

## Washington State SHAP Grant Project Narrative

### INTRODUCTION

**Background:** “Washington’s continued success as a state depends on the health of its individuals.” With this challenge, Governor Gregoire and thirteen other state agency leaders formed the 2006 Blue Ribbon Commission on Health Care Costs and Access (BRC) to develop a five-year plan for substantially improving access to affordable health care for all Washingtonians. Although fiscal realities have timing implications, among the BRC’s desired goals the first has particular relevance to our State Health Access Program (SHAP) grant proposal:

*All Washingtonians will have access to health coverage that provides effective care (by 2012).*

The 16 BRC recommendations included “*organize the insurance market to make it more accessible to consumers*” (through an exchange or other public/private mechanism that envisions shared responsibility from the state, individuals and businesses to finance insurance coverage). The BRC also recommended taking steps toward building a *sustainable* high-performing health care system, “*in which every dollar spent goes toward the most appropriate, highest quality treatment delivered in the most cost-effective way*”. Since the final BRC [report](#), a variety of legislation has passed in support of the BRC recommendations. **Our SHAP grant proposal is directed toward two coordinated initiatives that spring from that work:**

- a. Through E2SHB 1569, the 2007 Washington State Legislature established a small business exchange, the Health Insurance Partnership (HIP), to help small employers offer and their employees/families purchase affordable, predictable health coverage<sup>1</sup>.
- b. Via 2SSB 5945, the 2009 Washington State Legislature confirmed principles to guide Washington’s health care reform deliberations and directed development of a federal waiver to resolve barriers to more cost effective, efficient, seamless delivery of coverage and services to low-income families.

**This SHAP grant will support** the expert resources and premium assistance needed to fully implement the HIP. If not for a \$9 billion budget shortfall projected in the biennium starting July 2009, the HIP would have begun subsidizing coverage of small employer groups in March 2009<sup>2</sup>. In the course of painful cuts to balance the budget, the HIP was suspended. With SHAP grant support, expanded coverage through an *improved* HIP program can begin by August 2010, operated through the Washington State Health Care Authority (HCA) in cooperation with private health insurance carriers.

**Target Population:** The target population for the HIP comes from the approximately 175,000 uninsured employees (and their dependents) of small business (approximately 25 percent of the uninsured population) who work in small firms for whom affordability issues are most acute. The specific target population for the HIP is a subset of this population – the group that is *full-time*. The HIP focuses on small businesses whose workers are predominantly full-time because these employers are the most likely to participate when offered affordable, predictable, and administratively simple coverage, and full-time employees are most likely to take up that coverage if available.

Estimates developed for the anticipated implementation of the HIP in March 2009 projected enrollment of approximately 5,000 employees and dependents in the first full year of operation, increasing to nearly 13,000 after five years. These numbers, based on a September 2008 analysis by a consortium of experts led by Mathematica Policy Research, Inc., reflect member enrollment in primarily low-cost plans. Their

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<sup>1</sup> Through 2SHB 2537, the 2008 Legislature amended HIP provisions based on recommendations by the HIP Board.

<sup>2</sup> As of late 2008, health plans were designated for subsidized coverage, a third-party administrator was under contract and ready to operate the program, and marketing materials were print-ready.

econometric simulations of employer offer and employee take-up showed that the HIP would have targeted about 43,700 *full-time* uninsured workers and dependents, of whom nearly 29,700 would likely be eligible if offered coverage. During the 2009-2011 budget process, HCA staff estimated average monthly enrollment in the HIP. Milliman, the actuarial consultant to Washington public purchasing programs, updated simulations in June 2009. These more recent estimates conservatively reflect member enrollment in more comprehensive coverage and are the basis of our latest projection of around 4,000 – 5,000 employees and dependents in the HIP after two years of operation. Actual numbers may be higher if enrollment is, in fact, primarily in the low-cost plans. Projections support that crowd-out is not a likely factor in HIP enrollment - we have assumed that even if offered coverage via the HIP, individuals enrolled in Medicaid, ESI, or CHIP, would not transfer to the HIP where they would have to make a premium contribution they don't make today.

**Implementation Context:** The HIP, Washington's principle SHAP coverage expansion effort, is being implemented in the context of **broader reform** geared toward a high-performing, seamless array of coverage options for our low-income population. This overarching effort is about **health care delivery and purchasing redesign** that supports an efficient, effective, and science-based system. On a national scale the Commonwealth Fund recently reported estimates developed from several sources<sup>3</sup> that support considerable savings potential from such activities. While to some degree we have already embarked on this path<sup>4</sup>, SHAP support will allow a greater focus on identifying initiatives we should pursue more vigorously and barriers that need to be overcome, through a federal waiver request for example. Savings estimates for Washington will depend on *specific* activities pursued in inter-agency discussions legislatively directed to begin this fall. We haven't yet attempted to guess their impact on furthering coverage expansion – that will evolve as we pursue more detailed analysis.

**The Five broad goals of our proposed SHAP project** are to (1) Implement the HIP, a small business exchange including premium assistance for low-income employees and their families (up to 200 percent of federal poverty), (2) Identify and implement purchasing and delivery system redesign initiatives that support more efficient, seamless coverage for low-income populations, (3) Design and implement data collection improvements for the monitoring /evaluation of the HIP and with an eye to establishing a high-level template adaptable to monitoring/ evaluation of future coverage expansion efforts, (4) Closely monitor and coordinate federal and state reform efforts for proactive interface and mid-stream adjustment as details become known, and (5) Fulfill SHAP grantee commitments to participate in regular meetings and complete fiscal and progress reporting.

As noted, health reform efforts in Washington State are occurring alongside an undecided national health reform agenda. Although we must track and synchronize federal and state reform, the proposed Washington effort stands on its own merits, **independent of federal reform** whatever direction it takes. We are also ready to adapt as needed.

**Specific objectives associated with the first four goals are to some degree inter-related:**

Washington's expectations for the HIP are to:

- *Improve access to employer-sponsored coverage by building on the private health insurance system.*  
The HIP enrollees become members of private health plans which are community-rated within each

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<sup>3</sup> "This report examines several policy options that could improve the value of the nation's investment in the health care delivery system and help finance federal support of coverage expansions. To illustrate the importance of the structure and details of the policy options, it presents a range of estimates from three different sources: 1) estimates prepared for The Commonwealth Fund by the Lewin Group and published in a recent report, *The Path to a High Performance Health U.S. Health System* (the Path report); 2) estimates by the Office of Management and Budget (OMB) for the president's budget proposal and the economic stimulus bill; and 3) estimates by the Congressional Budget Office (CBO)."

<sup>4</sup> *One example:* via an independent clinical committee, the Health Care Authority's technology assessment program uses scientific evidence to make decisions on whether to pay for certain medical devices, procedures, and tests.

health insurance carrier. By spreading risk across each carrier's small group<sup>5</sup> enrollment, the HIP enrollment is not initially jeopardized by potential adverse selection and could be better protected from future premium spikes.

- *Achieve health risk that emulates a conventional employer-group.* Many programs that target the low-income population, such as Washington's Basic Health, enroll *only* subsidized individuals and families who tend to have relatively poorer health status than typical employer groups. People with fair or poor health status make up a significant portion of those individuals who remain among the top health care spenders from year-to-year. In Washington, 18 percent of people in families with income under 100 percent of federal poverty have fair or poor health status; that figure is only 5 percent for people in families at or above 400 percent of federal poverty. As a program for low-income individuals, Basic Health has become a pool with greater risk than typical employer groups. Although it too will offer premium assistance, the HIP is also available to non-low income employees of eligible small employers. By enrolling families of varied incomes it will maintain an overall lower-risk pool.
- *Increase small employer offer and employee coverage rates.* Approximately 57 percent of Washington's employers offer coverage to at least some of their employees and take-up rates for the smallest firms with 2-9 employees are below 50 percent. By implementing an equitable premium subsidy schedule, the HIP can increase employer offers and employee take-up and retention by removing economic barriers. The HIP subsidy dollars provide more bang-for-the-buck - by making it affordable for low-income families to take-up their own-employer's coverage, the HIP subsidies have the added effect of bringing in non-subsidized families that have coverage available as members of the same HIP employer group.
- *Provide access to managed health care services.* The HIP enrollees will benefit from access to the same managed care environment as other employer-sponsored groups and receive the same advantages when health insurance carriers improve chronic illness care, target prevention, or promote wellness.
- *Select and manage the right level of plan choice.* Having no choice of health plan is unacceptable to consumers while unfettered choice among small group market products gives enrollees too much incentive to select comprehensive plans only when they are sick. "Too much" choice can be administratively disruptive and perilous to a carrier's small group risk pool. The HIP expects to strike the right balance so the choice available to members is geared toward managing the full cost of coverage, and thus, encouraging take-up and retention.

Expectations of Washington's purchasing and delivery system redesign for its low-income population center on the development of a federal waiver for flexibility to implement coverage reforms that appear to be in line with those envisioned in the current federal reform dialog:

- *An effective framework to expand the role of Medicaid* over time and/or dovetail with federal reform to cover low-income *adults* with incomes up to 200 percent (for example) of federal poverty;
- *Administrative simplifications* that include a single eligibility standard and application, core benefit design (potentially based on the Basic Health program with supplemental coverage available to individuals with greater needs - such as those who are elderly, blind or disabled);
- *Delivery system efficiencies and quality of care improvements* that include adoption of strategies to: increase preventive care; implement payment model(s) that support the delivery of patient-centered primary care through medical homes; support care management for high-risk individuals with co-occurring medical, mental health, and/or chemical dependency conditions; and adopt science-based care standards;
- *Cost-sharing* designed to incent more efficient use of services and narrow regional variation unexplained by illness severity, access to care, or informed patient preference; and

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<sup>5</sup> Washington's small group market is defined as employers with 2-50 employees.

- *An overarching high-performing health system* in which per capita savings<sup>6</sup> from purchasing and delivery system redesign efficiencies are effectively *shared with* rather than *accrued to* Medicare to increase financing available for coverage expansion.

While revisions and implementation of the HIP can be completed independently of the details of the federal waiver, both efforts must be coordinated to support an efficient and seamless coverage continuum for Washington's low-income population – with or without Federal reform. Tracking and synchronizing with Federal reform efforts is culled out as a separate goal to emphasize its importance to State coverage reform efforts. The attention placed on higher-level coordination of these efforts across multiple agencies is a measure of our intention to be ready to take advantage of the convergence of Federal reform and our State's economic recovery.

We also see the monitoring and evaluation of reform efforts as an important opportunity to ensure that data collection systems are in place for tracking the impact of coverage expansions (such as the HIP) in a more standard way. In that sense we expect to develop an evaluation “template” for this and future expansion options.

**Additional Proposal Goal:** We recognize the importance of **fulfilling grantee obligations** to HRSA so we have allocated SHAP resources specifically to meeting key program expectations, that is, attending grantee meetings, submitting all required reports, assisting in developing national and summary reports, and providing assistance to other grantee and non-grantee states.

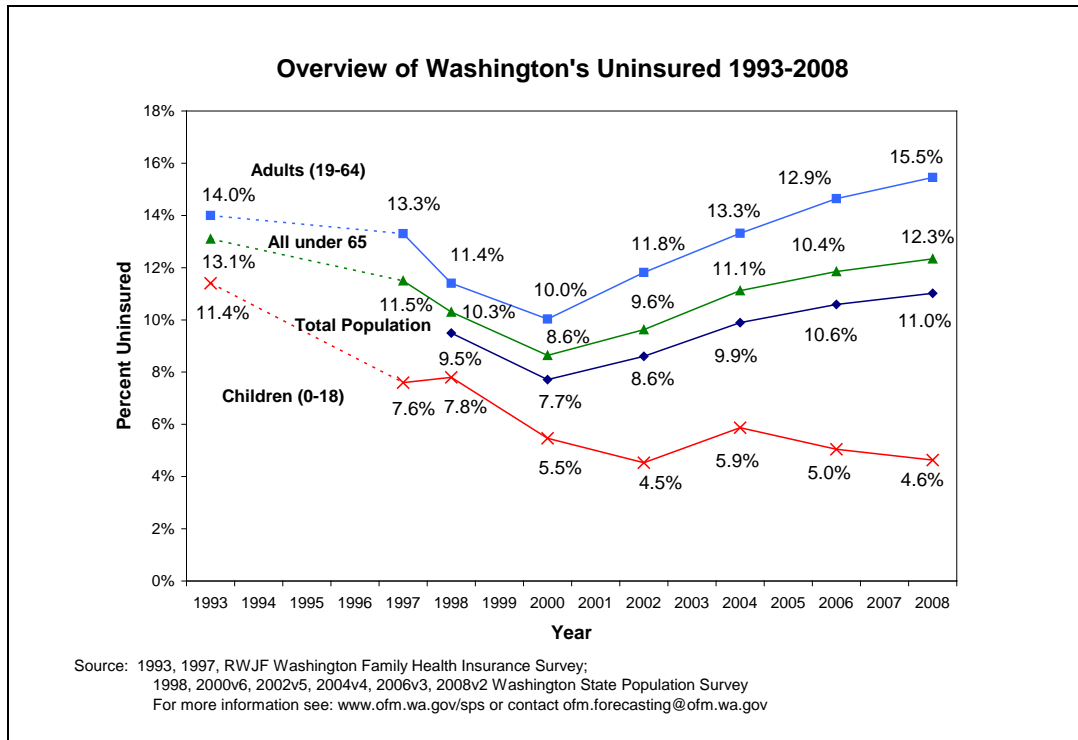
**Outstanding Question:** We have been asked why the public sector has taken on the coverage issue for small employers and their workers– couldn't the private sector handle it equally as well? Some have suggested that the private market could address the growing number of uninsured workers and families associated with Washington's small businesses if current restrictions (such as mandates and modified community rating rules) were lightened. Washington markets have had the opportunity to develop and offer “limited benefit plans” for many years to employers with up to 25 employees and more recently to employers with up to 50 employees. When the HIP was designed there had been little response to this opportunity, either in terms of carriers offering or employers purchasing. As the HIP developed, Washington carriers remained an integral part of conversations. We offer a letter of support from Group Health Cooperative in Attachment 6 which emphasizes the ongoing partnership we have with carriers in achieving the goals of our SHAP grant proposal.

