



HEALTH INSURANCE PARTNERSHIP

Program Development Report

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*Washington State Health Care Authority
Health Insurance Partnership Program Team*

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Executive Summary

Washington State's 2007 Legislature established and provided funding for the Health Care Authority (HCA) to implement and operate the Health Insurance Partnership (HIP). The intent of the legislation was to reduce the state's uninsured population through the creation of a public/private partnership that would increase access to health insurance coverage for small employers and their employees.

The HIP combined public and private resources to help small employers and their employees purchase health insurance coverage through the commercial market. It also provided eligible participants a subsidy to help pay their portion of their monthly health insurance premium.

In November 2008, declining revenue forecasts had created a \$500 million shortfall for the remainder of fiscal year 2009, and a projected shortfall of \$5.7 billion for the 2009 – 2011 Biennium. Therefore, the HCA and the Governor's office determined that continued subsidy funding for 2009 – 2011 was unlikely and HCA terminated implementation of the HIP. This report provides the legislative history and overview of the program development phases of the HIP including planning, analysis, design, and implementation. Lessons learned are also provided.

The planning phase included:

- The formation of the project team.
- Identifying operational challenges to implementation.
- Building stakeholder relations.
- Consultation with legal, actuarial and health care market experts.
- Determining whether to administer the program in-house or through a third party administrator (TPA).
- Making recommendations for amendments to the enabling legislation.

The analysis phase included establishing the board-defined policies, defining the HIP program policies, releasing a request for proposal (RFP) for a third party administrator (TPA), selecting a TPA, and beginning the draft rules.

The Design and Implementation phases included:

- Creating procedures.
- Determining program requirements.
- Developing program-specific timelines for billing.
- Premium payment.
- Transfer to participating health insurance carriers.
- System build.
- Developing marketing materials.
- Graphic identity.
- Finalizing the program rules.

Background of the Health Insurance Partnership Legislation

Washington's small employers are increasingly less able to offer health insurance benefits to their employees, primarily because of its cost. In their report titled [2007 Employer Health Insurance Data Book](#), the Office of Financial Management reported that approximately 90,000 low-wage full-time employees of small employers are uninsured.

In response to this issue, in the 2007 Washington Legislative session, a health care reform bill was introduced that would have significantly restructured the state's insurance market.¹ Similar to Massachusetts' 2006 health care reform legislation, Washington's proposed reforms included the creation of a "connector" to act as a market organizer to combine public and private resources to help small employers and their employees purchase health insurance coverage through the commercial market.

Eventually the bill was significantly scaled back and a more limited "connector" program was fashioned from a voucher style program that had been delayed in its implementation.² This revised bill passed the legislature as [Chapter 260, Laws of 2007](#).³

The HIP would provide small employers in Washington State access to health insurance coverage at a lower employer contribution rate than in the traditional small group health insurance market. The HIP would also offer a premium subsidy to eligible participants, based on their family income.

The primary objectives of the program were to:

- Improve access to employer-sponsored health insurance coverage.
- Remove economic barriers to health insurance coverage for low-wage employees of small employers.
- Build on the private sector health benefit plan system.
- Encourage employer and employee participation in employer-sponsored health benefit plan coverage.

Key features of the program included:

- Subsidy payments were to be combined with employer and employee contributions (for participants with a family income that does not exceed 200 percent of the Federal Poverty Level, FPL)

¹ [HB 1569](#), introduced January 23, 2007

² The Small Employer Health Insurance Partnership created by [Chapter 255, Laws of 2006](#). SEHIP was not implemented in favor of the Health Insurance Partnership.

³ The Governor vetoed section 3 of this bill in favor of a similar amendment found in [section 58, Chapter 259, Laws of 2007](#).

- A Board appointed by Governor Gregoire and tasked with:
 - Developing enrollment policies;
 - Designating plans to be offered through the HIP;
 - Approving a mid-range “benchmark” plan for calculating subsidies;
 - Developing appropriate rating methodologies based on small group rating;
 - Allowing individual choice of health plans offered through the HIP; and
 - Providing enrollee portability upon termination of employment.

- Administration of the HIP by the HCA, either directly or by contract:
 - Establishing and administering procedures for enrolling small employers and for participants’ enrollment in HIP-designated health benefit plans;
 - Providing technical assistance to participating small employers (who must establish an IRS Section 125 Premium-Only Plan to participate);
 - Establishing a mechanism to apply a premium surcharge for plans purchased through the HIP to help cover the program’s administrative expenses;
 - Developing and managing a sliding scale premium subsidy schedule, similar to the one used for Basic Health;
 - Establishing and managing a monthly premium billing and payment system;
 - Handling appeals related to program eligibility and subsidy determination; and
 - Drafting and filing all rules necessary to implement and administer the HIP.

- Required the Board to submit two studies intended to explore the impact of implementing the original more expansive bill.

See [Appendix A](#) for the complete text of the HIP legislation and laws.

In November 2008, the state revenue forecast projected a \$5.7 billion shortfall for the 2009 – 2011 Biennium and a \$500 million shortfall for the remaining fiscal year (ending June 30, 2009). Given the projected revenue shortfalls, the HCA and the Governor’s office determined that continued subsidy funding for the HIP in the 2009 – 2011 Biennium was not likely and therefore decided not to implement the HIP as planned. The HCA believes it would be disruptive to implement this program when it is uncertain whether or not funding would be available to sustain the program in the years to come. In late November 2008, the HCA suspended HIP operations, terminated contracts to provide third party administrative services and consultation for the Board studies, and notified key stakeholders that HIP would not be taking applications as planned beginning January 1, 2009.

