funding, reducing or eliminating broker fees was one of the ways that HIPC could lower the cost for small employers (Yegian et al., 2000). <ul style="list-style-type: none"> <li>◦ Employers were allowed to enroll directly and bypass brokers and fees.</li> <li>◦ Brokers’ fees were itemized on employer’s bill rather than being rolled into the premium.</li> <li>◦ Broker’ fees paid by HIPC were lower than commissions outside the HIPC.</li> </ul> </li> <li>• These policies created animosity in the broker community, while small firms rely heavily on brokers for information on their options (Yegian et al., 2000). <ul style="list-style-type: none"> <li>◦ 70 percent of firms enrolled in first three years came through brokers and voluntarily paid the commission.</li> <li>◦ Groups enrolling directly required more time and staff resources.</li> </ul> </li> <li>• Enrollment structure was altered in 1998 (Yegian et al., 2000): <ul style="list-style-type: none"> <li>◦ Increase broker compensation and new incentive program to reward agents.</li> <li>◦ Eliminate bypassing fees with direct enrollment.</li> </ul> </li> <li>• Include 8 percent broker fee into premium.</li> </ul>
<b>Marketing</b>	<ul style="list-style-type: none"> <li>• The administrator participated in a couple marketing tasks such as doing a direct mailing to eligible businesses twice a year, and also followed up with telemarketing (Wicks et al., 2000).</li> <li>• The HIPC also used radio advertising effectively. But HIPC staff believed that it would take three time amount of purposed budget to accomplish an effective marketing (Wicks et al., 2000).</li> <li>• HIPC had brochure clearly laid out the premiums charged by each participating carrier by region, age and family category, making it easy for employers to make apple-to-apple comparisons (Yegian et al., 2000).</li> </ul>

**Table 3 – Connecticut**

<b>Indicator</b>	<b>Connecticut Health Connections Alliance</b>
<b>Risk Adjustment</b>	<ul style="list-style-type: none"> <li>• Health Connections uses the same rating rules (age, gender, geographic area, family tiers) as those in the small-group market required by CT law (Kaminiski, 2005).</li> <li>• CT law requires insurers to use modified community rating (Kaminiski, 2005).</li> <li>• Modified community rating develops a community rate then adjusts it for specific case characteristics. “Case characteristics” means demographic or other objective characteristics of a small employer group’s employees, including age, gender, family composition, location, size of group, administrative cost savings resulting from the administration of an association group plan or a plan written through the municipal employee health insurance plans (“MEHIP”), and industry classification (Kaminiski, 2005).</li> <li>• CT also operates a non-subsidized reinsurance pool for the small-group market. Reinsurance is insurance for insurance carriers. Any insurer may purchase reinsurance from the pool, with a \$5,000 deductible per covered life, for individuals, dependents, or small-groups (State Coverage Initiatives, 2010).</li> </ul>
<b>Affordability</b>	<ul style="list-style-type: none"> <li>• Modified Community Rating (Kaminiski, 2005).</li> <li>• Employers that participate must select either of two “suites” of plan design options to make available to their employees (Chollet et al., 2008).</li> <li>• Each employer must establish a minimum premium contribution level, equal to at least 50 percent of the premium for the lowest cost plan in the suite. Typically, employers identify a “benchmark” plan of benefits within the suite; that benchmark plan becomes the basis for their premium contribution and monthly premium budget. Employees may choose to enroll in the “benchmark” plan or opt to “buy up” or “buy down” to an alternative level of benefits within the suite offered. This concept allows employers to establish their premium budget while providing employees the opportunity to choose a plan that best meets their needs (Chollet et al., 2008).</li> </ul>
<b>Accessibility</b>	<ul style="list-style-type: none"> <li>• Health Connections is administered by the Connecticut Business and Industry Association, a private not-for-profit organization and is only available to small business employers, their employees, and dependents (Chollet et al., 2008).</li> <li>• Enrollees need not switch coverage when they change jobs if the new employer also participates in Health Connections (Chollet et al., 2008).</li> <li>• In 2007 there were more than 6,000 businesses with 88,000 covered lives within Health Connections and yet Health Connections only has a small-employer market penetration of a little more than 10% (Altarum Institute, 2011).</li> <li>• Currently Health Connections is an online portal where information about its products and services are disseminated on its website for employers, employees, and brokers; and transactions are primarily made online (Connecticut Business and Industry Association, 2011).</li> </ul>