## ***NEEDS ASSESSMENT***

Washington State has long been a national leader in providing health care coverage to its residents, emphasizing incremental steps that target low-income populations through affordable public programs. However, in recent years Washington has been losing ground. The current status of health insurance coverage is a story with several enduring messages: (1) rates of uninsurance appear to be increasing among adults, (2) characteristics and key health issues of the uninsured remain consistent, (3) fiscal deficits continue with no end in sight, (4) the delivery system faces growing challenges in providing care for the uninsured, and (5) the insurance market appears unable to offer affordable coverage to many small employers.

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<sup>6</sup> Our intent is to garner support for federal relaxation of traditional arbitrary budget neutrality standards in favor of an innovative approach that rewards and incents more efficient and effective care delivery.



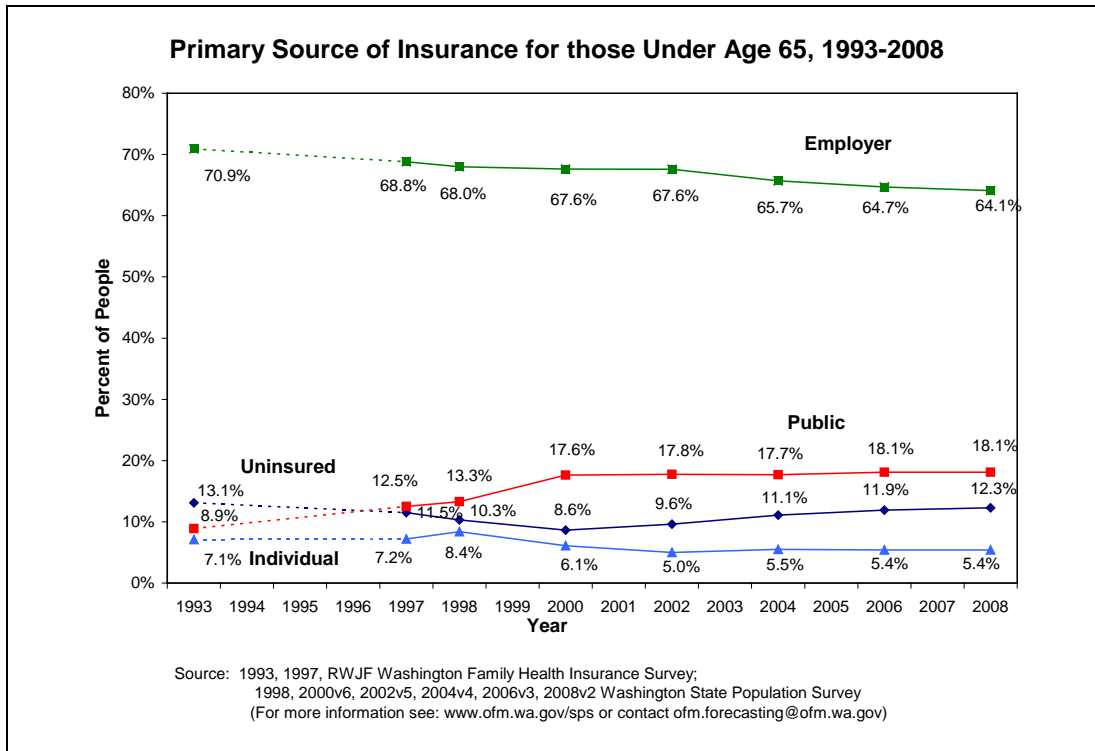
### (1) Rates of Uninsurance are Increasing for Adults

In the 1980's and 1990's Washington was a leader on many coverage fronts – expansion of coverage for low-income working families (Basic Health) and for children and their families (Medicaid coverage for children up to 200 percent federal poverty before CHIP); pre HIPAA market reforms; early adoption of a high risk pool; sweeping health care reform to achieve universal coverage (subsequently repealed); dedication of tobacco litigation dollars to health care (with an emphasis on prevention). Coverage steadily increased.

Since the dawn of the 21<sup>st</sup> century, however, Washington has been losing ground. The uninsurance rate for the total population increased from 7.7 percent in 2000 (the lowest it reached) to 11.0 percent in 2008<sup>7</sup> - close to 726,000 uninsured individuals. Orders-of-magnitude estimates just released by the Office of the Insurance Commissioner suggest that, as a result of the current recession and unemployment, the uninsurance rate is likely now 2 percentage points higher, around 13 percent uninsured in 2009. The majority of the uninsured are under age 65.

Since 2000, the rate of uninsurance dropped for children and has remained relatively steady at around 5 percent (differences are not statistically significant) – policies to cover all children have clearly taken effect. For adults however the story has been getting steadily worse. Rates of uninsured adults have increased significantly this century. Approximately 15.5 percent of adults aged 19-64 are now uninsured; of low-income adults under 200 percent of federal poverty, more than 35 percent are uninsured.

<sup>7</sup> Uninsurance rates are based on information collected by Washington State's biennial household survey. The Office of Financial Management (OFM) contracted with Westat to improve the 2008 survey response rate and to help adjust for nonresponse bias in the weighting process. (see <http://www.ofm.wa.gov/sps/default.asp>.)



For those that do have coverage, the trend mirrors the national story - a decline in access via employers coupled with a rise in access through public programs. For the **under age 65 group**, coverage via an employer has slowly but steadily dropped from about 71 percent in 1993 to 64 percent in 2008. Over the same period, coverage via public programs (Medicaid and Basic Health) more than doubled, increasing from about 9 percent in 1993 to over 18 percent in 2008. But, public program expansions have not been able to keep pace with declines in the employer-based (and individual) markets. The devil is in the details – although access via employers *appears* to have changed rather modestly over time, it has been the primary driver of the increasing uninsurance rate simply because so many of Washington’s residents traditionally gained access to health insurance via an employer. If employer coverage had continued in 2008 at the same levels as in 1993, an additional 390,000 individuals would have been covered via an employer. Even more striking is that if public coverage had continued at 1993 levels, close to 540,000 more individuals would *not* have coverage today.

## (2) Characteristics and Key Issues of the Uninsured Remain Consistent

Although rates of uninsurance have varied over time, the profile of Washington’s uninsured population has remained consistent and also repeats the story conveyed by national surveys for most states and the nation. For the **under age 65 uninsured** population, Washington’s 2008 story is that:

- Over 72 percent are **members of working families** (about 25 percent are connected to small employers, about 33 percent are self-employed, and the rest are connected to large employers).
- About the same number (71 percent) are **members of families that earn less than 200 percent of federal poverty**<sup>8</sup> (this group continues to have the greatest risk of being uninsured).
- Almost 48 percent are **members of working families and also low-income**.
- About 47 percent are **adults without dependent children**.
- Adults are now close to 6 times as likely to be uninsured as children. Close to 52 percent are **young adults age 19-34** while only 11 percent are children under age 19.

<sup>8</sup> Income for 2007 was collected during the 2008 survey - poverty level for a family of four in 2007 was defined as \$20,650.

- There continue to be major disparities in rates of uninsurance for more **rural regions** of the state compared to more urban regions, and for **racial and ethnic minorities**, American Indians / Alaskan Natives and Hispanics. However, these disparities are decreasing as more attention to preventive care is emphasized in efforts consistent with the Healthy People 2010 initiatives.
- The proportion of uninsured workers employed in large firms (with 50 or more employees) has been steadily growing since the late 1980's<sup>9</sup>. However, in 2008, nine out of every ten jobs in firms that do not offer health coverage are in **small firms employing 50 or fewer workers**.

The **key reasons** Washingtonians give for not having health insurance (consistent with national surveys) are that:

- **Insurance is unaffordable.** Overwhelmingly this is the reason given for not having health insurance. In Washington, many families cannot afford to buy private coverage unless their incomes are above 250 percent of federal poverty. Applicants in Washington's individual market must pass a health screen. Many of those who do not pass and are referred to the state's high-risk pool do not follow-through because it's too costly (even for those with some subsidy assistance).
- **Their employer doesn't offer insurance.** In some cases the employer offers coverage but the individual is ineligible (e.g., may be part-time, seasonal, hasn't worked for the company long enough, or dependent coverage isn't offered). For employees, there are three components to having coverage via one's own employer – working where it's available (offer), being eligible for it (eligibility), and (if eligible) accepting the offer (take-up). The relative importance of each component as a determiner of coverage differs by employer size and comparison period. Using Washington data from the 2006 Medical Expenditure Panel Survey and *focusing on workers in small firms* since they are the targeted expansion population:  
Within a given year, a worker is at greatest risk of not having own-employer coverage because it simply is not available, that is, the employer does not offer coverage at all.  
Across time, the picture is more complex. Decomposing the decline of coverage (1998-2006) into its three components is complicated by the interactions among the components. The resulting analysis shows that for employees of *small employers*, the decline of just over 6 percentage points is primarily driven by the worker's decision to not take-up coverage (about 6 percentage points). In addition there is a roughly 2 percentage point decline in offer offset by a similar sized increase in eligibility.

The **key health issues facing the uninsured population come as no surprise** – as national and state data show, lack of insurance means that people “live sicker and die earlier” than would be the case if they were insured. They delay or do without preventive, diagnostic and other treatment services. In early June 2009, the University of Washington reported a substantial drop in planned elective surgeries, as a result of insurance losses.

### (3) Fiscal Deficits Continue

Washington State faced a FY2003-2005 biennial budget gap of \$2.7 billion in a budget of \$23 billion. As in many states, this gap occurred primarily as a result of slower than expected revenue growth related to the recession of that time; growing public program caseloads (i.e., Medicaid, Basic Health and CHIP) and corresponding health care cost increases; increases in higher education enrollment; a growing prison population; and ballot initiatives that required increased teacher salaries and reduced classroom sizes in the K-12 education system (subsequently not funded). In response to this budget crisis, the 2003 and 2004 budgets directed that “a number of steps be taken to reduce the growth in spending on low-income medical assistance”.<sup>10</sup> These included eligibility limitations, increased cost sharing, and benefit cuts.

That was the backdrop for our 2005 State Planning Grant Pilot proposal to support the design of a small business assistance program --- which subsequently morphed into what we now know as the HIP. But

<sup>9</sup> Glied, S. 2003. The Growing Share of Uninsured Employed by Large Firms. *The Commonwealth Fund*.

<sup>10</sup> Testimony by fiscal staff, Senate Ways and Means Committee hearing, February 9, 2005.

those were relatively “good” financial times. In the recent development of the FY2007-2009 biennial budget, a \$9 billion shortfall was projected in a budget of about \$32 billion. Without a clearly supported (tax or other) vehicle for increasing revenues, the Washington Legislature had little option but to make painful cuts. One of those was the suspension of the HIP program.

The latest Washington state Economic and Revenue Forecast Council *Economic Review: June 5, 2009*, noted that “*the worst of the ‘Great Recession’ is behind us....bringing to an end the scary free-fall we experienced in the late fall and winter*”. However we have not yet reached the trough of the recession, although it “*is near*”. “*Initial unemployment claims appear to have peaked and monthly job losses appear to be moderating. ...But we expect the state’s unemployment rate will continue to rise, even after the recovery is underway, and to peak at 10.6 percent in the first half of 2010.*” “*The weakest areas have been construction, professional and business services, and non-aerospace manufacturing.*” “*The recovery in revenue will lag the recovery in economic activity because consumers need to be more confident of their economic circumstances before they increase their spending levels.*”

To successfully expand access to health insurance in this fiscal climate we will need assistance to shore up employer coverage via private/public partnerships like the HIP. If ever there was a time when states needed assistance in providing health insurance to their population it is now, and even with federal reform, help will likely be needed for a while to come. As is clear from our proposal, we will do our part.