The HIP staff and stakeholders believe this program has remarkable potential and value for small employers and their employees, health insurance carriers, agents or brokers, and the taxpayers in Washington State. This document is a comprehensive report to memorialize the hard work that was done and the support and effort of all our stakeholders. This document will provide an overview of the program planning and development processes for future reference - in the event the HCA can resurrect the HIP when state or federal funding is available.

Health Insurance Partnership Overview

To help small business owners contribute to this vital protection for their employees, the Washington State Legislature created the HIP which would combine public and private resources to help small employers and their employees purchase health insurance coverage through the commercial market.

Small employers (with 2-50 employees) would be able to enroll in the HIP if they did not currently offer health insurance coverage to their employees and if at least 50 percent of their employees were low-wage. To be considered low-wage, an employee could not make more than \$10.00/hour or \$1,733.41 a month.

The Board designated health benefit plans from those that were offered in the small group market for offer through the HIP. See the [Designated Health Benefit Plans](#) section for more information.

Employers wanting to enroll in the program would have to agree to purchase health insurance coverage through the HIP and establish an IRS Section 125 Premium-Only Plan, which would allow employers to deduct payments for health insurance premiums from employees' pay on a pre-tax basis and lowering both the employees' taxable income and the employer's payroll tax obligation.

At least 75 percent of a business's eligible employees would be required to purchase the employer-sponsored health insurance coverage and employers would need to contribute at least 40 percent toward their employees' premiums. Employers would not be required to make a contribution toward spouse or dependent coverage.

Employees who were Washington State residents with a family gross income at or below 200 percent of the Federal Poverty Level (FPL) would be eligible to have a portion of their premium obligation subsidized. The amount of subsidy an employee would receive considered income of all family members and the family size.

HIP Program Development Overview

The Project Team

The HCA formed a project team (HIP staff) to begin development of the program and support the board. The HIP identified several principal activities needed for a successful implementation, including:

- Soliciting stakeholder input and maintaining stakeholder relations through communications and public meetings.
- Identifying policy challenges that needed to be resolved prior to implementation.
- Establishing the program infrastructure to support program activities.
- Developing policies and procedures for accepting applications from eligible partnership participants.

The HIP Board

Governor Gregoire appointed the Board in August 2007. The Board included persons with expertise in the health insurance market and benefits design and was chaired by the HCA Administrator, Steve Hill. The Board held its first meeting on October 2, 2007, and met monthly until November 2008.

The Board prescribed rules for the conduct of its business. Board meetings were called by the chair and all Board decisions were made in a very transparent, public process. HIP staff prepared meeting materials and included presentations and other research documents to assist the Board in its deliberations. HIP staff also prepared proposed motions requiring Board action and documented all Board decisions as they were made.

The Board was also required to produce two studies analyzing significant reforms to Washington's health insurance market. The first study (or preliminary report), due December 1, 2008 was to examine the impact of incorporating the Individual and Small Group markets in the HIP, including:

- Analyzing the utilization of services and cost of plans.
- Access and cost of coverage of applying Small Group regulations.
- Board composition.

The second study (or final report), due September 1, 2009 was to examine the impacts of more markets participating in the HIP, including:

- High risk pool.
- Basic Health Plan.
- Public Employees' Benefit Board.
- Public school employees.
- Individual and Small Group markets.

In the final report the Board was required to identify the risks and benefits of maintaining the current markets vs. incorporating them into the HIP, including:

- Utilization of services and cost of plans.
- Access and cost of coverage of applying Small Group regulations.
- Distinct participation of active and retired PEBB employees.
- Board composition.

Finally, the Board was required to look at mandating individual coverage and identifying how the mandate would be enforced.

See [Appendix B](#) for the Board roster, Bylaws, and Guiding Principles.

Building Partnerships

The enabling legislation required the Board to work collaboratively and to consult with small employers, the Office of the Insurance Commissioner (OIC), actuaries, health insurance carriers, agents or brokers, and employees of small businesses. The law also granted the agency the flexibility to contract for the program's administration with third parties and solicit consultation in support of the program. This section briefly describes the partnerships the HIP created and maintained during the planning and development of the program.

Nationally Recognized Subject Matter Experts

Throughout the early implementation planning process and thereafter, the HIP consulted with several nationally recognized health policy and subject matter experts. For example, in June 2007, key members of the HIP staff visited and consulted with the Massachusetts' Commonwealth Connector Authority in Boston. Key topics included program structure, benefit design, marketing and communications, stakeholder management, and funding.

Working with the National Governors Association, the Board hosted a panel of experts at its January 3, 2008 meeting. Panelists included Amy Lischko, a key architect of the Massachusetts Connector, Ed Haislmaier, a Heritage Foundation fellow who aided the Massachusetts' health reform efforts, and John Grugrina, a senior policy consultant from the Institute for Health Policy Solutions. The panel offered assessments of the program's progress and explored potential solutions to several difficult and challenging issues. HIP staff also hosted and facilitated a day-long work session with the panel to explore further into the identified implementation barriers and possible responses. This invitation-only "Experts' Intensive" was attended by representatives of health insurance carriers, agents or brokers, the governor's and legislative policy staff, affected state agency staff, Board members, HIP staff, and key stakeholders. Based on the results of the Experts' Intensive, the HIP staff and Board refined the implementation plan and identified further issues for resolution. See [Appendix C](#) for materials from the Experts' Intensive.

The HIP Technical Advisory Committee (TAC)

To further assist the Board, a technical advisory committee (TAC) was assembled and comprised of representatives of health insurance carriers, agent and broker community, small employers, business interests, and the OIC. The TAC met twice a month and provided consultation and recommendations to the HIP staff and Board regarding the program's scope, structure, and design. The TAC reported to the Board at monthly meetings, providing advice, proposed solutions, and workarounds, on various issues identified by the committee. This partnership helped build trust and goodwill between interested parties and proved to be an invaluable resource for the HIP staff and Board. See [Appendix D](#) for the TAC Roster, Charter, and Guidelines.