	<ul style="list-style-type: none"> <li>At the beginning of 2011 there were three insurance carriers – ConnectiCare, CIGNA Corps., and Oxford Health Plans, yet CIGNA Corps is exiting the Alliance in November, 2011 (Sturdevant, 2010).</li> </ul>
<b>Implementation and Administration</b>	<ul style="list-style-type: none"> <li>The CBIA is a private trade non-profit organization that provides services to businesses that are members of the organization, thus its main source of revenue comes from membership dues that are on a sliding scale (State Health Access Data Assistance Center, 2010), (Connecticut Business and Industry Association, 2011).</li> <li>CBIA is the sole administrator of Health Connections and is not subsidized by the government for the implementation and administration of Health Connections (State Health Access Data Assistance Center, 2010) .</li> <li>Reduces the administrative burden for small employers by offering them full-service human resources services, which has been particularly successful in the less than 25 employee small-group market (State Health Access Data Assistance Center, 2010).</li> </ul>
<b>Agents and Brokers</b>	<ul style="list-style-type: none"> <li>Since its inception to 2011, Health Connections’ policies have been sold and distributed through independent insurance agents/brokers. Health Connection executives report that developing and maintaining a role for agents/brokers was essential in order to gain market share since the beginning (Chollet et al., 2008).</li> </ul>
<b>Marketing</b>	<ul style="list-style-type: none"> <li>To ensure that Health Connections keeps growing, the exchange works through agents/brokers to recruit new employer groups (Schilling, 2010).</li> <li>Information about Health Connections is distributed both online and in print solely both by CBIA and partnering agents/brokers (Connecticut Business and Industry Association, 2011).</li> </ul>

**Table 4 – Florida**

<b>Indicator</b>	<b>Florida Community Health Purchasing Alliances (CHPAs)</b>
<b>Risk Adjustment</b>	<ul style="list-style-type: none"> <li>Small-group insurers are required to offer basic/standard health plans to all small businesses regardless of employees' health status, preexisting conditions or claims history (OPPAGA, 1996).</li> </ul>
<b>Affordability</b>	<ul style="list-style-type: none"> <li>Modified Community Rating method: risks spread across a large population to allow for adjustments for specified characteristics. Premiums are established solely on: county of residence, age, gender, family composition and tobacco usage. Little premium savings in CHPAs because insurers are usually unable to gain sufficient market share. 1993 law enacted managed competition model: pooling purchases together to broker best health care available for lowest price, enabling consumers to make informed, cost-conscious selections. Managed competition model hinders competition; most small businesses within CHPA have few employees which pose greater risks (OPPAGA, 1996).</li> </ul>
<b>Accessibility</b>	<ul style="list-style-type: none"> <li>Agency for Health Care Administration developed statewide system of CHPAs and data system to provide members with provider prices, utilization, patient outcomes, quality and patient satisfaction comparisons. Comparison sheets became tools to create informed consumers (Feldheim, 2000).</li> <li>Rating regions are comprised of a large number of geographic areas (OPPAGA, 1996).</li> </ul>
<b>Implementation and Administration</b>	<ul style="list-style-type: none"> <li>All CHPAs contract with one company to provide administrative services (billing and payment distribution) (Feldheim, 2000).</li> <li>Cost per covered individual: 1994-\$100.70 to 1998-\$126.35 (data reporting makes accurate comparison difficult) (Feldheim, 2000).</li> <li>Insurance plan costs increased all but the first year due to heavy administrative burdens (not seen in outside market) (Feldheim, 2000).</li> <li>Initial state funding was over \$8m (Wicks et al., 2000) and state funding was withdrawn in June 1997 (Feldheim, 2000).</li> <li>Employers let employees chose from a minimum of 2 plans, employers contributed at least 50% of premium of the least expensive plan (Wicks et al., 2000).</li> </ul>
<b>Agents and Brokers</b>	<ul style="list-style-type: none"> <li>Yes. Number of agents and commissions are not set by CHPAs, so they often receive less for selling CHPA-sponsored products. Those agents who do not want to sell CHPA-sponsored insurance severely limit number of and size of businesses in CHPA (OPPAGA, 1996).</li> </ul>
<b>Marketing</b>	<ul style="list-style-type: none"> <li>Law mandated all sales to go through agents; CHPA couldn't market directly to small employers (Wicks et al., 2000).</li> <li>Each CHPA had its own marketing budget and strategy, producing duplication of effort, inconsistent strategies, and majority of funding was not allocated where majority of people were (Wicks et al., 2000).</li> </ul>