#### **(4) The delivery system faces growing challenges in providing care for the uninsured**

There is broad recognition in Washington, and in the nation, that primary care is in crisis.<sup>11</sup> Primary care physicians are worn down by ever increasing complexity coupled with a reimbursement system that does not provide a sustainable business model to support a ‘medical home’ concept in practice. Consumers are increasingly dissatisfied with their health care experience; purchasers and insurers are frustrated with continually escalating costs and disappointed with the quality of care they buy.

Studies of Washington’s safety net *before* the full impact of the recession and subsequent rising unemployment levels (ranking Washington 2<sup>nd</sup> in the nation) indicated that the capacity to serve the uninsured in Washington was strong.<sup>12</sup> Today the safety-net is increasingly burdened as it is throughout the nation. For example, local National Public Radio reported on June 8, 2009 that Washington’s primary trauma center, Harborview Medical Center is seeing an increase of 2-3 percent in their charity care cases. While this may seem like a small increase, when applied to a large amount – Harborview is a high-level regional trauma center for Washington, Oregon and Idaho – that reflects a large number of cases. In this same report, a prominent chain of safety-net clinics reported a 27 percent increase in patients, with a demographic make-up that looks a lot more like the typical “middle-class” population. On the bright side, our Medicaid program, key in serving low-income children, is not seeing degradation in service or any apparent increased burden on the safety-net. It is the clinic system, serving increasing numbers of uninsured adults, which faces the greatest challenges.

#### **(5) The insurance market appears increasingly unable to offer affordable coverage to many small employers.**

Within the employer-based coverage market, Washington law distinguishes between small employers (groups of 2-50) and large employers (groups larger than 50.) Individuals not provided coverage through an employer have an opportunity to purchase health insurance through the individual market, in which approximately 8 percent with the highest health risk are screened into a high-risk pool. Three major carriers, Premera Blue Cross, Regence Blue Shield, and Group Health, provide coverage for over 80

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<sup>11</sup> Washington Coalition for Primary Care, “The Future of Primary Care in Washington State”, December 2007

<sup>12</sup> Holahan, J. & Spillman, B. (January 2002). Health Care Access for Uninsured Adults: A Strong Safety Net is Not the Same as Insurance. *New Federalism, Series B, No B-42*. The Urban Institute.

percent of the total market<sup>13</sup>. To be successful, any options that propose to increase coverage of Washington’s uninsured through the private market require the support of these “big three” carriers.

Of the 109,789 firms included in Washington’s 2009 Employer-Sponsored Health Insurance report, the vast majority are small. However, it is the larger firms that account for the bulk of total employment. One out of 3 workers is employed in small firms with under 50 employees. Taken from the 2009 Washington Employer-Sponsored Health Insurance report, the table below shows that regardless of the data source, small firms are least likely to offer coverage to their employees. These are the candidates for the targeted HIP expansion population.

<b>Comparison of Employer Health Insurance Sponsor Rates</b> (percentage of firms offering coverage to any employees)					
<b>2007 Washington Employer Health Insurance Database</b>		<b>2007 Kaiser Survey (National Rates)</b>		<b>2006 MEPS-IC Survey (Washington rates)</b>	
<b>Firm Size</b>	<b>Sponsor Rate</b>	<b>Firm Size</b>	<b>Sponsor Rate</b>	<b>Firm Size</b>	<b>Sponsor Rate</b>
2-9	49%	3-9	45%	1-9	33%
10-24	70%	10-24	76%	10-24	66%
25-49	83%	25-49	83%	25-99	90%
50-99	91%	50-199	94%	100-999	94%
100-499	96%	200+	99%	1000+	98%
500+	98%				
All (2+)	57%	All (3+)	60%	All (1+)	54%

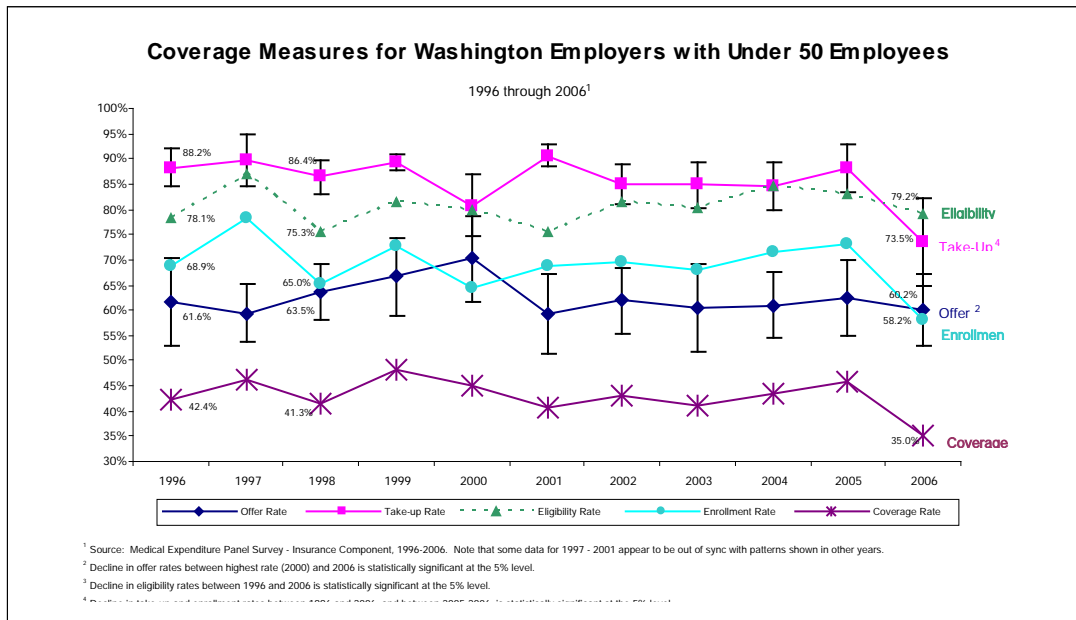
The 2007 Washington Employee Benefits Survey had a response rate of 57%.  
The 2007 Kaiser/HRET Employer Health Benefits Survey had a response rate of 75% for the question used to determine employer sponsor rates.  
The 2006 MEPS-IC Survey had an 81% response rate, but relatively small (~600) samples at the state level.

While virtually all large employers have sponsored health insurance since 1993, less than half of all small employers have been able to do so. Close to half the potential small group market includes workers in agriculture, construction, retail-trade, health care / social assistance, and accommodation and food service industries. These are also the industries in which we find low-wage workers and the lowest rates of employer sponsor in Washington, and thus also the likeliest candidates for premium assistance from the HIP.

Although employees in large employers remain more likely to be covered by their own employer than employees in small employers, the trend for being covered by one’s own employer is downward regardless of employer size. The degree of decline is difficult to precisely pinpoint and, like other measures, it differs by employer size and comparison period. However, it is fair to say that over time lower percentages of Washington workers are getting coverage through their own employer. For employees of small employers, an estimate based on the yearly rates in the chart below shows that coverage through one’s own employer, in Washington, declined a little more than 6 percentage points between 1998 and 2006<sup>14</sup>. The same chart shows a decline of nearly 15 points in take-up rates. As noted earlier it is the take-up rate that drives loss of coverage for employees in small firms over time, a measure of the increasing unaffordability of premiums.

<sup>13</sup> Managed care penetration (i.e., HMO penetration) in the state, taken from the current (2008) Kaiser Family Foundation state health facts is 18.6%, ranking the state at 28 in the nation. HMO enrollment (approximately 1,203,000 enrollees) includes enrollees in both traditional HMOs and HMO point-of-service plans through: group/commercial carriers, Medicare, Medicaid, FEHBP, direct pay plans and unidentified HMO products.

<sup>14</sup> 1998 (not 1996) is compared to 2006 in order to better ensure that comparable time periods are used for both yearly and moving-average forms of the data.



Although Washington’s health insurance market works well for many groups and individuals in the state, the high level and volatility of premiums create barriers for small groups seeking private insurance coverage<sup>15</sup>. In comparison with large firms, small firms have consistently experienced greater increases in insurance premiums since 1989, and greater variability in increases each year<sup>16</sup>. Their premiums buy fewer benefits with higher cost-sharing that varies more from firm to firm. The 2009 Employer-Sponsored Health Insurance report shows that while estimated employer expenditures on health care were about 8.6 percent of wages on average, the smallest firms (with 2-9 employees) contributed about 11.2 percent of payroll toward health expenditures. For small firms in the lowest wage quartile<sup>17</sup> the percentage increases to over 26 percent, inflated to some degree by part-time workers, but nonetheless an unsustainable contribution. Compared with large employers, administrative costs for small employers in general are higher and their risk pools more unstable as a result of greater cycling in and out of the market, employee turnover, and firm failure<sup>18</sup>. These factors drive carriers’ concerns about unpredictable risk and consequently impact premiums and benefit designs.

Insurance products in this market are therefore becoming increasingly costly, prompting small employers to shift costs to their employees or drop coverage altogether. For small firms that do not currently offer coverage, especially those small firms with low-wage workers, employer-sponsored coverage is simply unaffordable. It is likely that our recession has exacerbated these patterns.

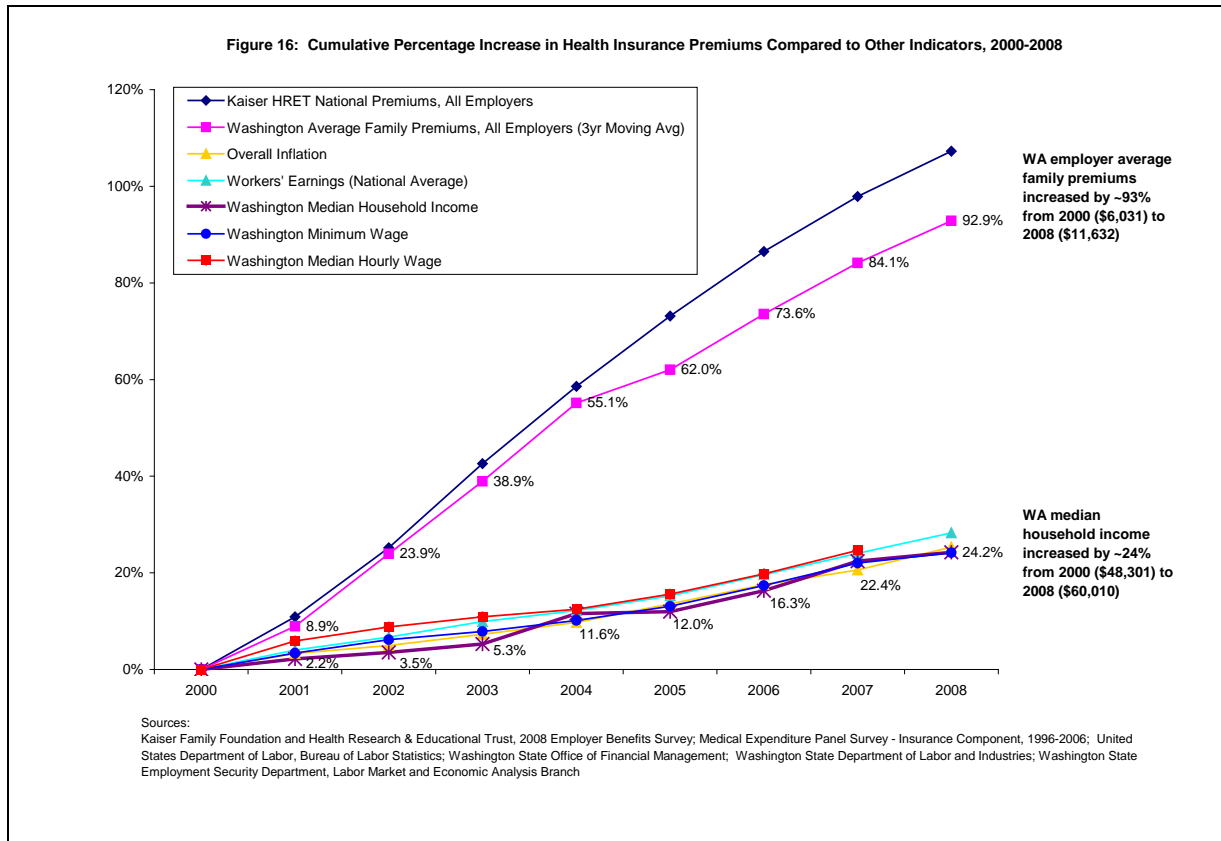
To put the issue in perspective, “*Figure 16*” below, excerpted from the 2009 Employer-Sponsored Health Insurance report, shows the cumulative increase in premiums compared with a variety of indicators of family income.

<sup>15</sup> Watts, C., et al. Pooling and Reinsurance in Washington state Health Insurance Markets: Review of the OIC Proposal. February 25, 2005.

<sup>16</sup> Gabel, J., et al. 2004. Risky Business: When Mom and Pop Buy Health Insurance for their Employees. *The Commonwealth Fund*.

<sup>17</sup> Firm assignment to quartiles was calculated simply based on total wages/total number employees.

<sup>18</sup> Lee, J. 2002. Are Health Insurance Premiums Higher for Small Firms? *The Synthesis Project*. Robert Wood Johnson Foundation.