Insurance Agents and Brokers

Enlisting the support of the agent or broker community (also known as the producer community) was critical for the success of the HIP. This was crucial not only in providing the HIP staff and Board with the expertise and guidance of the producer community, but also to understand how to make the program more marketable to small employers. The HCA created a Distribution Team of interested agents or brokers from all geographic areas of the state to help the HIP staff and

Board better understand the dynamics of the small group market in the real world, especially for small employers and micro-employers (10 employees or less) not currently offering health benefits and who employ primarily low-wage workers.

This partnership resulted in the creation and marketing of the HIP's successful HIP-Preferred Agent/Broker training program, attended by over 160 interested insurance professionals during October and November 2008. To meet the producer community's demand for additional training sessions, at the time of the program's cancellation, the HIP had scheduled several additional sessions in December 2008. See [Appendix E](#) for the Distribution Team Roster.

Evaluating the Legislation

As the HIP staff, Board, national experts, and retained consultants reviewed the enabling legislation, it became clear that there were legal, policy, and legislative issues that needed to be addressed prior to implementation, including:

- Individual choice.
- Potential conflicts with state and federal law.
- Small employer requirements.
- Surcharge.

Individual Choice

The stated intent of the HIP as enacted was to “remove economic barriers to health insurance coverage for low-wage employees of small employers by building on the private sector health benefit plan system and encouraging employer and employee participation in employer-sponsored health benefit plan coverage.” The bill also states that “...neither the employer nor the partnership shall limit an employee's choice of coverage from among all the health benefit plans offered.” The HIP was required to select its designated health benefit plans from those available in the small group market and was subject to small group rating rules. However, the element of individual choice worked against the existing small group rating methodology and benefit plan designs. Once an individual selected a different health benefit plan or carrier from the rest of the small employer group, the entire foundation on which the small group market rests would be undermined because rates are established for groups, not individuals. The TAC wrestled with the concept of how rates could be set for individuals using the small group structure, but did not identify a solution.

The HIP staff investigated whether maintaining individual choice was critical to support the stated intent of the legislation and how it would be implemented. Proponents of the legislation made it clear that individual choice was crucial to the intent of a “connector” and advocated for its inclusion in the program components. Realizing the value individual choice would bring to the HIP, Board, HIP staff, consultants, and the TAC looked for options on how maintaining individual choice would be operationally possible without significant and largely untested reforms within Washington's small group market. We were unable to resolve the issue in time for the scheduled implementation. Working with the legislature, the HIP received a two-year deferral for implementing the individual choice provision in the technical corrections bill (see below).

Potential Conflicts with State and Federal Law

The Board also identified several potential conflicts between the HIP legislation and Washington's insurance code (Title 48 RCW). These included the ability of the HIP to diverge from the current small group market rules regulating minimum participation and employer contribution requirements, and the Board's latitude regarding development of rating methodologies for the HIP.

Additionally, the OIC advised the HIP staff that it was potentially subject to the HIPAA guaranteed offer requirement. See [Appendix F](#) for the OIC letter. Therefore, any newly designed plans offered through the HIP would also have to be offered by the health insurance carriers outside the program in the existing small group market. The HIP determined that this was not an issue because the health benefit plans designated by the Board would be selected from those plans currently offered in the small group market. In addition, the HIP staff created a voluntary process with health insurance carriers to include their recommendations for plans that should be considered for designation by the Board.

The OIC also took the position that although rating requirements could be developed specifically for health benefit plans in the HIP, under Title 48 RCW, participating health insurance carriers would be required to offer these benefit plans under the same terms as outside the HIP (for example, a lower employer contribution.)

The HIP identified two options for resolving the Title 48 RCW conflicts: request a broad exemption from Washington's insurance code (Title 48 RCW) or several narrow exemptions. The first option could create a single risk pool, with the HIP assuming a purchaser role and negotiating rates for the pool. The second option would specifically exempt certain aspects of the HIP from state small group market rules and embed the program more firmly into the current small group market structure. The HIP staff recommended the second option, which was included in the technical corrections bill.

In addition, the authorizing legislation directed that the HIP "establish and manage a system for the partnership to be designated as the sponsor and administrator of a participating small employer health benefit plan and to undertake the obligations required of a plan administrator under federal law." This language had implications with a primary federal law which governs employer benefit plans, the Employee Retirement Income Security Act (ERISA). This law regulates the duties of employers in establishing pension and health care plans for their employees.

The HIP contracted with Ice Miller, a law firm that specializes in ERISA regulations, to conduct a preliminary analysis of any potential conflicts of the authorizing HIP legislation with ERISA. Ice Miller and HIP staff reviewed the implications of the federal definition of a plan sponsor or administrator role. It was determined that federal law requires the employer to serve as the plan sponsor, so the HIP could not take on that role. Furthermore, while it would be legally possible to define the HIP as the ERISA plan administrator, doing so would not offer any benefit to participating employers and would carry significant risks, such as subjecting the Board and the HCA administrator to fiduciary burdens under ERISA, because the duties are far ranging and persons undertaking them may incur personal liability for any noncompliance with federal

regulations. Fiduciaries that breach their duties under ERISA may be subject to court imposed sanctions. This risk, together with the addition of significant cost and administrative complexity for the HIP program to comply with ERISA, resulted in the Board requesting the removal of the above requirement from the enabling legislation.