**Table 5 - Massachusetts**

<b>Indicator</b>	<b>Massachusetts Connector</b>
<b>Risk Adjustment</b>	<ul style="list-style-type: none"> <li>Because the exchange handles administration and coverage changes between employees vs. individuals, carriers can reduce premiums because they don't have to account for individuals leaving plans early which is a cost built into most premiums (Haislmaier &amp; Owcharenko, 2006).</li> <li>The more options there are for rate variation, the more risky the insurance pools are. If there are tighter programs on community rating, there is less need for risk adjustment (though, this might also entice healthy people to forego insurance entirely) so The Connector tries to limit the number of plans to reduce risk for carriers (Haislmaier &amp; Owcharenko, 2006).</li> </ul>

	<ul style="list-style-type: none"> <li>Aggregate risk sharing program: If rates were higher or lower than expected, the Connector would share in both the payments and the savings – purpose is to decrease risk to insurance providers and the state and encourage participation (Lischko et al., 2009, p. 5-6). [This means that there is a built-in expectation that if you pay in more than expected then you will be compensated and if you save more than expected then you will be required to give some back to the Connector of carriers that did pay in more than anticipated]</li> </ul>
<b>Affordability</b>	<ul style="list-style-type: none"> <li>Affordability is defined by board of the Connector –however, unclear definition in legislation (Holahan &amp; Blumberg, 2006).</li> <li>Legislation allows product provisions for young adults, offering mandate-light plans (Haislmaier &amp; Owcharenko, 2006).</li> <li>Connector includes a provision requiring that participating employers provide Section 125 Cafeteria Plan, which offers voluntary salary reductions on a pretax basis. This includes premiums that workers would otherwise pay out of pocket – making it so that all payments are made using pre-tax money (Haislmaier &amp; Owcharenko, 2006).</li> <li>[Individual plans] Initial Commonwealth Care program had 4 different plans determined solely by income level: (1) less than 100% FPL – premium \$0, (2A) 100.1%-150% of FPL – premium \$0, (2B) 150.1% - 200% - premium \$39, (3/4) 200.1%-300% FPL – premium \$77 - \$116. Note, plan 3 &amp; 4 gave a choice, #3 had lower premiums and higher copays, #4 had higher premiums and lower copays. (Chart of plan and costs, p. 3) (Lischko et al., 2009).</li> <li>Connector creates a plan each year to determine levels of affordability then brings is to statewide hearings for approval (Lischko et al., 2009).</li> <li>Subsidized population makes up its own risk pool (Lischko, 2009, p.4).</li> <li>The Connector offers employers plans from at least nine different insurance carriers. (Health Connector, 2011)</li> </ul>
<b>Accessibility</b>	<ul style="list-style-type: none"> <li>Must include any plan wanting to participate – no limit to the number of plans available – though, they just have to be approved by the state’s insurance regulator (Haislmaier &amp; Owcharenko, 2006).</li> <li>“...two-income couples [may] combine contributions from their respective employers to buy the plan they want, instead of being forced to choose one employer’s plan while forgoing the subsidy offered by the other employer. Similarly, a worker with two part-time jobs could combine contributions from each employer to purchase coverage” (Haislmaier &amp; Owcharenko, 2006, p. 1589). &lt; this encourages employers to consider partially subsidizing health benefits</li> <li>Connector uses heavily web-based sign up, driving many people to contact insurance carriers directly and get help with set up (Lischko, 2009).</li> </ul>