It's clear that the discrepancy between premiums and income is an issue for the sustainability of health insurance in general. This is why we believe that **coverage expansion efforts without attention to long-run efficiency improvements and cost reductions in health care delivery cannot be sustainable.** We are not alone. President Obama has said that fixing what's wrong with our health care system "is no longer just a moral imperative, but a fiscal imperative." Gone are the days when we can depend on our prosperity to pay for the escalating cost of health care coverage. Washington State's access problem is a result of declining affordability – and the affordability crisis is a result of the quality issues in health care delivery and financing. Comprehensive reform will need to rein in costs, expand access, improve the quality of our health care services, and transform the health of our population.

**Past efforts to reduce the number of uninsured residents:** Notwithstanding the budget difficulties of the last few years and the recent increase in Washington's uninsured rate, we have a long-standing commitment to creating a "culture of coverage" for all residents, a vision consistent with the full-coverage goals of **Healthy People 2010** and the SHAP program. A 2002 assessment of health policy for low-income people in Washington noted that Washington has been a leader in health reform beginning with a major legislative package passed in 1993.<sup>19</sup> That package included employer and individual mandates, expansion of Medicaid coverage for low-income children, extended home and community based coverage for the elderly and disabled, major reforms of the individual and small-group insurance markets, and expanded enrollment of the state's Basic Health<sup>20</sup> program.

<sup>19</sup> Holahan, John and Mary Beth Pohl. "Recent Changes in Health Policy for Low-Income People in Washington." Assessing the New Federalism, State Update No. 24, February 2002. Washington D.C.: *The Urban Institute*.

<sup>20</sup> Basic Health is a state-only funded program for low-income working individuals. It contracts with private health plans and provides subsidized coverage, using an income-based sliding scale, to people at and below 200% of federal poverty, not eligible for Medicare, and not institutionalized at the time of enrollment. (There are a few nuances to these eligibility rules, such as for homecare workers, but the above cover the main criteria.)

While many of the health reform components were repealed by the Legislature in subsequent years, major public program expansions continued and were very successful. By 2002, nearly 96 percent of the state's children were insured. These expansion efforts built upon the Medicaid and Basic Health programs, targeting (1) uninterrupted coverage for low-income children ages 0-18, (2) affordable public / private pooling for low-income working adults, and (3) family unity by coordinating coverage for children and adults across programs.

Between Medicaid and Basic Health, approximately 958,900 residents, (i.e., 16 percent of all state residents), including 538,000 (i.e., 33 percent) children were covered in July 2001. At the same time that employer-based coverage rates were declining, Washington's overall insured rates were increasing due in no small part to public programs, as noted – at least up until 2002.

Washington's history beginning with the 2001-03 biennium, vis-à-vis public programs is a little different. The nexus of our progressive social policy and our conservative fiscal policy (coupled with the economic downturn that is now considered the most challenging in decades) have produced a health system in which individuals are losing coverage and rates of uninsurance are increasing as described earlier. In recent legislative sessions in response to one of the longest recessions and deepest budget deficits in recent Washington history, difficult policy and budget decisions have been made to reduce the growth in spending on public programs through eligibility limitations, increased cost sharing, and benefit cuts.

In the midst of this bad news, incremental steps for public programs have been made. In particular, a cycle of debate, legislation, subsequent debate, and adopted statutory revisions, resulted in the passage of legislation to design and implement a small business exchange, the Health Insurance Partnership (HIP) (see [www.HIP.HCA.WA.GOV](http://www.HIP.HCA.WA.GOV) for details on the design and implementation planning). A history of Legislative action in support of small business is included as an Attachment to the Project Narrative. In spite of the economic environment, political support for the HIP is as strong as it's ever been – letters of support from the Chairs of the House and Senate Health committees are included in Attachment 6.

In parallel with specific coverage expansion interest, there has been equally strong ongoing support for efforts to increase the efficiency of public purchasing programs and the care delivery systems. In 2005 Governor Gregoire launched a five-point health care strategy that (a) emphasizes evidence-based health care, (b) promotes prevention, healthy lifestyles and healthy choices, (c) better manages chronic care, (d) creates more transparency in the health care system and (e) makes better use of information technology. Known as the Governor's "Big 5", initiatives being implemented in these areas are a major piece of Washington's health reform. Two nationally recognized initiatives are described below.

**Application to Other State Efforts to Reduce Numbers of Uninsured:** During the prior State Planning Grant (SPG) activities, Washington tapped into a broad range of expertise that would otherwise have been much less readily available. And, in the spirit of shared learning Washington gave presentations on its efforts to other SPG participants at SPG meetings in Washington D.C., and at conferences sponsored by the Robert Wood Johnson Foundation-funded State Coverage Initiatives program. In the area of Medicaid-related coverage expansion we have been active participants in sharing lessons learned through the National Academy for State Health Policy (NASHP). We have a reputation for sharing our knowledge in a collaborative endeavor to replicate what works and revise what doesn't work. We expect that to continue.

Implementation of the HIP as a small business exchange offers model learning for other states in which small firms are struggling to offer and sustain coverage for their employees and families. While Massachusetts was able to pursue health coverage expansion on a grand scale through its comprehensive Connector initiative, the introduction of the exchange concept in Washington has been acceptable only on a much smaller scale. The experience of the HIP in Washington will continue to offer concrete and

readily applicable information for many states that are more tentative about the potential of an exchange than was Massachusetts.

In tandem with coverage expertise, Washington has embarked on high-performance system efficiency efforts that have application elsewhere and are receiving national interest. Programs of note include:

**Health Technology Assessment:** This program uses rigorous analysis of evidence and an independent clinical committee to make decisions about whether certain medical devices, procedures, and tests are safe and proven to work; only then do state programs pay for the services. For example, Health Technology Assessment has made evidence-based decisions to cover a lumbar fusion under certain conditions. An implantable infusion pump for chronic, non-cancer pain is not covered. Upright MRIs are not covered. The committee's most recent decision is striking: comparing two types of cardiac stents (drug eluting and bare metal), the committee found that each was equally good at preventing death and heart attack, and that while drug eluting stents reduced the need for repeat procedures by about 10 percent, the additional cost of \$3,800 per stent was not worth the benefit for most patients. *The reduction in payment of using each lower-cost stent is equal to the cost of covering one Basic Health enrollee for a year.*

**Medical Homes:** The Washington State Legislature directed a multi-agency and multi-payer effort that focuses on delivering patient-centered primary care through medical homes, specifically evaluating and modeling payment strategies tied to provider participation in patient-centered medical homes. Reimbursement pilot activity will be convened by the state with planning and design activities to begin in June 2009 and pilot implementation targeted for July 2010. This public-private collaborative effort is supported by the Puget Sound Health Alliance and the Primary Care Coalition, primary care physicians and practices in Washington State organized to advance recommendations for high quality primary care delivery and payment models that are consistent with the patient-centered medical home model.

## ***METHODOLOGY***

Project goals, tasks and activities, timetable, task leads and coordinating parties, anticipated results, and evaluation/measurement tools (deliverables) are summarized in the Project Management Plan included as Attachment 3. The following is a narrative version of that information.

### ***Goal 1: Implement the Health Insurance Partnership – Washington's Small Business Exchange***

The Health Insurance Partnership (HIP) increases access to health insurance by subsidizing small group enrollment of low-income workers and their families, those with incomes below 200 percent of federal poverty guidelines, in an exchange. The subsidies help pay the premium share of the low-income workers. The HIP does not negotiate rates or design and offer its own health plans, rather it collaborates with health insurance carriers to designate up to five private plans, ranging from catastrophic to comprehensive coverage, and selected from plans already being offered in Washington's small group market. The carriers then offer those plans through the HIP to predominantly low-wage firms. Employers enrolling through the HIP must offer Section 125 plans to help finance employee contributions. Employers select the plan, but the HIP was also directed by the Legislature to develop and implement individual employee choice of plan within two years of initial implementation. An employer must contribute at least 40 percent of the premium for a single employee, and at least 75 percent of eligible employees must participate in the plan, the same as the private small group market. The shared responsibility of employer and employee contributions, combined with HIP subsidies, pays the premium for small groups of subsidized and nonsubsidized enrollees. Health insurance carriers rate HIP enrollees in the same community-rated risk pool as the carrier's other small group enrollees.

A seven-member Board of health benefits experts sets policy for the HIP and provides guidance. For example, the Board designates the small group health plans offered through the exchange and determines the minimum employer premium contribution.

SHAP grant dollars will support the re-examination of policies that were perceived likely to raise barriers to some employers who wish to sponsor coverage. The Health Care Authority (HCA) Administrator chairs the Board, and the HCA is responsible for operating the HIP. For example, the HCA administers eligibility and enrollment for small employers and develops and implements a sliding-scale premium subsidy schedule. It may also apply a surcharge to each health plan to help pay administrative and operational expenses.

### **HIP Phase 1: Pre-implementation Activities (September 2009 – August 2010)**

Phase 1 activities will finalize details for implementing the HIP so that applications can be accepted on August 1, 2010 for coverage beginning September 1, 2010. Although the HIP was ready to provide coverage in March 2009 to meet its initial Legislative deadline, some issues were identified that might have created barriers to enrollment. In collaboration with the Board, the HIP's Technical Advisory Committee and agency leaders, the SHAP grant affords an opportunity to examine modifications to the HIP that will enhance its ability to a) provide coverage to uninsured employees of small employers and (b) coordinate with other state and federal reform initiatives.

We expect that some desirable policy modifications, once approved by the Board, will require legislative amendments to implement. The process to begin amending the statute would begin when Washington's Legislature convenes in January, 2010. Legislative changes adopted by mid-April 2010 (end of the 2010 session), would take effect with HIP implementation in August 2010. If changes are not adopted by the 2010 Legislature, HIP implementation in August would follow the public/private partnership currently directed by the legislature in [Chapter 70.47A RCW, Small Employer Health Insurance Partnership Program](#).

Irrespective of program modifications, pre-implementation activities will result in refining marketing and application materials, confirming the staffing and readiness of the third-party administrator, designating health benefit plans, and broker training would be performed by the HCA from July 2010 through September 2010.

The University of Washington research team will monitor and document discussions, processes, alternatives, and decisions. The team will determine what data is needed and design how to capture and analyze the data to produce a thoughtful and timely evaluation.

**Task 1** (Sep 09 – Oct 09) initiates HIP project planning. The pre-existing HIP project structure and administrative details would be reconstituted and confirmed. The HCA will confirm and assign project resources to support successful implementation in August 2010. Reports, deliverables, documents, contracts, and web resources from the previous HIP design will be assembled to jumpstart the project. The HCA will re-convene the HIP Project Team (Project Director and Staff), the HIP Board, and the Technical Advisory Committee. Preliminary meetings will be held with brokers/agents, carriers, business groups, and other key stakeholders to explain the SHAP grant project direction and timeline. The HIP Project Team, in coordination with HCA executives and the HIP Board will develop a detailed project plan identifying assignments, resources, due dates and linkages to other agencies, Boards, and committees. Preliminary consulting contracts and agreements<sup>21</sup> will be negotiated based on the

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<sup>21</sup> Experts who have agreed to participate in the HIP implementation effort (pending agreed-upon contracts if Washington receives an award since we legally cannot commit anyone in the absence of an award) include Harrington Health (Third Party Administrator (TPA) which was prepared to administer the program in March); Milliman (actuarial consulting on policy impact analysis, application systems quality assurance testing, focus group

preparatory legwork done in this area in preparation for the anticipated March 2009 implementation of coverage.

Under **Task 2** (Sep 09 – Dec 09) modifications and enhancements for an “ideal” HIP that were identified by consultants and the HCA during the original design of the HIP, will be compiled. Identifying and describing the goals and important features of each improvement will be a key discussion in pre-implementation kick-off meetings of the HIP Board, its Technical Advisory Committee, and stakeholders. The HIP Project Team and HCA executives, in collaboration with the Board and technical advisors will prioritize improvements to be examined as potential modifications to the HIP. Issues will be separated into (a) those that can reasonably be resolved pre-August 2010 for adoption into the initial program and (b) those too complex or challenging that will need further study or should be examined at some point after implementation successes and challenges have been identified.

In **Tasks 3-6** (Sep 09 – Dec 09) we will examine modifications selected by the HIP Board for further analysis. The HIP Project Team with support from its actuarial consultants will complete analysis of issues raised, summarize findings, and offer potential alternatives for review and adoption by the Board and subsequent Legislative action as needed. Currently anticipated analysis includes:

**Increasing employee take-up in the HIP.** To enroll more small groups, the HCA will consider extending premium subsidies to families with incomes up to 300 percent of federal poverty guidelines. Design of multiple subsidy schedules would need to ensure that equitable premium assistance could increase take-up within limited funds. Federal reform may also consider the possibility of extending subsidies to higher levels of income to achieve enrollment goals. Washington’s experience with extending subsidies to additional families who cannot afford health insurance premiums will likely provide leaders with additional knowledge and flexibility to reduce the number of uninsured people in our state under federal reform.