Small Employer Requirements

The initial legislation required employers to have at least one subsidy-eligible employee to enroll in the HIP. Since employers cannot require an employee to furnish proof of family gross income, this requirement created a barrier for the small employer wanting to enroll in the HIP, if the employees did not voluntarily provide information about their family gross income to their employer. The HIP identified two options to remove this barrier. One option was to ask that the requirement be stricken from statute, providing for administrative simplicity, and not subjecting the employer to asking for family income. This option found opposition as several stakeholders argued that it went against the legislative intent to focus the program on employers of low-wage workers. The other option was to find an administrative work-around that would allow employers to declare that they believed they employed an eligible employee based on wages paid. This would not require legislative action, and would provide the administrative simplicity.

Surcharge

The enabling legislation allowed the HIP to charge a surcharge on the premiums of the health benefit plans offered through the HIP to cover administrative costs of the program. The surcharge was intended to be the HIP's sole funding mechanism for administrative functions. However, with modest initial enrollment expectations this would make premium costs significantly larger than in the private market and cause HIP-offered plans to be unattractive to the very employers it was designed to reach. Therefore, the Board believed the initial administrative start-up phase should be entirely funded by a state appropriation.

Board Request for Legislative Action

With the above challenges identified, the Board submitted a letter to Governor Gregoire and Legislature requesting technical corrections to the enabling legislation, and more time to implement the program. See [Appendix G](#) for the Board letter submitted to the Governor.

The Governor and key sponsors of the enabling legislation supported the requested amendments, and the technical corrections bill was drafted with the following provisions:

- Authority for the Board to limit the plans eligible for a subsidy to a subset of those offered through the HIP;
- Removal of the requirement for the HIP to act as the plan sponsor and to allow the Board the flexibility to determine whether the HIP should act as the plan administrator;
- Removal of the requirement that participating small employers have at least one subsidy-eligible employee;
- A two-year delay of the individual choice provision, and limiting portability only to former employees eligible for coverage under the Consolidated Omnibus Reconciliation Act (COBRA), a federal regulation which allows employees who terminate employment to be covered under the employers health plan for a certain amount of time;

- Clarity that the premium surcharge would be applied only to coverage purchased through the HIP, and would not be part of the small group community rate;
- Creation of a potential funding vehicle for administrative expenses through legislative appropriation, and clarification that any surcharge levied would reflect administrative and operational expenses remaining after any appropriation;
- Amendments to Title 48 RCW stating that any HIP risk adjusters would be outside of small group rating rules;
- Clarification that any minimum participation and minimum employer contribution requirements adopted by the Board would not apply to any plans outside of the HIP;
- Provision of a two-year window for the Board to explore the use of rating tools such as risk adjustment and reinsurance;
- Modification of the dates to begin enrollment to January 1, 2009, and coverage on March 1, 2009 (the Board requested delaying the implementation to September 1, 2009).

This technical corrections bill passed the legislature as [Chapter 143, Laws of 2008](#) largely as requested by the Board. See [Appendix H](#) for text of the Technical Corrections bill and HIP law. However, following intense debate, the final version also contained amendments not requested by the Board. The new law:

- Only delayed the initial date for accepting applications to January 1, 2009, and directed that coverage begin March 1, 2009. (Neither the enabling legislation nor the Board-requested corrections included a date-certain for enrollment in insurance coverage.)
- Required small employers to attest that at least fifty percent of employees were “low wage” without defining the term. (The enabling legislation required that an employer have at least one subsidy-eligible employee. The Board requested this provision be stricken because there is no practical way an employer could know whether an employee’s family gross income would meet the definition of “low wage”.)
- Required small employers to attest that they did not “currently offer health insurance.” This requirement later generated significant discussion. Several stakeholders insisted that the legislative intent was for a “look-back” period of at least three to six months. This was a contentious issue because of pre-existing conditions implications for enrollees and the possibility of crowd out, a situation where public programs designed to decrease the number of uninsured individuals prompt some privately insured persons to drop their private coverage and take advantage of the public subsidy. The issue was resolved upon confirmation from the Senator who introduced the amendment that the intent was not to include a look-back period. See Appendix I for Senator Keiser’s letter to the Board.
- Changed the number of Board-designated health benefit plan designs from at least 4 to up to 5 plan designs, with at least one HSA-qualified plan.
- Directed the HCA to “make every effort” to coordinate premium subsidies for children with federal funding available under Medicaid and SCHIP through DSHS’ Employer-Sponsored Insurance (ESI) program.

Implementation of the HIP

Once the technical corrections bill was passed, the program moved forward with implementation activities. One of the HIP’s main challenges was to create a program framework which would complement the small group market, and include health insurance carriers, agents or brokers, and

employers as willing participants. It soon became clear that any policies which would create difficulty or additional administrative burdens for health insurance carriers, agents or brokers, or employers would not improve the chances of the program's success.

Clearly, the HIP's impact on the overall health insurance market would vary based on how the program was implemented. The HIP expected that it could add value to the current small group market by providing subsidies to low-wage workers, and adding new enrollees for health insurance carriers. Therefore, the HIP coordinated closely with stakeholders including representatives of small employers, health insurance carriers and agents and brokers to publicize the HIP program and develop outreach and education plans.

Designated Health Benefit Plans

One of the most important tasks for the Board was the time consuming effort of selecting the health benefit plans that should be designated for offer through the HIP and, of those selected, which should be eligible for subsidy payments. The process began with formulation of a recommendation from members of the Technical Advisory Committee (TAC), the Distribution Team and the health insurance carriers interested in having subsidy-eligible plans.

The legislation mandated that the Board select up to five health benefit plans to be offered through the HIP, ranging from comprehensive to catastrophic coverage. At least one of the plans was to be eligible for pairing with a Health Savings Account.