<b>Implementation and Administration</b>	<ul style="list-style-type: none"> <li>Connector is “an independent, quasi-governmental entity that is self-governing and a separate legal entity from state government” (Lischko, 2009 p.3).</li> <li>The Connector administers both insurance programs in the state: Commonwealth Care &amp; Commonwealth Choice</li> <li>Developed website: <a href="http://www.MAhealthconnector.org">www.MAhealthconnector.org</a> to assist with necessary information about the Connector (Lischko et al., 2009).</li> <li>The Connector received \$25 million for start-up but is expected to be self-sustaining through administrative fee on all health plans and receipt of percentage of capitation payments (Lischko et al., 2009). <ul style="list-style-type: none"> <li>See table 4 (Lischko et al., p. 10) for administrative costs – fee is a percentage of all health benefit plans and decreases each year.</li> </ul> </li> <li>Due to streamlined effort, both Care and Choice programs go through connector decreasing (de-duplicating) administrative efforts (Lischko et al., 2009).</li> </ul>
<b>Agents and Brokers</b>	<ul style="list-style-type: none"> <li>Little success in getting brokers and agents on board has created some difficulties– particularly in the small-group market (Lischko, 2009): <ul style="list-style-type: none"> <li>Reasons being that a broker makes more money if they don’t have to share fees with the Connector and can take an employer directly to an insurance carrier. Also, they get more commission from higher volumes with a single insurance carrier – and the Connector ranges from different carrier options</li> </ul> </li> </ul>
<b>Marketing</b>	<ul style="list-style-type: none"> <li>Developed a Public Information Unit (PUI) to field questions that people had about the Connector and the process – respond via email, letter, direct calls about individual issues and employer questions (Lischko et al., 2009).</li> <li>Partnered with state agencies, community organizations, corporate and civic organizations for public education and outreach campaigns (Lischko et al., 2009).</li> <li>Efforts Included (Lischko et al., 2009): <ul style="list-style-type: none"> <li>Outreach and marketing were supported by commercial carriers</li> <li>Held statewide “Connect-to-Health” forums (30 events in 20 communities)</li> <li>Direct mail effort to nearly 3 million MA taxpayers providing info about the new law and how they could purchase insurance through the Connector</li> <li>Collaborated with the Massachusetts Bay Transportation Authority (MBTA) to display information and offer contact cards with information in all MBTA cars</li> <li>Partnered with CVS stores and Boston Red Sox to share information about health reform with all MA residents</li> </ul> </li> </ul>

**Table 6 – Utah**

<b>Indicator</b>	<b>Utah Health Exchange</b>
<b>Risk Adjustment</b>	<ul style="list-style-type: none"> <li>Had regular hearings with industry &amp; business leaders all along, &amp; assured them the primary uninsured targets of the exchange are young, healthy people (Girvan, 2010).</li> <li>Premium aggregator - combine contributions from many employers to reduce adverse selection, stabilize premium prices in &amp; out of exchange; enhanced competition will put downward pressure on cost of premiums (Girvan, 2010).</li> <li>Limited defined contribution launch in 2009 found irregular premium rates, suggested possible adverse selection problems (Girvan, 2010).</li> </ul>