**Voluntary employer establishment of a Section 125 plan.** Section 125 plans are not consistently the best option for the lowest-income employees because they can interfere with their Earned Income Tax Credit. The HIP is well-positioned to offer technical (not legal) assistance to employers to establish a Section 125 plan, and many will find this an attractive option for their employees.

**Increasing employer take-up in the HIP.** Offering the HIP to more employers necessitates examining the regulation of Washington’s current private health insurance market. The HIP is currently restricted to covering employer groups through the small group health insurance market<sup>22</sup>. Washington has a thriving market for Association Health Plans (AHPs) which covers many small employers and their employees as members of an association group, and has been growing in recent years as the small group market declines. AHPs are not regulated as small employer groups in Washington and so do not purchase their coverage through the small employer market. Consequently, HIP subsidies can not be made available to individuals who enroll in AHPs. The HCA could examine the possibility of providing AHPs with the option of offering their member plans through the HIP. An exchange designed under federal reform may target a broader set of small employers than the HIP, so any opportunity that allows the HIP to gain experience with serving a broad population would enhance Washington’s ability to adapt to federal reform.

Recent amendments to the HIP’s statute -- in the 2009 legislative session -- may have unintentionally created barriers to entry that would negatively influence enrollment. To target employers with the greatest economic barriers to coverage, eligible employers must have 50 percent low-wage workers. (The

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follow-up); University of Washington (qualitative and quantitative outcomes evaluation planning and findings); Gilmore / Westat Consulting (Survey instrument and weighting methodology design and fielding).

<sup>22</sup> The small group market offers products to employers with 2-50 employees.

Board set \$10 per hour as the initial low-wage standard for 2009.) Based on analysis by Mathematica Policy Research, Inc., targeting employers with 50 percent low-wage workers made many employers -- not currently offering coverage -- ineligible for the HIP. With the help of HIP subsidies, these employers might have been able to enroll low-income employees who did not meet the definition of low wage.

**Benefit package design:** Although not likely to be completed in Phase 1, analysis of alternative benefit designs will begin in Sep 2009 and be completed in subsequent years along with options adopted by the Board as legislative proposals. Washington's small employers continue to be interested in purchasing less expensive benefit designs and the legislature encouraged the HIP to offer benefit plans that maximize quality of care and improve health outcomes. We can draw upon a reservoir of hands-on research to examine potential benefit designs: Washington's health insurance carriers offer different benefit designs to AHPs and may well want to propose other alternatives to the HIP Board. Value-based benefit designs have been pioneered by Pitney-Bowes and other innovative employers and are promoted by the HCA's Washington Wellness Team. In response to the Blue Ribbon Commission, Washington's Insurance Commissioner reported, in collaboration with Milliman, on the potential to lower premiums by 10 percent through a combination of aggressive rating and benefit restrictions. Recently, Miami-Dade Blue Cross has begun offering a nonsubsidized benefit package for \$100 for a 35 year-old man. Rhode Island inserted consumer expectations that included regular checkups and participation in care management into HealthPact plans to reduce premiums by 15 percent. Finally, the plans offered through the Massachusetts Connector will continue to inform our perception of affordability. Even if the HIP Board decides not to adopt any options for legislative consideration, the research into alternative benefit designs should offer guidance on the level of coverage expected in any exchange designed under federal reform.

**Individual employee choice and portability of a HIP health plan** (not to be completed by initial implementation). Offering individual choice of plan would constitute the HIP as a full-fledged exchange. The legislature directed the HIP to offer individual plan choice but also allowed the Board more time to examine concerns about adverse selection and develop feasible processes and options for offering and rating plans. We expect to examine options that offer levels of choice more feasible to known rating practices and options such as reinsurance or risk adjustment. Options for choice and their associated rating mechanisms must support a stable risk pool. We will develop an analysis plan, examine processes for offering individual choice, develop and examine rating options, and analyze and discuss findings, implications, and feasible policy options and the potential for any legislative proposals that modify how choice should be offered. In this effort we will consider risk adjustment processes<sup>23</sup>, and how the Massachusetts Connector employed reinsurance, as methods for developing a feasible and equitable rating mechanism for the HIP.

**Task 7** (Oct 09 – Dec 09) will afford an opportunity to “test” the potential impact of modifications to the HIP for implementation in August 2010. Actuarial consultants will model the likely impact on employer offer and employee take-up in the HIP. We anticipate that focus groups, (two employer groups and two employee groups) similar to those conducted for the preliminary HIP design, will test out the likely impact on small employers and their employees. Results from this task will inform Board and Legislative deliberations.

**Task 8** (Oct 09 – Dec 09) is where legislative changes for HIP modifications are drafted, discussed and adopted by the Board. With Board support, we will seek the Governor's approval and Legislative sponsorship for a 2010 legislative session technical corrections bill to amend the HIP statute. While these changes will likely make the HIP more successful, they are not a necessary requirement for implementation. If the Legislature does not adopt them in 2010 they will not delay HIP implementation.

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<sup>23</sup> In 1997 the HCA implemented risk adjustment among managed care plans that contract to provide coverage for State employees and their dependents.

In **Task 9** (Oct 09 – Jun 10) we contract with the third-party administrator (TPA) that will ultimately administer the HIP. The timing on this task may be tight since we cannot get consultant contracts in place until after the SHAP grant award announcement. However, much of this task is about confirming the readiness to implement in August 2010, the administrative and operational tasks completed by the contracted TPA in place when the HIP was delayed. We do not expect an issue since Harrington Health has agreed to support the HIP in the future, pending a finalized contract. With support from Milliman, the HCA's actuarial consultant, we will conduct the quality assurance system testing to determine the readiness of the TPA. This will include modifications (especially computer system modifications) required to support changes identified in tasks 3-7. Linkages to HCA accounting and financial operations and procedures will be verified and completed. Information for ongoing monitoring or evaluation will be identified and procedures for data collection established. At the end of this task, HIP operations, administrative functions and procedures within the HCA and the TPA will be ready to go live.

**Task 10** (Sep 09 – Aug 10) refines HIP administrative products, rules, and procedures. The HIP was implementation-ready when it was suspended. However, this task is crucial for verifying and updating, for example, employer and employee applications and the employer agreements. The Section 125 handbook will likely need revision if employers are no longer mandated to provide a Section 125 plan. Each document will be reviewed for cultural competence that includes a determination of the need for translation into multiple languages. The HCA will need to coordinate changes needed in agency rules to support the HIP's governing statute or to clarify how compliance is achieved. Internal HCA policies and procedures for the HIP will be reviewed and modified as needed. The HIP Project Team and the TPA will develop and conduct training for staff involved in operating the HIP.

**Task 11** (Jan 10 – Mar 10) is where the Board selects specific health plans to be offered by the HIP for coverage in September 2010. The HIP Project Team will convene meetings with prospective carriers to reaffirm the coverage needs of the HIP target population, discuss requirements of offering plans under the HIP, and provide necessary guidance. Carriers will then identify and propose health plans – that are currently offered or will be offered in the small group market – to the HIP Board. The HCA and HIP Project Team will evaluate the options submitted by the carriers with assistance from the actuarial consultant. Analysis will confirm the categories of plans, from catastrophic to comprehensive, to be offered by the HIP. To best communicate the contents of the benefit packages, the health plans will be arranged by these categories. When this process was conducted prior to suspension of the HIP it resulted in plans being offered by each of Washington's three major domestic carriers and covered all 39 Washington counties.

**Task 12** (Jan 10 – Mar 10) is where we communicate with the Governor and Legislature on progress and support needed to implement the HIP (i.e., Legislative changes identified and drafted in task 8). Although the overall SHAP Project Leader will maintain regular contact with both the Governor and Legislature, this task is a scheduled opportunity for policy or resource issues posing implementation challenges to be formally raised by the day-to-day Project team, and options for resolution discussed. Briefings will clarify priorities for future policies and gauge support for future modifications. If requested, a formal report to the Governor and Legislature will be provided.

**Task 13** (Sep 09 – Aug 10) completes the full design of a two-part evaluation, qualitative and quantitative, of the HIP program. An active evaluation of the HIP is crucial to sustaining the partnership between the private and public sectors, and continued coverage of low-wage small employers. With the assistance of the contracted University of Washington research team, a series of design meetings will be held to distinguish data collection needs for (a) monitoring the program on an ongoing basis, and (b) evaluating outcomes to understand the longer-term impact on goals. These meetings dovetail with Goal 3 and the ongoing improvement in data collection to support assessment of the effectiveness of coverage expansion efforts.

For both monitoring and evaluation efforts there are qualitative and quantitative components. The HIP Project team will focus on the program monitoring needs with a view to detecting early-warning signs of operational issues and quick-fix steps that can be taken to improve the HIP. The University of Washington will focus on program evaluation elements. At a minimum, questions we will want to answer to design an effective monitoring / evaluation process include:

- What specific policy and program management questions do we want to answer via monitoring? Via evaluation?
- What data need to be collected to monitor real-time impacts (e.g., to judge if immediate changes are needed)?
- What data need to be collected to evaluate the longer-term impacts such as impacts on small employer offer rates, employee/family take-up rates, employee retention, the impact of (new) health insurance on employee absenteeism, premium levels and premium volatility, carrier participation and satisfaction, impacts on markets outside the small business exchange? What else needs to be on this list?
- How long would the program have to run to have the ability to conduct a viable evaluation? (We have anticipated at least 1 year).
- How well does the program meet the needs of small employers in different areas of the state?
- How well does the program meet the needs of small employers with different work force characteristics (e.g., employees are predominantly full-time versus part-time, predominantly low-wage or not, predominantly female or not, predominantly younger or not, predominantly one versus multiple-employer)?
- What impact does the HIP have on micro firms (less than 10 employees) where offer and take-up rates are lowest? Or other target employer groups?
- Should we consider the age of a firm as we refine our targeting? Do older, established firms seem to be more likely to be in a position to consider coverage?
- Does there appear to be an issue of crowd-out?
- In the end, what design elements need to be tweaked to make the program easy to access and use for employers and their employees?

In terms of lessons learned that may have value for other states interested in the outcomes of the HIP or other exchange-like opportunities, we want to understand “WHY” we achieved the results we did.

- What were the processes, policy decisions, structures, implementation approaches, federal subsidies/other available financing that combined to cause the outcomes we see?
- How did these interact to achieve the successes, challenges, and failures experienced by the HIP in its development and ongoing operation?
- What does this effort suggest for improvement in future expansion coverage efforts?
- What administrative changes are suggested – for the HIP in its current state and/or to improve future coverage expansion efforts?

Monitoring and Evaluation efforts will inform future conversations with the Board and update other states following Washington’s progress. The intent is to develop an evaluation template for the HIP that can be easily adapted to future coverage expansion efforts in Washington. In addition to the tangible evaluation design details, the University of Washington research team will document the progress of the HIP up to its implementation to gather input for understanding the “why” of implementation results. Following implementation they will continue this effort until the program has been operating for at least 1 year when the more rigorous quantitative evaluation can be performed (task 19).

**Task 14** (Apr 10 – Jun 10) prepares for an outreach effort to inform small employers that “the HIP is now operational and providing coverage”. Any remaining issues involving outreach must be identified and resolved to maximize the HIP’s engagement of eligible small employers. A consultant will be procured to develop a media campaign with guidance and approval of the HIP Project Director. Marketing materials will be revised, with attention to cultural competency needs (e.g., alternative languages).

Documents will be readied for mass publication and media campaigns scheduled – awaiting the final GO decision in task 16.

**Task 15** (Jul 10 – Aug 10) conducts broker training and convenes stakeholder meetings (e.g., for employer associations and advocates) to inform essential partners of their role and the timing of the HIP’s start-up. This task is important to limiting the potential for miscommunication or the need to alter or clarify expectations about the program. We envision the development of a training video to reinforce concepts heard in trainings and meetings. Given that the HIP was suspended by the 2009 Legislature we will need to counteract any last minute “fall-out” in terms of ongoing insecurity about the program. Broker training and stakeholder meetings will occur around the state so that small employer groups can begin enrolling in August for coverage effective September 2010. These meetings will be used to maximize support and assistance during initial implementation and ongoing operation of the HIP. They will also afford an opportunity to communicate essential modifications and key expectations of the program to a broad audience.

**Task 16** (Jul 10 – Aug 10) is the final opportunity to take stock of any incomplete assignments or last minute unresolved issues before implementation. Identification of outstanding systems, marketing and outreach, enrollment, customer service, evaluation, and other implementation issues will confirm a need for immediate attention and resolution and assess the final readiness to “flip the switch”. This will be a hands-on exercise led by the HIP Project Director and involving all HIP-related staff. Issues that must be resolved before implementation will be quickly elevated. Although we would not anticipate an issue, in this task we will need to confirm the availability of SHAP subsidy funding in year 2 of the grant so a final GO decision can be issued by the HCA.

**Task 17** (Aug 10) **IMPLEMENTATION** - triggers the acceptance of applications for enrollment in the HIP for coverage beginning September 2010. Covering employees (and their dependents) of small employers initiates Phase 2 of the HIP project, the Post-Implementation activities.