The HCA coordinated with health insurance carriers, brokers and the TAC to recommend the health plans through an iterative and interactive process. The initial step was for the health insurance carriers to each independently present an initial set of recommendations to the Board during a monthly meeting. The recommended plans became the starting point for Board designation and were assembled by category into a grid ranging from comprehensive to catastrophic.

The second step asked each carrier to provide plans from its line of products that were comparable to the grid of independent recommendations. There were three health insurance carriers involved in the first two steps of this process. After the comparable plans were provided by each carrier, there were twenty-four plans for consideration. Throughout the process, the plan grid was distributed to the entire TAC and Distribution Team with a request for comments and feedback in regards to the popularity of plans in the current small employer market, and the likelihood the recommended plans would attract small employers not currently offering insurance.

With the carrier grid of plans to consider for a recommendation developed, the final step was to have HCA contracted actuaries from Milliman assign each plan an actuarial value. Each plan's actuarial value was compared with a baseline plan, in this case another HCA program, Basic Health. The actuarial value measured only the relative cost sharing of each plan. With the Basic Health benefit plan design being assigned an actuarial value of 1.0, a plan with an actuarial value greater than 1.0 would have less cost sharing by the enrollees than the Basic Health program. With the variety of plans under consideration the health insurance carriers' primary concern was

to mitigate potential adverse selection for a specific plan by minimizing the degree of variation in the actuarial values of all plans within each designated plan category.

The plans were sorted by actuarial value and recommended 'benchmark' plans were selected after a third round of discussions with the TAC, Distribution Team, and health insurance carriers. The HIP staff recommended unique 'benchmark' plans for each carrier, which was their mid-range plan from those offered through the HIP. The benchmark plans were used for the purpose of calculating premium subsidies. Any plan with an actuarial value at or below the benchmark plan would be subsidized at the given percentage. Plans with an actuarial value more than the benchmark plan would subsidize at a lower percentage rate, so as not to exceed the amount paid under the benchmark plan. The challenge was to balance affordability with relative richness of the benefit plans. Since the 'benchmark' plan was intended to limit the maximum subsidy payment an eligible participant could receive, the actuarial value needed to have very minimal variation for the benchmark. Once that process was complete, the Board had several plans for consideration, with recommendations for the relative division among categories and a 'benchmark' plan.

Each Board member was individually briefed on the plans for consideration and provided additional proprietary and confidential information in regards to the premium rates each health insurance carrier would charge for two hypothetical groups enrolled in each of the plans. This discussion provided the opportunity for each member to consider the relative premium cost and enrollee cost sharing. It also provided an opportunity to explain the process used in the formulation of the recommendations and demonstrate the involvement of all the constituents. See [Appendix J](#) for the Designated Health Benefit Plan summaries.

TPA Selection: Harrington Health

Given the complexity of the new program, the compressed implementation timeline, and the status of HCA's outdated eligibility system, the agency chose to contract for the administration of the HIP to a third party administrator (TPA). A Request for Proposals (RFP) process resulted in the selection of Harrington Health. Harrington brought considerable expertise, resources, and skills to the table and together with the HIP staff, formed a solid partnership that met or exceeded every deadline. Harrington staff was also instrumental in representing the agency in negotiation with participating health insurance carriers, working with the agency-contracted actuaries, and providing input to initial drafts of the program rules.

This partnership made it possible for the HIP to meet all of its statutory and legal obligations, including the capacity to accept subsidy applications on January 1, 2009, for coverage beginning March 2009. See [Appendix K](#) for the Harrington Health Statement of Work.

Budget

The HIP was tasked with implementing a very complex program, not only with a compressed timeline, but also with limited funding. The HIP was initially appropriated 4.0 FTEs and \$2.1 million for fiscal year (FY) 2008 and 4.0 FTEs and \$1 million for FY09, to establish the HIP and support the Board, as well as develop the two Board reports. During the first year of development, the HIP operated with 2.0 FTEs (the program manager and regulations analyst).

Although the HIP had the authority to include a surcharge in the premiums for administrative expenses, it was believed that the state should fund 100 percent of the initial administrative expenditures, to include TPA costs. The alternative would have distributed the costs over a small enrollment pool and would have made the HIP prohibitively expensive.

The HIP submitted a decision package to the legislature for additional funding, in order to fully develop the program. This decision package included a projected enrollment goal of 10 percent of the 90,000 full-time, low-wage uninsured population or 9,000 employees, by the end of calendar year (CY) 2013. This enrollment goal would also likely include some additional insured enrollees, for example, spouses. See [Appendix L](#) for a copy of the HCA decision package for expansion of the HIP.

Enrollment Assumptions for Implementation

The HIP estimated that the largest enrollment of uninsured low-wage employees would be in the first year of the program and that the number of uninsured low-wage employees would be reduced by 300 employees per month for the first year and 113 employees per month for the following years. The HIP estimated that the program would reduce the amount of uninsured low-wage employees by the following amount (enrollment is shown as the total for the calendar years):

	CY 09	CY 10	CY 11	CY 12	CY 13
Uninsured Low-Income Employees	3,600	4,950	6,300	7,650	9,000

Using current Basic Health demographics as a starting point, the HIP estimated that the average family size of the employees would be 1.7; therefore, almost every family would have a dependent. The HIP also estimated that for every two enrolled uninsured low-wage employees there would be one insured low-wage employee enrolled. The HIP estimated the following total subsidized enrollment (shown as fiscal year averages):

	FY 09	FY 10	FY 11	FY 12	FY 13
Avg. Subsidized Enrollment	2,678	8,726	12,766	16,208	19,651

The HIP assumed that for the majority of employers who participated in the HIP, half of their employees would be eligible for a subsidy; therefore the HIP would have an equal amount of low-wage members as non low-wage members. In total, the HIP estimated the total enrollment as:

	FY 09	FY 10	FY 11	FY 12	FY 13
Avg. Total Enrollment for HIP	5,355	17,452	25,532	32,417	39,302

Since the HIP participants are employed, it was assumed that they would likely be in the higher income bands. The HIP used Basic Health's current demographics for members in the corresponding income bands to estimate the income bands for the HIP participants.