	<ul style="list-style-type: none"> <li>• Risk assessment of pool before &amp; after individual enters, then compensates the insurer accordingly (Girvan, 2010).</li> <li>• The Exchange collects limited health histories from all employees from a business, then creates a risk premium for the employer and applies it in determining the individual's final premium. Then the employee can choose from 66 plans offered through the portal (Lischko, 2009).</li> </ul>
<b>Affordability</b>	<ul style="list-style-type: none"> <li>• They're pushing defined contribution plans, so the employer just pays X amount and the employee chooses the best plan for them (State of Utah, 2011).</li> <li>• Defined contribution plans will increase plan portability, will improve quality of medical care by strengthening the patient/doctor relationship, and will increase the number of insured with premium assistance from employers (Girvan, 2010).</li> <li>• Employee has 66 options of plans to choose from, after all the administration. Employer decides how much money to give employees for insurance (Lischko, 2009).</li> </ul>
<b>Accessibility</b>	<ul style="list-style-type: none"> <li>• Must complete online Employer Health Insurance Application (State of Utah, 2011).</li> <li>• Currently, carriers in the defined contribution plan include Humana, Regence Blue Cross Blue Shield, and Select Health, United Health Care. They anticipate more carriers (State of Utah, 2011).</li> <li>• Initial universal insurance form was too complicated for many people; also when employers tried to switch from having plans to just defined-contributions, they were started as new customers, which raised their rates (Girvan, 2010).</li> <li>• Both spouses can get defined contribution from employers instead of having to choose one plan (Girvan, 2010).</li> <li>• Three of the largest insurers in the state (9 total) are participating in the defined contribution market through the exchange; others wanted to but couldn't due to internal technology challenges (Lischko, 2009).</li> <li>• The website is great at expanding and adding new services as they come (Lischko, 2009).</li> <li>• Utah's Exchange is the only outlet for employers to do defined contribution plans; individual s can use the site to compare plans, but the system was made for small businesses &amp; covers comparison, enrollment, premium determination, billing &amp; collection (Lischko, 2009).</li> </ul>
<b>Implementation and Administration</b>	<ul style="list-style-type: none"> <li>• Applications completed online, through exchange, then enrollment after that; lots of various deadlines &amp; due dates (State of Utah, 2011).</li> <li>• Using defined contribution b/c it greatly simplifies the planning &amp; mgmt of a company's health benefit options; the Exchange handles everything, employers just decide how much \$ to give (State of Utah, 2011).</li> <li>• Legislators were willing to be educated; created Health System Reform Task Force in 2008, includes legislators, focuses on most relevant demographics; must be reauthorized every year (incentive to do a good job) (Girvan, 2010).</li> <li>• Defined contribution plans reduce administrative burden &amp; make annual cost of providing insurance more predictable (Lischko, 2009).</li> <li>• Two employees within the Governor's Office of Economic Development; mission to promote the growth of Utah's business community; first 2 years small businesses only, then all (Lischko, 2009).</li> <li>• Much of operational work of exchange done by private entities with 1-year contracts; wants to build on existing technology &amp; use existing entities in health care system (Lischko, 2009).</li> <li>• No board of directors; convenes business leaders, mostly through Salt Lake Chamber of Commerce, for advice (Lischko, 2009).</li> </ul>
<b>Agents and Brokers</b>	<ul style="list-style-type: none"> <li>• They are encouraging participants to work with an insurance agent/producer with Defined Contribution experience; they offer an Agent Search on their website (State of Utah, 2011).</li> <li>• Exchange relies on brokers &amp; businesses to promote it; 100 test slots were quickly filled with 150+ org. waiting list (Lischko, 2009).</li> <li>• Exchange staff developed strong relationships with brokers in designing &amp; implementing their reform plan; this has contributed to enthusiastic reception the Exchange has received (Lischko, 2009).</li> </ul>
<b>Marketing</b>	<ul style="list-style-type: none"> <li>• Relied on unpaid marketing and policy guidance from private sector; established cooperative relationship with business community (Lischko, 2009).</li> <li>• Marketing budget for outreach &amp; education is \$10,000 (Lischko, 2009).</li> </ul>