### **HIP Phase 2: Post-Implementation activities (September 2010 – August 2012)**

**Task 18** (Sep 10 – Jun 12) will conclude the analysis of individual choice and portability of a health plan begun in Phase 1, task 6. By this time extensive modeling, policy discussions, and stakeholdering will already have been performed. This task will conclude the analysis of options for offering choice of plan and the rating mechanisms needed to support each option. Employers will have selected the health plan for each small group during initial implementation of the HIP. If it is not clear that individual employee choice and portability is more acceptable to consumers than their employer choosing the small group’s health plan, then the Board retains the option of requesting that the Legislature remove the requirement of offering individual choice and portability through the HIP. That decision would require a statutory change to be negotiated during the 2012 session.

**Task 19** (Sep 10 – Sep 13/ or merge with federal reform in Goal 3) is where we conduct the evaluation (quantitative and qualitative) designed earlier in task 13. This includes both the quantitative and qualitative components conducted by the University of Washington research team. Their reports will provide the HIP with opportunities to apply lessons learned and improve its performance. If at all possible we would expect to transition the evaluation to the HIP (Operations) Project team after the first year’s evaluation. A report by the University of Washington will also initiate the formal process of disseminating information to other states or local programs and likely prepare the HIP for becoming a model for federal reform or merging with federal reform.

### **HIP Phase 3: Evolution in Response to State and Federal Reform (Overlapping) (January 2012 – September 2014)**

**Task 20** (Jan 12 – Sep 14) Included here as a technical placeholder, Goal 3 describes the full extent of Federal Reform tracking, monitoring and response that cuts across all agencies engaged in this task.

***Goal 2: Implement Initiatives for Seamless Coverage and Purchasing/Delivery System Efficiencies***

Washington has an interest in ensuring that all its residents have access to health insurance and a delivery system that is efficient, effective and science-based. Alongside the HIP implementation, SHAP grant dollars will initially support pre-implementation activities geared toward the examination of purchasing and delivery system components seen as dragging down and fragmenting public programs that serve low-income populations. We envision a seamless system for this growing group, with expansion financed through system savings that can be applied to coverage. Key to this reform is a federal Medicaid waiver, which may change as federal reform negotiations proceed. Nonetheless, this work is a Legislated directive and will *begin before a SHAP award is known* regardless of any other reform activities. We would obviously be very glad to receive an award as it would supplement our current commitment and enable a more comprehensive and rigorous analysis and design, and speedier implementation of reform elements.

**Task 21** (Pre-SHAP grant Jul 09) covers pre-project activities (completed at State expense) designed to jumpstart the SHAP project. They include an environmental scan of literature and local/national experts, to identify as much detail as possible on known or projected opportunities for improving low-income population purchasing and delivery systems. We are looking for transferrable ideas that will be briefly documented to lay the foundation for our “visioning” retreat in task 23. Planning and preparation for the retreat will occur at this time.

**Task 22** (Sep 09 – Oct 09) is where we focus on ensuring that administrative details for this goal (and its linkages to other goals) are confirmed; refining and finalizing the project plan, staffing, and governance approaches; holding an initial inter-agency project team meeting to confirm project goals and general direction; and doing remaining legwork needed for consultant contracts.

**Task 23** (Sep 09 – Oct 09) is where we hold the “visioning” retreat, a series of brainstorming meetings, that will lay out the potential elements of our purchasing and delivery systems reform. An interagency team of subject-matter experts from the Department of Social and Health Services - Health Recovery and Services Administration (DSHS-HRSA), the HCA, and the Office of Financial Management (OFM) will use briefing materials from task 21 as the starting point. Arcadia Point Consulting (APC) will be contracted to facilitate the meetings and help winnow the myriad ideas to those on which in-depth analysis is needed to inform further consideration. We initially anticipate that elements of our higher-performing system will fall roughly into buckets that are likely to include:

- Entitlement Financing (e.g., budget neutrality alternatives);
- Purchasing Redesign (e.g., revised eligibility standards, standardized benefits, procurement processes, increased employer participation - which could potentially interface with the HIP);
- Delivery System Efficiencies (e.g., integration of medical, mental health and chemical dependency service delivery, cost-sharing options, medical home payment reforms, generic drug incentives); and
- Administrative Simplification (e.g., streamlined eligibility.)

Preliminary identification of federal barriers to reform will occur, with a charge to complete follow-up analysis. Following each brainstorming session (likely 3-4), APC will guide the development and refinement of the analysis plan.

**Task 24** (Sep 09 – Jan 10) is where the *analytic* work occurs. Staff will be supported by the actuarial consultants Milliman and Mercer, as needs be, in completing detailed policy and data analysis defined during brainstorming sessions and in subsequent analytic review meetings (Task 25). Where needed,

estimates of potential costs and benefits (e.g., savings, efficiencies) of each alternative will be determined. Directed by the DSHS-HRSA Project Director, analysis will help identify areas of enabling statute that may need to be changed to support reform elements and specific federal waiver needs. Planning and preparation for meetings of the interagency subject-matter experts will occur at this time – we expect that an initial set of criteria will be necessary to help the group prioritize what to do, when to do it, and who will do it.

For example, it will be important to settle on criteria like the following (developed to aid the BRC decision-making process) to prioritize reform efforts that should be targeted for near-term vs. long-term implementation.

<b>Sample Criterion:</b>
Promises, in a significant and measurable way, to <b>move the health care system</b> in Washington to where we believe it should be in 5 years <b>by increasing the efficiency, effectiveness and science-basis</b> of State purchasing and delivery systems.
<b>Reflects active collaboration</b> , in both its design and implementation, among various stakeholders in the health care system
Is <b>feasible</b> .
Is <b>sustainable</b> .
Is <b>affordable</b> .
Serves as a <b>bridge to future opportunities</b> .
<b>Builds the capacity of health care organizations</b> in the state <b>to continue to address deficiencies</b> in the health care system on a long-term basis
<b>Addresses long-term core issues</b> rather than episodic or time-limited issues.
Is <b>creative and innovative</b> in both what is done and how it is accomplished, <b>building on and streamlining existing policies &amp; programs</b> , rather than simply duplicating them.
Other Criteria of Interest:

**Task 25** (Dec 09 – Jan 10) is where we convene a series of critical meetings with our interagency subject-matter experts to discuss analytic findings, identify additional analysis needs, and come to consensus on next step priorities. Timing is not ideal given holidays, executive budget development and the initiation of the 2010 Legislative session, so we will do everything possible to complete this task sooner rather than later.

After adopting decision-making criteria (drafted in task 24) the group will make recommendations on elements of a federal waiver needed to approve variations from standard federal practice to enable implementation of our purchasing and delivery system reforms. As in the brainstorming sessions, our APC consultants will facilitate the consensus-building process and assist with revisions to the analysis plan. As clear reform directives are identified, materials needed for executive decision-making will be developed by staff. We will develop a standard template to use in laying out issues, synthesizing discussions and options, and providing recommendations and rationales so that decisions on moving forward can happen as soon as possible, whether they require a federal waiver request or not. We anticipate that some reform activities will be naturally incorporated as revisions to current operating procedures; others will be reliant on federal approval.

*This task is mission critical for decision-making to move reform efforts forward.*

**Task 26** (Dec 09 – Jan 10) and subsequently (Jun 10 – Sep 10) is where we develop and implement a stakeholdering plan to engage critical stakeholders in our work. Briefing materials on preliminary reform design details, including any draft legislative changes (**Task 27**) will be developed for the Project Lead

(and others) to engage in targeted discussions with the Governor, Legislature and key stakeholders as the 2010 Legislative session begins.

The outcome of these meetings and subsequent Legislative action will help in refining the ongoing stakeholdering plan for engaging low-income advocates, health care industry experts, and other health policy experts. Initially we plan one-on-one meetings with key stakeholders to garner “big-picture” support while details of our preliminary discussions with the Centers for Medicare and Medicaid Services (CMS) take shape. Once we have a clearer idea of what’s possible we plan a series of 6 meetings (one meeting in each of the DSHS regions supported by 3-4 key Project team members), to solicit public and advocacy input from around the state (including our tribal representatives). Planning of these meetings would occur in early summer for a late summer “road show”.

**Task 28** (Feb 10) is when our analysis, recommendations and preliminary stakeholdering come together in a draft concept paper to share with CMS in early March 2010. Our intent is to begin a 6-month dialog (**Task 29**) that will engage CMS in a back-and-forth conversation on the viability of our reform design - what they believe will be approvable, where additional analysis will be necessary, where there may be roadblocks – with a goal to uncovering and resolving issues before we begin the statewide public input meetings. This will be a comprehensive and complex reform package, so our objective is to obtain *verbal* agreement from CMS on the elements to increase our confidence (and efficiency) in drafting the full federal waiver application (**Task 30**) for submission to CMS in October 2010. Our APC consultants will be critical to the drafting of the concept paper and application, with support from project staff. We have planned this iterative process with CMS to ensure that any implications of Federal reform are known and incorporated in our project as soon as possible. It is also our intent to avoid a prolonged and challenging process by doing the upfront work to obtain CMS agreement before we do the complex crafting of the waiver application. We have employed this partnering approach in the past and found it better informs the later negotiation of final waiver approval and brings the expertise of CMS officials into our design process early on. **Task 31** (Oct 10 – Jan 11) is where we obtain agreement from CMS to move forward.

Task 28 will be built upon national health reform effects (tracked in Goal 4). For example, if national health reform is based on the Senate Finance Committee and Senate Health, Education, Labor and Pensions Committee proposals that employ a Medicaid expansion and health insurance exchange plus a subsidized model to cover low and moderate income persons, our Medicaid waiver would not include an expansion of Medicaid beyond the limits set in national reform. Instead, our waiver would request exemptions dealing with purchasing/payment, benefit design, and delivery system requirements that promote a more effective, efficient and evidence-based program to improve quality and **reduce the per-capita growth rate in Medicaid and CHIP expenditures**.

The focus of **Tasks 32** and **33** (Dec 10 – Jan 11) is progress reports to the Administration and Legislature. As in tasks 26-27 these could take the form of formal reports (e.g., if required by pending legislation), presentations at legislative committee work sessions or Executive branch meetings, or informal small group briefings. Regardless, we will target this period for updating Governor’s Office staff, the Legislature, and other Administration and Elected Officials.

**Task 34** (Jan 11 – Mar 11) is where details are known and come together for the Project Lead and Project Director(s) to obtain final Go-No Go implementation decisions on individual elements approved by CMS to proceed. Because of the extensive amount of stakeholder and briefing activities built into the project plan, we hope all the groundwork will have been laid and there will be no surprises at this point. However, as with everything, the devil is in the details and this is the point at which decision makers need to finally buy-off on the details. In addition, there may be aspects of procurement (e.g., will it follow standard public program processes) that influence the Go-No Go decision and need to be kicked into gear immediately. As a result, Task 34 also includes procurement readiness activities (e.g., potentially drafting/revising an RFP) and links with (**Task 35**) which is where enabling statute is passed to

implement waiver activities. This is also where detailed implementation planning occurs to define resource needs, timing, transition (as needs be) to seamless coverage for low-income populations now covered, and all elements of an operational plan that kicks purchasing and delivery system reforms into gear.

The success of the program now depends on the ability to continue to seamlessly include additional low-income populations into the program. Systems interventions (i.e., potentially an efficient eligibility interface) may be needed to support “seamless” coverage – this need would have been potentially identified early on when specific reform details were known. It is unlikely that a new front-end would be created until the details of Federal reform are known and their implications for current information systems understood. The phase-in of reforms will begin in **Task 36** (Jul 11) with regular reporting on progress and support from the Administration and Legislature occurring in the fall 2011 (**Task 37**). Revisions and ongoing support will be discussed as a precursor to the 2012 Legislative session. We would hope by that time that Washington’s economy is looking brighter, and federal reform direction is clear at the State level – we will have done everything imaginable by this time to be poised to take advantage of new opportunities for coverage expansion.

### ***Goal 3: Test Data Collection Infrastructure Improvements for Ongoing Coverage Evaluations***

Washington has a variety of routine efforts that support sub-state level data collection on critical characteristics of the population. Since 1998 we have conducted a bi-annual household survey<sup>24</sup> to gather comprehensive information about Washington’s regional demographic, insurance, and other characteristics. Ongoing patterns of individual insurance coverage typically are developed from this source. We also conduct a limited annual survey of employer benefits including sponsorship of coverage. This ties to the national Medical Expenditure Panel Survey data to provide trends in employer coverage over time in our annual Employer Health Insurance Databook. Both these sources contributed to the detailed needs assessment. However, while we are able to report changes in coverage at a high level, the link between employer and employee (*and their dependents*) to determine the impact of coverage interventions and project “off-year” estimates of insurance changes is limited. Goal 3 is about improving this data collection infrastructure.