The HIP would have several different health plan options, and the costs and plans would vary, therefore, it would be difficult for the HIP to project the cost to the small employers. The HIP assumed that all of its participants would enroll in a mid-range health plan. With guidance from the actuaries, Milliman, the HIP estimated that mid-range health plan coverage, for an average adult would cost \$329.95 pmpm for fiscal year 2009, and the average child cost was estimated to be \$201.06 per member, per month for fiscal year 2009.

Although the Board set the minimum employer contribution at 40 percent of the employees' premiums, the HIP initially assumed that the employer will pay 60 percent of the health care premium for an employee. The remaining 40 percent of the health care premium will be shared between the employee and the HIP. The employee's share would be based on a premium structure, where participants would pay a premium based on their FPL. HIP subsidies would also be capped at 90 percent of participants' premium obligation for each carrier's mid-range (benchmark) plan, so participants could not receive a subsidy greater than this amount. The benchmarks would be chosen yearly by the Board for each participating carrier, for that given Calendar Year.

The HIP also assumed that employers would pay 30 percent of the health care premium for dependents of their employees. The remaining 70 percent of the dependent's health care premium would be shared between the employee and the HIP.

Subsidy Calculation

The HIP legislation included the mandate: "Design a schedule of premium subsidies that is based upon gross family income, giving appropriate consideration to family size and the ages of all family members based on a benchmark health benefit plan designated by the board. The amount of an eligible partnership participant's premium subsidy shall be determined by applying a sliding scale subsidy schedule with the percentage of premium similar to that developed for subsidized basic health plan enrollees under RCW 70.47.060. The subsidy shall be applied to the employee's premium obligation for his or her health benefit plan, so that employees benefit financially from any employer contribution to the cost of their coverage through the partnership."

The HCA and the Board created a HIP premium subsidy scale that varied based on the following factors:

- Employer contribution.
- Employer-selected health benefit plan.
- Participant's (Employee's) family gross income.
- Participant's family size (employee plus dependents).

The amount of subsidy the state pays to a participant considers the factors in the order listed above starting with the group-specific small employer premiums. These small employer premiums are the same premiums as approved by the OIC and adjusted for the rating factors of the specific employer.

Employer contribution: The minimum required employer contribution was at least 40 percent of the employee only premium, was consistent for each employee, and was not required to cover the cost of dependents. The employer contribution was also set at a percentage that would encourage eligible employees to participate so that employers could meet the same minimum participation requirements the health insurance carriers have for other small groups.

Employer-selected health benefit plan: The employer selects the carrier and plan option for all participating employees from the HIP designated plans. The Board designated a benchmark health plan offered by each participating carrier along with a limited selection of other plans offered by the specific carrier, including one eligible for a Health Savings Account. The employer-selected health benefit plan also needed to encourage participation of employees in conjunction with the employer contribution.

Participant's family gross income: To qualify for a state subsidy, the employee's family gross income could not exceed 200 percent of the federal poverty level (FPL). The state subsidy rate varied based on the participant's family gross income.

The income calculation is conducted at enrollment and locked-in through the plan contract year. Since the participant's income would be determined once per plan year and then not adjusted, the state subsidy rate (the percentage of the participant's premium paid by the state) would also be determined only once per year. If the premium amount changed for a participant due to the addition or disenrollment of family members allowed under the special enrollment rules of HIPAA the state subsidy payment would change while the state subsidy percentage did not.

The following income bands and state subsidy percentage were established:

Income Band	FPL Percentages	Percent Subsidy
A	0 – 100	90
B	101 – 150	80
C	151 – 175	70
D	176 – 200	60

The Board and the HCA developed this table with the intent of subsidizing a large portion of the participants at the lowest percentage of the FPL, income band A, under the greatest subsidy percentage. The bands were compressed from those developed in Basic Health so that participants would be less likely to move in and out of bands with small fluctuations of family income.

Participant's family size: Although a participating employer was not required to contribute to the premium for an employee's dependents, the state subsidy percentage would be applied to the employee's premium obligation, at the percentage established for the income band. Therefore, a participant who enrolled as their spouse or dependent children for coverage would receive a significant subsidy for the entire family premium.

See [Appendix M](#) for the complete Income Band Table.

Program Policies and Rules

The HIP staff was dedicated to developing policies that would promote simplified administration and encourage compliance. The main priority was to establish a balance between an attractive program where a group could easily enroll in the program and the State's obligation to verify individuals' subsidy eligibility. This would ensure that an individual would not hold up an entire group during enrollment.

All policy decisions supported sound public policy that would ensure the HIP was a good steward of state appropriated funds. In developing the program rules, the HIP asked for feedback from all interested stakeholders. Drafts of the proposed rules were sent to everyone on the HIP Rules Distribution List on three occasions throughout spring and fall 2008. All stakeholders' questions, comments, and suggestions were carefully considered and most were incorporated into the succeeding versions of the draft rules. All HCA responses included the rationale behind the decision to accept, amend, or reject a suggested revision.

This partnership helped ensure transparency in the process and with the stakeholders' assistance the adopted rules were comprehensive in scope, easy to understand and comply with, and also organized in a logical fashion.

See [Appendix N](#) for a summary of the major policy decisions that were developed by the HIP staff and the program rules.

Communications Plan

The HIP's unique and complex nature required a strategic communications plan to educate stakeholders, and clearly communicate the value and benefits of the HIP without generating enrollment numbers that would immediately exceed the budget capacity. HCA learned through the Basic Health program that a waitlist situation should be avoided at all cost. Therefore, the communications plan for the initial phase of the HIP did not include a media campaign, but focused on:

- Researching the target market.
- Creating a graphic identity.
- Creating enrollment and marketing materials.
- Creating content for the website.
- HIP-preferred Agent training.
- Education and Outreach.

The program's complexity also warranted the use of an external advertising/PR consultant to research the target audience and get input to guide the design of the HIP's graphic identity and the development of key messaging.

PRR, Inc. is an advertising/PR firm that was already contracted by HCA to re-fresh the Basic Health logo and marketing materials. Since they had good references within HCA, they were contracted (via convenience contract) to do the following tasks:

1. Develop HIP graphic identity
2. Develop HIP taglines and key messages
3. Test HIP graphic identity, taglines and key messages
4. Modify HIP graphic identity, tagline and key messages based on focus group responses
5. Develop HIP program mailer
6. Provide Media training for spokespeople
7. Provide project management and coordination

Tasks six and seven were not completed, as they were unnecessary due to the cancellation of the HIP.

Research

Two focus groups were conducted to get input from small employers on the Health Insurance Partnership. One session was held in Seattle and the second one in Spokane.

Working collaboratively with the HIP staff, PRR developed a moderator guide to learn more about the following with regard to small business owners:

- Sources of information on health insurance coverage and past experience
- Understanding of the Health Insurance Partnership
- Appeal and preferences for key messages, logos and taglines pre-developed for the Health Insurance Partnership
- Preferences for direct mail delivery approach
- Appeal and usability of the Health Insurance Partnership Employer Agreement form

Each group discussion lasted two hours and consisted of eight participants. The moderator guide was used to structure the discussions. Audio and video recordings of both sessions were conducted and both groups were observed from behind one-way mirrors by HCA staff. See [Appendix O](#) for the Summary Report of Focus Group Findings and the Moderator Guide.

Graphic Identity

To ensure the HIP was recognized as a new program and to differentiate it from any other program, the HIP needed a standardized graphic representation that would be used for identification and branding. The HIP logo and taglines were created by PRR and many versions tested with the focus group participants, as well as the internal and external stakeholders. Below is the final logo which was approved by the HIP staff, the Board, and the Governor's Office.



**HEALTH INSURANCE
PARTNERSHIP**

*The small business connection
to health coverage*

Enrollment and Marketing Materials

The HIP enrollment materials include the Employer Agreement form, a Subsidy Application, an IRS Section 125 Premium-Only Plan Handbook, and letters the TPA would use for correspondence with the HIP applicants and participants. The forms, manual, and letters were designed based on the HIP rules and requirements. They were reviewed and tested by internal and external stakeholders.

Few marketing materials were created for the HIP due to the minimal budget, and the communication strategy for the HIP start-up phase. PRR, Inc. developed a comprehensive mailer that could be used to educate the small employer, the employee, and the general public.

See [Appendix P](#) for HIP enrollment and marketing materials.

Website

A HIP web page was added to the HCA website and was updated as needed during the HIP development. Monthly status, as well as tools and enrollment materials were posted upon finalization. See [Appendix Q](#) for screenshots of the web pages that were created and maintained during the development of the HIP.

Web Tools

A training registration tool was created by the HCA web team and was published to the HIP website in October 2008. The registration tool allowed licensed agents or brokers to submit an electronic registration for the HIP-Preferred Agent training sessions.

A Subsidy Estimation tool was created by the HCA web team and was published to the HIP website in December 2008. This tool allows an individual to enter their monthly or weekly family gross income and family size, and then calculates the estimated percentage of subsidy the individual may qualify for. The Subsidy Estimation tool also provides a sample calculation so the user can get a better idea of how much they would end up paying for their health insurance premium if they received a subsidy from the HIP.

HIP-preferred Agent Training

Only licensed agents and brokers may enroll an individual or group in a health benefit plan. The licensed agents or brokers also earn commissions from the health insurance carriers for enrolling individuals and groups in their plans. Therefore, the HIP staff decided to concentrate on educating this group by marketing the HIP-Preferred Agent/Broker Training course. A training curriculum and materials were developed with the focus on training the agent or broker on the specifics of the HIP so they could successfully market the program to small employer groups.

Initially, seven training sessions were scheduled throughout the state. Over 160 interested insurance professionals took the training during October and November 2008. At the time of the program's cancellation, the HIP had scheduled several additional sessions at the request of agents and brokers.

See [Appendix R](#) for the HIP Preferred Agent Training Materials.

Outreach and Education

The main strategy for communicating the value and benefits of the HIP was through education and outreach to stakeholders and the general public who had a direct interest, involvement, or investment in the HIP, for example, small employers, their employees, health insurance carriers, agents or brokers, state government agencies, and community organizations.

Outreach and education was achieved through several free and inexpensive forums. The following forums were used to communicate and educate stakeholders and the general public:

- News/Press Releases
- Community Chamber Meetings
- WA CAN Association
- 2007 and 2008 Health Policy Conferences
- HIP-Preferred Agent/Broker Training Sessions – Bothell, Seattle, Tacoma, Olympia, Spokane, Yakima, and Bellingham

Conclusion/Lessons Learned

The authorizing legislation posed a number of complex questions to be resolved by the HIP staff and Board, creating a challenging and exciting environment. Many questions were successfully resolved working with the TAC, stakeholders, and national experts, however, some of the more complex issues had to be deferred. This section documents several valuable lessons learned during the development of the HIP, with the hope that it will benefit any future efforts to continue with the HIP.

Stakeholder Engagement is Vital, the Earlier the Better.