In **Task 38** (pre-SHAP grant) we are confirming questions to be included in the 2010 survey (**Task 40**). To meet the operational deadlines we need to be pretty certain of the survey instrument before SHAP grant awards are actually made. As a placeholder to support potential “off-year” assessment of insurance coverage, and inform the evaluation of the impact of the HIP, we have included a question to solicit support to resurvey 2010 survey respondents. The timing of any follow-up (**Task 41**) mini-survey (approximately 10 questions) would be fairly good to see changes in insurance status at least at a high level and link those to demographic and other characteristics already collected. The opportunity to engage households in a follow-up survey might also allow us to dig deeper into the impact of the HIP. This goal is therefore about linking existing data collection opportunities with the evaluation of coverage expansion efforts, the evaluation of the HIP in particular (**Task 39/13**). To do this we will need to engage a variety of survey and quantitative measurement consultants in workgroup discussions with the Project Team to design a “template” for evaluating coverage expansions in the future.

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<sup>24</sup> Washington State Population Survey – [see www.ofm.wa.gov](http://www.ofm.wa.gov)

#### ***Goal 4: Link and Integrate Federal and State Coverage Reforms***

We have noted that our key SHAP project tasks are independent of Federal reform and would be pursued regardless. Nonetheless, the practical reality is that Federal reform of some sort is highly likely. We have therefore carved out **Tasks 42, 43, and 44** to emphasize the importance we place on taking note of changes, and being proactively ready to take advantage of reform when and if it happens. Already our project Goals 1 and 2 appear to dovetail with ideas bubbling to the surface of current conversations. Goal 3 pushes our interagency SHAP project team to track and monitor changes with implications for expanding the HIP to become a full exchange (e.g., for all non-large group coverage). The potential for far-reaching effect is one of the reasons we saw the need for the Governor's Policy Advisor to lead the SHAP project. While it isn't necessary for him to get into the nitty gritty details of day-to-day project activities, the importance his leadership places on the ongoing coordination of the project across multiple agencies cannot be overstated. In the arena of federal reform this will be critical, for (a) understanding the conceptual implications and recommendations for Washington adaptations and (b) defining specifics of operation-level changes to Washington public programs and the SHAP project. **Task 44** anticipates that years 4 and 5 of the SHAP grant will look very different when the time comes than we might imagine today. We have therefore included that task as a placeholder for continuing improvements in the effectiveness and efficiency of our systems and to be well along in the implementation of a high-performing seamless system of coverage for our low-income population.

#### ***Goal 5: Fulfill SHAP Grantee Commitments***

The four tasks (**Tasks 45, 46, 47, and 48**) of Goal 5 address our commitment to fulfilling HRSA's grantee requirements. Because we previously had SPG funding we clearly understand the commitments and are fully prepared to meet these obligations. Specifically, two members of the leadership trio, (i.e., the Project Lead and the two Project Directors) will attend and actively participate in the semi-annual grantee meetings in Washington D.C., (including pre-meeting planning sessions and preparation of meeting materials as needed) (**Task 45**); we will meet all progress, final, and financial reporting requirements using formats and schedules set by the HRSA Project Officer and supporting on-site performance review as needed (**Task 46**); we will cooperate in preparing progress and summary reports to the Secretary of HHS (including sharing materials and lessons, providing data, and assisting in review of products) (**Task 47**); and, we are happy to act as a resource to other states (grantee and non-grantee) and to organizations providing assistance to other states as our track record indicates we always do (**Task 48**).

#### ***WORK PLAN***

**Steps:** Activities and steps that will allow Washington to achieve the 5 broad goals of our SHAP grant project are described fully in the **Methodology** section of this proposal. A project management plan and Gantt Chart are included as Attachment 3.

**Governance of the SHAP grant:** A graphical representation of the organizational structure for Washington's SHAP project is included as Attachment 7, and described as follows:

The SHAP project team whose bios are included in the budget is a group with far reaching expertise in the public sector, the Legislature, and the private sector – team members cover the gamut on anything to do with health coverage policy. This is a strong team with long-term connections, historical memory, and a support network that runs deep into each agency and the Legislature. Three agencies are key:

- The Office of Financial Management, (OFM) – the agency that provides central policy and budget advice to the Governor and is Lead Agency for the SHAP project,

- The Health Care Authority (HCA) – the agency responsible for purchasing health care for public employees (through the Public Employees Benefits Board [PEBB] program) and the low-income working poor (through the state-only funded Basic Health program which contracts with private health plans and provides subsidized coverage, using an income-based sliding scale, to people up to 200 percent of federal poverty, not eligible for Medicare, and not institutionalized at the time of enrollment). The PEBB operates with key policy decision-making and guidance from a Board, a successful model that guides the HIP governance structure. The HCA is responsible for the design and implementation of the HIP.
- The Department of Social and Health Services, Health Recovery and Services Administration (DSHS-HRSA) – the State agency that administers Washington’s Medicaid and CHIP programs and is the lead for the overarching purchasing and delivery system reforms targeted in Goal 2.

**Lead Agency Role:** Beginning with the award of Washington’s first State Planning Grant in 2001, leadership for grant initiatives that *cut across multiple health agencies and require both independent and closely coordinated decision-making*, has typically been housed in OFM. This ensures close connection to the Governor and the ability to elevate and resolve policy issues that can appear to have a different face in different agencies with different missions. More practically, it maintains a single point of contact for coordinating regular fiscal and progress reporting through staff that has long-term experience in such tasks.

Having the Governor’s Executive Health Policy Advisor (who administratively falls under the OFM umbrella) designated as the SHAP Project Lead is a strategic step to ensure that Washington’s health reform efforts are coordinated, aligned with the Governor’s intent and directives, and “missteps” are avoided. In the trenches it can be easy to get tunnel-vision when limited resources are focused on targeted initiatives. The SHAP project governance has been carefully structured to take advantage of *State-level health reform planning* (through the Project Lead and Lead Agency); and *Agency-specific program implementation* (through the Project Director for each agency’s key activities.) In this way the SHAP project will maintain high visibility (and support) in Washington State and stay on a unified track.

**Stakeholdering:** The State Planning Grant project began in 2001 with a formal Management Oversight Panel that provided input and guidance to the project. We subsequently disbanded this formal group in favor of informal relationships, and ad hoc “advisor gatherings” planned around specific topics. For example, we had targeted policy and technical work groups that met to discuss a wide variety of data and policy challenges. With multiple responsibilities and limited time, people were able to be more responsive and engaged when not faced with long-term “standing meeting” commitments. We plan to continue this model, as the tasks in our project plan make clear. Where regular formal groups have been necessary and effective they will continue. For example:

- Through meetings of the Health A-Team, the Governor’s health policy oversight advisors and cabinet executives share the implications, issues, successes and strategies of key efforts. Meetings are chaired by the Governor’s health policy advisor, (i.e., the SHAP Project Lead). As a result, we can expect that a close watch on the progress of the project will be maintained at the highest policy level and in a setting for safe candid multiple agency exchange. This is the arena in which Federal reform implications will be shared and in which strategies for State-level health reform take conceptual shape. The Project Sponsors for the agencies responsible for day-to-day activities on Goals 1 and 2 are members of the Health A-Team. Opportunity for problem resolution that needs to be elevated has a natural vehicle for resolution where there is a cross agency implication.
- A seven-member Board of health benefits experts representing Washington state was established in statute to provide guidance and set policy for the HIP program. Prior to the suspension of the HIP, the Board was chaired by the Administrator of the Health Care Authority (HCA) and staffed by HCA employees. We would re-engage the Board as detailed in the work plan to complete decision-making

necessary for a highly successful implementation. The HCA Administrator would continue to chair meetings and staff support would naturally come from the HCA's SHAP Project team.

- A ten-member advisory committee will be established for decision regarding the Medicaid waiver. Ideally the committee will include the legislative chairs and ranking minority members of the legislative health policy committees, the Secretary of DSHS, the Assistant Secretary of HRSA (also the Project Sponsor), the HCA Administrator (also chair of the HIP Board), the Deputy Director for the Office of Financial Management, and the Director of the Governor's Policy Office. The Committee will advise and give final approval on the Medicaid concept paper and waiver application.

**Preparation of HRSA Reports:** Members of the SHAP team have successfully prepared and submitted multiple formal HRSA progress reports, several summarized progress reports as requested, and participated in supplying information and reviewing aggregated state reports compiled by the State Coverage Initiatives (SCI) program, State Health Access Data Assistance Center (SHADAC), and American Institutes for Research (Health Practice Group) on HRSA's behalf. The reporting process was helpful for tracking progress, evaluating lessons learned and polishing work products for updating stakeholders. Suitable components of each report were identified as grant tasks and activities progressed and some have since become routinely updated documents. *This process was effective in the past and would continue under the SHAP grant.* Production of the fiscal and operating reports are represented as a distinct activity and deliverable in the overall SHAP work plan to ensure that they are completed along with all other work as a condition of the grant. Specifically, Tasks 45 and 46 of the Project Management Plan speak directly to our monitoring and reporting obligations and processes.

Staff is very interested in sustaining an ongoing cooperative and collegial relationship with our HRSA colleagues and other SHAP program grantees and affiliates. State Planning Grant activities were highly valuable for strengthening connections between Washington and other states and for providing the occasion to share information, options, challenges and frustrations. We are committed to maintaining similar fruitful connections should we be awarded a SHAP grant.

In addition to completing the final report to the Secretary as requested, and other HRSA requests, we are also committed to supporting HRSA requests for the key data elements (e.g., total number of uninsured in Washington State and their characteristics) needed for HRSA's aggregated state reporting. Consistent with Washington's SHAP project governance structure, the lead agency will remain accountable for coordinating a Washington state response.

**SHAP Grant Monitoring** will occur through regular review of the Project Management Plan plus internal "action step" elements on more comprehensive project work plans that allow regular assessment of progress and adjustment as needed to ensure that the grant's goals and tasks are completed as planned. This will be vital as the HIP is implemented and interfaces with the purchasing and delivery system redesign and national reform strategies. The governance structure allows for multiple levels of monitoring – at the Health A-Team where State-level policy is discussed, and at the Agency-level where accountability for key individual goals resides.

Agency work plans will serve as gauges for project status – on Goal 1 and the implementation of the HIP, major milestone tasks (2, 9 and 16) will serve as early warnings if tasks are not on schedule. We are confident that what we have proposed can be successfully completed. However, we also recognize the need to remain flexible and adapt approaches and schedules accordingly to support decision makers' policy and data needs. If for any reason (e.g., unforeseen delay; radical change in environment) we feel a substantive change to the Project Management Plan is necessary we will work closely with designated federal program staff to ensure that revised activities are consistent with our overall project goals and tasks, and that SHAP funds are expended appropriately and effectively.

## ***RESOLUTION OF CHALLENGES***

As in most projects we see challenges in administrative, policy, stakeholdering, and fiscal areas. To some degree the SHAP project governance structure previously described has been established with resolution of *administrative* challenges in mind. We will not repeat those here.

The HIP authorizing legislation posed a number of complex *policy* and *stakeholdering* challenges, creating an exciting, albeit challenging environment. Many questions were successfully resolved working with the HIP Board's Technical Advisory Committee (TAC), stakeholders, and national experts, however, some of the more complex issues had to be deferred to meet the intended implementation deadline. We learned several valuable lessons on a broad array of challenges which include:

### **The need for early stakeholder engagement.**

Stakeholder involvement *prior to passage of the HIP's legislation* would have freed the HIP program team from spending precious months of implementation design bringing stakeholders to the table, educating them on policy goals of the program, provisions of the legislation, and gathering support. This would have saved considerable time and resources – hence we have planned for stakeholder engagement in SHAP project goals early on.

However, the original HIP project did demonstrate that disparate interests can constructively address the difficult issues facing our health care market (even in a highly political arena) *if* issues are faced head on, proactively resolved, and clear options for moving forward discussed openly. Finding consensus among stakeholders was often the most challenging component of implementation. However, by maintaining a transparent process and communicating regularly with stakeholders, the HIP staff ensured a fair and open process for determining program rules and recommending policies to the HIP Board.

This included the assembly of a Technical Advisory Committee comprised of representatives of insurance carriers, the agent and broker community, small employers, business interests, and the Office of the Insurance Commissioner. This diverse group, chaired by a carrier representative, offered recommendations to the HIP staff and Board regarding the program's scope, structure, and design.<sup>25</sup> This partnership helped build trust and goodwill between all of the interested parties and proved to be an invaluable resource for the HIP Board and staff. It will continue as a vehicle to ensure alternative viewpoints are aired and respected *before* legislative action is sought.

### **Engaging health insurance agents/brokers.**

The health insurance agent/broker community provided the HIP staff and the Board with the expertise and guidance of the producer community, specifically informing decisions around making the program more marketable to small employers. The HCA created a statewide representative group of interested producers to bring real-world experience to the HIP staff and Board - primarily that of small employers and micro-employers (10 employees or less) not currently offering health benefits and whose employees are low-wage. It is important to hear from the trenches – too often policy making occurs absent a complete real-world perspective. To be efficient the HIP needs to understand and address outstanding “real-world” issues – in addition to the open public HIP meetings we plan to “test” policy changes through employer and employee focus groups. This was invaluable to the initial program design – we expect it will help us identify outstanding issues and target marketing messages, *before* the HIP goes live.