The HIP project demonstrated that it is possible to bring some very distinct interests to the table to constructively address the issues facing our health care market. There were many diverse and sincerely held expert positions and opinions represented on the Board, the TAC, and the Distribution Team. To the credit of all parties involved, this fostered spirited and fruitful debate which built trust and helped frame the program and hugely contributed to its successful development. If resurrecting the HIP becomes an option, it will be vital to involve stakeholders *before* taking any legislative action. In the HIP staff's conversations with all actors in the Massachusetts Connector program, the most commonly stated reasons for its success were the discussions and collaboration that occurred for three years before passage of the final bill.

More stakeholder involvement prior to passage of the HIP's legislation would have freed the HIP staff from needing to spend the first several months of implementation bringing stakeholders to the table, educating them of the policy goals of the program, provisions of the legislation, and gathering support. Ultimately, this would have saved considerable time and resources.

The Difficulty to Introduce Limited Reform Into an Existing Regulatory Framework is Significant.

The authorizing legislation had broad policy reform goals but left the current regulatory framework largely undisturbed. Additionally, the mechanisms for achieving the policy goals were left undefined, such as the rating necessary to achieve individual choice and portability within a small group market regulatory framework. The timeline did not allow the Board to fully explore options for important and undefined policy issues. This created uncertainty for regulators who interpreted their current responsibilities conservatively, the HIP staff who were attempting to implement the program's goals, and participating health insurance carriers who were concerned with violating current regulations and the disruption of the market. Ultimately, the HIP was successful in developing a workable infrastructure for enrolling employers and employees, and distributing subsidies to eligible employees. By not disrupting the current market infrastructure we contributed to the buy-in of participating health insurance carriers and agents or brokers. That said the HIP deferred the major component of offering unlimited individual choice and portability for HIP participants until after the initial implementation, due to the complex nature of the issue and the disruption to the current small group rating mechanism. If the HIP is continued, this is an issue that will require broad and ongoing stakeholder support and involvement.

Selecting Health Benefit Plans Solely From Existing Products in the Current Small Group Market Offered Both Opportunities and Drawbacks.

Selecting health benefit plans that were already designed and marketed by the health insurance carriers and approved by the OIC provided some administrative simplicity, encouraged carrier participation, and satisfied the HIPAA regulation of guaranteed offer. Adversely, it eliminated the opportunity for the HIP staff and Board to create innovative plan designs that would positively impact premium costs. With premium cost being the largest concern for small employers and their low wage workers, there was limited interest from key business associations to participate in the development of the HIP. The business community resisted the HIP because their efforts to promote and permit limited health benefit plans were not included during the conceptual design, drafting of legislation, or passage of the HIP. The HIP staff was successful in building positive momentum during development. However, this did not overcome the business community's concerns that were not adequately resolved earlier for a program meant to serve their constituents. Although not entirely lacking support from small business owners, the small business community did not champion the HIP implementation.

Use of an Experienced Third Party Administrator was Invaluable and Greatly Simplified Implementation.

The small group market is a complex system and understanding its dynamics and nuances was critical to the HIP's viability. The partnership with Harrington Health greatly simplified the implementation because of their significant resources and expertise in administration in the health care industry and experience in serving small employers. Any third party administrator that is a partner in a "connector-type" design must be adaptable and flexible in collaborating with participating health insurance carriers and in developing procedures consistent with the law. Harrington's ability to be flexible with processes, while still keeping in line with small group regulations was a major contributor to the successful development.

A Mandate to Establish Section 125 Plans are Not Always Beneficial for Small Employers. During development, the HIP staff discovered that participating in a Section 125 Premium-Only Plan could negatively affect low-wage individuals by limiting their ability to claim an earned income tax credit on federal income taxes. Furthermore, establishing a Section 125 Premium-Only Plan could be seen as an administrative hassle for small employers, especially those with predominantly low-wage employees who would not benefit and would be less likely to enroll in the Plan.

In addition to working with consultants, the HIP staff learned that employees can only have only one employer contribute to their Plan. If the HIP continues and looks at the value of having multiple employers contribute to employees' premiums, such a mandate would create an administrative barrier to collecting premium payments from those multiple employers, and it would be unlikely that it would add value.

While certainly beneficial as an option, the value the HIP brings small employers is in providing technical assistance in the voluntary establishment of the Plans.

The State's Demonstrated Commitment to a New Program is Crucial for Stakeholder Involvement.

One of the first questions the HIP staff was commonly asked was the amount of funding dedicated to the program. Coming on the heels of the recently unfunded SEHIP program, the subsidy funding appropriated to the HIP was not seen as a strong commitment to the program, especially to stakeholders who were invested in its success. As a result, the HIP staff struggled to market the program to its stakeholders, trying to overcome the looming question of adequate funding.

Definitions and Acronyms

The Health Insurance Partnership would like to thank the following people for their support and guidance throughout the program development.

Actuaries - business professional who have a deep understanding of financial impact of risk and uncertainty.

FTE, Full-Time Equivalent

HIP, Health Insurance Partnership

IRS, Internal Revenue Service

OIC, Office of the Insurance Commissioner

OFM, Office of Financial Management

PEBB, Public Employees Benefits Board

RFP, Request for Proposal

TAC, Technical Advisory Committee

TPA, Third Party Administrator

APPENDIX A: HIP legislation and laws
APPENDIX B: HIP Board Roster, Bylaws, and Guiding Principles
APPENDIX C: Experts' Intensive Materials
APPENDIX D: TAC Roster, Charter and Guidelines
APPENDIX E: Distribution Team Roster
APPENDIX F: OIC letter to the HIP Board
APPENDIX G: Board Letter Submitted to the Governor
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APPENDIX J: Designated Health Benefit Plan Summaries
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