### **Introducing limited reform into an existing regulatory framework.**

While the debate around a small business exchange in Washington began with the far-reaching concept of a “non-large group” connector, the authorizing HIP legislation had a narrower focus on small employers.

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<sup>25</sup> Meetings were held monthly and were open to the public.

The challenge it raised was in directing broad policy reform goals that left the current regulatory framework largely undisturbed. In addition, mechanisms for achieving the policy goals such as the rating of individual choice and portability were not limited. A tight timeline, however, left no time to fully explore options for select policy issues. Under the SHAP project the time element is less of an issue – we have carefully aligned the most reasonably doable activities with the goal of implementation in August 2010 - but the other balancing act remains. Ongoing public input will be essential to the success of the HIP.

**The difficulty of introducing limited reform into an existing regulatory framework is significant.**

The authorizing legislation had broad policy reform goals within the limits of the current regulatory framework. A very tight timeline did not allow the HIP Board to fully explore options for such important issues such as the rating necessary to achieve individual choice and portability within a small group market regulatory framework. The short time frame created uncertainty for regulators who interpreted their current responsibilities conservatively, the program team who was attempting to implement the program's goals, and participating carriers who were concerned with violating current regulations. Ultimately, the HIP was very successful in developing a workable infrastructure for enrolling employers and employees and distributing subsidies to eligible employees. In fact, not disrupting the current market infrastructure contributed to the buy-in of participating carriers and producers and would have provided HIP enrollees with a stable risk pool. HIP requested and received more time to address individual choice and portability for HIP participants after the initial implementation. When the HIP is continued, this challenge will require broad and ongoing stakeholder support and involvement.

**Selecting health benefit plans solely from existing small group market products.**

On the positive side, selecting health benefit plans that were already designed and marketed by the health carriers, and approved by the OIC, provided administrative simplicity, encouraged carrier participation, and satisfied the HIPAA regulation of guaranteed offer. Adversely, it eliminated the opportunity for introduction of more innovative and affordable plan designs that would be attractive to key business associations. When their efforts to promote limited health benefit plans did not result in supporting statute, some business representatives became somewhat resistant to the HIP and did not champion the original implementation. The economic context has changed, even in the last year, but nonetheless, it will be crucial to address these concerns assuming a SHAP grant is awarded to implement the HIP. Broad support from the small business community will be essential to the ongoing viability of the HIP.

**A mandate for Section 125 plans.**

One challenge we will address in pre-implementation activities is to minimize unintended administrative barriers. For example – participation in a Section 125 Premium Only Plan may negatively affect low-income 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 in light of its impact on low-income employees. We expect to address this unnecessary challenge through a legislative change that makes Section 125 Plans optional not mandatory.

**The great debate: will small employers who don't currently sponsor health insurance choose to do so – and if they do will their employees choose to take-up the offer?**

There is an ongoing debate in Washington between those who say that small employers who *can* offer health coverage to their employees do, but those who don't, *can't* (i.e., the affordability issue is too great for small business). The most effective way to address the ongoing challenge this poses to progress in our coverage expansion is to implement the HIP, test its effectiveness as a small business exchange, and rigorously evaluate the outcomes and reasons for them. Through this investigation, we will be able to inform political and fiscal dialog over the future expansion of the HIP in the context of Federal and/or other state reforms. In addition, based on the data we gather, we will be able to choose among several high-level paths:

- Grow the program with improvements in health plan offerings and other revisions that better meet the needs of small employers.
- Declare success, kill the program, and go back to the drawing board.
- Morph the program into the Federal and State reform efforts – this is the most likely outcome given what we know today, but a lot more needs to be known.

### **Sustainable Financing and Federal Reform.**

At this juncture in US history, sustainable *financing* is an enormous challenge for *every* state committed to developing a health system that offers affordable, available, and adequate health insurance to all its residents. The options we hear discussed by other states for increasing revenue sources are options we've at least entertained and adopted or discarded years ago. For example, since **1993**:

- Non-profit and public hospitals have been required to pay a Business and Occupation tax. Placed on entities doing business in Washington State, the tax is a fixed percentage based on industry type and is applied to the business's gross income.
- A health carrier premium tax of 2.0% is applied to health maintenance organizations, health care service contractors, and self-funded multiple employer welfare arrangements for premiums and prepayments for health care services received during the prior calendar year.

Our track record indicates we've been among the leaders in looking for ways to expand coverage but while the recovery of our economy is uncertain we cannot responsibly *commit* to sustainable financing on expansion initiatives five years from now. No one can. We do have a plan however.

We know our economy will improve. We also know that Federal reform is likely. When they happen our challenges will be lessened. Unfortunately, actual *implementation* details on Federal reform, at a level that informs *operational* State action are not realistic for at least another 1-2 years. In the meantime, as our Governor and Legislature have clearly said, we cannot sit idle. As we implement incremental steps to increase access to coverage, the most difficult issues are left to be "addressed"<sup>26</sup>. Even *if* we could get all eligibles enrolled in public programs, leverage public and private dollars to maximize employer-based coverage, and make benefit products more affordable,<sup>27</sup> we still would not have addressed the problem of "poor quality health care" that is chiefly responsible for our financial woes<sup>28</sup>. That is an ongoing challenge.

Our SHAP project proposal is an important element in helping us at a time when we most need it. It resolves the convergence of sustainability, economic recovery, and Federal reform challenges in the following ways:

- The HIP stands on its own merits, designed to be implemented and carried forward independent of Federal reform, expanding coverage in partnership with small business;
- Our explicit goal of tracking and proactively coordinating Federal reform with our State reform initiatives will allow us to reshape our plans promptly as the State's economy improves;
- Most importantly we have elevated our attention to revamping our broad array of public programs towards more seamless and efficient coverage for Washington's low-income population. No matter what happens at the Federal level this is essential to the sustainability of coverage expansion in the future.

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<sup>26</sup> Some think of this in terms of "solving" the issue of access to coverage, we prefer to couch it in terms of "managing" our way through a health care system that is constantly changing in response to financial, demographic, technological and other forces.

<sup>27</sup> Skinnying products down to primary and preventive care only, catastrophic only, or stripping out mandates doesn't appear to result in products that are attractive in the short run and the costs don't go down much in the long run anyway. Subsidizing products through various mechanisms takes us immediately back to the unsustainability of current public financing sources.

<sup>28</sup> Estimates vary, but a best guess from research to-date is that we spend in the neighborhood of 25-30 cents of every direct health care dollar for the costs of poor quality health care (i.e., overuse, misuse, and underuse of care).

**EVALUATION AND TECHNICAL SUPPORT CAPACITY**

Experience and qualifications of project team members and brief bios are included in the Staffing Plan and Personnel section of the application. Here we include an explanation of why project team members have been chosen. This is a very strong team whose members have worked together on many different projects for years; sometimes in large groups; sometimes just 1-2 at a time. They have amassed well over 120 years of public service in the health care arena and have a respected track record of hard work. And they have worked in different agencies over the years so many of them know each other’s working environments as if they were still there. The team is not only ready to roll; members work together on a regular basis already.

As an aside – while it may seem “mushy”, it is a testament to the team and the State that the same players want to re-engage in implementing the HIP and making continued improvements in purchasing and delivery systems. *No one* has given up, in spite of the economic challenges that directly impact their work daily. This is a passionate and committed group!

Agency/Person	Relevant Experience and Fit to the Project
<p><b>OFM:</b> Jonathan Seib – Project Lead</p> <p>Jenny Hamilton</p> <p>Erica Gardner</p>	<p>As the Governor’s Policy Advisor and the previous lead staff to the Senate Health and Long-term Care Committee, Jonathan facilitates communication between Executive and Legislative branches and brings high-level attention and visibility to the project. i.e., he ensures its success.</p> <p>As a prior senior analyst on Washington’s SPG team, Jenny’s familiarity with the HRSA requirements simplifies coordination of multiple agency reporting. Her experience working with other team members on various multi-agency, coverage-related projects supports the multi-agency collaborative effort.</p> <p>Erica has intimate knowledge of the Washington State Population Survey – her expertise in managing the survey and its consultants for the past 3 cycles maximizes the likelihood that data collection in support of coverage measurement will succeed.</p>
<p><b>HCA:</b> Beth Walter – Project Director</p> <p>Michael Arnis</p> <p>Richard Onizuka (Project Sponsor)</p>	<p>Beth directed the initial development of the HIP – she knows all the players, was well respected as a collaborative leader in that effort, and is the ideal person to pick up and carry on the actual implementation of the HIP.</p> <p>Michael’s expertise across State agencies makes him a natural fit for a multi-agency project. He already has a working relationship with everyone and with many of the critical industry stakeholders from his role in leading the Insurance Commissioner’s Task Force and reinsurance-related studies.</p> <p>As a member of the Governor’s Health A-Team Richard is engaged in ongoing discussions re health reform initiatives. He is accountable for several innovative initiatives to improve the health care delivery system, most of these in collaboration with other agencies. He too knows all the players.</p>
<p><b>DSHS-HRSA:</b> Roger Gantz – Project Director</p> <p>Dia Tornatore</p> <p>Doug Porter (Project Sponsor)</p>	<p>Roger has extensive knowledge and experience of public policy for low-income populations – he has been engaged in inter-agency collaborations on public programs for many years; is a member of the Health A-Team; knows all the players; has a working relationship with the Federal government. He is integral to the project’s success.</p> <p>Dia is Roger’s right hand. She too has expertise in low-income population public programs that cuts across states. She brings expertise on Medicaid programs and a strong set of analytic skills to the project as staff support.</p> <p>As a member of the Governor’s Health A-Team and the National Association of State Medicaid Directors’ Executive Committee, Doug participates in the design and implementation of national and state health reform initiatives. The Director of the Medicaid program, he has been a constant voice for increasing efficiencies and a supporter of innovations that improve purchasing and delivery systems – in Washington and other states. Doug has an extensive network of Medicaid officials at the regional and national level.</p>

**ORGANIZATIONAL INFORMATION**

To explain the governance structure of the proposed SHAP project, shown graphically in Attachment 7, information requested on key organizations involved was described in the Work Plan under “Governance of the SHAP Grant”. The following elaborates on this with brief descriptions of the anticipated consultant team and its expertise. Experts who have agreed to participate in the SHAP project (pending agreed-upon contracts if Washington receives an award since we legally cannot commit to anyone in the absence of an award) are as follows:

Consultant Name	Primary Role and Expertise
Harrington Health	<p><b>Role:</b> Third Party Administrator for the HIP program.  <b>Expertise:</b> Previously engaged to support the HIP program planned for implementation in March 2009 they have significant resources and expertise in serving small employers - collecting premium contributions from employers and employees, processing premium subsidies to employees, and maintaining confidentiality of employee subsidy transactions. They understand how to keep processes flexible and in compliance with small group regulations.</p>
Milliman	<p><b>Role:</b> Actuarial consulting on policy impact analysis for the HIP implementation and the purchasing/delivery system seam coverage redesign, application systems quality assurance testing for the HIP administration, employer/employee focus group follow-up  <b>Expertise:</b> Comprehensive actuarial and policy investigation on all public programs.</p>
University of Washington	<p><b>Role:</b> qualitative and quantitative outcomes evaluation planning and findings  <b>Expertise:</b> UW researchers have worked closely with each of the agencies on many quantitative and qualitative investigations over years – development of the original PEBB risk adjustment model, design of the HIP (as a member of the Board), evaluation of shared-decision making pilots, SPG consortium efforts targeting an “affordability” policy/economic model, reinsurance policy design peer-review, and have chaired task forces on Certificate of Need, Strategic Health Planning. Their experience is enormous.</p>
Gilmore / Westat Consulting	<p><b>Role:</b> Design and fielding of the Washington State Population Survey (contracts in place) and follow-up survey as needed  <b>Expertise:</b> Gilmore has been contracted to conduct the biennial Washington State Population Survey since 2004. Westat Consulting provided heavy-duty technical assistance to improve the 2008 survey with respect to non-response bias, weighting, and other issues and enable linkage back to prior surveys to determine trends.</p>
Arcadia Point Consulting	<p><b>Role:</b> Coordinate the design of the waiver, including: assisting with defining the CMS concept paper and producing the federal waiver application; facilitating the “visioning” retreats and analytic plan; facilitating meetings with stakeholders and the Advisory Committee.  <b>Expertise:</b> Arcadia has extensive background and knowledge of Washington’s insurance markets, state health reform initiatives and the state’s low-income coverage programs. Arcadia supported Washington’s Blue Ribbon Commission on Health Care Costs and Access. Arcadia conducted analysis and prepared a report for HCA and DSHS on payment reforms to support medical homes; facilitated a series of legislative/ stakeholder meetings for DSHS; and prepared a report on approaches for public program and employers to provide coverage for low-wage employees. Arcadia reviewed and provided input to Mathematica, Inc. on modeling health insurance partnerships under contract with the Washington State Legislature.</p>